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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GX68

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245499**

2. STATE VENDOR OR MEDICAID NO. (L2) **190176100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CALEDONIA CARE AND REHABILITATION CENTER**
(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

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) **07/01/2004**

6. DATE OF SURVEY **8/29/2017** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Kyla Einertson, HFE NE II 9/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/11/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245499
September 8, 2017

Mr. Larry Passel, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

Dear Mr. Passel:

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

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

Effective August 15, 2017 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
September 8, 2017

Mr. Larry Passel, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

RE: Project Number S5499024

Dear Mr. Passel:

On July 25, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 30, 2017. (42 CFR 488.422)

In addition, on July 25, 2017, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies being imposed:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on July 6, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On August 29, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 9, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on July 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 15, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 6, 2017, as of August 15, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 15, 2017.

However, as we notified you in our letter of July 25, 2017, 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 July 6, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of July 25, 2017:

- Civil money penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GX68

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(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

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) **07/01/2004**

6. DATE OF SURVEY **07/06/2017** (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

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To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Vicky Hamersma, HFE NE II 08/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/07/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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01-Merger, Closure
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04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted
July 25, 2017

Mr. Larry Passel, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

RE: Project Number S5499024

Dear Mr. Passel:

On July 6, 2017, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate

jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 2, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

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

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective July 30, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Caledonia Care And Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 6, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

Failure to submit an acceptable 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 PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 6, 2017 (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 6, 2018 (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.

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	07/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

(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 A survey was conducted by the Minnesota Department of Health on June 26, 2017 through July 6, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to develop interventions to minimize the risk of injuries and accidents related to independent wheelchair mobility out of the facility for resident. The IJ began on 6/24/16, when staff observed the resident wheeling back to facility in the road and after dark was at immediate risk for injury or death. The Administrator, director of nursing and area manager were notified of the IJ on 6/30/17 at 11:40 a.m. The IJ was removed on 7/2/17, at 4:00 p.m. when the facility implemented interventions including assessing the residents safety, educating staff, implementing a safety contract with the resident, and ultimately discharging the resident from the facility. An extended survey was conducted by the Minnesota Department of Health from June 30, 2017 through July 6, 2017. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/03/2017

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
	245499	A. BUILDING _____ B. WING _____	07/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

(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 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean and sanitary environment for 10 of 10 resident (R9, R14, R18, R28, R33, R35, R42, R43, R55 and R61) rooms in good repair for residents comfort. Findings include: On 6/27/17, during stage one observations of resident rooms, several bathrooms and residents' rooms were noted to be unsanitary and or in disrepair. R28, R43 and R9's shared bathroom was noted to have a strong urine odor, and a ceiling tile with large brown stain and vent with thick dust. R14's shared bathroom was noted to have a strong urine odor, bathroom floor had debris thru out, and an incontinent product was in the bathroom wastebasket. The inside bathroom doorframes had missing paint. R42's private bathroom was noted to have a dark substance smeared on toilet. R18's room was noted to have dirty windows, feces in bathroom on the toilet and wall and the commode. R55's room had multiple scratch marks on walls. R61's room had dark black marks on the wall, heat register, along with peeling wallpaper. R35's head of bed wall was noted to have large paint scrapes on the blue wall with red paint showing through. On 6/27/17, at 1:15 p.m. during an interview R33	F 253	It is a policy at Care and Rehab Caledonia to provide maintain a sanitary, orderly, and comfortable environment. R9, R14, R18, R28, R33, R35, R42, R43, R55, and R61 sustained no ill effects from a lack of clean environment. A clean environment will be monitored by ridding of our universal worker program. We will establish a regular housekeeping department. Housekeepers will have daily routines during their work days, including checklists for daily light resident room cleanings and weekly deep resident room cleanings. Housekeeping will also be responsible for daily cleaning of the common areas and public restrooms. The facility will conduct Clean Environment audits. These audits will be performed in the following manner: one (1) hall per day for two (2) weeks, then each hall weekly for six (6) weeks, then random audits thereafter. Administrator or designee will be responsible for compliance. In response to room repairs, the following will be implemented. Windows will be cleaned regularly and logged. Vent cleaning to be completed by maintenance every six (6) months and logged with a completion date. All resident rooms will be	8/15/17

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F 253	Continued From page 2 stated the bathrooms are not clean and added, "I never see anyone cleaning them." On 6/27/17, at 9:03 a.m. during interview nursing assistant (NA)-F stated that NAs assigned to the residents are to clean the bathrooms. On 6/27/17, at 10:01 a.m. R18 stated, "I just clean my bathroom myself as staff don't get to it." On 6/29/17, at 10:20 a.m. during the environmental tour with environmental services manager (ESM), R28's shared bathroom vent was noted to be covered in very thick dust, and continued to have urine odor, and to have a stained ceiling tile above sink and toilet. R35's room was observed to have paint scrape marks on the blue wall with red paint showing 4-5 egg size areas with red paint showing. R61's room had peeling wallpaper, also black scrape marks on the walls and heat radiator. ESM stated that he does not have a maintenance routine where he goes and checks rooms for need repairs. ESM also stated that they have been using universal workers, but have just recently started to go away from them and started hiring housekeepers again. During interview with administrator at 10:35 a.m. on 6/29/17, regarding concerns found with environment, the administrator stated that they have just started to move from universal workers and having housekeepers again. The administrator added, "We increased the housekeeping hours. Hired back a full time supervisor and have hired a full-time housekeeper so far they are the only two in housekeeping."	F 253	checked for needed repairs including but not limited to missing paint, peeling wallpaper, and scuff marks on the walls. A log will be kept of all needed repairs with a completion date documented. Maintenance will perform monthly room checks for any maintenance repairs thereafter. Administrator or designee will be responsible for compliance. The results of this plan of correction will be reported to the QAPI committee for review and further recommendations. Upon review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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F 253	Continued From page 3 On 6/29/17, at 11:00 a.m. ESM handed writer a piece of paper with hand written note stating that vents and ducts were scheduled for cleaning May 10, 2017, with a "not done" written behind it and not scheduled again until November 2, 2017. He stated that he was coming early on 6/30/17 to clean vents. Also received a typed housekeeping schedule with a Caledonia Care and Rehab requisition for repairs stapled to it which indicated daily cleaning of resident rooms, which includes bathrooms.	F 253		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 279		8/15/17

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F 279	Continued From page 4 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care plan was developed for 1 of 2 residents (R27) who was on anticoagulation therapy reviewed for unnecessary	F 279	It is a policy at Care and Rehab □ Caledonia to access and develop, review, and revise the resident comprehensive plan of care, to attain or maintain the	

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F 279	Continued From page 5 medications. Findings include: R27 had diagnoses including cerebral infarction, type 2 diabetes and muscle weakness (generalized), obtained from physician orders printed 6/28/17. R27's care plan with a print date of 6/28/17, indicated resident had a previous stroke that effected his left side. The care plan however, did not address resident was on Coumadin and the side effects and/or adverse reactions staff were to monitor for. R27's Physician Orders dated 6/23/17 indicated the resident had the following orders: -Warfarin Sodium (Coumadin-used to treat or prevent blood clots in veins or arteries) 5 milligram (mg) one time a day every Monday. -Warfarin Sodium 7.5 mg six times a week, one time a day every Saturday, Sunday, Tuesday, Wednesday, and Thursday. On 6/29/17, 10:22 a.m. the director of nursing verified the care plan did not address Coumadin use and did not have the side effects of the medication listed anywhere in the care plan. The DON stated expected a care plan to be developed for the use of the Coumadin to include monitoring for bruising and bleeding. On 6/29/17, 5:08 p.m. the interim director of nursing (IDON) stated R27's admission orders indicated R18 was on Coumadin upon admission to the facility on 8/8/16. A policy and procedure was requested for	F 279	resident medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. R27 had no ill effects from his Coumadin being omitted from his care plan. MDS/RN was educated on completing and updating care plans per the RAI manual. Care plans will be monitored by the following: audits of four (4) care plans per week until all care plans reviewed, then reviewed quarterly thereafter per the RAI manual. All new admissions will have their comprehensive care plan brought to IDT for review. The Director of Nursing or designee will be responsible for ensuring compliance. The results of this plan of correction will be reported to the QAPI committee for review and further recommendations. Upon review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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F 279	Continued From page 6 development of a care plan and was not provided.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 record review, the facility failed to follow the care plan to provide assistance for 1 of 1 resident (R14) assessed to need assistance with nail care. In addition the facility failed to ensure assistance with grooming of facial hair was provided according to the plan of care for 2 of 4 residents (R38, R18) reviewed for activities of daily living. Findings include: LACK OF NAIL CARE: R14's annual Minimum Data Set (MDS) dated 5/24/17, identified the need for extensive assist with personal hygiene and grooming. R14's Care Plan dated 8/13/14, indicated a self-care deficit related to mild cognitive impairment and decreased mobility. Needs extensive assist with grooming. R14's CNA Assignment Card dated 6/28/17, indicated that resident is unable to participate in	F 282	It is a policy at Care and Rehab Caledonia for staff to provide ADL care based on assessments and comprehensive care plan. R14, R38, and R18 had no ill effects from their ADL care plan not being followed. Care audits were developed to ensure proper hygiene and overall ADL cares are completed properly. The audits will be completed in the following manner: daily for two (2) weeks, then two (2) times per week for two (2) weeks, then weekly for two (2) weeks, then random thereafter. New CNA care plans will be developed based on the current comprehensive care plan. CNA care plans will be updated according to any change made on the comprehensive care plan. CNAs were also reeducated on documenting refusal of cares when charting.	8/15/17

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F 282	Continued From page 7 upper body activities of daily living (ADLs) related to diagnosis of hydrocephalus evidenced by the need of 1 assist for ADL's. R14's undated, "Daily Bath Schedule" identifies R14 receives a bath on Tuesday evenings and Fridays mornings. R14's last scheduled bath was documented on 6/27/17, at 10:25 p.m., dependent + 2 physical assist, shower given, hair shampooed. On 6/26/17 at 7:47 p.m., R14 observed to have long fingernails on both hands, with brown debris noted under the nails. On 6/27/17, at 12:31 p.m., R14 sitting in broad chair in the south wing common area and observed to have long fingernails, with brown debris underneath the nails on the left hand. On 6/28/17, at 12:40 p.m., R14 sitting in broda chair on the south wing and fingernails on both hands continue to be long, brown debris remain under left hand fingernails. During interview on 6/28/17, at 1:21 p.m., Nursing Assistant (NA)-I verifies that R14's nails are long and that there is brown debris underneath the left fingernails. NA-I further stated that nail care should be done on resident bath days. NA-I expectation would be to clean and trim nails on bath days and as needed. During interview on 6/28/17, at 2:20 p.m., NA-D verifies R14's fingernails are long and brown debris are under the fingernails on R14's left hand. NA-D further verified resident had a shower last night and nail care should have been done.	F 282	The Director of Nursing or designee will be responsible for ensuring compliance. The results of this plan of correction will be reported to the QAPI committee for review and further recommendations. Upon review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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F 282	Continued From page 8 NA-D stated, "Still has dirt in his nails after his shower!" During interview on 6/28/17, at 2:23 p.m., Licensed Practical Nurse (LPN)-A verifies R14's fingernails are long with brown debris under left fingernails. LPN-A further verified fingernails should have been clipped and trimmed with R14's shower last night. During interview on 6/28/17, at 2:26 p.m., Interim Director of Nursing (IDON) verified R14's fingernails are long and there is brown debris under fingernails on left hand. IDON stated R14's fingernails should have been cleaned and trimmed with the shower last night. A policy for following the care plan was requested, no policy received. LACK OF FACIAL GROOMING: R38's Minimum Data Set (MDS) dated 5/3/17, identified R38 to have severe cognitive impairment and required 1 person extensive assist with grooming. R38's Care Plan dated 12/16/15, identified R38 with Dementia and required extensive assist of 1 with grooming related to Dementia and decreased mobility. The care plan identified an approach of "Grooming with extensive assist of 1." R38's CNA Assignment care dated 6/28/17, identified R38 extensive assist of 1 with grooming. On 6/27/17, at 1:20 p.m., R38 was observed unshaven yesterday and again today.	F 282		

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F 282	Continued From page 9 On 6/27/17, at 4:08 p.m., R38 was sitting in the south wing common hall, observed to have long, thick dark hairs noted on upper lip. During interview on 6/28/17, at 7:15 a.m., R38 stated she could use some help with shaving the hairs off of upper lip. On 6/28/17, at 7:16 a.m., R38 sitting in her wheelchair, continues to have long, black hairs on upper lip. On 6/28/17, at 1:02 p.m., R38 sitting in her wheelchair in the hallway. Long, black hairs remain on R38's upper lip. During interview on 6/28/17, at 1:26 p.m., Nursing Assistant (NA)-I verified R38 did have long, black upper lip hairs and should be shaved every day to help with resident dignity. Further verified R38 needs extensive assist with grooming. During interview on 6/28/17, at 2:04 p.m., Registered Nurse (RN)-B verified that R38 does have long, dark hairs on upper lip that should have been shaved. Further stated residents should be checked every morning if they need to be shaved, "it's a part of morning cares." During interview on 6/28/17, at 2:09 p.m., Interim Director of Nursing (IDON) verified R38 having long, dark hairs on upper lip and should be shaved every morning. R18 was observed on 6/27/17, at 9:25 a.m. to be eating breakfast in the dining room. R18 had several short facial hairs across her chin and patches of 3 to 4 millimeters long facial hair around her upper lip.	F 282		

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R18 was observed on 6/29/17, at 8:25 a.m., to be eating breakfast in the dining room and the facial hairs on her chin and upper lip remained.

R18's quarterly Minimum Data Set (MDS) dated 5/3/17, identified R18 required extensive assist of one for personal hygiene.

R18's CNA ASSIGNMENT CARD included, "remove facial hair as needed on chin and upper lip or as she allows."

R18's care plan with a print date of 6/28/17, included, R18 required extensive assist of one for grooming.

R18 was observed during morning cares on 6/28/17, at 9:27 a.m. with NA-F and NA-G. Morning cares were completed without offering to shave R18's facial hairs.

During an interview on 6/28/17, at 3:30 a.m. with family member (FM)-A stated prior to R18 having dementia the facial hair would have bothered her mom. FM-A stated she stopped voicing her concerns to the facility about R18's facial hair because it did not make a difference. FM-A stated I just shave R18 when I am here and she needs to be shaved. FM-A verified R18 had facial hair around her chin and upper lip.

During an interview on 6/29/2017, at 9:48 a.m., trained medication assistant (TMA)-B stated she looked at facial hair of residents' every day when providing cares. TMA-B stated we have a few residents that we shave on a regular basis and this included R18. TMA-B stated I always shave R18 two to three times a week. I always make sure it is done before her daughters come, but I

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F 282	Continued From page 11 do not provide cares for her every day. I just try to have her looking nice for her daughters when they come. TMA-B stated R18's daughter used to do the shaving when she visited more often, and now that she visits on Wednesday, I have taken the shaving over. During an interview on 6/29/17, at 10:03 a.m., the director of nursing (DON) stated facial hair should be monitored every morning with cares and stated should provide shaving as needed. The DON stated when the staff chart under grooming or hygiene they can put in a note and I would expect them to write in there the resident refused shaving. The Don stated staff should still offer to shave a resident even if they refuse every time, it should still be offered. During an interview on 6/29/17, at 10:11 a.m., the DON completed an observation of resident. The DON stated R18 definitely needed to be shaved as she had facial hair. The DON described R18's facial hair as patchy on her upper lip, was white in color, and stated it was approximately 3 to 4 millimeters long. The DON also stated she noticed a little bit of facial hair along her chin. The DON verified the facility did not follow the care plan to shave R18's facial hair as she allowed. A policy and procedure was requested for following the care plan, and none was provided.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the	F 309		8/15/17

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F 309	Continued From page 12 facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor bruising for 1 of 3 residents (R18) reviewed for non-pressure related skin concerns. Findings include:	F 309	It is a policy at Care and Rehab Caledonia to provide care and services for the highest wellbeing to maintain quality of life. R18 had no ill effects from incident report not being completed on a bruise. Licensed staff were reeducated on	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 R18 was observed on 6/27/17, at 9:27 a.m. with a bruise on her left wrist area. R18's record did not reflect identification or monitoring of this bruise. Quarterly Minimum Data Set dated 5/3/17, identified her as being cognitively impaired. R18's progress notes were reviewed from 6/1/17 to 6/29/17, and the documentation did not reflect identification or monitoring of the bruise. R18's physician orders included aspirin 81 milligrams (mg) tablet, give 1 tablet by mouth daily for hypertension. R18's current electronic care plan did not address R18 was at increased risk for bruising related to the use of aspirin. R18's current CNA (certified nursing assistant) ASSIGNMENT CARD included, "Report changes to nurse regarding skin or comfort." During an interview on 6/28/17, at 9:50 a.m. nursing assistant (NA)-G stated when assisting residents with bathing in the morning, you are monitoring skin for any changes. NA-G stated she reported any changes to the nurse right away. During an interview on 6/29/17, at 9:46 a.m. trained medication aide (TMA)-B stated every day when they assist residents with bathing they look at their skin and would call the attention of a bruise to the charge nurse right away. TMA-B stated the nurse completed a full skin assessment weekly on bath day. During an interview on 6/28/17, at 3:30 p.m. family member (FM)-A stated R18 gets a lot of	F 309	filling out incident reports for such events. CNAs were reeducated on observing skin daily with cares and reporting to licensed staff any alterations in skin integrity. Care and Rehab □ Caledonia will create a policy on performing weekly skin checks of all residents. Audits of the process will be completed in the following sequence: daily for two (2) weeks, then once weekly for two (2) weeks, then monthly for ninety (90) days. The audits will include a review of the nurses notes from the day prior, focusing on the weekly skin checks to ensure they were completed and the appropriate follow up was completed with any new skin issues. The Director of Nursing or designee will be responsible for ensuring compliance. The results of this plan of correction will be reported to the QAPI committee for review and further recommendations. Upon review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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	245499	A. BUILDING _____ B. WING _____	07/06/2017

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F 309	Continued From page 14	F 309		

bruises and verified the bruise on her left wrist.

During an interview on 6/29/17, at 8:33 a.m. registered nurse (RN)-C stated R18 was on aspirin and was at increased risk for bruising. RN-C stated skin was monitored for bruising with daily cares and the licensed nurse completed a skin check on bath day. If a bruise was observed, they (nursing assistants) are to inform the nurse, the nurse goes and looks at it and tried to determine what would have been the cause. RN-C stated the nurses would check every week to see if the bruise was still there when the nurse completed the weekly skin check.

During an interview on 6/29/17, at 9:59 a.m. the director of nursing (DON) stated she would expect the NAs to be monitoring residents' skin daily during cares and to notify the nurse immediately if they see something. The DON stated expected the nurse to monitor skin weekly on bath day, when they complete skin assessment. The DON stated she expected the nurse to look at the bruise, measure it, complete an incident report and they are supposed to notify the DON, physician and family. They review the bruise for possible vulnerable adult and would expect the bruise to be monitored until healed.

On 6/29/17, at 10:11 a.m. the DON verified through observation R18 had a bruise on her lower left wrist and stated she thought the bruise looked pretty new. The DON stated the bruise was bluish and purple in color. The DON stated there was not an incident report made related to the bruise and confirmed there was no documentation in the progress notes or weekly skin assessment note that was completed on her bath day on Tuesday (6/27/17) related to the

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F 309	Continued From page 15 bruise. The DON stated absolutely she would have expected staff to have noticed this bruise and have reported it. The DON also stated she would have expected the skin assessment that was completed on Tuesday to have included the bruise on her wrist. The DON verified the care plan did not address R18 was at increased risk for bruising. The DON stated R18 was on aspirin and was at increased risk for bruising and stated she would have expected a care plan to be developed for increased risk for bruising related to aspirin use. The DON confirmed the staff did not follow the facility policy to complete an incident report and monitor the injury for healing. R18's progress note completed by the DON dated 6/29/17, at 11:38 a.m. included, "Bruise noted to left dorsal wrist measuring 6 cm [centimeters] x 3.5 cm. Bruise is dark purple in color. Bruise was identified by the state surveyor Tuesday, June 27th at 0927. There was a skin assessment documented by [RN-D] on 6/27/17 as well with nothing documented on bruising. I called [RN-D] to ask him about the bruising and he stated he did not see the bruise when he did his assessment. I have spoke with other staff working the floor and they have also not seen the bruising." Review of the Documentation, Acute Charting Log policy dated 6/2017, included, "Procedure: The Charge Nurse will place resident on the "to do list" In ESC [facility electronic medical record] for furthering monitoring needs & documentation for the following reasons: ...3. Incident/accident x 72 hours. Injury will be monitored until resolved ..."	F 309		
F 312	483.24(a)(2) ADL CARE PROVIDED FOR	F 312		8/15/17

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F 312 SS=E	Continued From page 16 DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance for 1 of 1 resident (R14) assessed to need assistance with nail care. In addition, the facility failed to ensure grooming needs (facial hair removal) was provided for 2 of 4 residents (R38, R18) reviewed who were dependent upon staff assistance with activities of daily living (ADL). Findings include: LACK OF NAIL CARE: R14's annual Minimum Data Set (MDS) dated 5/24/17, identified the need for extensive assist with personal hygiene and grooming. R14's care plan dated 8/13/14, indicated a self-care deficit related to mild cognitive impairment and decreased mobility. Needs extensive assist with grooming. R 14's Certified Nursing Assistant (CNA) Assignment Card dated 6/28/17, indicated that resident is unable to participate in upper body ADL's related to diagnosis of hydrocephalus evidenced by the need of 1 assist for ADL's. R14's undated, Daily Bath Schedule identified R14 received a bath on Tuesday evenings and Friday mornings.	F 312	It is a policy at Care and Rehab Caledonia for staff to provide ADL care for dependent residents. R14, R38, and R18 had no ill effects from their ADL care plan not being followed. Care audits were developed to ensure proper hygiene and overall ADL cares are completed properly. The audits will be completed in the following manner: daily for two (2) weeks, then two (2) times per week for two (2) weeks, then weekly for two (2) weeks, then random thereafter. New CNA care plans will be developed based on the current comprehensive care plan. CNA care plans will be updated according to any change made on the comprehensive care plan. CNAs were also reeducated on documenting refusal of cares when charting. The Director of Nursing or designee will be responsible for ensuring compliance. The results of this plan of correction will be reported to the QAPI committee for review and further recommendations. Upon review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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F 312	Continued From page 17 R14's last scheduled bath was documented on 6/27/17, at 10:25 p.m. and dependent with 2 physical assist for shower given, hair shampooed. On 6/26/17, at 7:47 p.m. R14 observed to have long fingernails on both hands, with brown debris noted under the nails. On 6/27/17, at 12:31 p.m. R14 sitting in Broda chair in the south wing common area and observed to have long fingernails, with brown debris underneath the nails on the left hand. On 6/28/17, at 12:40 p.m.. R14 sitting in Broda chair on the south wing and fingernails on both hands continue to be long, brown debris remain under left hand fingernails. During interview on 6/28/17, at 1:21 p.m. nursing assistant (NA)-I verified that R14's nails were long and that there was brown debris underneath the left fingernails. NA-I further stated that nail care should be done on resident bath days. NA-I's expectation would be to clean and trim nails on bath days and as needed. During interview on 6/28/17, at 2:20 p.m. NA-D verified R14's fingernails were long and brown debris were under the fingernails on R14's left hand. NA-D further verified R14 had a shower last night and nail care should have been done. NA-D stated, "Still has dirt in his nails after his shower." During interview on 6/28/17, at 2:23 p.m. licensed practical nurse (LPN)-A verified R14's fingernails were long with brown debris under left fingernails. LPN-A further verified fingernails should have	F 312		

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F 312	Continued From page 18 been clipped and trimmed with R14's shower last night. During interview on 6/28/17, at 2:26 p.m. interim director of nursing (IDON) verified R14's fingernails were long and there was brown debris under fingernails on left hand. IDON stated R14's fingernails should have been cleaned and trimmed with the shower last night. A facility policy for nail care was requested and one was not provided. LACK OF FACIAL GROOMING: R38's MDS dated 5/3/17, identified R38 to have severe cognitive impairment and required 1 person extensive assist with grooming. R38's care plan dated 12/16/15, identified R38 with dementia and required extensive assist of 1 with grooming related to dementia and decreased mobility. The care plan identified an approach of "Grooming with extensive assist of 1." R38's CNA Assignment care sheet dated 6/28/17, identified R38 required extensive assist of 1 with grooming. On 6/27/17, at 1:20 p.m. R38 was observed unshaven with long hairs on upper lip. On 6/27/17, at 4:08 p.m. R38 was sitting in the south wing common hall, and observed to have long, thick dark hairs noted on upper lip. During interview on 6/28/17, at 7:15 a.m. R38 stated she could use some help with shaving the	F 312		

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F 312	Continued From page 19 hairs off of upper lip. On 6/28/17, at 7:16 a.m. R38 was observed sitting in her wheelchair, and continued to have long, black hairs on upper lip. On 6/28/17, at 1:02 p.m., R38 was observed sitting in her wheelchair in the hallway. Long, black hairs remained on R38's upper lip. During interview on 6/28/17, at 1:26 p.m. NA-I verified R38 did have long, black upper lip hairs and should be shaved every day to help with resident dignity. NA-I further verified R38 needs extensive assist with grooming. During interview on 6/28/17, at 2:04 p.m. registered nurse (RN)-B verified that R38 did have long, dark hairs on upper lip that should have been shaved. RN-B further stated residents should be checked every morning if they need to be shaved, "it's a part of morning cares." During interview on 6/28/17, at 2:09 p.m. IDON verified R38 as having long, dark hairs on upper lip and should be shaved every morning. R18 was observed on 6/27/17, at 9:25 a.m. to be eating breakfast in the dining room. R18 had several short facial hairs across her chin and patches of 3 to 4 millimeters long facial hair around her upper lip. R18 was observed on 6/29/2017, at 8:25 a.m. to be eating breakfast in the dining room and the facial hairs on her chin and upper lip remained. R18's quarterly MDS dated 5/3/17, identified R18 required extensive assist of one for personal hygiene.	F 312		

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F 312	Continued From page 20 R18's CNA ASSIGNMENT CARD included, "remove facial hair as needed on chin and upper lip or as she allows." R18's care plan with a print date of 6/28/17, included R18 required extensive assist of one for grooming. R18 was observed during morning cares on 6/28/17, at 9:27 a.m. with NA-F and NA-G. Morning cares were completed without offering to shave R18's facial hairs. During an interview on 6/28/17, at 3:30 p.m. family member (FM)-A stated prior to R18 having dementia facial hair would have bothered her mom. FM-A stated she stopped voicing her concerns to the facility about R18's facial hair because it did not make a difference. FM-A stated, "I just shave [R18] when I am here and she needs to be shaved." FM-A verified R18 had facial hair around her chin and upper lip. During an interview on 6/29/17, at 9:48 a.m. trained medication assistant (TMA)-B stated she looked at facial hair of residents every day when providing cares. TMA-B stated we have a few residents that we shave on a regular basis and this included R18. TMA-B stated she always shaves R18 two to three times a week. TMA-B added she always makes sure it is done before her daughters come, but she does not provide cares for her every day. TMA-B stated, "I just try to have her looking nice for her daughters when they come." TMA-B stated R18's daughter used to do the shaving when she visited more often, and now that she visits on Wednesday, she has taken the shaving over.	F 312		

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F 312	Continued From page 21 During an interview on 6/29/17, at 10:03 a.m. the DON stated facial hair should be monitored every morning with cares and staff should provide shaving as needed. The DON stated when the staff chart under grooming or hygiene they can put in a note and would expect them to document if the resident refused shaving. The DON stated staff should still offer to shave a resident even if they refuse every time, it should still be offered. During an interview on 6/29/17, at 10:11 a.m. the DON completed an observation of R18. The DON stated R18 definitely needed to be shaved as she had facial hair. The DON described R18's facial hair as patchy on her upper lip, was white in color, and stated it was approximately 3 to 4 millimeters long. The DON also stated she noticed a little bit of facial hair along her chin. Requested policy related to providing activities of daily living, and none was provided.	F 312		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		8/15/17

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F 323	Continued From page 22 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a street safety assessment and implement interventions in regards to independent wheelchair mobility out of the facility for 1 of 1 resident (R47) who was observed to use the car lanes when traveling from facility to the local downtown businesses. This put the resident at high risk of being struck by a car/truck causing serious harm, impairment, or death that resulted in an immediate Jeopardy (IJ) situation. The immediate jeopardy (IJ) began on 6/24/17, when the facility first became aware of R47 traveling in his wheelchair on the city streets after dark when returning from the downtown businesses to the facility alone. On 6/30/17, at 11:40 a.m. the area manager, administrator (newly hired), and director of nursing (DON) were informed of IJ situation for R47. The immediate jeopardy was removed on 7/2/17, at 4:00 p.m. but noncompliance remained at the lower scope and severity level of D which indicated no actual harm with potential for more than minimal harm that is	F 323	It is a policy at Care and Rehab Caledonia to keep our residents free from accidents, hazards, supervision/devices. R47 had no ill effects from being out in the community independently. We as a facility are disputing this tag based on the information that was presented to the survey team on June 30, 2017. R47 had a thorough assessment done by occupational therapy for independently functioning in the community on June 30, 2017. He was deemed safe and had been safe in the community prior to the occupational therapy assessment. He continues to sign out of the facility and participates in events in the community. Going forward, any residents who wishes to leave the facility independently will undergo an occupational therapy assessment for independent functioning in the community. The resident will also be	

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F 323	Continued From page 23 not immediate jeopardy. Findings include: R47 had been observed in his wheelchair self propelling down Kingston street road in the car lane on 6/29/17, at 1:50 p.m. by three surveyors who were driving back to the facility from a downtown restaurant. During the observation of R47 by the three surveyors they noted R47 was unaccompanied at the time, wearing a red and white cap and had his one leg fully extended and the other leg was resting in the leg support. Several seconds later the surveyors saw a large milk truck pull up behind R47 then pass R47 (they both were going the same direction down the street) by going into the oncoming lane to move around him. There was no audible truck horn made to notify R47 of the milk truck was going to pass him. There were no cars observed coming the opposite direction when the milk truck made the pass around R47. Kingston street had multiple cars parked on both sides of the road only leaving the car lanes open for travel and the side walks. After the milk truck had safely passed R47, R47 was observed to exit the street and go onto the sidewalk. It was learned later that R47 had signed self out of facility and went to local liquor bar located down town. On 6/29/17, at 1:54 p.m. on immediate return to facility the surveyors informed the DON of observing R47 using the street while in his wheelchair and the milk truck passing him due to being in the car/truck lane. The DON stated R47 is cognitively intact, safe to be out in the community, and is his own person. DON further stated that they (facility) are not responsible for him once R47 signs out of the building. No further	F 323	presented with a risk vs. benefit form. Audits of process will be completed weekly for two (2) weeks, then once every two (2) weeks for one month, then monthly for ninety (90) days. Residents/resident representatives/staff have been educated on the sign out process to ensure staff area aware of when/where a resident is going out of the facility. A policy for leave of absence was also developed. The Director of Nursing or designee will be responsible for ensuring compliance. The results of this plan of correction will be reported to the QAPI committee for review and further recommendations. Upon review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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F 323	Continued From page 24 action was taken by facility after being informed of unsafe street safety by R47. The following interviews were conducted to determine R47's past behavior when out of facility in regards to street safety: On 6/29/17, at 2:10 p.m. nursing assistant (NA)-B stated seeing R47 sign out to leave the facility today. Further NA-B added that R47 usually goes out to the local bars which are located down town. On 6/29/17, at 2:10 p.m. NA-C stated R47 was seen one time wheeling self in wheelchair on the right side of the road, heading down Pine Street, unaccompanied. On 6/29/17, at 2:15 p.m. NA-G stated R47 leaves the facility unsupervised, usually in the evening. NA-G further stated R47 goes to local bars, usually leaves the facility around 3:30 p.m.. On 6/29/17, at 2:16 p.m. NA-D stated R47 was seen outside unsafely. NA-D further said they had been walking home either last Saturday (6/24/17) or Sunday (6/25/17) night past the down town bars around 10:30 p.m. when NA-D saw R47 wheeling self in the street back to facility. On 6/29/17, at 2:20 p.m. trained medication assistant (TMA)-A stated that R47 sometimes just leaves the facility and does not tell anyone. TMA-A further stated R47 is out of the facility more in the evening then during the day. On 6/29/17, at 2:22 p.m. DON verified there was not a safety assessment done for R47 to determine safety while using wheelchair independently in the community unsupervised.	F 323		

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On 6/29/17, at 2:42 p.m. NA-B stated R47 is not safe wheeling down the street in his wheelchair.

On 6/29/17, at 2:52 p.m. physical therapy assistant (PTA)-D stated that R47 likes to go to the liquor bar. PTA-D further stated she did not think it would be safe for R47 to be wheeling self in wheelchair in the community if using the road to get downtown and not the sidewalks and also verified that R47 had not been assessed for street safety with mobility in the community independently. Additionally, PTA-D stated R47 would not be safe coming home late at night after dark, especially if R47 had a few drinks.

On 6/29/17, at 4:54 p.m. physical therapist (PT)-E stated they had not done a safety assessment for R47 to be mobile in wheelchair independently in the community alone, especially after dark. PT-E further stated it does not sound like it would be safe for R47 to be wheeling self in a manual wheelchair going down the car lane of a road.

On 6/29/17, at 5:11 p.m. NA-I stated R47 had left the facility to drink (alcohol). NA-I further stated, about 1 month ago R47 drank so much you could tell the way he acted on return and also could smell the of liquor when near him. NA-I continued to say that R47 should certainly have someone with him for safety. NA-I stated we (staff) all have said R47 needs some kind of limitation, because going out in the community independently with wheelchair and drinking is dangerous.

On 6/29/17, at 5:59 p.m. licensed practical nurse (LPN)-B stated that R47 does not always sign self out when leaving for the day. When they (facility) realizes R47 is gone they do not call the police,

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and usually just call the bar to see if R47 is there. LPN-B further stated she lives between the facility and the bar and has observed R47 wheeling self after dark back to the facility unaccompanied. Additionally, LPN-B said R47 used the road because there are no sidewalks for a few blocks and the ones that do have side walks he refuses to use them due to uneven surfaces. LPN-B then said, "I think it is very dangerous for [R47] to be wheeling self in the dark."

On 6/29/17, at 6:03 p.m. NA-A stated R47 has no reflectors on his wheelchair and thinks it is very dangerous for him to be wheeling himself in the dark all alone.

On 6/30/17, at 8:30 a.m. surveyor determined it was approximately seven (7) blocks from the nursing home to the downtown area which included the two liquor stores frequented by R47. The roads were noted to be busy with cars coming and going during the afternoon hours. There were restraints located on these roads too.

During interview on 6/30/17, at 9:19 a.m. R47 stated he goes to some of the local bars for fun at night which is every other day. R47 added, "It takes me about fifteen minutes to get down town and about a half hour to get back. It's harder to get back here because you have to go uphill." R47 verified as having a hard time hearing. At 9:50 a.m., R47 stated he had to use the road to wheel self downtown because the sidewalks are terrible due to cracks and bumpy. "It's a good block and half before they even have sidewalks anyway."

During interview on 6/30/17, at 10:55 a.m. family member (FM)-B stated that R47 tries to get

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downtown to the bar every day. FM-B added, "I sure think it would be good for [R47] to have those reflectors on wheelchair if [R47] is going to be out after dark. [R47] is hearing impaired, how would [R47] hear for traffic, can basically only see." FM-B also stated. "[R47] lost right leg last October, to get through all of that and then get run over. I mostly worry about [R47] riding in the dark."

Review of R47's quarterly Minimum Data Set (MDS) dated 4/12/17, showed an admission date of 10/21/16, R47 has minimal difficulty hearing: difficulty in some environments-when settings are noisy, Brief Interview Mental Status (BIMS) score of 14 indicated no cognitive impairment. Has diagnosis of right below the knee amputation. Used walker, wheelchair, and limb prosthesis for mobility. Range of Motion to lower extremity-has impairment on one side.

Review of R47's care plan dated 6/27/17, identified a self-care deficit related to amputation of right lower extremity manifested by loss of independence and identified R47 needed set up assist of wheelchair when out of the building.

Review of Care Area Assessment dated 6/29/17, identified hearing impairment, moderate difficulty hearing-does not use hearing aids.

Review of progress notes from 4/11/17, to 5/24/17, shows documentation of resident leaving the facility seven times with concerns of R47's safety in regards to alcohol consumption and returning from local taverns safely in his wheelchair independently.

Review of resident sign out sheets for May 2017,

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F 323	Continued From page 28 showed R47 signed out 14 times, and for June 2017, indicated only once he was going downtown. The time he signed out ranged from 9:05 a.m. to 5:00 p.m. and returned from 4:25 p.m. to mid to late evening. Requested a facility policy for accident prevention and none received. The immediate jeopardy that began on 6/24/17, was removed on 7/2/17, at 4:00 p.m. when the facility implemented the following interventions: -occupational therapist (OT) evaluated R47 for street safety, finding R47 to be safe with wheelchair mobility outside of the facility; -staff were interviewed and found knowledgeable of the removal plan interventions as outlined on the "STAFF EDUCATION ON PROMOTING SAFETY TO [R47] WHILE OUT OF THE FACILITY"; -social worker (SW) educated R47 on safety recommendations when going out in the community and R47 signed a risk/benefit agreement stating that R47 understood the risks involving wheelchair mobility (safety) outside of the facility; - added reflector strips and a tall orange flag to the back of R47's wheelchair; and - the director of nursing had provided staff education on a safety plan for R47 while out of the facility and had developed a safety care plan interventions to minimize the risk of injuries and accidents.	F 323		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations	F 334		8/15/17

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F 334	Continued From page 29 (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the	F 334		

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F 334	Continued From page 30 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R28) reviewed for pneumococcal and influenza vaccines, was offered the vaccinations. Findings include: R28 was admitted to the facility on 12/2/16, with diagnosis of dementia, according to facility face sheet. Document review of R28's facility progress notes dated 12/2/16, revealed immunization status on admit and noted influenza vaccine not current.	F 334	It is a policy at Care and Rehab Caledonia that influenza and pneumococcal immunizations are offered and documented in the resident's medical record. R28 had no ill effects from not being current on her influenza and pneumococcal vaccines. A policy for administering influenza vaccines will be developed to include that the vaccine will be offered during the months of October 1st and March 31st. A policy for Pneumococcal vaccines will be developed according to CDC guidelines.	

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F 334	Continued From page 31 There was no documentation in the progress notes of pneumococcal vaccine status on admit. Document review of R28's facility immunization information connection, a facility immunization record, revealed the most current influenza vaccine was received 10/13/14. The same record indicated pneumo-poly (PPSV23) was received 6/25/98. The same record indicated vaccines recommended included influenza and pneumo-conj (pneumococcal vaccine). There was no documentation the facility had offered the influenza and pneumococcal vaccines. During interview on 6/29/17, at 10:45 a.m., registered nurse (RN)-A verified R28 was admitted in 12/16. RN-A stated R28 was not offered the influenza vaccine because admission date was after the facility wide influenza immunization vaccination month of 11/2016. During interview on 6/29/17, at 11:35 a.m. interim director of nursing (IDON) verified R28 was not offered influenza or pneumococcal vaccines since admission. IDON stated they would have to revise the policy for influenza vaccine to include offering vaccines from October to March yearly. IDON stated facility routine was to order enough influenza vaccine to administer facility wide yearly in November. Document review of facility Influenza Vaccine Program policy dated 6/2010, directed the vaccine program ran from early October to March 31st, but was flexible depending on recommendations from the Health Department and Centers for Disease Control, every admission	F 334	All current residents residing at Care and Rehab Caledonia have been reviewed for influenza and pneumococcal status to ensure they are up to date. These immunizations will be offered if needed, and administered accordingly. All new admissions to Care and Rehab Caledonia will have their immunization status checked prior to entering the facility. If they are found to be in need of the influenza or pneumococcal vaccines, it will be asked of the hospital to administer them prior to their admission. If they enter the facility without being current on their influenza and pneumococcal vaccines, they will be offered according to our policy. Audits of new residents will be completed after the first business day after admission in IDT. Findings will be reported to MDS RN for accurate MDS submission. The Director of Nursing or designee will be responsible for ensuring compliance. The results of this plan of correction will be reported to the QAPI committee for review and further recommendations. Upon review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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F 334	Continued From page 32 was screened, educated regarding the vaccine, and given the vaccine if indicated. The policy directed to document the following in the medical record and on the immunization record: education provided, medication, route of administration, sight of injection, temperature prior to administration, and the time the vaccine was given. The policy directed document resident refusal and education of risk and benefits. Current Centers for Disease Control (CDC) recommends pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older: Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23. If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23. This information was not included in the facility policy/procedure. Document review of facility Administration of Pneumovax Vaccine policy, undated, directed every admission was screened for contraindications and administered the vaccine if indicated. The policy directed to document the following in the medical record and on the immunization record: medication, route of administration, sight of injection, temperature prior to administration, and the time the vaccine was given.	F 334		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		8/15/17

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F 431	Continued From page 33 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		

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F 431	Continued From page 34 controls, and permit only authorized personnel to have access to the keys. (2) 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 follow safe and current practices in regards to borrowing prescribed narcotics from residents to use for another resident, keeping open narcotic tablets for use vs. destroyed when open and/or refused by resident, also failed to monitor insulin outdates so residents do not receive the insulin after outdated. This had the potential to affect several residents who utilized narcotics and insulin. Findings include: During review of the controlled medication storage in the main medication room on 6/28/17, at 8:39 a.m. with licensed practical nurse (LPN)-A observed a hand written note that included the initials of a staff member, which read: borrowed one for (a room number listed) and the date 6/26. This was found on the inside cover flap of the Fentanyl (narcotic) transdermal system 12 micrograms (mcg)/hr box of medication. LPN-A was interviewed immediately, and the director of nursing (DON) informed of the	F 431	It is a policy at Care and Rehab Caledonia to store and label drugs according to state and federal regulations. R34, R46, R27, and R15 had no ill effects from medications either being shared or having an expired date. All licensed staff were educated that it is our policy to not share narcotics between residents. They have been educated on the process of obtaining narcotics after hours and from alternate pharmacies. They were also reeducated on the 5-6 rights of medication administration which includes checking the expiration dates on all medications. They were also educated on not taping or tampering with any medication, especially narcotics. They were educated on when to destroy medications if needed. A policy for narcotic administration to include instructions on obtaining narcotics after hours from alternate pharmacies will be developed. A policy on insulin	

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F 431	Continued From page 35 findings. LPN-A stated the borrowed patch found this morning during narcotic counts, it was taken from resident (R)-34 and placed on R46, when R46 received an increase in the pain medication. LPN-A stated if she were working, she would have called the backup pharmacy Walgreen's to have them deliver the newly ordered Fentanyl patches and not taken it from another residents box. LPN-A verified the initials on the box to be registered nurse (RN)-E who had used R34's Fentanyl patch for R46. Further findings of the narcotic counts found R34 verified a Fentanyl patch was missing during count and no indication of determining why it was missing such as used for another resident or aversion. During an interview with RN-E on 6/29/17 at 3:27 p.m., verified a Fentanyl patch was borrowed from R34 and placed on R46. RN-E stated sometimes this happens when the emergency kit does not have the correct dose. R46 had an increase in her pain medication which was not immediately ordered from the pharmacy but borrowed from R34's prescribed Fentanyl patch until pharmacy was contacted and the new order for R46 arrived at facility. RN-E stated a fax of the order was sent to the pharmacy when she noticed it was over looked. The Certified Nurse Practitioner had ordered an increased in R46 pain medication a couple days before her shift. RN-E stated she updates this kind of practice to the oncoming shift verbally and leaves a note on the medication. RN-E verified there is a back-up pharmacy, but there is a window of time to get the medication. R46 was in the process of increasing her pain medication. RN-E noticed the medication was not in the facility at 8 p.m. RN-E stated that	F 431	administration including checking the 5-6 rights will be developed. All licensed staff to be observed on competency of administering insulin injections. The Director of Nursing or designee will to audits of the medication room in the following sequence: weekly for two (2) weeks, once every two (2) weeks for one (1) month, then the pharmacy consultant to do monthly checks thereafter. The audits will consist of checking for expired medications, proper storage of medications, and narcotic compliance. The Director of Nursing or designee is responsible for ensuring compliance. The results of this plan of correction will be reported to the QAPI committee for review and further recommendations. Upon review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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F 431	Continued From page 36 the latest the back-up pharmacy would deliver is 6:00 a.m. RN-E stated she did not want to miss giving her the medication. RN-E was asked about the tracking of the borrowed medication. RN-E stated initials are placed on the box of mediation and the word borrowed is written on the box. RN-E stated that normally we would start a narcotic counting sheet to identify the borrowed medication. RN-E stated if that was not completed it was an oversite. RN-E continued to state this practice is not a normal situation and would not complete due to the risk of safety. Further finding during the medication storage observation found medication bubble pack of a controlled substance to be taped on the back holding the medication in place. During an observation of medication pass with LPN-A on 6/28/17 at 7:31 a.m. with R27 found Percocet medication in a bubble pack was taped over one tablet. LPN-A was asked why it was taped and if found during the narcotic shift count. LPN-A stated she did not notice it and was not sure why it was like that. LPN-A had administered the taped tablet to R27, Review of R27 remaining bubble packs found to be intact. LPN-A stated the taping of the medication occurs all the time claiming sometimes they fall out because the foil gets weakened. R25 medication bubble pack of Percocet (a pain medication) was found to be taped on the back of the remaining two tablets. LPN-A stated they were told to do this because there was medication in the bubble pack that will be expiring soon. LPN-A explained they moved the pills from one side of the bubble pack to the other and placed a hand written bracket to identify the expired medication read (5/17 and	F 431		

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	245499	A. BUILDING _____ B. WING _____	07/06/2017

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F 431	Continued From page 37	F 431		

7/17). The dates represent expired on May 2017 and July 2017. LPN-A stated they completed this for easier counting. The two tablets left in the bubble pack were in the bracket dated 5/17. Review of the narcotic count sheet and the medication administration record found one tablet of Percocet was administered this date of 6/28/17.

RN-E on 6/29/17 at 3:27 p.m. was also questioned regarding the taping of the Percocet medication. RN-E stated that she has only done this once because the resident refused and the medication was not placed in the mouth. If the Percocet was refused not sure what to do with medication.

During an observation and interview on 6/27/17 at 10:43 a.m. RN-D had completed a glucose check and administration of Novolog (insulin) of four units for R15. In the review of the insulin pens found to have an expiration date of 5-25-17. RN-D verified the date and asked what the expiration date is on Novolog insulin pens. RN-D stated either they expire 28 or 42 days, I will have to check. RN-D verified at 12:32 p.m. the insulin pen used for R15 expired once opened in 28 days, verified R15 received expired insulin for 5 days after it had expired. When asked what can happen to the insulin, RN-D stated that the insulin loses its potency.

During an interview with the pharmacy consultant on 6/28/17 at 10:48 a.m. verified the Novolog pens expire within 28 days of being opened. Pharmacist was asked regarding the borrowing of controlled medications and said, "Not allowed, under no circumstances." Also pharmacist stated the facility needs to verify the orders are current,

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F 431	Continued From page 38 check the emergency supply kit and if there is no medication that can be used the facility will then check the emergency dispensing pharmacy or check with the physician if there is something else from the emergency kit can be used. Regarding the taping of the medication consultant stating there is no taping allowed, the facility can only remove medication at time of administration. Pharmacist further added this practice is not allowed by law to move medication such as narcotics, only the pharmacy can manipulate the medication packaging such moving and dating of the medication. In stead of tapping meds and keeping them for another time the staff should have destroyed the medication and reordered them at that point one could not validate the product. The facility nurses monitor the resident rooms because the medication are kept in each room although the narcotics are kept in the medication room and verifies when in the building. Surveyor asked consultant when the last time he was in the facility and stated a couple weeks ago. During an interview with the intern director of nursing (IDON) and newly hired DON on 6/28/17 at 9:01 a.m. verified there should be no borrowing of narcotics. The process is to call the on-call pharmacy if additional medications are needed. When asked their expectation regarding the taping of narcotics for use, both IDON and DON stated no moving of the medication and to call the pharmacy. On 6/28/17 at 9:15 a.m. interviewed continued with DON regarding the expired medication, DON verified the insulin pens in use were expired with them having an expiring date 28 days after opened. DON would expect her staff to verify the	F 431		

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F 431	Continued From page 39 5-6 rights of any medication pass.	F 431		

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K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Caledonia Care and Rehab Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/01/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Caledonia Care and Rehab is a 1-story building. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(000)construction, with a full basement. In 1971, addition was constructed and was determined to be of Type II(000) construction, with no basement. In 1975, addition was constructed and was determined to be of Type II(000) construction, with no basement. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 223 SS=D	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Findings Include: On facility tour between 11:30 AM and 03:30 PM	K 223	POC Remedy: Robert Krzebietke (Plant Manager) has contacted the local electrician (Hoskin Electric) and we will install a self-closer device for the rated corridor on the Dietary Office. Completion date: buying parts and bidding (est by 09/01/2017) Responsible party to correct and monitor: Robert Krzebietke(Plant Manager) will be the contact person for the correction and once it is fixed the doors will be checked per our quarterly fire checks.	8/1/17

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K 223	Continued From page 3 on 6/29/2017, based on observation and interview revealed that the following include: The door to the dieter office does not have a self closer device for the rated corridor. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 223		
K 281 SS=F	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is not met as evidenced by: Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Findings Include: On facility tour between 11:30 AM and 3:30 PM on 6-29-2017, based on observation and interview revealed that the following include: The hallway lighting are switched and can be turned out at any time.	K 281	POC Remedy: Robert Krzebietke (Plant Manager) has contacted the local electrician (Hoskin Electric) and we will install lights on the ends of the hall and in the middle, that will come on when there is a power outage. These will be put in the same as our new addition lighting on the Exit signs. These turn on when there is a power outage and run on batteries. Completion date: buying parts and bidding (est by 09/1/2017)	8/1/17

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K 281	Continued From page 4 This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 281	Responsible party to correct and monitor: Robert Krzebietke(Plant Manager) will be the contact person for the correction and once it is fixed the lights will be checked per our quarterly fire checks.	
K 781 SS=E	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Findings Include: On facility tour between 11:30 AM and 03:30 PM on 6/29/2017, based on observation and interview revealed that the following include: Space heaters were found in rooms 318 and 321. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment.	K 781	POC Remedy: Robert Krzebietke (Plant Manager) has initiated a Policy and Procedure for Space Heaters and has removed the two space heaters from the rooms. Completion date: 8/1/2017 Responsible party to correct and monitor: Robert Krzebietke(Plant Manager) will be the contact person for the correction.	8/1/17

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K 781	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 781		