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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GYQH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00589

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245227**
2.STATE VENDOR OR MEDICAID NO.
(L2) **1821433426**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE RESIDENCE & REHAB CTR**
(L4) **1601 ST LOUIS AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

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) **07/01/2013**

6. DATE OF SURVEY **01/28/2016** (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)
12/31

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

12.Total Facility Beds **139** (L18)
13.Total Certified Beds **139** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	139			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kimberly Settergren, HFE NEII — 02/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 02/29/2016 (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
01/22/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/11/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5227

On January 28, 2016, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiency issued pursuant to a PCR, completed on January 13, 2016. We presumed, based on your plan of correction, that the facility had corrected this deficiency as of January 22, 2016. Based on our visit, we determined that the facility had corrected the deficiency issued pursuant to our PCR, completed on January 28, 2016, effective January 22, 2016
As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective January 22, 2016. In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Per day civil money penalty, beginning October 22, 2015 and continuing through November 17, 2015, remain in effect. (42 CFR 488.430 through 488.444)
- Per day civil money penalty, beginning November 18, 2015 be discontinued, effective January 22, 2016. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016, be rescinded. (42 CFR 488.417 (b))

As we notified the facility in our letter of November 13, 2015 and CMS notified the facility in their letter of December 31, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 18, 2015. The CMS Region V Office will notify of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Refer to the CMS 2567b form for the results of this visit.

Effective January 22, 2016, the facility is certified for 139 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245227

February 29, 2016

Mr. Don Babbitt, Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, Minnesota 55802

Dear Mr. Babbitt:

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

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

Effective January 22, 2016 the above facility is certified for:

139 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 139 skilled nursing facility beds .

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

February 25, 2016

Mr. Don Babbitt, Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, Minnesota 55802

RE: Project Number S5227026

Dear Mr. Babbitt:

On November 13, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 18, 2015. (42 CFR 488.422)

On December 31, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of $3,100.00 for twenty-seven (27) days beginning October 22, 2015 and continuing through November 17, 2015 for a total of $83,700.00. (42 CFR 488.430 through 488.444)

- Per day civil money penalty of $250.00 per day beginning November 18, 2015 until substantial compliance is achieved. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

Further, 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, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015. 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.

This was based on the criteria that the facility not be given an opportunity to correct due to a "G" level deficiency cited at the previous abbreviated standard survey complete on February 20, 2015 and the

most recent abbreviated standard survey completed on October 23, 2015, an extended survey completed on November 18, 2015, where conditions in the facility at the time of the extended survey constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 13, 2016. The most serious deficiency at the time of the revisit was a widespread deficiency that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

As a result of the revisit findings, the Category 1 remedy of State monitoring remained in effect.

In addition, this Department recommended to the CMS Region V office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Per day civil money penalty, beginning October 22, 2015 and continuing through November 17, 2015, remain in effect. (42 CFR 488.430 through 488.444)

- Per day civil money penalty, beginning November 18, 2015 until substantial compliance is achieved, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016, remain in effect. (42 CFR 488.417 (b))

On January 28, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiency issued pursuant to a PCR, completed on January 13, 2016. We presumed, based on your plan of correction, that your facility had corrected this deficiency as of January 22, 2016. Based on our visit, we determined that your facility had corrected the deficiency issued pursuant to our PCR, completed on January 28, 2016, effective January 22, 2016

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective January 22, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Per day civil money penalty, beginning October 22, 2015 and continuing through November 17, 2015, remain in effect. (42 CFR 488.430 through 488.444)

- Per day civil money penalty, beginning November 18, 2015 be discontinued, effective January 22, 2016. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016, be rescinded. (42 CFR 488.417 (b))

As we notified you in our letter of November 13, 2015 and CMS notified you in their letter of December 31, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 18, 2015.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

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

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245227 Y1	A. Building B. Wing Y2	1/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/22/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	✓
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	CC/KJ	02/25/2016	34089	01/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/18/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GYQH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00589

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245227**
2.STATE VENDOR OR MEDICAID NO.
(L2) **1821433426**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE RESIDENCE & REHAB CTR**
(L4) **1601 ST LOUIS AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

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) **07/01/2013**

6. DATE OF SURVEY **01/13/2016** (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)
12/31

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

12.Total Facility Beds **139** (L18)
13.Total Certified Beds **139** (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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	139			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 01/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/25/2016 (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
01/22/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/11/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5227

On January 13, 2016, the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification Program and on December 23, 2015 the Department of Public Safety, completed a Post Certification Revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed October 23, 2015 and an extended survey, completed on November 18, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2015. Based on our visit, we have determined that the facility has not obtained substantial compliance with the deficiency issued pursuant to our extended survey, completed on October 23, 2015. The deficiency not corrected is as follows:

- **F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens**

The deficiency in the facility was found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). As a result of the revisit findings, the Category 1 remedy of state monitoring remains in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Per day civil money penalty for twenty-seven days beginning October 22, 2015 and continuing through November 17, 2015
- Per day civil money penalty, beginning November 18, 2015 until substantial compliance is achieved, remain in effect.
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 23, 2016, remain in effect.

Further, 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, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015.

Refer to the CMS 2567b forms and CMS 2567 along with the facilitys plan of correction for the results of this visit. PCR to follow.

Certified Mail # 7015 0640 0003 5695 5484

January 19, 2016

Mr. Don Babbitt, Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, Minnesota 55802

RE: Project Number H5227053, H5227054, S5227026

Dear Mr. Babbitt:

On November 13, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 18, 2015. (42 CFR 488.422)

On December 31, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal civil money penalty of $3,100.00 per day for the twenty-seven (27) days beginning October 22, 2015 and continuing through November 17, 2015 for a total of $83,700.00.

- Federal civil money penalty of $250.00 per day beginning November 18, 2015 until substantial compliance is achieved.

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on October 23, 2015 and an extended survey completed on November 18, 2015. At the time of the November 18, 2015 extended survey conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health and safety. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On January 13, 2016, the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification Program completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed October 23, 2015 and an extended survey, completed on

November 18, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2015. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiency issued pursuant to our extended survey, completed on October 23, 2015. The deficiency not corrected is as follows:

F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiency in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Federal civil money penalty of $3,100.00 per day for the twenty-seven (27) days beginning October 22, 2015 and continuing through November 17, 2015 for a total of $83,700.00, remain in effect.

- Federal civil money penalty of $250.00 per day beginning November 18, 2015 until substantial compliance is achieved, remain in effect.

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 23, 2016, remain in effect. (42 CFR 488.417 (b))

Further, 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, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015. 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.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

Enclosure

cc: licensing and Certification File

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

RECEIVED
JAN 22 2016
MN Dept of Health
Duluth

PRINTED: 01/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

(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 An onsite resurvey was conducted by surveyors of this department on 1/11/16, 1/12/16, and 1/13/16, to determine compliance with Federal deficiencies issued during a recertification survey exited on 11/18/15. During this visit the following regulations were determined to be not corrected. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}	1. ~~Residents # 166 and # 73 were not~~ affected by the alleged deficient practice. 2. All residents may have been affected by the alleged deficient practice. No residents have developed any infection requiring isolation. 3. Staff were re educated on Infection Control Isolation procedures : - Standard precautions - Droplet precaution procedures - Contact precaution procedures with an emphasis on contact precautions related to C-Diff; Specifically; - Staff will donne gown and gloves prior to entering the resident room with or without the resident in the room - Staff will remove gown and gloves then go and wash hands with soap and water before leaving the room - Staff were educated on the new "orange wipes" that will be used to wipe down any equipment such as a mechanical lifts, that leave the room . - The new "orange wipes " are a new product called PDI Sani	
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility (2) Decides what procedures, such as isolation, should be applied to an individual resident and (3) Maintains a record of incidents and corrective actions related to infections.	{F 441}	OK 1/25/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Don Babler	Administrator	1-22-2016

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
	245227	A. BUILDING _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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

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

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{F 441}	Continued From page 1 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control isolation precaution practices were implemented for 2 of 2 residents (R166, R73) diagnosed with clostridium-difficile (C-Diff) infection. This had the potential to affect all 108 residents in the facility. Findings include: The Center for Disease Control (CDC) guidelines for health care facilities directed the following when caring for residents with a C-Diff infection (a spore-forming bacteria that can cause swelling	{F 441}	The new "orange wipes a new product called PDI Sani-Wipe bleach germicidal wipe with a bleach additive. Specifically developed to kill the C-Diff spore. - Housekeeping staff were re educated on guidelines for cleaning an Isolation room. Specifically: - Step 1) prior to entering resident room prepare for isolation cleaning: gather all supplies/equipment and cleaning solutions required and leave supplies and cart outside of room; follow the facility policy for donning PPE for isolation rooms. Hand hygiene and donne PPE gown and gloves - Wipe down all furniture and high touch areas with Bleach Germicidal wipes, include all bathroom surfaces, overbed tables, hand rails, etc. - Mop floor with bleach solution and allow to air dry - Wipe down any housekeeping equipment used with bleach germicidal wipes before leaving the room	

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{F 441}	Continued From page 2 and irritation of the large intestine, or colon. This inflammation, known as colitis, can cause diarrhea, fever, and abdominal cramps): Isolate patients with C-Diff immediately. Wear gloves and gowns when treating patients with C-Diff, even during short visits. Hand sanitizer does not kill C-Diff, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves. Use gowns when entering patients' rooms and during patient care. Clean room surfaces thoroughly on a daily basis while treating a patient with C-Diff and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing disinfectant. R166's Admission Record identified diagnoses that included osteomyelitis, osteoarthritis and sepsis. R166's admission Minimum Data Set (MDS) dated 12/22/15, indicated R166 was cognitively intact, required extensive assistance of one staff for toilet use and had a colostomy. Laboratory results on 1/7/16, identified the presence of C-Diff in R166's stool. On 1/11/16, at 1:00 p.m. the director of nursing (DON) stated R166 was in isolation precautions due to a C-Diff infection. -At 1:45 p.m. R166's room was observed. There was an isolation cart outside of the room that contained gowns, gloves and purple-top PDI Sani-Wipes (germicidal wipes not effective against C-Diff spores). A sign on R166's door directed please see nurse before entering. On 1/12/16, at 9:17 a.m. R166's call light was on, and nursing assistant (NA)-C was observed to enter R166's room. NA-C knocked on the door,	{F 441}	- Dispose of gloves and gown and wash hands with soap and water before leaving the room .	

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{F 441}	Continued From page 3 entered the room and used an alcohol-based gel on her hands. NA-C shut off R166's call light, spoke with him, used an alcohol-based gel on her hands and left the room. At 9:23 a.m. NA-C walked to R166's room with a cup of coffee in her hands, placed the coffee on the isolation cart, used an alcohol-based gel on her hands, grabbed the coffee cup and entered R166's room. At 9:24 a.m. NA-C used an alcohol-based gel on her hands and left R166's room. On 1/12/16, at 9:35 a.m. NA-C was interviewed, and stated she was taught to wash her hands and donne gloves to go into R166's room and remove the gloves and wash her hands when she left the room. NA-C stated she was told she did not need to wear a gown unless she was doing cares on R166. NA-C verified she used an alcohol-based gel for hand hygiene. R73's Admission Record identified diagnoses that included hypertension, hypothyroidism and anemia. The quarterly MDS dated 12/8/15, indicated R73 was cognitively intact, required extensive assistance of two staff for transfers and toilet use and was continent of bowel. Laboratory results on 1/12/15, identified the presence of C-Diff in R73's stool. On 1/12/16, at 12:51 p.m. registered nurse (RN)-B was observed to place an isolation cart in front of R73's room and placed a sign that directed please see nurse before entering on R73's door. On 1/13/16, at 7:58 a.m. NA-P was observed	{F 441}	4. Observation audits to monitor staff are following isolation procedures will be conducted on all three shifts: four (4) audits per week on the day shift; and one (1) audit per week on the evening (2-10:30) shift and one (1) audit per week on the night (10-6:30) shift. The results of the observation audits will be presented to the monthly QAPI committee for three months to monitor the staff is following the Infection control-Isolation guidelines. After three months, the QAPI committee will recommend if further monitoring is recommended . 5. The Director of Nursing, the Infection control Nurse and the Housekeeping Supervisor will be responsible for compliance with oversight from the Administrator. Completion date of January 22, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 441}	Continued From page 4 gowned and gloved and used PDI purple top sani-wipes to wipe off the hoyer lift. NA-P brought the hoyer lift into R73's room. At 8:04 a.m. NA-P came out of R73's room and wiped the hoyer lift down with PDI purple top sani-wipes. On 1/13/15, at 9:08 a.m. trained medication assistant (TMA)-F was interviewed and stated the facility did not have dedicated equipment (such as hoyer lifts, stethoscopes, blood pressure cuffs or thermometers) for residents who were in isolation. TMA-F stated any shared equipment would be cleaned by nursing staff with PDI purple top sani-wipes. On 1/13/16, at 9:32 a.m. RN-B was interviewed and stated the facility did not have dedicated equipment for those residents in isolation precautions. RN-B verified the facility used PDI purple top sani-wipes to clean dedicated equipment, however she was unaware if PDI purple top sani-wipes killed C-Diff spores. RN-B further stated she had met with nursing staff yesterday and today to review isolation precautions with them. On 1/13/16, at 10:15 a.m. the DON was interviewed and stated she would expect all staff to follow isolation precautions. At 11:40 a.m. the DON confirmed that PDI purple top sani-wipes were not effective and did not kill C-Diff spores. On 1/13/16, at 10:44 a.m. housekeeper (H)-B was interviewed and stated he used bleach wipes to clean rooms in isolation precautions for C-Diff	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 441}	Continued From page 5 and did this daily. H-B stated the protective gear he would wear when cleaning a room with C-Diff depended on whether or not the resident was in the room. H-B stated if the resident was present in the room, he would donne a gown and gloves, but if the resident was not in the room he would only wear gloves. The undated facility policy and procedure on Clostridium Difficile directed the following: gloves must be donned and worn by all healthcare providers before entering the room, donne gown upon entering the room when anticipating contact with the resident or the resident's immediate environment, perform hand hygiene with soap and water upon exiting the resident's room, when possible, non-critical care equipment should be dedicated to the resident and cleanse reusable equipment with house wipes.	{F 441}	4.Audits will be conducted four (4) times per week times four (4) weeks, then two (2) times per week times (8) weeks to monitor staff are following the Infection Control guidelines for Isolation procedures. The audits will be presented to the monthly QAPI committee for three months to monitor the Facility/ staff is following the Infection Control –Isolation guidelines. After three months, the QAPI committee will recommend if further monitoring is recommended. 1. The Director of Nursing, the Infection Control Nurse, and the Housekeeping Supervisor will be responsible for compliance with oversight from the Administrator. Completion date of January 22, 2016	

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing	1/13/2016

Name of Facility	Street Address, City, State, Zip Code
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0161** Reg. # **483.10(c)(7)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **12/31/2015**
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **12/31/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/31/2015**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/31/2015**
ID Prefix **F0285** Reg. # **483.20(m), 483.20(e)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/31/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/31/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **12/31/2015**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	01/19/2016	29433	01/13/2016
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing	1/13/2016

Name of Facility	Street Address, City, State, Zip Code
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/31/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0494** Reg. # **483.75(e)(2)-(3)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0495** Reg. # **483.75(e)(4)** LSC	Correction Completed **12/31/2015**
ID Prefix **F0496** Reg. # **483.75(e)(5)-(7)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0498** Reg. # **483.75(f)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0500** Reg. # **483.75(h)** LSC	Correction Completed **12/31/2015**
ID Prefix **F0502** Reg. # **483.75(i)(1)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0508** Reg. # **483.75(k)(1)** LSC	Correction Completed **12/31/2015**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **12/31/2015**
ID Prefix **F0519** Reg. # **483.75(n)** LSC	Correction Completed **12/31/2015**				

Reviewed By _____ **State Agency**	**Reviewed By** CC/mm	**Date:** 01/19/2016	**Signature of Surveyor:** 29433	**Date:** 01/13/2016
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/18/2015	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing **01 - MAIN BUILDING 01**	12/23/2015

Name of Facility	Street Address, City, State, Zip Code
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **12/01/2015**	ID Prefix	Correction Completed **12/01/2015**	ID Prefix	Correction Completed **12/01/2015**
Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0067		Reg. # **NFPA 101** LSC K0147	
ID Prefix	Correction Completed **12/01/2015**	ID Prefix	Correction Completed **12/01/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0154		Reg. # **NFPA 101** LSC K0155		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	01/19/2016	27200	12/23/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/12/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GYQH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00589

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245227**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1821433426**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE RESIDENCE & REHAB CTR**
(L4) **1601 ST LOUIS AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

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) **07/01/2013**

6. DATE OF SURVEY **11/18/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **139** (L18)

13.Total Certified Beds **139** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	139			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, HFE NEII — 12/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 01/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/22/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5227

On November 13, 2015, we notified the facility of the following enforcement remedies:

-State Monitoring effective November 18, 2015.
- Civil money penalty for deficiency cited at F333 (S/S=G), effective October 23, 2015.

This was based on the criteria that the facility not be given an opportunity to correct before remedies are imposed as a result of a level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy (level G)) cited at the previous intervening abbreviated standard survey completed on February 20, 2015 as well as the current abbreviated standard survey completed on October 23, 2015 (Investigation of complaint H5227053).

On November 18, 2015 an extended survey was completed at this facility, Conditions in the facility constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health safety. The survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J, whereby corrections were required. In addition, at the time of the November 18, 2015 extended survey, an investigation of complaint number H5227054 was conducted and found to be unsubstantiated.

As a result of the November 18, 2015 standard survey, the Category 1 remedy of State monitoring would remain in effect.

In addition, we recommended the following action to the CMS Region V Office related to the enforcement remedy detailed in our letter of Novmeber 13, 2015:

- Civil money penalty for deficiency cited at F333 (S/S=G), effective October 23, 2015, remain in. effect.

Based on the findings of the extended survey completed November 18, 2015, we are recommending the following additional remedies to the CMS Region V Office:

- Civil money penalty for deficiency cited at F309 (S/S=G), effective November 18, 2015.
- Civil money penalty for deficiency cited at F323 (S/S=J, reduced to a S/S=G when the IJ was removed), effective November 18, 2015. (42
- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 23, 2016.

Futher, 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, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015.

Refer to the CMS 2567 forms along with the facilitys plan of correction. Post Certification Revisit (PCR) to follow.

Minnesota Department of Health

Sent via United Parcel Service (UPS) Priority Ovenight
on
December 9, 2015

Mr. Don Babbitt, Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, Minnesota 55802

RE: Project Number H5227053, SS5227026, H5227054

Dear Mr. Babbitt:

On November 13, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 18, 2015. (42 CFR 488.422)

On November 13, 2015, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for deficiency cited at F333 (S/S=G), effective October 23, 2015. (42 CFR 488.430 through 488.444).

This was based on the criteria that the facility not be given an opportunity to correct before remedies are imposed as a result of a level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy (level G)) cited at the previous intervening abbreviated standard survey completed on February 20, 2015 as well as the current abbreviated standard survey completed on October 23, 2015.

On November 18, 2015, 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. In addition, at the time of the November 18, 2015 extended survey the Minnesota Department of Health completed an investigation of complaint number H5227054 that was found to be unsubstantiated.

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. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

As a result the the facility continues to not be in substantial compliance, the Category 1 remedy of state monitoring will remain in effect.

In addition, we are recommending the following action to the CMS Region V Office related to the remedy detailed in our letter of November 13, 2015:

- Civil money penalty for deficiency cited at F333 (S/S=G), effective October 23, 2015, remain in effect. (42 CFR 488.430 through 488.444).

Based on the findings of the extended survey completed November 18, 2015, we are recommending the following additional remedies to the CMS Region V Office:

- Civil money penalty for deficiency cited at F309 (S/S=G), effective November 18, 2015. (42 CFR 488.430 through 488.444).

- Civil money penalty for deficiency cited at F323 (S/S=J, reduced to a S/S=G when the IJ was removed), effective November 18, 2015. (42 CFR 488.430 through 488.444).

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

Futher, 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, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015. 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.

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

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

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

<u>No Opportunity to Correct</u> - 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;

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 November 18, 2015, 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:

Chris Campbell, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 302-6151 Fax: (218) 723-2359

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, Bayshore Residence & Rehab Ctr is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015. 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.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by January 23, 2016 (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 April 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

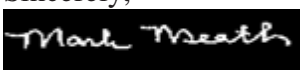
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,



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

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

Enclosure (s)

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1801 ST LOUIS AVENUE DULUTH, MN 55802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility plan of correction (POC) will serve as you allegation of compliance upon the department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint #H5227054 was completed. The complaint was unsubstantiated. An extended survey was conducted on 11/12-18/15. At the time of survey on 11/12/2015, an extended survey was initiated due to an Immediate Jeopardy at F323. The Immediate Jeopardy was removed on 11/18/2015. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to comprehensively assess and effectively implement interventions in order to minimize the risk of falls with serious injury or death for R61 who had frequent falls. The immediate jeopardy was removed on 11/18/15, at 10:30 a.m. after it was verified that the facility effectively implemented a removal plan.	F 000	OK 12/30/15	
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS	F 161	1. No residents were affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Don Barbut — TITLE: Administration — (X6) DATE: 12-31-2015

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

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

RECEIVED
DEC 28 2015
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility plan of correction (POC) will serve as you allegation of compliance upon the department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint #H5227054 was completed. The complaint was unsubstantiated. An extended survey was conducted on 11/12-18/15. At the time of survey on 11/12/2015, an extended survey was initiated due to an Immediate Jeopardy at F323. The Immediate Jeopardy was removed on 11/18/2015. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to comprehensively assess and effectively implement interventions in order to minimize the risk of falls with serious injury or death for R61 who had frequent falls. The immediate jeopardy was removed on 11/18/15, at 10:30 a.m. after it was verified that the facility effectively implemented a removal plan.	F 000	The Plan of Correction constitutes Bayshore Residence and Rehabilitation Center's written compliance for the deficiencies cited. However, the submission of this Plan of correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law.	
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS	F 161	1. No residents were affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Don Babbitt — TITLE: Administrator — (X6) DATE: 12-17-2015

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 161	Continued From page 1 The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the surety bond was sufficient to cover the total amount in the resident fund accounts. This had the potential to impact 83 previous and current residents who had money in the account. Findings include: A review of the facility's surety bond (insurance that protects the resident personal funds in trust fund account held by the facility), revealed the amount of the surety bond was less than the total of the resident funds held by the facility. The surety bond dated 10/24/13, indicated the resident personal funds were protected up to a total of $39,000. The facility trust fund balance report dated 11/11/15, indicated 139 residents who now reside in the facility or who previously resided in the facility had an open trust fund account for a total of $58,829.27. 83 of 159 current residents had money in the trust fund. The surety bond was not sufficient to secure the total resident monies held by the facility. During an interview on 11/17/15, at 3:15 p.m. the administrator verified the surety bond was not	F 161	2. Residents may have the potential to be affected by the alleged deficient practice. 3. The facility purchased a new Surety Bond November 17, 2015, which covers the amount in the resident trust fund. 4. The facility will monitor the resident trust fund every month for three (3) months to monitor the Surety Bond covers the resident trust fund balance. If there would be a negative occurrence, the facility will take immediate action to cover the trust fund balance. 5. The results of the audits will be reported to the monthly QAPI committee for three months. 6. The Administrator/designee will be responsible.	

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F 161	Continued From page 2 sufficient to cover the resident fund balance . The facility policy and procedure for Resident Trust Account dated 7/2015, indicated a surety bond would be maintained on the resident trust fund account and would be renewed annually	F 161		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	1. Resident #46 was not affected by the alleged deficient practice as documented by Social Services. 2. All residents have the potential for being affected by the alleged deficient practice.	

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F 164	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident privacy during a pain assessment/medication pass for 1 of 1 residents (R46) reviewed for privacy. Findings Include: R46's Admission Record identified diagnoses that included chronic kidney disease stage 4, type 2 diabetes, and chronic pain due to trauma. The quarterly Minimum Data Set (MDS) dated 9/4/15, indicated R46 was cognitively intact and received scheduled pain medications. The physician's orders dated 11/13/15, directed R46 to receive oxycodone every four hours, as needed, for pain. On 11/12/15, at 8:55 a.m., trained medication aide (TMA)-B was observed at the medication cart in the hallway. While standing at the cart, TMA-B called loudly, "What's your pain?" to R46, who was in his room with the TV on. This could be heard by any resident, staff or visitor who was in the hallway. When asked if this method of asking about R46's pain maintained privacy, TMA-B replied, "I guess not", and continued to explain R46 is hard of hearing so she had to yell. In an interview on 11/13/15, at 9:52 a.m., registered nurse (RN)-A stated the facility expected licensed staff to ask about pain level in privacy. RN-A continued she would expect the nurse would go into a resident's room and have that conversation with the resident. RN-A also stated if the resident were hard of hearing, that is even more reason for the nurse to be at the resident's side.	F 164	3. Staff will be educated on the resident's right to privacy during cares. Completed 12-18-2015. 4. Observation rounds will be conducted two (2) times per week times 12 weeks to monitor the facility's system of respecting a resident's right to privacy. Any negative occurrence will be addressed with the staff member immediately. The observation round documentation will be presented to the monthly QAPI committee for review. After three months, the committee will recommend as to the need to continue to monitor that the facility demonstrates good practice on a resident's right to privacy is respected at all times.	

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

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F 164	Continued From page 4 The facility policy on Privacy undated, reviewed in 5/11, directed staff will speak with residents regarding their conditions in a private area. In addition, the facility's HIPAA and Confidentiality policy, dated 10/14, directed staff to lower their voice when discussing protected health information or move to a private area.	F 164	5. The Director of Nursing/designee will be responsible with oversight by the Administrator. Completed 12-31-2015.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt resolution of grievances, and feedback to residents, for 1 of 1 residents (R42), reviewed for grievances. R42's Admission record indicated diagnoses that included quadriplegia, type 2 diabetes, depression, and anxiety. R42's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated intact cognition. The MDS also indicated R42 required extensive assistance for transfers, bed mobility, dressing, eating, toileting and personal hygiene. R42's care plan dated 10/4/13, indicated R42 was at risk for injury/abuse due to mobility deficits, with the goal to not become a target of abuse, retaliation or receive injuries from another. Interventions included to observe for psychological, emotional and physical side effects.	F 166	1 .Resident #42 stated to the Director of Social Services that he was not affected by the alleged deficient practice. Weekly meetings between Social Services and resident # 42 have been initiated. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Administrator and Director of Social Services reviewed and revised the Policy regarding Resident Concerns. The Policy is revised to include documentation that the resident has been informed of the investigation and resolution of the concern. The Administrator and Director of Social services will review all resolutions.	

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F 166	Continued From page 5	F 166		

In an interview on 11/9/15, at 6:03 p.m., R42 stated he has made multiple complaints about a specific nursing assistant (NA) being very loud at night. R42 said every night this NA works, he gets woken up. R42 stated at the supper meal he just left, the NA didn't ask him a question directly, but asked another staff person to ask R42 a question. R42 stated this "attitude" all started when he made a complaint.

In the interview, R42 stated the facility social worker has said they're doing something about noise at night, but nothing has changed. R42 has requested that a NA not care for him, but has been told that the NA can't be taken off the unit and that if he won't have the NA in his room, then his cares won't get done.

During the interview, R42 said he was done complaining because all that happens is more attitude from nursing assistants. R42 said that when he recently complained, a nurse wrote up a behavior incident on him and then the nurse practitioner asked if he wanted to re-start antidepressant medication. R42 stated he is worried that if he says anything, he'll have to go back on his antidepressant.

In an interview on 11/13/15, at 11:07 a.m., the social service director (SSD) stated when a complaint is filed, they notify the Director of Nursing and the administrator; they report to the state agency if necessary, and make sure the resident is safe. Ultimately, the written complaint comes to the SSD and social services completes the follow-up and coordinates work with the appropriate department. The SSD stated residents can verbally complain and staff can

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F 166	Continued From page 6 write it on the grievance form. The social services department tracks complaints and reports to quality assurance (QA). The SSD stated some residents are care planned for making false accusations about staff, but the facility still investigates. The facility will care plan this only after a pattern is identified with a resident. During the 11/13/15, at 11:07 a.m., interview, the SSD stated that R42 did request to not have a staff person work with him, a long time ago, maybe in June. The SSD stated R42 will make these requests and then change his mind. The NA does not normally work with R42, but if two people are needed the NA will come to assist, unless R42 "says no." In an interview on 11/18/15, at 7:57 a.m., R42 stated he did talk to the facility social worker and the unit's nurse manager more than once about his concerns of loud NA's at night. R42 stated they did tell him they are "working on it" but he has gotten no other information about the status of the grievance. In an interview on 11/18/15, at 8:03 a.m., SSD stated the facility has a grievance process that typically begins with completion of a complaint form. Residents can report orally, but they prefer a written complaint because it is better for tracking purposes. SSD stated social services followed up on complaints and kept a log of concerns/grievances. SSD stated she had received one complaint on 10/22/15, by R42 of noise at night. SSD stated she talked to the night nurse about the complaint. SSD stated the night NA's happened to be working an evening, so she talked to them about	F 166		

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F 166	Continued From page 7 keeping noise down at night, acknowledging that it is their day, but it is the resident's night. SSD stated when she arrived in the morning, she will check in with the night nurse if anything was out of the ordinary. SSD stated she has not asked the night nurse about noise level recently and they have not audited night noise. SSD stated she had not received any other complaints from R42 regarding noise or other concerns. The facility resident concern policy, revised 5/2/15, directed concerns may be written or present orally. The policy further directed all concerns will be investigated and resolved within 30 days, except in extenuating circumstances that have been explained to and are acceptable to the complainant.	F 166	4. All resident concerns and the resolution that those concerns were presented to the resident will be reported at the monthly QAPI meeting for (3) three months. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that the facility informs the resident of the investigation and resolution of those concerns. 5.The Director of Social Services /designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225	1 .Residents # 96 and #90 were not affected by the alleged deficient practice. Social Services has initiated weekly meetings with resident # 90. Two staff members will be assigned to provide cares to resident #96. 2. All residents have the potential for being affected by the deficient practice.	

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F 225	Continued From page 8 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential mistreatment to the State Agency (SA) and thoroughly investigate allegations of potential mistreatment for 2 of 3 residents (R90, R96) reviewed for potential mistreatment. Findings include: R90 stated he had been verbally abused by a staff member, he had reported it to the facility, and the facility told him they couldn't do anything about it unless he put it in writing. R90's quarterly Minimum Data Set (MDS) dated 9/14/15, identified diagnoses that included cerebral vascular accident (CVA, commonly known as a stroke). The MDS also identify R90	F 225		

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F 225	Continued From page 9 had no behaviors, was continent of urine, and required extensive staff assistance with bed mobility, personal hygiene and toileting. The care plan dated 1/8/14, indicated R90 used a condom catheter at night, and used the urinal with staff assistance every two hours and as needed. On 11/10/15, at 12:45 p.m. R90 stated (a while ago) his condom catheter had come off during the night. Nursing assistant (NA)-N came into his room, and when he asked her to leave the condom catheter off, he would use the urinal, she became angry. NA-N stated she didn't have time to change him if he became wet (with urine). R90 described her behavior as loud, rude and snotty. R90 stated he reported NA-N's verbal abuse the following day. On 11/12/15, at 12:24 p.m. family member (F)-A stated she went with R90 to report NA-N's verbal abuse to staff the following day. F-A stated they reported to registered nurse (RN)-G, who told them a resident's report of verbal abuse by a staff member must be put in writing, or the facility was unable to do anything about it. On 11/12/15, at 7:10 a.m. the director of nursing (DON) verified there was no mistreatment report for R90's report of verbal abuse by NA-N. On 11/12/15, at 4:30 p.m. RN-G was interviewed and stated she remembered R90 and F-A reporting verbal abuse by NA-N. RN-G stated she reported it to the DON, and was told either by the DON or the social worker R90 that F-A needed to fill out a grievance form. RN-G further stated the nursing assistant union was strong, and a complaint had to be in written form by the resident. At 5:48 p.m. RN-G stated she gave R90's completed grievance form to the DON.	F 225		

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F 225	Continued From page 10 On 11/12/15, at 5:52 p.m. the DON was interviewed, and stated R90 and F-A filled out a grievance form regarding alleged verbal abuse by NA-N. The DON stated she did not report R90's allegation of verbal abuse to the state agency, and she did not investigate. "It was a 'he said she said' " the DON verbalized, "I have a union here," and she instructed NA-N not to go into R90's room again. On 11/13/15, at 2:10 p.m. the director of human resources (HR)-I stated she did not receive a grievance form completed by R90 and F-A, and there was no documentation in NA-N's file indicating any type of discipline regarding R90's complaint of alleged verbal abuse. On 11/13/15, at 2:16 p.m. the director of social services (SW)-B stated she did not have a grievance form completed by R90 and F-A. On 11/13/15, at approximately 2:15 p.m. the facility provided a copy of R90 and F-A's grievance form. The grievance form was dated 7/29/15, and indicated the following: "Resident's (sic) rang for staff on NOC (night) shift to come in as condom catheter was falling off. Staff (NA-N) was CNA (certified nursing assistant). Resident asked to have condom cath removed and he would use urinal rest of night. Staff responded 'no, I don't want you to piss the bed' and demanded resident have condom cath put back on." The form was signed by RN-G and dated 7/30/15, and the DON and administrator were notified on 7/30/15. The facility policy and procedure on Abuse Prevention Plan undated, directed the administrator must be informed immediately of all	F 225		

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F 225	Continued From page 11 incidents. The Abuse Prevention Plan defined verbal abuse as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or their families. The policy further directed that all incidents are to be reported, documented and investigated internally. 2. R96 had diagnoses of physiological condition, low back pain, generalized arthritis. The quarterly Minimum Data Set (MDS) dated 10/19/15, identified R96 had no cognitive impairment and required extensive limited assistance from one person for activities of daily living (ADL)'s. The MDS also identified R96 as having no behaviors. R96's care plan dated 11/10/13, indicated "Resident is a vulnerable Adult, at risk for injury/abuse from others due to cognitive deficits. Potential for retaliation related to Bipolar Disorder. Resident also noted to give money away." Also "[R96] has potential to demonstrate verbally abusive behaviors." An applicable intervention to this was to give R96 as many choices as possible. An Interview on 11/10/15, at 12:50 p.m. R96 said "One time I was abused. It was a nurse assistant. I was sitting on the toilet with my sweater on. She wanted to take the sweater off and I said no but she took it off anyway. She fractured my thumb. When I told her she was hurting me she said 'I don't give a fuck'. I told everyone, she was gone as long as my thumb	F 225	3. Staff were inserviced on the Abuse, Neglect, and Mistreatment Policy. The Administrator reviewed the policy and procedure with the Director of social services and the DON reviewing with them the procedures and expectations for a thorough investigation. The Administrator directed the Director of Social Services to resume primary responsibility for conducting the investigation relating to any allegation of abuse , neglect or mistreatment o the resident. Any alleged abuse, neglect or mistreatment will be reported to the proper State agencies.	

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F 225	Continued From page 12 was healing. That isn't much of a penalty for hurting me. Everyone that knows me know I don't need to be treated like that, I cooperate". An Interview on 11/12/2015, at 1:50 p.m. the director of nurses (DON) said R96 kept telling them different events that had happened to her . R96 had a "tussle" in the smoking area, a fall and this event. The DON said no other staff received a report. The DON said the next day R96 reported nursing assistant (NA)-T grabbed her finger. The DON said she investigated it right away but did not have a through investigation regarding this issue. The report dated 06/30/15, indicated "The resident was interviewed several times, including by this writer. She told different stories of event each time. She had forgotten that she fell, or that the day prior to the report that another resident grabbed something from that same hand and that she had complained of pain at the time as well. Bruise is healing. The staff in question was also interviewed by this writer, and stated that there was no incident of her bumping or grabbing the resident's hand. She had helped her remove a shirt, and a bit later offered help with cares which resident refused . Resident has multiple dx [diagnosis] and has been angry that she needs staff supervision for her smoking There is no findings of abuse in this case." Under incident description "The resident reports that her hand is sore, and that an aide last evening hurt her hand during cares. Employee suspended pending investigation, and care can changed that 2 staff be in the room during cares. Investigation ongoing." There is no further investigation.	F 225		

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

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F 225	Continued From page 13 An interview with registered nurse (RN)-A on 11/17/15, at 11:13 a.m. said she (R96) reports abuse to us regularly. RN-A said there is a correlation between not R96 getting her way and making reports of abuse. An interview on 11/17/2015, at 11:25 a.m. with social services (SS)-B stated she hasn't been completing the vulnerable adult (VA) report for 9 months to a year. SS-B said it was transitioned to nursing at that time, but in the last couple weeks was being transitioned back to the social services department again. SS-B said she had nothing to do with R96's VA report from July or the investigation. An interview with DON on 11/17/2015, at 3:01 p.m. said she does not have any further investigation of the broken finger. The DON said this is a she said/she said and R96 has a lot of diagnoses that make her unreliable. A final radiology report dated 7/1/15, indicated "There are likely degenerative in etiology, however small avulsed fracture fragment is not completely excluded". A physician office visit dated 7/8/15, indicated "There is dark purple ecchymosis present on the thenareminence, the volar wrist, and the dorsal thumb". Nursing progress notes were requested for this event but were not received.	F 225	4. All allegations – and the investigations- of abuse, neglect and mistreatment will be presented to the QAPI monthly meeting every month for three (3) months to monitor the thoroughness of the investigations. After three months the QAPI committee will make a recommendation as to the need to monitor that the facility has properly investigated and reported all alleged abuse , neglect and or mistreatment. 5. The Director of Social Services/designee with oversight from the Administrator will be responsible. Completion date of 12-31-2015.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226	1. Residents # 96 and #90 were not affected by the affected deficient practice. Social services has initiated weekly meetings with Resident #90. Two staff members will be assigned to provide cares to resident #96.	

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F 226	Continued From page 14 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their abuse policy to ensure immediate reporting of allegations of potential mistreatment to the State Agency (SA) and thoroughly investigate allegations of potential mistreatment for 2 of 3 residents (R90, R96) reviewed for potential mistreatment. Findings include: R90 stated he had been verbally abused by a staff member, and the facility failed to report to the SA, and thoroughly investigate. The facility policy and procedure on Abuse Prevention Plan undated, directed the administrator must be informed immediately of all incidents. The Abuse Prevention Plan defined verbal abuse as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or their families. The policy further directed that all incidents are to be reported, documented and investigated internally. R90's quarterly Minimum Data Set (MDS) dated 9/14/15, identified diagnoses that included cerebral vascular accident (CVA, commonly known as a stroke). The MDS also identify R90	F 226	2. All residents have the potential for being affected by the alleged deficient practice. 3. Staff were inserviced on the Abuse, Neglect, and Mistreatment Policy. Completed 11-18-2015. The Administrator reviewed the Mistreatment Policy and Procedure with the Director of Nursing and the Director of Social Services and the procedures and expectations for a thorough investigation. The Administrator directed the Director of Social Services to resume primary responsibility for conducting the investigation relating to any alleged abuse, neglect and or mistreatment. Completed 12-4-2015. 4. All allegations and the subsequent investigations will be presented at the monthly QAPI meeting for three months to monitor that the faculty followed its Policy on Mistreatment. After three months the QAPI committee will make a recommendation as to the need to monitor that the facility has properly investigated and reported all alleged abuse , neglect and of mistreatment. 5. The Director of social services with oversight from the Administrator will be responsible. Completion date of 12-3-2015	

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F 226	Continued From page 15 had no behaviors, was continent of urine, and required extensive staff assistance with bed mobility, personal hygiene and toileting. The care plan dated 1/8/14, indicated R90 used a condom catheter at night, and used the urinal with staff assistance every two hours and as needed. On 11/10/15, at 12:45 p.m. R90 stated (a while ago) his condom catheter had come off during the night. Nursing assistant (NA)-N came into his room, and when he asked her to leave the condom catheter off, he would use the urinal, she became angry. NA-N stated she didn't have time to change him if he became wet. R90 described her behavior as loud, rude and snotty. R90 stated he reported NA-N's verbal abuse the following day. On 11/12/15, at 12:24 p.m. family member (F)-A stated she went with R90 to report NA-N's verbal abuse to staff the following day. F-A stated they reported to registered nurse (RN)-G, who told them a resident's report of verbal abuse by a staff member must be put in writing, or the facility was unable to do anything about it. On 11/12/15, at 7:10 a.m. the director of nursing (DON) verified there was no mistreatment report for R90's report of verbal abuse by NA-N. On 11/12/15, at 4:30 p.m. RN-G was interviewed and stated she remembered R90 and F-A reporting verbal abuse by NA-N. RN-G stated she reported it to the DON, and was told either by the DON or the social worker R90 that F-A needed to fill out a grievance form. RN-G further stated the nursing assistant union was strong, and a complaint had to be in written form by the resident. At 5:48 p.m. RN-G stated she gave R90's completed grievance form to the DON.	F 226		

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F 226	Continued From page 16 On 11/12/15, at 5:52 p.m. the DON was interviewed, and stated R90 and F-A filled out a grievance form regarding alleged verbal abuse by NA-N. The DON stated she did not report R90's allegation of verbal abuse to the state agency, and she did not investigate. "It was a 'he said she said' " the DON verbalized, "I have a union here," and she instructed NA-N not to go into R90's room again. On 11/13/15, at 2:10 p.m. the director of human resources (HR)-I stated she did not receive a grievance form completed by R90 and F-A, and there was no documentation in NA-N's file indicating any type of discipline regarding R90's complaint of alleged verbal abuse. On 11/13/15, at 2:16 p.m. the director of social services (SW)-B stated she did not have a grievance form completed by R90 and F-A. On 11/13/15, at approximately 2:15 p.m. the facility provided a copy of R90 and F-A's grievance form. The grievance form was dated 7/29/15, and indicated the following: "Resident's (sic) rang for staff on NOC (night) shift to come in as condom catheter was falling off. Staff (NA-N) was CNA (certified nursing assistant). Resident asked to have condom cath removed and he would use urinal rest of night. Staff responded 'no, I don't want you to piss the bed' and demanded resident have condom cath put back on." The form was signed by RN-G and dated 7/30/15, and the DON and administrator were notified on 7/30/15. R96 had diagnoses of physiological condition, low back pain, generalized arthritis. The quarterly Minimum Data Set (MDS) dated 10/19/15,	F 226		

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F 226	Continued From page 17 identified R96 had no cognitive impairment and required extensive limited assistance from one person for activities of daily living (ADL)'s. The MDS also identified R96 as having no behaviors. An interview on 11/10/15, at 12:50 p.m. R96 said "One time I was abused. It was a nurse assistant. I was sitting on the toilet with my sweater on. She wanted to take the sweater off and I said no but she took it off anyway. She fractured my thumb. When I told her she was hurting me she said 'I don't give a fuck'. I told everyone, she was gone as long as my thumb was healing. That isn't much of a penalty for hurting me. Everyone that knows me know I don't need to be treated like that, I cooperate." An interview on 11/12/2015, at 1:50 p.m. the director of nurses (DON) said R96 kept telling them different events that happened to her . R96 had a 'tussle' in the smoking area, a fall and this event. The DON said no other staff received a report. The DON said the next day R96 reported nursing assistant (NA)-T grabbed her finger. The DON said she investigated it right away, but did not have a through investigation regarding this issue. The report dated 06/30/15, indicated "The resident was interviewed several times, including by this writer. She told different stories of event each time. She had forgotten that she fell, or that the day prior to the report that another resident grabbed something from that same hand and that she had complained of pain at the time as well. Bruise is healing. The staff in question was also interviewed by this writer, and stated that there was no incident of her bumping or grabbing the resident's hand. She	F 226		

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F 226	Continued From page 18 had helped her remove a shirt, and a bit later offered help with cares which resident refused . Resident has multiple dx [diagnosis] and has been angry that she needs staff supervision for her smoking. There is no findings of abuse in this case." Under incident description "The resident reports that her hand is sore, and that an aide last evening hurt her hand during cares. Employee suspended pending investigation, and care can changed that 2 staff be in the room during cares. Investigation ongoing." There is no further investigation. An interview on 11/17/2015, at 11:25 a.m. with social services (SS)-B who said she hasn't been doing the vulnerable adult (VA) for 9 months to a year. She said it was transitioned to nursing at that time but in the last couple weeks was being transitioned back to the social services department again. SS-B said she had nothing to do with R96's VA report from July or the investigation. An interview with DON on 11/17/2015, at 3:01 p.m. said she did not have any further investigation of R96's broken finger. The DON said this is a she said/she said and R96 has a lot of diagnosis' that make her unreliable. A final radiology report dated 7/1/15, indicated "There are likely degenerative in etiology, however small avulsed fracture fragment is not completely excluded". A physician office visit dated 7/8/15, indicated "There is dark purple ecchymosis present on the thenareminence, the volar wrist, and the dorsal thumb".	F 226		

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F 226	Continued From page 19 Nursing progress notes were requested but were not received. R96's care plan dated 11/10/13 indicated "Resident is a vulnerable Adult, at risk for injury/abuse from others due to cognitive deficits. Potential for retaliation related to Bipolar Disorder. Resident also noted to give money away." Also "[R96] has potential to demonstrate verbally abusive behaviors." An applicable intervention to this was to give R96 as many choices as possible. An interview with registered nurse (RN)-A on 11/17/15, at 11:13 a.m. said she (R96) reports abuse to us regularly. RN-A said there is a correlation between R96 not getting her way and making reports of abuse.	F 226	1 .Resident # 49 has had no negative outcomes from the alleged deficient practice. Social Services purchased additional items of clothing for R49, which she has shown acceptance. 2. Residents who do not have the ability to make choices or do not have the ability to communicate likes and dislikes or needs have the potential to be affected by the alleged deficient practice. 3. Residents will be assessed which may include but not limited to making choices concerning clothing, grooming, name they preferred to be called, and or appropriate conversation with resident, etc. staff will be in-serviced on areas that relate to dignity, dignity related to resident care with resident interaction. Residents found to have needs or issues identified via assessment are assisted to assure that needs are met in n dignified method. Observation rounds will be conducted two times per week for 12 weeks to monitor that residents are appropriately dressed, groomed and that staff interaction are appropriate. Any negative occurrence will be addressed immediately.. Staff will be in serviced on the resident's right to be dressed in a dignified manner and promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that 1 of 1 residents (R49) was dressed in a dignified manner, ensuring that her back, shoulder and legs were covered and ensuring that her incontinent product was not visible. Findings include:	F 241		

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F 241	Continued From page 20 R49's admission record indicated diagnoses that included failure to thrive, depression, restlessness and agitation and diabetes. R49's annual Minimum Data Set (MDS), dated 7/8/15, indicated R49 had severely impaired cognition, required extensive assistance with bed mobility, transfers, dressing, eating, toileting and personal hygiene, and was frequently incontinent of bladder and bowel. On 11/9/15, at 3:46 p.m., R49 was observed in the second floor dining room wearing a top that snapped up the back. The shirt was not fully snapped and R49's lower back and green incontinent product were visible. On 11/13/15, at 12:48 p.m., R49 was sitting in the second floor dining room with a tab alarm pulling down the right side of her brown shirt collar so that R49's entire right shoulder was visible. When asked if R49 usually wore shirts off-shoulder, Nursing Assistant (NA)-F stated, "Not usually". During the observation, R49 spilt her hot chocolate on her shirt, pants and on to the floor. On 11/13/15, at 1:30 p.m., shortly after the above observation, R49 was observed sitting in her wheelchair in front of the second floor nursing station. R49 was no longer wearing the brown shirt or pants, but had on a long shirt, or dress, that snapped down the back. This piece of clothing only went half-way down R49's thighs, leaving her knees and lower legs uncovered. Because R49's lower legs were uncovered, knee-high nylons and a wander guard were also visible.	F 241	4.. Observation rounds will be conducted two (2) times per week for 12 weeks to monitor that residents are dressed and groomed in a dignified manner. Any negative occurrence will be addressed immediately. The observation round documentation will be presented to the monthly QAPI committee for three months to monitor the facility's system of having the resident's dressed and groomed in a dignified manner. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that the facility consistently practices that the resident's right to be dressed and groomed; that the facility promotes care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition fo their individuality. 5. The Administrator/designee will be responsible. Completed 12-18-2015.	

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F 241	Continued From page 21 The facility policy titled Quality of Life-Dignity dated 10/09, directed staff shall promote, maintain and protect resident privacy, including bodily privacy.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor frequency of bathing choices for 1 of 3 residents (R146) reviewed for choices. Findings include: On 11/9/15, at 2:49 p.m. family member (F)-B stated R146 would like to be bathed daily, and had bathed daily prior to admission to the facility. F-B stated he had given this information to staff, and the facility responded by telling him R146 is bathed twice a week. R146 was present during the interview, and nodded her head in agreement. R146's Admission Record identified diagnoses that included Down's syndrome and acute respiratory failure. The Minimum Data Set (MDS) dated 8/13/15, indicated R146 had severe cognitive decline, and required extensive assist	F 242	1. A family care conference was held on 12-9-2015. Resident # 146 's family would like two showers per week and changed from pm to am shift. However, the resident has discharged. 2. All residents have the potential to be affected by the alleged deficient practice. 3.. The Interdisciplinary Team was reeducated on F-242 regarding a Resident having the right for self-determination and choices in their plan of care. Completed 12-31-2015	

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F 242	Continued From page 22 with bathing. On 11/17/15, at 9:48 a.m. registered nurse (RN)-C stated the facility assigned residents a weekly bath day upon admission, and will provide 1 or 2 baths a week. RN-C stated R146 was bathed twice a week, however she was unsure if the facility had asked R146 or her family member her preference for more then one or two baths a week, and was unsure if they asked about her previous bathing routine. On 11/18/15, at 12:04 p.m. the director of nursing (DON) was interviewed and stated she would expect the facility honor resident choices for bathing frequency. The facility policy and procedure on Quality of Life - Accommodation of Needs dated 10/09, directed the resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.	F 242	4. The resident's right for self-determination and choices will be discussed with the resident and of guardian upon each admission. And The Interdisciplinary Team will review each resident's right to self-determination and choices in their plan of care at each quarterly care conference. Initiated 12-1-2015. 5. An audit will be completed each month for the next three months to monitor that choices are offered and documented in the Plan of care. Audits will be presented to the monthly QAPI committee for three months and then quarterly for the next year to monitor that a system assuring self-determination and resident choice is functioning.. 6. The Director of Social Services / designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	1 .Residents #152, who was on Hospice at the time of his skin issue, expired 7-2-2015. Resident #158, who is on Hospice has MD documentation that weight loss is unavoidable;, however resident does eat meals in her room where staff offer choices and encourage resident to eat. Resident # 61 has scheduled pain medication and documented as effective.	

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F 280	Continued From page 23 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revised the plan of care to include the moderate to severe pain assessment for 1 of 1 (R61) reviewed for pain from post tramatic head injury requirein gsurgical interventlon and acetabulum fracture, In addition, dietician's recommendations for 1 of 4 residents (R65) reviewed for dietary concerns and in addition, the facility did not update the plan of care for 1 of 1 residents (R152) reviewed in need of pressure ulcer prevention/treatment. Findings include: R61's care plan dated 11/3/15, indicated "Potential for pain r/t [related to] steatohepatitis (fatty liver), osteoarthritis, diabetes, cardiac issues, history of CVA [cerebral vascular accident], compression fracture in back, dermatitis in anal area and buttocks". There is no mention in the above care plan of the post surgical pain or the fractured acetabulum pain. R61's admission record indicated a diagnosis of	F 280		

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

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atrial fibrillation, depression, hypertension, diabetes mellitus, coronary artery disease. R61's admission Minimum Data Set (MDS) dated 10/29/15, indicated R61 was severely cognitively impaired, had no behavior problems, and felt sad in the past seven days. The MDS identified R61 had pain, and received pain medication daily, and was at risk of falls, and had a history of two or more falls without injury. and a fall with injury.

Pain assessments dated 9/8/15, 10/29/15 and 11/10/15, were analyzed and R61 went from not being awaken from the pain in the night to being awaken in the night from the pain. The pain was rated moderate to severe on all. The assessment dated 9/8/15, indicated R61 only needing pain medication every 3-4 days, but the two dated 10/29/15, and 11/10/15 both indicated daily pain and pain medications needed.

An interview on 11/12/2015, at 7:03 a.m. R61 said I'm okay but my legs hurt.

An observation of R61 on 11/12/2015, at 10:38 a.m. lying in his bed with his knees up and a pillow under them. When asked he rated his pain at a 8/10 (on a verbal scale where 1 was no pain and 10 was the most pain he has ever had).

An Interview with Registered nurse (RN)-A on 11/16/2015 at 4:07 p.m. stated she has seen R61 in a lot of pain and agreed he does not have pain control. She said she has seen him grimace in pain. She said all the staff should be using the same pain scale and she realized they are not. She will get all staff using the same pain scale . She said they do not us any non pharmaceutical pain interventions and they should.. She also said she spoke with the pharmacist, he reviewed

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F 280	Continued From page 25 R61's medications and the medical doctor will review the medications. The medical doctor scheduled a pain medication because of the facilities request. We realize since you have been here he doesn't have good pain control and his pain may be affecting his relentlessness and requested a regular pain medication. His new pain order is for oxycodone 10 mg 3 times daily. The medical doctor also reviewed his other medications. RN-A also said R61 does not have any behaviors. R152 did not have a comprehensive care plan developed to minimize the risk of development and promote healing of pressure ulcers. According to the undated face sheet, R152 was admitted on 5/28/15, with metastatic neuroendocrine carcinoma, inferior vena cava obstruction and significant nutritional deficits. A Care Area Assessment dated 6/5/15, identified R152 had the "potential" to develop pressure ulcers. The care plan dated as initiated on 6/5/15, identified a goal of having intact skin. The interventions identified included following facility protocols and policies and weekly treatment documentation. There were no individualized interventions in place to minimize the identified potential for skin breakdown. A progress note dated 5/28/15 revealed R152 had mepiplex on his coccyx at the time of admission for "preventative measures." A physician order dated 6/17/15, identified mepiplex (foam dressing) to the coccyx. On 6/19/15 a physician order directed staff to place an Optifoam dressing (an absorbent all in one wound dressing with a moisture barrier on the outside) to the skin breakdown on the right buttock. A	F 280		

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6/19/15, progress note identified skin breakdown noted on the right buttock measuring 2 centimeter (cm) by 2 cm. A weekly skin assessment completed 6/20/15, identified the skin was intact but then identified "skin broken at coccyx" with no further assessment. R152 expired on 7/5/15.

On 11/17/15, at 12:55 p.m. Registered Nurse (RN)-A stated there was no further care planning for R152. RN-A stated the care plan hadn't been finalized for R152 yet.

On 11/18/15 at 8:35 a.m. the director of nursing (DON) stated she recalled R152. The DON stated she believed R152 "never really opened up." The DON stated she would have to look at R152's record and would provide additional information. On 11/18/15 at 10:00 a.m. the DON provided copies of documentation and stated it was "everything we have on the wounds." Upon review of the documents, there was no additional information provided, including no other care planning content.

R158's significant change Minimum Data Set (MDS) dated 9/30/15, indicated R158 had moderate cognitive impairments. The MDS indicated R158 was independent with eating after set- up with a 5% decline in weight loss indicated. The MDS included diagnoses of cancer and dementia.

R158's care plan dated 10/9/15, indicated R158 was at risk for nutrition secondary to fluid restrictions, weight loss and infection problems. Interventions included:
- provide and serve diet as ordered
- monitor intake and record every meal
- weigh weekly on shower day

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R158's physician orders dated 11/10/15, included an order for a regular diet. The physician orders lacked an order for a nutritional supplement.

R158's Weights and Vitals Summary included the following weights:
- 11/7/15 119 pounds (lbs) -10% weight change
- 10/2/15 123 lbs -5% weight change
- 9/25/15 123.6 lbs
- 9/15/15 134.4 lbs
- 9/14/15 135.6 lbs
- 8/26/15 133 lbs
- 8/25/15 131.9 lbs

R158's meal intake record from 9/15/15, to 11/1/15, indicated the following meal intake percentages:

- 31 meals at 0% -25%
- 48 meals at 26% -50%
- 55 meals at 51% - 75%
- 27 meals at 76% - 100%

The medical record lacked evidence of a nutritional reassessment with a revision to the care plan.

On 11/17/15, at 8:03 a.m. R158 was observed eating in the dining room for the breakfast meal. R158 was served hot cereal, eggs, toast, a cup of frozen orange juice and a cup of coffee. During the observation R158 asked for more coffee and and was served a total of 3 cups during breakfast. R158 was being encouraged to eat throughout the meal and was assisted to put jelly on her toast, staff did not offer to place brown sugar or raisins on her hot cereal. During the meal R158 stated "I don't do eggs" when

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F 280	Continued From page 28 encouraged by the staff member to eat. The staff member did not offer R158 anything else to eat. R158 ate 75% of hot cereal, bites of eggs and her toast, leaving the crust. R158 consumed 3 cups of coffee, 1/2 of her milk and no orange juice. R158 stated "I've had enough." On 11/17/15, at 12:23 p.m. R158 was observed eating independently in the dining room for the lunch meal. R158 was served a cup of oranges with whipped topping, taco hotdish, mexican corn, 8 ounces (oz) of milk and 8 oz of coffee R158 ate 100% of the oranges and whipped topping and only bites of the taco hotdish and mexican corn. R158 drank 100% of her milk and coffee. During the observation R158 was busy playing with her dining room ticket and would frequently pick up her fork and not take a bite of food and then put the fork back down. R158 then pushed herself from the dining room table and propelled herself back to her room via her wheelchair. When interviewed on 11/18/15, at 9:05 a.m. the registered dietician (RD) stated residents are to be weighed monthly at a minimum and weights and food intakes are reviewed monthly by the dietician. The RD further stated if there is a decline in weight and food intake the resident would be reassessed for interventions to prevent further weight loss. The RD stated that R158 was a difficult case as she was on hospice care, however stated R158 is not actively in the dying process. Upon review of the RD's spreadsheet compared to the weights in the medical record the RD stated R158 was not looked at for a decline in weight do to the RD Inputting R158's weight of 123.6 lbs dated 9/25/15, as the residents weight to compare subsequent weights to, rather than the admission weight of 131.9 lbs	F 280	2. all residents have the potential to have issues with care planning. 3. .IDT members and licensed staff will complete in-service on care planning including updates as needed for change of status or condition, to be completed by 12/18/15. Care plans will be reviewed quarterly and discussed with resident and or family, and updated as needed; care plans are reviewed updated as needed with any change in condition such as, but not exclusively, falls, skin issues, changes in mentation or ADL status.; the Nurse Managers will recheck that care plans and care sheets are updated with above changes. 4.The DON will be responsible and report results of nurse manager findings to the QAPI committee for three months. After three months the nurse mangers will report any care plan issues to the DON and further education will be provided to staff as needed. 5.The Director of Nursing /designee will be responsible. Correction will be completed on or before 12-31-2015.	

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F 280	Continued From page 29 dated 8/25/15. The RD stated that she had missed the weight in her review and should have been reassessed for possible interventions.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow intervention on the care plan to prevent pressure ulcers for 1 of 4 residents (R22) reviewed for pressure ulcers. R22's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R22 had severe cognitive impairments and required extensive assistance with bed mobility and total assistance with transfers. The MDS included diagnoses of diabetes mellitus, hemiparesis and cerebral palsy. The MDS indicated R22 had a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), that was unhealed and was not present at the time of the previous assessment. R22's care plan dated 9/22/15, indicated the resident had a pressure ulcer to the right ischium (forms the lower and back part of the hip bone), Interventions included: - administer medications as ordered - administer treatments as ordered and monitor for effectiveness. - weekly skin assessment by a nurse, with	F 282	1 .Resident # 22 is followed by the WCC nurse; the wound has decreased in size and remains free of symptoms of infection. Resident has documented history of refusing re-positioning, which results in periodic skin issues. Staff continues to encourage resident to re-position. 2. All residents would be considered at risk for deficient practice. 3. Nursing staff will be re-educated on skin care with emphasis on prevention. Charge nurses are placing a laminated card under the resident with instruction to turn return to nurse and keeping a log on the unit to track repositioning. 4. Nurse mangers will collect the logs and present their report to the monthly QAPI committee for three months. After three months the QAPI committee will make a recommendation as to the need to continue to monitor or develop further interventions as needed. The Director of Nursing/designee will be responsible Completion date of 12-31-2015.	

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F 282	Continued From page 30 changes reported to the MD - skin risk assessment, Braden [assessment for predicating pressure ulcer risk] and tissue tolerance [assessment for repositioning schedule] quarterly and as needed (PRN) - monitor nutritional status, serve diet as ordered - moisturizer applied twice daily and PRN to skin, do not massage over bony prominences - weight bearing assist from staff for significant repositioning every two hours and PRN in wheelchair and bed, resident has a history of refusing. - requires an alternating air mattress on his bed and cushion in wheelchair. R22's medical record lacked evidence of a comprehensive skin risk assessment, to be done quarterly and PRN per the care plan. R22's medical record lacked a Tissue Tolerance Assessment, to be done quarterly and PRN per the care plan. The medical record lacked any assessments related to tissue profusion. R22's medical record lacked evidence of consistent weekly skin assessments since June of 2015. The following skin assessments after June of 2015 were dated 7/1/15, 8/19/15, 10/21/15, and 11/11/15. Review of the medical recorded indicated the stage 2 pressure ulcer was discovered on 9/2/15, and measured 4.5 centimeters (cm) x 0.5 cm x a depth of less than 0.1 cm. "Wound base was 90% red with 10% yellow tissue and was moist in appearance. No exudate, no odor. Surrounding tissue intact, pink and blanched. Writer applied foam border dressing and will seek physician orders. Interventions in place include alternating pressure mattress and wheel chair cushion."	F 282		

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F 282	Continued From page 31 When interviewed on 11/17/15, at 2:19 a.m. registered nurse (RN)-B stated that the nurses do a quarterly Braden Scale and weekly skin observation on residents, but they do not use a Tissue Tolerance assessment and added she has never seen that type of assessment since starting in the facility. RN-B verified that the weekly skin observations were not completed weekly as care planned for. When interviewed on 11/17/15, at 2:38 p.m. RN-H stated the facility does not use a Tissue Tolerance assessment for assessing for appropriate individualized repositioning schedules. When interviewed on 11/18/15, at 10:20 a.m. the director of nursing (DON) stated that all residents are on a every 2 hours repositioning schedule and that the nurses utilize the Braden Scale to determine an appropriate repositioning schedule for residents. The DON further stated that R22 was repositioned timely according to his care plan. The DON stated the facility does not use a specific tool to assess for tissue profusion. The DON further stated that weekly skin observations should be completed and documented.	F 282		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 285		

Don Babbitt Administrator
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F 285	Continued From page 32 (i) Mental illness as defined in paragraph (m)(2)(I) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (II) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (II) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess programming needs	F 285	1. The facility did receive a Level II PASSR for resident #146 and no outside resources/interventions were required for the resident. 2. Four residents were identified in the facility requiring a Level II PASSR. None of the residents required outside resources/interventions. 3. The Administrator reviewed the Standards for Level II residents requiring programming needs with the Director of Social Services. The Director of Social Services will include a specialized plan if care for all Level II residents identified in the Level II PASSR requiring special programming.	

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F 285	Continued From page 33 based on the Level II Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 1 residents (R146) reviewed with a developmental disability. Findings include: R146's Admission Record identified diagnoses that included Down's syndrome. The care plan dated 8/17/15, lacked indication of active treatment needs. R146's Level II PASRR dated 8/10/15, indicated R146 had a developmental disability, and required convalescent care from 8/6/15, to 10/6/15. The Level II PASRR further identified R146 required active treatment, and the facility assured active treatment needs will have been specified in R146's individual service plan, and would be met while R146 resided in the nursing facility. On 11/13/15, the facility was requested to provide a copy of R146's Level II PASRR. On 11/17/15, social worker (SW)-A provided a copy of R146's Level II PASRR, and stated the facility had just received a copy of it from the county via fax. SW-A verified the facility had not reviewed R146's Level II PASRR previous to this time. On 11/18/15, at 8:24 a.m. SW-A stated the facility was meeting R146's active treatment by having R146 participate in the facility activity programs. On 11/18/15, at 9:41 a.m. SW-A stated it was the county's responsibility to ensure the facility received the Level II PASRR, and the facility was currently waiting for R146 to be assigned a county worker. SW-A further stated R146 participates in many of the facility activities, and	F 285	An audit of all residents and all new admissions requiring a Level II screen and assed as needing special programming will be conducted every month to monitor that specialized plans of care have been developed for these residents. 4. the audits will be presented to the monthly QAPI committee for three months. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that Level II residents have the PASSR and specialized care plan. Completion date of 12-31-2015.	

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F 285	Continued From page 34 she spends a lot of time in her room. A policy and procedure on Level II PASRR evaluations was requested, but not provided.	F 285		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pain and implement interventions to relieve moderate to severe pain following lumbar (low back) and acetabulum (ball of femur) fractures for 1 of 1 residents (R61) reviewed for pain. This deficient practice caused actual harm to R61. In addition, the facility failed to provide coordination of care between the facility and the hospice agency for 1 of 1 residents (R109) reviewed for hospice. The facility also failed to provide services to a resident as directed by the physician for 1 of 1 residents (R143). Findings include: R61's admission record identified multiple diagnoses including traumatic subdural hematoma, lumbar compression fracture and hip fracture. R61's admission Minimum Data Set	F 309		

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F 309	Continued From page 35 (MDS) dated 10/29/15, indicated R61 was severely cognitively impaired and had no behavior problems. The MDS identified R61 had pain and received pain medication daily, and was at risk of falls with a history of falls with injury. The MDS further identified R61 required extensive assistance of one staff for activities of daily living (ADLs) and had not ambulated the past seven days. Pain assessments were completed 9/8/15, 10/29/15 and 11/10/15. R61 was awakened at night from the pain. The pain was rated moderate to severe on all. The most recent assessment dated 11/10/15, identified daily pain and pain medications needed. The Care Area Assessment (CAA) dated 10/29/15, indicated verbal behaviors such as moaning, groaning, and crying to demonstrate pain. The characteristics, frequency and intensity of the pain was not completed. R61's care plan dated 11/3/15, identified a potential for pain. The care plan directed pain medications as ordered, monitor for and report changes in routine or appetite and verbal/non-verbal complaints of pain. The care plan did not include any non-pharmacological interventions to help alleviate pain. The Medication Administration Record for 8/15, 9/15, 10/15, and 11/15 were reviewed. R61 started receiving oxycodone every three hours as needed (PRN) on 10/22/15, until 11/16/15, (during survey) when the medication order was change to provide pain medication at scheduled times. The oxycodone was given 9 times in 10/15, of the 60 potential opportunities for PRN doses, and was given 26 times in 11/15, of the 96 potential	F 309	Mon-Fri and the nurse managers review any resident changes or /issues. Any issues with follow through are addressed with staff immediately, education is provided as needed. 4.The DON reports any issues to the QAPI monthly. After three months the QAPI committee will make a recommendation as to the need for reeducation or revisions to the process. Completion date of 12-31-2015.	

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 309	Continued From page 36 opportunities for PRN doses which could have been provided. An observation of R61 on 11/12/2015, at 10:38 a.m. lying in his bed with his knees up and a pillow under them. When asked he rated his pain at a 8/10 (a verbal pain scale where 1 was no pain and 10 was the most pain he has ever had). An interview on 11/9/15 at 1:00 p.m. with physical therapist (PT)-A identified they had started seeing R61 10/22/15, to 10/30/15, and restarted 11/3/15 to current. She said when he came back from the hospital after his subdural hematoma in 9/15, he had orders for all three disciplines (physical, occupational, speech) to assess and treat him. PT-A stated they use a Wong-Baker pain scale (facial pictures) with R61 to measure his pain. PT-A continued to state after the 10/22/15, referral they only saw him for eight days. They attempted to ambulate him but he could not ambulate. He could only ambulate 3-4 steps from bed to chair with a walker. PT-A said, "He was in a lot of pain cause of his back [lumbar fracture]." The next request for therapy services was on 11/3/15, after returning from the hospital with the hip fracture from another fall. R61's orders were for weight bearing as tolerated and all three disciplines evaluated him. They tried a TENS unit (transcutaneous electrical nerve stimulation) for his pain. R61 rated his pain at a 10/10 and you could tell by his facial expressions if he was in pain. An interview on 11/12/15, at 8:50 a.m. physical therapy assistant (PTA)-A asked R61 to rate his pain using the Wong-Baker faces pain scale. R61 rated his pain a 10/10. PTA-A said she always utilized that pain scale. PTA-A verified he was	F 309		

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F 309	Continued From page 37 given pain medication at 8:13 a.m.. PTA-A indicated she evaluated R61's wheelchair on 11/9/15. She stated the leg of the wheelchair was too short for R61. She could not explain why the leg rest had not been adjusted for R61. PTA-A put R61's leg on a stool and R61 hollered out in pain. PTA-A told PT-D that his leg kept falling off the leg rest as the leg rest on the wheelchair was too short for him. R61 moaned and whimpered the whole time PTA-A was moving his leg. R61 repeatedly said "it hurts" and "ouch, ouch, ouch." At 8:54 a.m. PTA-A asked R61 what his pain level was and he said 10/10. PTA-A was not able to continue the therapy on his legs so she used a balloon to play ball. A subsequent interview on 11/12/15, at 9:02 a.m. PTA-A said R61 has not been able to move his leg due to pain. PTA-A stated he was weight bearing as tolerated but can't walk due to his pain level. She said she usually walks people sooner after an injury but has not walked him due to "extreme pain." She said she didn't ask if they gave him something for pain. She said it is important to have scheduled pain medications. Interview on 11/12/15, at 10:11 a.m. nursing assistant (NA)-H stated R61 cried out in pain a lot because of his back and hip injury. He said the pillow between R61's legs in bed was because he wouldn't straighten his leg out. She went on to say R61's wheelchair did not fit him and the wheelchair hurt him. An interview on 11/12/15, at 10:38 a.m. while R61 was lying in bed, this writer asked R61 to rate his pain and he rated his pain at an "8/10". On 11/12/15, at 12:45 p.m. PT-A stated her expectation was a resident would get a pain	F 309		

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F 309	Continued From page 38 medication when they are in pain. She said R61 rated his pain as 10/10. PT-A said if the resident is still able to move and transfer they go ahead with therapy. PT-A said he used the sliding board to the Nu Step but R61 grimaced in pain. PT-A said there were no non pharmacological interventions used for R61's pain today. She didn't know why the TENS was not put on him. PT-A said when physical therapy did an evaluation on 11/6/15, post fall with injury, she said they changed his wheelchair because it didn't fit him well. PT-A was aware his wheelchair leg didn't fit him well and his leg kept sliding off the leg of the wheelchair. She said they put a calf pad in place that morning after the discussion with PTA-A. An interview on 11/13/15, at 8:47 a.m. occupational therapy (OT)-K asked R61 to rate his pain and he rated it at a 6/10 located near his left hip. She told him she would tell the nurse. NA-G said on 11/13/15, at 2:28 p.m. that she normally works another hall but "I know he is always in pain and yelling in pain." An interview on 11/13/15, at 2:29 p.m. trained medication assistant (TMA)-K said she used a pain scale called pain AD. She said it uses breathing, negative vocalization, facial expression, body language and consolable to determine pain level. She didn't know what others used to determine pain levels. The order was for oxycodone 5 mg (milligram) 1 - 2 tablets every 3 hours for pain PRN. She said if R61 had a pain level of 1-5 /10 she gave 1 tablet. If he had a pain level of 6-10 /10 she give 2 tablets. An interview with registered nurse (RN)-A on 11/16/15, at 4:07 p.m. stated she has seen R61 in	F 309		

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F 309	Continued From page 39 a lot of pain and agreed he did not have adequate pain control. She said she has seen him grimace in pain. RN-A stated all staff should be using the same pain scale and they are not. She said they do not us any non pharmacological pain interventions and "we should." RN-A stated since survey started R61 doesn't have good pain control. She further stated R61's pain may be affecting his restlessness so staff requested a regular pain medication. His new pain order is for oxycodone 10 mg 3 times daily. A progress note dated 10/24/15, at 1:11 a.m. identified R61 was restless and climbing out of bed several times. When asked if he had pain and wanted a pain pill R61 said yes. An observation on 11/17/15, at 9:05 a.m. PT-M said the TENS unit blocks the nerve synapse. She said it is a 15 minute treatment. PT-M indicated R61 had horrible pain some day's. PT-M stated therapy used a Wong Baker pain scale. R61 rated his pain as "a lot" on the Baker Wong scale before he started physical therapy . While PT-M was working with his left leg, R61 was saying his right side hurt. PT-M did not ask a nurse if he had his pain medication before therapy and did not apply the TENS unit. An interview on 11/17/15, at 7:55 a.m. RN-H stated she didn't use a pain scale. She just asked the resident if their pain was mild, moderate or severe. The last time she asked R61 about his pain, he said it was moderate. She said she was not aware of any standardized method in the facility, for pain management assessments. Interview with the DON on 11/18/15 at 7:58 a.m. identified R61 was placed on some	F 309		

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F 309	Continued From page 40 non-pharmocological interventions for pain on 11/17/15. "We saw that as a need for him." A facility policy titled: PAIN ASSESSMENT PROTOCOL reviewed 11/02, indicated. "It is the policy of Bayshore to provide for the optimum quality of life for every resident. Quality of Life includes individualized management of pain. Management of pain includes accurate assessment, pharmacological and non-pharmacological methods, and physical and psychosocial interventions." R109 received hospice services, and the facility failed to provide coordination of care. Findings include: R109's Admission Record identified diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 9/14/15, indicated R109 had severe cognitive impairment, and required extensive to total assistance of staff with bed mobility, transfers, dressing, eating, mobility, personal hygiene, bathing and toileting. R109 began receiving hospice services on 12/2/15, for end of life services due to the diagnosis of Alzheimer's disease. The most recent certification by the hospice agency was 9/17/15, and at that time it was determined he would receive skilled nursing services once a week for nine weeks, and nursing assistant (NA) services twice a week for nine weeks. On 11/12/15, at 1:27 p.m. nursing assistant (NA)-K was interviewed, and stated the hospice NA came to the facility two or three times a week. NA-K stated they came at different times of the week, and different times of the day. NA-K stated	F 309		

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F 309	Continued From page 41 the facility was unaware of when the hospice NA was going to be at the facility to care for R109. On 11/17/15, at 9:36 a.m. registered nurse (RN)-C was interviewed, and stated the hospice NA schedule was "sporadic" and "they just come." RN-G stated the facility does not have the hospice NA-s schedule, and they do not call the facility prior to coming out. RN-G further stated the hospice NA's have their own schedule, and the facility does not know when they are coming. On 11/18/15, at 11:57 a.m. the director of nursing (DON) was interviewed and stated she assumed the facility was aware of the hospice NA visit schedule. The facility policy and procedure on Hospice Program dated 2/14, directed when a resident participates i the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed. R143 did not receive timely and accurate assessments of clinical changes with corresponding physician updates as needed. According to his admission face sheet, R143 was admitted on 7/13/15, with a short term admission plan for rehabilitation services. The resident diagnosis report dated 7/13/15, identified multiple diagnoses including right below the knee ambulation (RBKA), diabetes and hypertension. Admission orders for R143 on 7/13/15, included full code status; accucheck (blood sugar) four times a day, call if results >250 milligrams/deciliter mg/dL or <70 mg/dL; daily weights - if resident gains more than 3# overnight	F 309		

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F 309	Continued From page 42	F 309		

or 5# or more in one week - call MD; and multiple medications. R143's admission weight was 233 pounds. R143's admission Minimum Data Set dated 7/20/15, identified he needed extensive to full assistance with cares and was moderately confused. In addition, it identified R143 did not have a shortened life expectancy.

On 7/14/15 at 12:22 p.m. the Medication Administration Record (MAR) identified a blood sugar (BS) of 297 mg/dL R143's daily weight was 229 pounds. There was no assessment for hyperglycemia (high BS) and the physician was not updated as ordered. R143 was on no medications to assist with blood sugar management.

No weight was obtained on 7/15/15. On 7/16-17/15 R143 weighed 230 pounds. There was no weight obtained on 7/18/15. On 7/19/15 R143 weighed 231 pounds. On 7/20/15 no weight was obtained.

On 7/21/18 a fax was sent to the primary physician identifying "Many abnormal values" for labs. There was no further assessment information documented or relayed to the physician. The physician responded indicating the low hemoglobin was "the only critical one". The physician then ordered medications changes and to check stool for occult blood, orthostatic blood pressure - tell me if >20 millimeter systolic drop - will see him on 7/23/15. On 7/21/15 at 10:58 p.m. R143 had a BS of 277 mg/dL. The physician was not updated and there was no assessment for hyperglycemia.

On 7/22/15 another fax was sent to the physician identifying increased swelling to the scrotum and

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F 309	Continued From page 43 right side of penis. The daily weight had not been obtained and there was no assessment to correspond with this identified problem. At 2:00 p.m. R143 had a BS of 260 mg/dL. The physician was not updated and there was no assessment for hyperglycemia. There was no daily weight on 7/23/15. In addition on 7/2315 at 5:51 a.m. R143's blood pressure was 217/93. His previously documented blood pressures had never gone above 166/80. No other assessment was completed and the physician was not updated. Another fax was sent to the physician on 7/24/15 identifying on 7/19/15 R143's weight was 231.5 pounds and today was 242.3 pounds. It further identified R143 had a notable increase in edema of legs, scrotum, hands/arms. There was no further assessment obtained or provided. On 7/24/15 the physician ordered labs and medication changes and requested the facility fax the results of the stool occult and orthostatic blood pressures. In addition the physician ordered a chest x-ray (CXR), and electrocardiogram (ECG). Although the orders were written on 7/24/15 they were not transcribed until 7/25/15. The blood for the lab work was no collected until 7/28/15. Interview with RN-A on 11/17/15 at 1:10 p.m. revealed she did not know why the transcription and implementation of the new physician orders had been delayed. On 7/2515 the ECG identified "possible coronary ischemia." There was no evidence the physician was informed. The CXR dated 7/25/15 identified a "pulmonary edema pattern" which was faxed to the physician on 7/26/15. There was no daily weight obtained 7/25/15. On 7/26/15 the occult stools came back positive. There was no evidence it was faxed to the physician. Although it was stamped "Faxed" the area for	F 309		

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F 309	Continued From page 44 date/time/initials was blank. Interview with Registered Nurse (RN)-A on 11/15 at 1:10 p.m. indicated there was no indication in the record the physician had been notified of the occult stool results. On 7/26/15 R143's weight was 258.5 pounds for a total gain of pounds 25 since admission on 7/13/15. No further assessments were completed and no further physician updates were provided. On 7/29/15 at 2:00 a.m. progress notes identified a caregiver answered the call light. He stated his back hurt wanted to be turned on his side. While the caregiver was talking to the resident he became cyanotic and unresponsive. A code blue was called and cardiopulmonary resuscitation was provided until paramedics arrived. R143 was determined to be expired at 3:05 a.m. Interview with RN-A on 11/17/15 at 1:10 p.m. indicated there had been no assessments of R143's condition. RN-A stated the physician was not updated with the blood sugars and nothing was being monitored for those changes. RN-A stated the facility had begun monitoring for hyper/hypoglycemia every shift but that had not been initiated here. RN-A further stated she recalled the physician being updated on some weights but "just not every day." RN-A stated she would have to "believe we notified him." However, she also stated it was "unusual and suspicious" that there was nothing documented and no further orders had the physician been updated. RN-A stated she remembered [R143] and was aware of "some of the problems but I can't say I was updated on all of them." RN-A acknowledged that as she reviewed things she would have "gone forward and updated the physician." She further said she would have sent R143 to the	F 309	1. No residents were affected by the alleged deficient practice of failing to coordinate care with Hospice. 2. All Hospice residents may be affected by the alleged deficient practice. 3. An interdisciplinary meeting was held with Hospice on 12-9-2015 regarding coordination of care. Meetings are scheduled every two weeks. Hospice is providing schedules of the nursing assistant visits every Monday.	

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F 309	Continued From page 45 emergency room had she received no response from the physician. Interview with the residents physician (P)-A on 11/17/15 at 2:45 p.m. indicated he had seen R143 on 7/24/15. He had been updated in R143's weight gain and he suspected ascites (fluid in the abdominal cavity) and fluid overload. P-A further indicated R143 had multiple co-morbidities and the facility had not received a lot of information at the time of this resident's admission. Based on the results received from the tests ordered on 7/24/15, "things looked terrible," going on to say R143 had the fluid overload, ascites, and pancytopenia (deficiency of all three cellular components of the blood - red cells, white cells, and platelets). P-A went on to say he believed R143 had bone marrow issues that would have required very aggressive tests to determine what the issues were followed by very aggressive treatment. When interviewed on 11/18/15 at 11:36 a.m. the director of nursing (DON) stated she did not have a quality review process for the care provided in death records. The DON stated when she reviewed a death record she reviewed for notifications but "since I've been here there hasn't been a question of wrongful death." The DON further stated that the majority of deaths were "hospice or expected" and no physician had ever questioned a death so death records weren't reviewed. The DON stated R143 was refusing things and it was difficult to get him to cooperate .	F 309	4. Minutes of the biweekly meeting with Hospice will be reviewed at the monthly QAPI committee to assure coordination of care is continuing. 5. The Director of Nursing/designee is responsible. 1 .Resident # 143 expired 7-29-2015. 2 .All residents have the potential to be affected by the alleged deficient practice. 3 .License staff will be in-serviced on providing services as directed by a physician. 4. The facility will audit two (2) resident charts per week times twelve weeks to monitor license staff are providing services as directed by a physician. Any negative occurrence will be immediately reported to the Director of Nursing. These audits will be presented to the monthly QAPI for three months for review and recommendations. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that the license staff are providing services as directed by the Physician. 5. The Director of Nursing /designee will be responsible. Completion date of 12-31-2015	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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F 314	Continued From page 46 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services to prevent and promote healing of pressure ulcers for 2 of 4 residents (R22 and R152) reviewed for pressure ulcers. Findings Include: R22's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R22 had severe cognitive impairments and required extensive assistance with bed mobility and total assistance with transfers. The MDS included diagnoses of diabetes mellitus, hemiparesis and cerebral palsy. The MDS indicated R22 had a stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), that was unhealed and was not present at the time of the previous assessment. The skin Care Area Assessment (CAA) dated 1/21/15, indicated that R22 was at risk for developing pressure ulcers due to impaired mobility, incontinence, needed extensive assistance with positioning and had a history of healed pressure ulcers.	F 314	1. Resident #22 is followed by the WCC nurse, the wound has decreased in size, and remains free of signs and symptoms of infection. Resident has history of refusing repositioning, which results in occasional skin issues. Staff continue to encourage repositioning. 2. All residents would be considered at risk for alleged deficient practice. 3. The Nursing staff were reeducated on skin with a focus on prevention of development of wounds. Charge nurses are placing a laminated card under residents with instructions to return to nurse and keeping a log on the Unit to track repositioning. 4. Nurse managers will collect the logs and report to the monthly QAPI committee. After three months the QAPI committee will make a recommendation as to the need to continue to monitor the repositioning program. 5. The Director of Nursing/designee with	

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F 314	Continued From page 47 R22's care plan dated 9/22/15, indicated the resident had a pressure ulcer to the right ischium (forms the lower and back part of the hip bone), interventions included: - administer medications as ordered - administer treatments as ordered and monitor for effectiveness. - weekly skin assessment by a nurse, with changes reported to the MD - skin risk assessment, Braden [assessment for predicating pressure ulcer risk] and tissue tolerance [assessment for repositioning schedule] quarterly and as needed [PRN] - monitor nutritional status, serve diet as ordered - moisturizer applied twice daily and PRN to skin, do not massage over bony prominences - weight bearing assist from staff for significant repositioning every two hours and PRN in wheelchair and bed, resident has a history of refusing. - requires an alternating air mattress on his bed and cushion in wheelchair. R22's medical record lacked evidence of a comprehensive skin risk assessment, to be done quarterly and PRN per the care plan. R22's Braden Scale dated 9/22/15, indicated R22 was at a low risk for developing pressure ulcers. R22's medical record lacked a Tissue Tolerance Assessment, to be done quarterly and PRN per the care plan. The medical record lacked any assessments related to tissue profusion. R22's medical record lacked evidence of consistent weekly skin assessments since June of 2015. The following skin assessments after	F 314	Oversight from the Administrator will be responsible. Completion date of 12-31-2015,	

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F 314	Continued From page 48 June of 2015 were dated 7/1/15, 8/19/15, 10/21/15, and 11/11/15. Review of the medical recorded indicated the stage 2 pressure ulcer was discovered on 9/2/15, and measured 4.5 centimeters (cm) x 0.5 cm x a depth of less than 0.1 cm. "Wound base was 90% red with 10% yellow tissue and was moist in appearance. No exudate, no odor. Surrounding tissue intact, pink and blanched. Writer applied foam border dressing and will seek physician orders. Interventions in place include alternating pressure mattress and wheel chair cushion." Skin/Wound Noted charted weekly from 9/22/15-11/10/15 with required wound descriptions. The medical record lacked any evidence of a re-assessment of the residents current pressure ulcer interventions or an analysis to the cause of the current pressure ulcer. A fax was sent to the physician on 9/29/15 regarding the current treatment of a foam dressing not staying in place. The physician responded and ordered a thin hydrocolloid dressing to be changed every 3 days. Review of the medical record lacked evidence that the wound or dressing with surrounding skin were observed daily. When interviewed on 11/17/15, at 7:14 a.m. nursing assistant (NA)-D stated that R22 was to be repositioned every 2 hours and needed assistance to reposition. NA-D stated that R22 has a roho cushion in his wheelchair and an alternating air pressure reducing mattress on his bed. NA-D was not aware of any changes to	F 314		

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F 314	Continued From page 49 R22's care plan since the development of the stage 2 pressure ulcer. When interviewed on 11/17/15, at 2:19 a.m. registered nurse (RN)-B stated she does the weekly measuring and assessments of the wounds in the facility. RN-B verified R22 developed a stage 2 pressure ulcer to his right ischium on 9/22/15, and the pressure ulcer has improved. RN-B described that the nurses do a quarterly Braden Scale and weekly skin observation on residents, but they do not use a Tissue Tolerance assessment and added she has never seen that type of assessment since starting in the facility. RN-B could not provide documentation of an analysis of why R22 had developed a pressure a ulcer. When asked what new interventions had been implemented for R22 RN-B stated that she thought he was seen by therapy but after reviewing the medical record could not provide a date or information regarding any therapy R22 had received. RN-B further stated that residents are always care planned for repositioning every 2 hours unless the frequency is required to be less. RN-B could not state or provide documentation on how R22 was assessed for an every 2 hour repositioning schedule. During the interview RN-B verified that the weekly skin observations were not completed weekly as care planned for. RN-B also stated that all wounds are discussed in the weekly weight loss and skin team meeting. R22's medical record lacked any documentation related to the weight loss and skin team meeting discussions. On 11/17/15, at 2:38 p.m. RN-H stated the facility does not use a Tissue Tolerance assessment for	F 314		

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F 314	Continued From page 50 assessing for appropriate individualized repositioning schedules. RN-H stated the facility gets instructions on admission from the hospital on the repositioning frequency a resident needs or from physical or occupational therapy. When interviewed on 11/18/15, at 7:43 a.m. the occupational therapist (OT) stated R22 was seen from 7/30/15 through 8/21/15 prior to the development of the current pressure ulcer. The OT stated R22 was assessed for wheelchair positioning to aid in independent eating. The OT stated R22 had a cushion removed from his wheelchair that had been placed on top of his roho cushion and they adjusted the back of his wheelchair to decrease leaning. The OT stated she was made aware of R22's development of a stage 2 pressure ulcer but did not pick him up for therapy as there isn't anything more therapy could do for R22. The OT further stated that the therapy department can do pressure mapping if requested and ordered but they do not do routine screening for tissue profusion and added that it is a nursing assessment. When interviewed on 11/18/15, at 8:23 a.m. RN-C replied "That's a really good question," when asked how a resident is assessed for appropriate repositioning schedules. RN-C reviewed R22's record and confirmed that R22's record lacked a comprehensive risk assessment and tissue tolerance assessment. RN-B stated she was taught to use the Braden Scale, then confirmed the Braden is not a comprehensive risk assessment. On 11/18/15, at 9:35 a.m. R22's wound was observed to be a stage 2 pressure ulcer to the	F 314		

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F 314	Continued From page 51 right ischium. The wound bed was beefy red, without slough or odor. The edges of the wound were intact and the surrounding tissue blanched. Registered nurse (RN)-B stated the measurements had not changed since 11/17/15 when she did her weekly rounds. The wound had measured 2.4 cm x 1.2 cm x a depth of less than 0.1 cm. When interviewed on 11/18/15, at 10:20 a.m. the director of nursing (DON) stated that all residents are on a every 2 hours repositioning schedule and that the nurses utilize the Braden Scale to determine an appropriate repositioning schedule for residents. The DON further stated that R22 was repositioned timely according to his care plan. The DON stated the facility does not use a specific tool to assess for tissue profusion. The DON further stated weekly skin observations should be completed and documented. The undated facility Skin and Wound Manual indicated assessment of potential skin problems are completed upon admission, weekly, readmission and daily for high risk patient/residents. Requested a policy on the prevention of pressure ulcers and the facility did not provide one. R152 did not receive services to minimize the risk of development and promote healing of pressure ulcers. According to the undated face sheet, R152 was admitted on 5/28/15, with metastatic neuroendocrine carcinoma, inferior vena cava obstruction and significant nutritional deficits. A Care Area Assessment dated 6/5/15, identified R152 had the "potential" to develop pressure	F 314		

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F 314	Continued From page 52 ulcers. The care plan dated as initiated on 6/5/15, identified no individualized interventions for R152 but did identify it would follow facility protocols and policies. A progress note dated 5/28/15 revealed R152 had mepiplex on his coccyx at the time of admission for "preventative measures." The Braden skin risk assessment of 5/28/15, identified R152 to be at low risk for skin breakdown. A physician progress note dated 6/2/15, indicated no skin breakdown. A physician order dated 6/17/15, identified mepiplex (foam dressing) to the coccyx - change dressing every 4-7 days and as needed (PRN) - float heels and remind [R152] to reposition every 2 hours. There was no documentation in the record to correspond with the need for the new physician's order. On 6/19/15 a physician order directed staff to place an Optifoam dressing (an absorbent all in one wound dressing with a moisture barrier on the outside) to the skin breakdown on the right buttock. A 6/19/15, progress note identified skin breakdown noted on the right buttock measuring 2 centimeter (cm) by 2 cm. A weekly skin assessment completed 6/20/15, Identified the skin was intact but then in a section for skin issues the weekly note identified "skin broken at coccyx" with no further assessment. There was no further wound documentation for R152. R152 expired on 7/5/15. On 11/17/15, at 12:55 p.m. Registered Nurse (RN)-A stated there was no further documentation available on R152's skin status. RN-A further stated the facility identified a need to	F 314		

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F 314	Continued From page 53 Improve their skin care and had one of the nurses take specialized wound care training. RN-A identified the facility policy was to complete weekly skin assessments and update the practitioners as needed. RN-A stated the care plan hadn't been finalized for R152 yet. On 11/18/15 at 8:35 a.m. the director of nursing (DON) stated she recalled R152. The DON stated she believed R152 "never really opened up." The DON further stated the dressings in place were for "protection" due to R152's high risk for skin break down. She clarified that dressings are used "all the time" for hospice residents. The DON stated she would have to look at R152's record and would provide additional information. On 11/18/15 at 10:00 a.m. the DON provided copies of documentation and stated it was "everything we have on the wounds." The DON believed it to be "all the documentation we need." Upon review of the documents, there was no additional information provided.	F 314	3. Nurse Managers will audit weekly that skin checks are completed timely for three months. Observations rounds will be conducted by the nurse managers and staff development to monitor that turning schedules are being performed per the resident's plan of care. 4. Audit outcomes will be discussed at QAPI for three months to determine if further education is needed. 5. The Director of Nursing/designee will be responsible. Completion date of 12-31-2015.	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 323		

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F 323	Continued From page 54 review, the facility failed to ensure comprehensive assessments were completed and individualized interventions were developed and implemented to minimize the risk for falls for 1 of 2 residents (R61) reviewed for falls. The facility failed to evaluate the causative factors of resident falls to determine the efficacy of current interventions and if new interventions were appropriate. The facility's failure resulted in an immediate jeopardy, with actual harm (hip fracture) for R61. In addition, the facility failed to ensure side rails were appropriately secured for 1 of 1 residents (R42), reviewed for side rails. The immediate jeopardy began on 10/22/15, when R61 returned from the hospital following a significant fall with subdural hematoma. R61 experienced a significant change in condition following that hospitalization. Upon return, the facility failed to assess R61's multiple changes including fall risk in order to assist in developing appropriate individualized interventions to minimize the risk for ongoing falls. The director of nursing (DON) was notified of the immediate jeopardy (IJ) for R61 on 11/12/15, at 6:23 p.m. The immediate jeopardy was removed on 11/18/15, at 10:30 a.m. but noncompliance remained at the lower scope and severity of a G, which indicated actual harm that was not immediate jeopardy due to fractured hip. Findings include: R61's admission record indicated multiple diagnoses including atrial fibrillation, hypertension, and diabetes mellitus. R61 experienced multiple falls, some of which resulted in significant injury. The facility did not evaluate the causative factors of the fall, the efficacy of	F 323	1. Resident #42 owns his own bed. Resident #42 was interviewed regarding the use of the side rails. Resident is unable to turn self or reach side rails due to disease and severe upper extremity contractures. Resident states he only uses the side rail on one side of the bed and only with staff present assisting with turns. The opposite side rail was removed, which eliminates the safety issue. Resident #61 does not have a side rail – only an assist bar, with no history of loosening. 2. The bariatric beds have been identified with side rails and would have the potential to be affected, however there has never been an issue identified with our current side rails becoming loose.	

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F 323	Continued From page 55	F 323		

interventions and the need for additions to the individualized interventions to assist in minimizing the risk for ongoing falls.

R61's quarterly Minimum Data Set (MDS) dated 9/8/15, identified he was cognitively intact and independent when ambulating in his room and in the hallway. On 9/21/15 he was admitted to the hospital with a subdural hematoma and fractured back following a fall. R61 returned from the hospital on 10/22/15. R61's MDS dated 10/29/15, indicated R61 was severely cognitively impaired and had no behavior problems. The MDS further identified R61 required extensive assistance of one staff for activities of daily living (ADLs). The MDS also identified R61's balance during transfers was not steady, but he was able to stabilize without assistance. The MDS identified R61 had pain, received pain medication daily, was at risk of falls, and had a history of falls with injury.
R61's Fall Care Area Assessment (CAA) dated 11/2/15, indicated R61 was at high risk for falls with a history of falls in the past. The Fall CAA did not address individualized interventions in place, their efficacy or the need for changes.

R61 had multiple Fall Risk Assessments completed, most recently on 11/12/15, however, they were checklists containing data which did not comprehensively assess R61's fall risk to ensure appropriate interventions were implemented. The data gathered indicated R61 was at a high risk for falls, had decreased coordination, used assistive devices, and had multiple falls.

R61's care plan initiated on 1/13/14, indicated he was a high risk for falls related to impaired balance and cognition, history of CVA (cerebral

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F 323	Continued From page 56 vascular accident), incontinence, diabetes and multiple falls with injuries. The identified goal was "The resident will be free of minor injury through the review date." R61's care plan dated 11/9/15, identified the following interventions: call light within reach and encourage use, prompt response to call lights, ensure appropriate footwear in use, PT as ordered, activities for diversion/distraction, TAB alarm in bed and wheelchair (w/c), pressure alarm in bed, transfer with assist of 1, gait belt and back brace. The care plan was revised on 11/9/15, following multiple observations of a motion sensor alarm not being appropriately implemented. Observation on 11/9/15, at 5:05 p.m. identified R61 lying in bed with his call light on the overbed table. The overbed table was approximately three feet away from R61's reach and the motion alarm was turned off. The TAB alarm was attached to him. Registered nurse (RN)-M verified the motion alarm was turned off and the call light was out of reach. RN-M turned the motion alarm on and identified it was not functioning. RN-M changed the batteries and was able to get the alarm to work. On 11/9/15, at 5:20 p.m. the motion alarm was found turned off. RN-A came in with R61's meal tray and left the room with out turning the alarm on. When asked to verify the motion alarm was turned off she stated it was. RN-A further stated the alarm was a problem as it was always sounding "so we don't turn it on all the time." On 11/9/15, at 6:20 p.m. R61's motion alarm was found to be turned off. This was verified by RN-A. RN-A turned the alarm back on again.	F 323		

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F 323	Continued From page 57 Review of R61's progress note dated 8/22/15, at 2:13 a.m. identified the resident self reported a fall. R61 stated he was walking around the bed in his room and tripped on the bed. R61 stated he hit his head and also complained of slight shoulder pain. Another progress note dated 9/21/15, at 3:51 p.m. identified R61 had fallen and hit his head. R61 was sitting on the edge of the bed and stated he hit his head. R61 stated he was in the bathroom when he fell and hit the back of his head on the doorknob of the bathroom door. R61 was not utilizing his walker at the time of the fall. R61 complained of dizziness, ringing in ears, and pain on palpation to back of head. R61 stated he was dizzy, his legs gave out, and he fell. The on call physician directed staff to monitor for any neurological changes and increased pain to head or back. On 9/22/15 at 7:15 a.m. R61 continued to complained of ringing in ears, dizziness, and a headache. R61 had increased back pain and was unable to roll or sit up in bed or ambulate. His blood pressure dropped to 94/53 and pulse was 53. R61 was sent to the emergency room and was admitted with a subdural hematoma (brain bleed) and fractured back. A progress note dated 10/22/15, at 1:47 p.m. indicated R61 returned form the hospital. On 10/24/15, at 1:11 a.m. a medication administration note indicated R61 was restless and climbing out of bed multiple times. R61 was up walking alone going through his closet. The alarm was off and did not sound. A nursing note dated 10/25/15, at 10:59 p.m. identified R61 was on neurological checks due to	F 323		

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F 323	Continued From page 58 a fall in the morning. R61 was up walking in the hallway looking for his dogs. R61 was unsteady on his feet. He had 3 alarms in place, however, he had one alarm tucked in his pants pocket, one alarm wrapped up in a blanket, and the third alarm did not sound. A progress note dated 10/29/15, at 6:18 p.m. identified R61 was found on the floor in the middle of the room. Although R61 had 2 TAB alarms and a motion alarm on the floor, none of the alarms sounded. The nursing progress note dated 10/31/15, at 9:22 a.m. indicated R61 was unable to bear weight on his right lower extremity (RLE) and was complaining of pain. Staff reported R61 complained on 10/30/15 as well. R61 had significant pain when up in the wheelchair. R61 was sent to the emergency room and was admitted with a right acetabulum (head/ball of the femur) fracture. R61 returned to the facility on 11/3/15 with a plan for non-surgical management of the hip fracture. On 11/12/15, at 2:45 p.m. R61 was observed by the surveyor to be sitting on the foot pedals of his wheelchair. R61 was in his room with his door closed. No alarms were sounding when he was discovered on his foot pedals. After being called to the room, LPN-A and RN-B agreed there were no alarms sounding and there was no call light within reach. An incident note dated 11/12/15, at 11:31 p.m. indicated R61 slid out of his wheelchair and was being held onto by RN-B. R61 slid out of his chair and was not quite on the ground. R61 stated he wanted to go to bed, and was trying to get there	F 323		

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F 323	Continued From page 59 when he slid off his chair. RN-B and licensed practical nurse (LPN)-A returned R61 to bed with the mechanical lift. R61's falls were reviewed with the director of nursing (DON) on 11/12/15, at 3:58 p.m. and the DON indicated the fall of 8/22/15, was a slip off the recliner with no injury. The DON stated R61 was independent with ambulation at that time so there were no specific interventions for falls at that time. The DON stated the next fall was on 9/21/15, when R61 fell in his bathroom, got himself up and went to the side of the bed. The DON said R61 self-reported the fall. R61 was not using his walker and there was no obvious injury. R61 reported he hit the back of his head on the bathroom door knob. The DON stated she wasn't sure when the TAB alarm was placed on R61. Other interventions in place at that time included: physical therapy (PT) to evaluate, call light within reach, appropriate foot wear, and transfer with assist of one, gait belt, and back brace on. The DON indicated when R61 fell on 10/25/15, at 10:30 a.m. he was found crawling toward his roommate's bed. The fall was unwitnessed. The DON stated R61 had gripper socks on at the time and he was confused. The DON identified a motion sensor alarm was added at that time. The DON further stated between this fall and the one on 10/29/15, alarms were the only additional interventions. The DON also indicated staff was "trying to manage his pain" as they felt the restlessness may have been related to his difficulty expressing pain. The DON stated R61 also fell on 10/29/15, at	F 323		

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F 323	Continued From page 60 6:30 a.m. None of the alarms were sounding when R61 was found. The TAB alarm was wrapped up in his blanket. The DON said there were no new interventions at that time. The DON stated she did not believe the hip fracture was a result of the fall because R61 did not report the problem until 2 days after the fall. The DON went on to say when R61 was found on the pedals of his wheelchair on 11/12/15, she did not believe that was a fall. The DON stated R61 slipped off the chair. However, the DON could not explain how R61 slipped out of the wheelchair. When asked about reviewing the specific fall interventions, the DON invited the nurse manager over to answer specific questions. RN-A stated after the 11/12/15, incident she placed a pressure pad alarm in R61's wheelchair with dycem (non-skid sheet) on the top and bottom of the pressure pad. RN-A also said they asked for a pharmacist review of R61's medications. A request was also sent to therapy for a reassessment. RN-A was informed about the alarms not sounding and indicated she was not aware there had been issues. When asked about an interdisciplinary team comprehensive assessment of the falls to determine the root cause of the falls, the efficacy of current interventions and identify other interventions that may be appropriate to minimize R61's risk for falls, both the DON and RN-A stated they had not done that. An interview on 11/9/15, at 1:00 p.m. with physical therapist (PT)-A identified they saw R61 from 10/22/15, to 10/30/15, and again 11/3/15, to current. PT-A said when they saw him back in 3/15, he was discharged as independent with a 4	F 323		

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F 323	Continued From page 61 wheeled walker (WW). PT-A stated when R61 came back from the hospital following his subdural hematoma in 10/15, he had orders for all three disciplines (physical, occupational, and speech) to assess and treat. PT-A stated therapy staff saw R61 for eight days. Staff attempted to ambulate him but he could not ambulate. PT-A stated R61 had a lot of pain due to his back fracture. PT-A stated the next request for therapy services was on 11/3/15, after returning from the hospital with the acetabulum fracture from another fall. R61's orders were for weight bearing as tolerated. Therapy staff utilized an TENS (Transcutaneous Electrical Nerve Stimulation) unit for his pain. PT-A stated R61 rated his pain at a 10/10 and staff could tell by R61's facial expressions when he was in pain. A subsequent interview on 11/12/15, at 12:45 p.m. PT-A stated physical therapy did an evaluation on 11/6/15, post fall with injury, she said they changed his wheelchair at that time because it didn't fit him well. PT-A was aware leg kept sliding off the leg of the wheelchair. She said they put a calf pad in place that morning. After notification of the IJ on 11/13/15, updated interventions for R61's fall care plan included the following interventions. However, the interventions were not observed to be implemented right away, or staff were not knowledgeable about the changes. Anticipate and meet the resident's needs. Do not leave the resident unattended when up in w/c. Follow facility fall protocol. Hoyer lift with assist of two staff for all transfers . Review information on past falls and attempt to determine cause of falls. Record potential root	F 323		

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F 323	Continued From page 62 causes. Alter any potential causes if possible. Educate resident/family caregivers/IDT Provide diversion and distraction such as news, music, socials and special events. Offer a snack (food and drink) when restless, states he's hungry or unable to sleep and monitor effectiveness. PT evaluate and treat as ordered. The resident uses TAB electronic alarm in bed and w/c. Pressure alarm in bed and w/c. Dycem on top and bottom of pressure mat in w/c. During an interview on 11/13/15, at 8:17 a.m. trained medication assistant (TMA)-K stated R61 had one pressure alarm in his chair and a pressure alarm in his bed. An observation on 11/13/15, at 10:00 a.m. R61 was sitting by the nurses station in the hallway with his TAB alarm on but not in attendance at the nearby activities program. During interview on 11/13/15, at 11:28 a.m. activities (A)-A said R61 went to activities but didn't attend much since returning from the hospital. A-A said they do 1:1's. She said if the documentation identified R61 as unavailable, he was usually in bed in a lot of pain or not feeling well. An interview on 11/13/15, at 2:25 p.m. nursing assistant (NA)-A said they did not receive report on any changes to R61's care. NA-G said on 11/13/15, at 2:28 p.m. they work on the other hall but, "I know he is always in pain and yelling in pain." An interview on 11/13/15, at 2:37 p.m. RN-F said	F 323		

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F 323	Continued From page 63	F 323		

she was told he was on fall precautions, so he has alarms in his chair and a TAB alarm. She was not aware of any new plan of care since yesterday.

An interview on 11/13/15, at 11:06 a.m. with family member (FM)-K indicated when R61 fell in September he slipped and fell in the bathroom. R61 told FM-K he was tired of waiting so long to get help. FM-K stated prior to his head injury, R61's mind was clear.

An interview on 11/16/15 at 3:43 p.m. NA-G stated, "I didn't know he fell. He is in a lot of pain. He has a back brace and is a full mechanical lift." NA-G further stated she hadn't been informed of any changes in his plan of care in the last couple days NA-G was aware he had alarms on his chair and his bed.

During an interview with RN-D on 11/16/15, at 3:47 p.m. stated the changes in R61's plan of care included: alarms in the wheelchair and bed, and when up he needs to be in the dining room or by the nurses station. R61 had a TAB alarm in his wheelchair and a pressure alarm in his bed. There was education for staff of the changes and staff signed after receiving the education .

An interview with RN-A on 11/16/15, at 4:07 p.m. stated staff placed a pressure pad and and a TAB alarm in his bed and wheelchair. R61 was not to be left unattended while in the wheelchair. He is to be engaged in activities. The pharmacist reviewed R61's medications and the medical doctor will as well. The physician ordered a scheduled a pain medication. RN-A further stated she has seen R61 in a lot of pain and agreed he did not have adequate pain control. She said she

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F 323	Continued From page 64 has seen him grimace in pain. RN-A stated all staff should be using the same pain scale and they are not. She said they do not us any non pharmacological pain interventions and "we should." RN-A stated since survey started R61 doesn't have good pain control. She further stated R61's pain may be affecting his restlessness so staff requested a regular pain medication. His new pain order is for oxycodone 10 mg 3 times daily. Interview on 11/16/15, at 4:28 p.m. with the DON indicated they changed the process of reviewing falls to include a weekly IDT meeting, including PT, to review all high risk fall residents. The new committee will review falls to ensure interventions are in place and all of residents were reviewed for fall risks. An interview on 11/17/15, at 8:35 a.m. A-A stated she had him in 3-4 activities a week. She said R61 will be visited 3-4 times a week. This plan started on 11/13/15. Before then, A-A had R61 do things independently, now he will have more planned 1:1's. The team planned to have weekly fall meetings and she will attend those meetings. An observation on 11/17/15, at 9:05 a.m. PT-M was doing therapy for R61. When he was asked about his wheelchair leg being too short, she agreed and said "the right leg could be lengthened a little." The w/c leg was lengthened at that time. An interview on 11/17/15, at 11:05 a.m. NA-J said the DON was on the unit and educated everyone on what to do for R61's falls.	F 323		

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F 323	Continued From page 65 An interview on 11/17/15, at 12:24 p.m. RN-A said the pharmacist and medical doctor's recommendations regarding R61's falls were in place. An interview on 11/17/15, at 12:39 p.m. RN-F said she had accident investigation training when she started but not with in the last couple months. The immediate jeopardy that began on 10/22/15, was removed on 11/18/15, when the facility implemented the following interventions to minimize the risk of falls for R61. However, noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy for R61. Actions taken to remove the IJ, which were verified through observation, interview and record review were as follows: 1. Comprehensive fall risk assessment was completed. 2. Physician orders for a Basic Metabolic Profile (BMP) and urinalysis were completed. 3. R61 was not left alone in his room during observations. 4. R61 was included in more activities and 1:1 sessions. 5. Alarms were in place in the wheelchair and in bed. 6. NA care sheets were changed and signed by the NAs. 7. Care plan was updated. 8. The medication and treatment administration records were updated as ordered. 9. The pharmacist and physician's recommendations were completed as ordered. 10. Weekly IDT meeting related to resident falls	F 323		

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F 323	Continued From page 66 was implemented. 11. Fall risk assessments will be done quarterly with high risk residents being focused on at the weekly IDT meeting. On 11/13/15 at 2:01 p.m. the DON confirmed the undated Root Cause Analysis Authors was the fall prevention policy. The policy identified, "During the daily standup meeting falls are discussed focusing on safety, fall risk, fall management, devices, care plan adjustments and updates to group sheets that direct the non-license staff care." The facility policy entitled, "Alarms for Bed and Chair" reviewed 10/14 indicated, "Alarms do not substitute for proper care and supervision." R42's right side rail was not secured to prevent movement to the side rail. R42's quarterly MDS dated 9/25/15, indicated R42 was cognitively intact and needed extensive assistance with bed mobility. The MDS included multiple diagnoses including quadriplegia. R42's care plan dated 10/1/15, indicated R42 used side rails as ordered by the physician for safety while in bed and to assist with bed mobility. The care plan directed staff to observe for injury or entrapment related to side rail use. On 11/10/15, at 9:28 a.m. and 11/12/15, at 7:45 a.m. R42's right side rail was not secured. When checking for the function of the right side rail it moved freely up and down at an angle. When pulling on the side rail a gap occurred that could entrap a body part, creating a potential hazard to R42.	F 323	1. A. All safety interventions for residents have been added to TAR for licensed staff to assess and to document that those interventions are in place and working properly. B. Safety care plans have been reviewed along with CNA care sheets for appropriate interventions by 12/18/15. C. A new fall assessment was done for all current residents. Completed 11/13/15. D. All residents will have a fall assessment on admission or readmission, quarterly and following any fall or significant change. This is ongoing. E. the Director of Nursing/designee is notified immediately of any fall. F. Interventions are reviewed and revised as necessary G. IDT meets Monday through Friday assessing any new falls, review and recommend interventions as necessary, and will update care plan as needed. H IDT meets weekly to discuss all residents considered high risk for falls, care plans reviewed, effectiveness discussed and updated as needed.	

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F 323	Continued From page 67 On 11/12/15, at 7:45 a.m. R42 verified that the right side rail was too loose for him and he had reported it to staff the day on 11/11/15. On 11/17/15, at 7:21 a.m. the right side rail was observed to be tightened up. There was no longer a gap. When interviewed on 11/17/15, at 9:24 a.m. NA-D stated that the side rails become loose at times and when R42 reports he did not feel safe, staff put in a maintenance ticket to have it tightened. NA-D verified that the right side rail had been tightened, but was not sure when. When interviewed on 11/17/15, at 3:43 p.m. the director of maintenance (DM)-B stated the side rails for R42's were the correct rails for the bed. He added, they do loosen up with use. DM-B stated the facility does not have a process in place to routinely check the safety and function of side rails. The facility policy Bed Safety dated 12/07, directed maintenance staff to inspect all bed equipment to try and prevent deaths/injuries from the beds and equipment including sides rails .	F 323	I. any side rails will be checked weekly to determine that they are properly attached to bed by maintenance. II. Nursing staff will be inserviced on fall, and fall prevention DON will review all falls and fall follow up to assure above is completed. 4. DON will report to QAPI monthly to determine any trends, patterns or issues with current fall policy. This will be on going. 5. The Director of Nursing/designee will be responsible. Completion date of 12-31-2015.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325	1. Resident # 158 was not affected by the alleged deficient practice. Resident is currently stable, MD has determined that resident's weight loss is unavoidable related to cancer diagnoses 2. All residents have the potential to be affected by the alleged deficient practice.	

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F 325	Continued From page 68 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to recognize and act upon a significant weight decline for 1 of 3 residents (R158) reviewed for nutrition. Findings Include: R158's significant change Minimum Data Set (MDS) dated 9/30/15, indicated R158 had diagnoses of cancer and dementia. The MDS further identified R158 had moderate cognitive impairments, and was independent with eating after set-up assistance, and a 5% decline in weight loss was indicated. R158's Dietary/Nutritional Assessment dated 9/8/15, indicated R158 had an average intake of 75% of food at meals with regular portions being served. The assessment also indicated that R158 had vision impairments and was a low nutritional risk at this time. Nutritional interventions included observe for weight changes. R158's Nutrition Care Area Assessment (CAA) dated 9/30/15, indicated R158 was a nutritional risk due to a poor memory, inability to perform activities of daily living without significant physical assistance and weight loss. The goal listed on the CAA was symptom relief or palliative measure and a care plan would be developed.	F 325		

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F 325	Continued From page 69 R158's care plan dated 10/9/15, indicated R158 was at risk for nutrition secondary to fluid restrictions, weight loss and infection problems. Interventions included: - provide and serve diet as ordered - monitor intake and record every meal - weigh weekly on shower day R158's physician orders dated 11/10/15, included an order for a regular diet. The physician orders lacked an order for a nutritional supplement. R158's Weights and Vitals Summary included the following weights: - 11/7/15 119 pounds (lbs) -10% weight change - 10/2/15 123 lbs -5% weight change - 9/25/15 123.6 lbs - 9/15/15 134.4 lbs - 9/14/15 135.6 lbs - 8/26/15 133 lbs - 8/25/15 131.9 lbs R158's meal intake record from 9/15/15, to 11/1/15, indicated the following meal intake percentages: - 31 meals at 0% -25% - 48 meals at 26% -50% - 55 meals at 51% - 75% - 27 meals at 76% - 100% The medical record lacked evidence of a nutritional reassessment. On 11/17/15, at 8:03 a.m. R158 was observed eating in the dining room for the breakfast meal. R158 was served hot cereal, eggs, toast, a cup of frozen orange juice and a cup of coffee. During the observation R158 asked for more coffee and	F 325		

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F 325	Continued From page 70 and was served a total of 3 cups during breakfast. R158 was being encouraged to eat throughout the meal and was assisted to put jelly on her toast, staff did not offer to place brown sugar or raisins on her hot cereal. During the meal R158 stated "I don't do eggs" when encouraged by the staff member to eat. The staff member did not offer R158 an alternative food. R158 ate 75% of hot cereal, bites of eggs and her toast, leaving the crust. R158 consumed 3 cups of coffee, 1/2 of her milk and no orange juice. R158 stated "I've had enough." On 11/17/15, at 12:23 p.m. R158 was observed eating independently in the dining room for the lunch meal. R158 was served a cup of oranges with whipped topping, taco hotdish, Mexican corn, 8 ounces (oz) of milk and 8 oz of coffee. R158 ate 100% of the oranges and whipped topping and only bites of the taco hotdish and Mexican corn. R158 drank 100% of her milk and coffee. During the observation R158 was busy playing with her dining room ticket and would frequently pick up her fork and not take a bite of food and then put the fork back down. R158 then pushed herself from the dining room table and propelled herself back to her room via her wheelchair. When interviewed on 11/18/15, at 9:12 a.m. nursing assistant (NA)-L stated that every meal is documented into the computer kiosk. NA-L also stated R158's intake is reported to the nurse on every shift for further documentation regardless of how much R158 ate at the meal. When interviewed on 11/18/15, at 8:41 a.m. registered nurse (RN)-C stated the dietician determined if a nutritional supplement is implemented. RN-C stated that R158 did not	F 325		

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F 325	Continued From page 71 have an order for a nutritional supplement. When interviewed on 11/18/15, at 9:05 a.m. the registered dietician (RD) stated residents are to be weighed monthly at a minimum, and resident's weights and food intakes are reviewed monthly by the dietician. The RD further stated if a resident has a decline in weight and food intake, the resident would be reassessed for interventions to prevent further weight loss. The RD stated R158 was a difficult case, as she was on hospice care, however, the RD stated R158 was not actively in the dying process. Upon review of the RD's personal spreadsheet of residents weight the RD stated R158 was not looked at for a decline in weight as the RD reported she entered R158's starting weight as 123.6 lbs dated 9/25/15. The RD stated the starting weight should have been her admission weight of 131.9 lbs dated 8/25/15. The RD stated that she had missed the weight in her review and should have been reassessed for possible interventions. The facility policy on Weight Assessment and Intervention undated directed the dietician to review the monthly weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met.	F 325	3. The Registered Dietician will follow the weight assessment and intervention guidelines.. This will be ongoing. Registered dietician will continue to work with nursing staff regarding weight frequency and follow-up. This will be ongoing. Weights will be taken weekly. 4. Registered dietician will review weights weekly to determine any significant changes, and will communicate with the IDT to determine appropriate interventions. Will continue to work with Wound and weight committee weekly.. Registered dietitian will report to QAPI monthly on all significant findings. 5. The RD/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 333	1. Resident #109 has had no ill effects from alleged deficient practice. 2. All residents would be considered at risk from alleged deficient practice.	

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F 333	Continued From page 72 by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R109) was free from a significant medication error. Findings include: R109's Admission Record identified diagnoses that included Alzheimer's disease. On 12/2/14, R109 was place on hospice services for end of life services due to Alzheimer's disease. The physician's orders on 12/28/14, directed morphine sulfate solution, give 2 milligrams (mg) by mouth every 1 hour as needed for shortness of breath pain (2 mg equals 0.1 milliliters [ml]). A review of R109's progress notes indicated the following: On 1/1/15, an entry indicated per the trained medication aide (TMA) and the nursing supervisor on day shift, and after researching the narcotics record book, it was discovered on 12/28/15, R109 received an incorrect dose of liquid morphine. R109 was prescribed 2 mg, and 2 mg was the equivalent of 0.1 milliliters (ml). R109 was given 2 ml, 20 times the amount ordered. On 11/17/15, at 9:42 a.m. registered nurse (RN)-C was interviewed, and stated she was not working at that time, and was unaware of the medication error. On 11/18/15, at 11:23 a.m. the director of nursing (DON) was interviewed and stated she reviewed medication errors at the Quality Assurance (QA) meeting. The DON was unaware of R109's medication error.	F 333		

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F 333	Continued From page 73 The facility was requested to provide a copy of the medication error investigation form. On 11/17/15, at 12:40 p.m. the admissions coordinator (AC)-H stated she was unable to find the medication error investigation. The facility policy and procedure on Adverse Consequences and Medication Errors dated 2/14, indicated a medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with the physician's orders. The policy directed the interdisciplinary team to review the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis.	F 333	3 .Licensed staff and TMAs will complete medication administration reeducation by 12/18/15. The transcription process is currently being audited for all new admission and readmissions. This is on going. All medication errors will be reviewed by Nurse Managers and DON, corrective reeducation will be done as soon as review is complete. This is ongoing. 4.. Medication error trends and or patterns will be reported to monthly QAPI committee.. This will be on going. The transcription process is being reported to the monthly QAPI committee. This will be ongoing. 5. The Director of Nursing /designee will be responsible. Completion date of 12-31-2015.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice.	

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F 356	Continued From page 74 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the nurse staff posting included the actual hours worked for partial shifts. This had the potential to affect all 159 residents residing in the facility. Findings include: A review of the direct care staff posting and the facility staffing schedule from 11/2/15, through 11/16/15, indicated partial shifts were worked by staff on 13 of 15 days. The direct care staff postings for each date did not specify the actual hours worked during the partial shifts. During an interview on 11/18/15, at 7:41 a.m. the director of nursing (DON), verified partial shifts were not included on the nurse staff posting . During an observation on 11/9/15, at 12:29 p.m. the staff posting to the left of the front desk could not be viewed by anyone seated in a regular wheelchair.	F 356	3. The posting of actual nursing hours was lowered so as to be at a level height for wheelchair residents. Hours posted include actual hours worked, which include partial shifts. 4. An audit will be conducted two (2) times per week times 12 weeks to monitor that actual hours , including partial shifts are recorded and posted on the nurse staff posting. Audits will be presented to the monthly QAPI committee to assure compliance with posting of actual hours worked.. After three months the QAPI committee will make a recommendation as to the need to continue to monitor the posting of hours. 5. the Administrator/designee will be responsible. Completion date of 12-31-2015.	

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F 356	Continued From page 75 On 11/18/15, at 1:58 p.m. the DON verified the staff posting was 59 inches from the floor to bottom of staff posting, and was not at a height that was accessible for anyone seated in a regular wheelchair to easily read.	F 356	5. The Administrator/designee will be responsible.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were promptly addressed for 2 of 5 residents (R38, R109) reviewed for unnecessary medications. Findings include: R38's admission record indicated diagnoses that included colostomy, adjustment disorder with mixed anxiety and depression, diabetes, dementia, delusional disorders, and brief psychotic disorder. R38's quarterly Minimum Data Set (MDS) dated 9/11/15, indicated she had moderate cognitive impairment, and exhibited no moods or behaviors.	F 428	1. Resident #38 has had no adverse or ill effects due to the alleged deficient practice. Resident #38 is less anxious and has minimal attempts at trying to remove her ostomy bag with current medications. Appetite is improved and she is participating in activties. Resident # 109 has had no adverse of ill effects due to the alleged deficient practice. Resident is demonstrating less grimacing, less moaning, less arching and less grinding of teeth, which has improved his quality of life. 2. All residents have the potential to be affected by the deficient practice.	

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F 428	Continued From page 76 R38's order summary report, dated 11/18/15, indicated R38 received sertraline HCl (Zoloft) (an antidepressant medication), 200 milligrams (mg) by mouth in the morning for anxiety with obsessive compulsive disorder (OCD) related to adjust disorder with mixed anxiety and depressed mood; the start date was 8/15/14. The order report also indicated R38 received quetiapine fumarate (an antipsychotic medication), 50 mg twice a day for paranoia related to delusional disorder with a start date of 8/16/13. In addition, R38's order summary indicated lorazepam (an antianxiety medication) 0.5 mg by mouth as needed for anxiety related to delusional disorder and 0.25 mg by mouth two times a day for anxiety related to adjustment disorder with mixed anxiety and depressed mood. R38's care plan indicated R38 had a behavior problem related to loosening her colostomy bags multiple times a day, and she exhibited hoarding type behaviors. The care plan also indicated R38 had a mood problem related to paranoia, dementia, delusions, and cognitive impairment. The care plan directed staff to observe/record/report to the physician any acute episodes or feelings of sadness, loss of pleasure and interest in activities, and to have positive interactions with resident at times other than when she is receiving medical care. A 6/19/15, Consultant Pharmacist's Medication Review form indicated an irregularity regarding R38's sertraline (Zoloft) medication. The irregularity comment stated: yearly risk versus benefit analysis/documentation is required for all psychotropic medications. This medication was last increased about 1 year ago. The comment	F 428		

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F 428	Continued From page 77 noted that R38 has a past history of focusing on her ostomy bag. Since starting this medication, that has improved, therefore, no further reduction is recommended at this time-still risk vs. benefit analysis/documentation is required by CMS. The suggested course of action was to provide a risk versus benefit statement and clinical rationale for continuation of the Zoloft as ordered. A hand written note dated 7/11/15, on the follow-up action section read to defer to the consultant psychiatrist. The signature is not legible. The 10/20/15, consultant pharmacist irregularity comment requested a risk versus benefit statement for the sertraline medication, including clinical rationale for continuation, per CMS guidelines. Under the follow-up or action taken section "rejected" is circled and a 10/29/15, hand written note indicated: reduction not indicated at this time. Benefits currently outweigh risks. The signature is not legible; however, in an interview on 11/17/15, at 2:07 p.m., registered nurse (RN)-G stated that the signature is that of the consultant psychiatrist's nurse practitioner. R38 was observed and interviewed on 11/9/15, at 3:20 p.m., sitting calmly on the edge of her bed. R38 made eye contact, answered questions and interacted appropriately throughout the interview. R38 was observed on 11/12/15, at 6:55 a.m. and again at 8:10 a.m., calmly sitting in the second floor dining room with a beverage in front of her. On 11/12/15, at 8:53 a.m. R38 was in the doorway of her room with a smile on her face. On 11/12/15, at 12:24 and again at 12:45 p.m. R38 was observed in the dining room on 11/15/15, at 8:00 a.m. with a beverage, waiting for breakfast to be served. On 11/17/15, R38 was	F 428		

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F 428	Continued From page 78 observed sitting with two others at the dining room table with beverages, waiting for breakfast. In an interview on 11/17/15, at 8:44 a.m. R38 stated she doesn't know her medication, but her brother is her responsible party. R38 stated she doesn't feel like she has any side effects from her medications, but feels that they help her. In an interview on 11/17/15, at 8:56 a.m. nursing assistant (NA)-J stated R38 does hoard sugar, gowns, towels and other items; R38 also pulls her colostomy bag off. NA-J stated R38 required set-up and stand-by assist with personal hygiene, but is independent with other cares. NA-J also stated they have not been told to watch for anything else. In an interview on 11/17/15, at 2:00 p.m. registered nurse (RN)-A stated the initials on the June 2015, medication review form are the nurse practitioner's who rounds at the facility. In an interview on 11/17/15, at 2:07 p.m. RN-G stated R38 just started visits with the consultant psychiatrist in October. RN-G stated the June 2015, response referred R38 to this consultant psychiatrist, who did not see R38 until October. RN-G stated the hand-written note in October was from the consultant psychiatrist's nurse practitioner. RN-G stated they (the consultant psychiatrist and the nurse practitioner) don't type up a formal risk versus benefit when it's requested from a physician. RN-G also stated they don't review it with residents. A rounding form indicated that the consultant psychiatrist rounded on R38 on 10/29/15.	F 428	3. The following systems will implemented by 12-31-2015 Pharmacist makes recommendations and emails to ADON along with DON ADON prints off recommendations, signs, and distributes to appropriate nurse managers Nurse Managers fax appropriate recommendations to providers or places in rounding book for Eldercare and Dr. Gish residents. . Nurse Managers follow through on nursing recommendations from pharmacist As recommendations are addressed by provider and nursing, a copy is made this copy is given back to ADON. Original is placed in resident chart and copy stays with ADON ADON uses the "nursing drug report" emailed by consultant pharmacist to check off recommendations that have come back from the nurse manager and ensures that the provider response is appropriate.	

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F 428	Continued From page 79 In an interview on 11/18/15, at 10:23 a.m., the consultant pharmacist stated he cannot account for the lapse of time between June and October when no action was taken. The consultant pharmacist stated that in his opinion the brief risk versus benefit on the October form was an adequate risk versus benefit and that the psychiatrist often puts a more detailed description in his notes, which would not yet be available in the medical record. No additional information was received from the facility. R109 had recommendations from the consultant pharmacist, and the facility did not act upon them. R109's Admission Record identified diagnoses that included Alzheimer's disease, anxiety disorder, depression, hypertension, gout and arthritis. The quarterly Minimum Data Set (MDS) dated 9/14/15, indicated R109 had severe cognitive impairment, and required extensive to total assistance of staff with bed mobility, transfers, dressing, eating, mobility, personal hygiene, bathing and toileting. R109's physician's orders indicated the following: Ativan (an antianxiety medication) 1 milligram (mg) twice a day. Risperdal (an antipsychotic medication) 1 mg/ml (milliliter) 0.1 mg daily. Zoloft (an antidepressant medication) 25 mg at bedtime. On 8/25/15, the consultant pharmacist gave the following recommendation: please provide documentation of the lowest effective dose for the Ativan, Risperdal, and Zoloft as well as how these medications improve the residents quality of life. On 10/9/15, R109's physician responded with the following: trial reduction of both Zoloft and	F 428	ADON and consultant pharmacist will review questionable responses and decide if further clarification is needed. Pharmacist will also review past due recommendations by reviewing the pending recommendation report with the ADON. Decision will be made at that time as to readdress with provider or Medical Director 4. Any negative occurrence will be reported to the consulting pharmacist immediately. Any issues with follow up with physicians will be discussed at the monthly QAPI committee. Any on going issues with the MD responses the Facility will contact the Medical Director to facilitate having the attending physician respond back more timely. System will be on going. 5. The Director of Nursing/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015	

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F 428	Continued From page 80 Risperdal. Question effectiveness, question if experiencing symptoms. The physician's response lacked documentation of how these medications improved R109's quality of life. On 11/17/15, at 8:03 a.m. registered nurse (RN)-G was interviewed, and stated the consultant pharmacist comes to the facility monthly, and she reviews the recommendations with him. On 11/18/15, at 11:59 a.m. the director of nursing (DON) was interviewed, and stated the assistant director of nursing reviews the consultant pharmacist recommendations with him, and the DON was told there was not a problem with them. The facility was unable to provide a policy and procedure on consultant pharmacist's recommendations.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential for being affected by the alleged deficient practice.	

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F 431	Continued From page 81 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure insulin was stored at the required temperatures in 1 of 4 medication refrigerators. In addition, the facility failed to provide security of insulin pens located on the first floor nurses station. Findings include: On 11/13/15, at 9:25 a.m. the Morning Light West medication refrigerator temperature was observed to be 32 degrees Fahrenheit (F) on one thermometer and 29 degrees F on another thermometer. The built in freezer had a large amount of frost build up on the outside extending into the refrigerator. A review of the temperature log indicated the acceptable range was 36-46 degrees F, and the temperature had been within	F 431		

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range for the last 13 days. The temperature log indicated the facility checked the medication refrigerator temperatures once daily. Licensed practical nurse (LPN)-C verified the frost build up and the temperature was 32 degrees F on one thermometer and 29 degrees F on the other.

The manufacturer's package inserts for the insulin stored in the medication refrigerator directed the following:

Unopened Novolog should be stored in a refrigerator between 36 degrees F and 46 degrees F
Unopened Lantus should be stored in refrigerator at 36 degrees F and 46 degrees F
Unopened Humulin N should be stored in the refrigerator and should be discarded if it has been frozen
Unopened Humalog should be stored in refrigerator at 36 degrees F and 46 degrees F

The refrigerator contained the following unopened resident insulin (medication to control diabetes) pens:

R1 7 Lantus pens
R142 3 Lantus pens
R87 1 Lantus pen and 2 Humalog pens
R9 2 lantus pens and 12 Novolog pens
R7 1 Humulin N pen

R1's signed physician orders dated 10/14/15, included a diagnosis of type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene. The physician orders directed staff to inject subcutaneously 27 units of Lantus solution daily at bedtime.

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F 431	Continued From page 83 R142's signed physician orders dated 11/10/15, included a diagnosis of type 2 diabetes without complications. The physician orders directed staff to inject subcutaneously 10 units of Lantus solution two times daily. R87's signed physician orders dated 10/8/15, included a diagnosis of type 2 diabetes without complications. The physician orders directed staff to inject subcutaneously 4 units of Humalog solution in the morning in addition to a sliding scale dose up to 8 units daily. The physician orders also directed staff to inject subcutaneously 10 units of Lantus solution at bedtime. R9's signed physician orders dated 11/5/15, included a diagnosis of type 2 diabetes mellitus with diabetic neuropathy. The physician orders directed staff to inject subcutaneously 10 units of Novolog solution every evening with supper and inject 17 units two times daily. The physician orders also directed staff to inject subcutaneously 10 units of Lantus solution every 12 hours. R7's signed physician orders dated 11/10/15, included a diagnosis of type 2 diabetes mellitus without complications. The physician orders directed staff to inject subcutaneously 20 units of Humulin solution daily at bedtime and to inject 25 units subcutaneously one time daily. When interviewed on 11/13/15, at 9:47 a.m. registered nurse (RN)-B stated she will pull the insulin from the medication refrigerator and contact the pharmacy consultant for instructions. When interviewed on 11/18/15, at 9:50 a.m. RN-B verified the insulin pens were destroyed and had been reordered. RN-B stated that a maintenance	F 431		

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F 431	Continued From page 84 ticket has been placed for the medication refrigerator. When interviewed on 11/18/15, at 10:20 a.m. the director of nursing (DON) stated that the Insulin pens were reordered and a new medication refrigerator was on order. The DON further stated the medication refrigerators in the facility are getting old. The facility policy Storage of Medications dated 4/14, directed medications requiring refrigeration or temperatures between 36 degrees F and 46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring. On 11/12/15, at 8:15 a.m. Novolog and Lantus insulin pens were observed at the first floor nurse's station, near the open door. The Novolog insulin pen had approximately 70 units of insulin in it, and the Lantus insulin pen had approximately 130 units of insulin in it. During continuous observation from 8:15 a.m. through 8:45 a.m. the insulin pens remained on the desk, and staff and residents were passing by the open door. At 8:45 a.m. registered nurse (RN)-D picked up both insulin pens, and stated she left them on the desk because she was going to administer it after breakfast. RN-D stated it was not normal practice to leave insulin pens unsecured. On 11/18/15, at 12:09 p.m. the director of nursing (DON) stated insulin pens should not be left lying out unsecured.	F 431	3. The medication refrigerators were replace with new refrigerators. The License staff were reeducated documenting refrigerator temps on a daily basis; the License staff and TMAs were reeducated on the proper storage of medications which included insulin pens. Completed 12-18- 2015. 4. An audit will be conducted one (1) times per week times 12 weeks to monitor the refrigerator temperatures for the proper storage of medications in the refrigerators. Observation rounds will be conducted one (1) times per week times 12 weeks to monitor proper storage of medications including insulin pens by nurse managers. Any negative occurrence will be addressed immediately. This documentation will be presented to the monthly QAPI committee to monitor the proper storage of medications. After three months the QAPI committee will make a recommendation as to the need monitor that the temperature logs are being documented daily. Refrigerator temperature logs will be collected weekly and placed in a three ring binder. Logs will be kept for one year. 5. The Director of Nursing/ designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 85 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 441		

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F 441	Continued From page 86 review, the facility failed to implement an infection control surveillance plan to identify, document and monitor resident infections. In addition, the facility failed to ensure appropriate hand washing and gloving practices were provided during cares for 1 of 1 residents (R49) observed during cares. In addition, the facility failed to implement contact precautions for 1 of 1 residents (R111) diagnosed with methicillin resistant staphylococcus aureus (MRSA) infection. The facility also failed to implement contact precautions for 1 of 1 residents (R88) diagnosed with clostridium-difficile (C-Diff) infection. These practices had the potential to affect all 159 residents in the facility. Findings include: In an interview on 11/17/15, at 2:47 p.m., RN-B stated three residents currently were currently on isolation precautions. RN-B stated she hasn't formally audited implementation of precautions for these residents. RN-B stated she expects all staff to see the door sign (directing all people to check with the nurse before entering) and ask the nurse what precautions they need to take before entering a room. In the interview on 11/17/15, at 2:47 p.m., RN-B stated each nursing station recorded what residents had infectious symptoms: loose stools, temperatures, coughing. RN-B also looked at residentprogress notes daily and attended a daily morning report in order to gather information related to potential infections. RN-B stated she educated staff to "foam in and foam out" of rooms. If a resident had C-Diff, then they are to wash their hands with soap and water	F 441		

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and also put on gloves. If she saw a concern she would talk to individual staff and then let their manager know.

RN-B stated she had done a full infection prevention and control class at the end of September, teaching 5 or 6 classes. If a staff person could not attend, they were to review a packet of the presentation and sign off. RN-B hds not reviewed to determine if all staff have received this education.

In an interview on 11/17/15, at 3:38 p.m., the Occupational Therapist (OT)-D stated the evaluating therapist would find out during an intial evaluation meeting with a resident if that resident was on precautions. OT-D stated that the information will "trickle down" to other therapists. OT-D stated if a resident became infectious while in the facility, nursing would inform her in some way and she would inform her staff the best she can, usually on a one-by-one basis.

OT-D stated there were a lot of new therapy staff; new to the facility and to the profession, and there was a lot of uncertainty around implementation of infection precautions. OT-D stated she had re-educated her staff to wash hands, and gown and glove prior to working with infected residents in their room. OT-D stated therapists use sani-wipes (a disinfectant) to wipe down all therapy equipment and wheelchair handles when an infectedresident is done with their therapy session.

In the interview on 11/17/15, at 2:47 p.m., RN-B advised staff if they are just going in and out of the room, they should put on gloves; if they are coming in contact with any surface in the room,

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F 441	Continued From page 88 they should also use gloves. RN-B stated housekeeping is not her area, so she doesn't train housekeeping staff on infection control . She stated that putting a mop back on the housekeeping cart to use in another room should not be done. RN-B stated she has not done any resident or infection-specific training across other departments. In an interview on 11/18/15, at 7:42 a.m., Maintenance (M)-A stated housekeeping staff are to remove a soiled dust mop and get it laundered after using it in a room with precautions. M-A stated staff are not to use the dust mop in additional rooms. In an interview on 11/18/15, at 8:42 a.m., RN-B stated she reviewed all resident progress notes daily upon her arrival in the facility to determine if there were any infection control related issues. RN-B stated staff were to inform her if anyone is on antibiotic therapy. RN-B stated she gathered information on resident's with infections by reading a daily log where nurses record resident specific information, a nurse manager would tell her or she would read it in the progress notes. R49 did not receive complete hand hygiene during daily cares. R49 ' s admission record indicated diagnoses that included failure to thrive, depression, restlessness and agitation and diabetes. R49 ' s annual Minimum Data Set (MDS), dated 7/8/15, indicated R49 had severely impaired cognition, required extensive assistant with bed mobility, transfers, dressing, eating, toileting and personal hygiene and was frequently incontinent of bladder and bowel.	F 441		

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During an observation of R49's cares on 11/12/15, at 8:31 a.m., nursing assistants (NA)-F and NA-G were observed to change gloves without using hand sanitizer or handwashing in between glove changes.

According to NA-G, R49's incontinent product was saturated with urine and R49 had also had a bowel movement. NA-F and NA-G took turns cleaning BM off of R49 with disposable wet wipes. After cleaning R49's perineal area, NA-G and NA-F took off their gloves and without handwashing or hand sanitizer, donned new gloves. NA-F then took a wet washcloth and washed under R49's breasts and her armpits. NA-G tied up the garbage with the soiled incontinent product and wet wipes and placed it on the floor.NA-G then brought a stand lift into the room, removed her gloves and used hand-sanitizer.

In an interview on 11/17/15, at 2:47 p.m., registered nurse (RN)-B stated that she hasn't monitored hand washing formally. She did do a few audits in July of 2015, but hasn't monitored hand-washing formally.

The facility's undated Infection Prevention and Control Program section on Glove Use (page 48-49) specified hand hygiene to be completed before donning and after removing gloves.

R111 had a methicillin resistant staphylococcus aureus (MRSA) infection and the facility did not implement appropriate infection control precautions.

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

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F 441	Continued From page 90 R111 Admission Record identified diagnoses that included methicillin resistant staphylococcus aureus infection, peripheral vascular disease, and aneurysm of artery of a lower extremity. R111's admission minimum data set (MDS), dated 8/31/15, indicated he was cognitively intact and had surgical wounds. An 11/15/15 progress note indicated a blister to R111's left heel. The note continued that the blister had popped with yellowish/red drainage. The area was cleaned with wound cleaner and applied a non-stick pad and wrapped. 11/16/15 physician orders for wound care directed staff to clean the wound, apply telfa and tegaderm dressing daily. Review of R111's Interagency Referral Form (IAR) dated 8/25/15, identified MRSA as a high priority, and present, on the first page of the form. In addition the IAR indicated R11 was on a new medication sulfamethoxazole-trimethoprim (an antibiotic) for 14 days after discharge. In an observation on 11/15/15, at 7:04 a.m., R111's room had an infection control station outside the room, but no sign on the door directing staff or visitors to check with the nurse before entering. An observation on 11/17/15, at 9:47 a.m., revealed there was still no sign on R111's door. RN-B had a sign put on R11's door on 11/17/15 at 10:58 a.m. On 11/15/15, at 7:04 a.m., nursing assistant (NA)-H and NA-N entered R111's room with gloves on, but no gowns. Upon exiting the room at 7:50 a.m., NA-N was observed to use purple (MRSA-killing) wipes to wipe down the surfaces of the Hoyer lift.	F 441		

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F 441	Continued From page 91 In an interview on 11/17/15, at 2:47 p.m., RN-B stated CDC guidelines were used to determine which isolation precautions are put in place. She did not know if all three of R111's wounds had been cultured and if not, the reasoning behind why they weren't. RN-B stated, "I'd have to check." No further clarification was provided. RN-B also stated any nurse can implement precautions, they don't have to wait for orders In an interview on 11/18/15, at 8:42 a.m., RN-B stated R111 had returned from the hospital on 8/25/15. RN-B stated as soon as she found out R111's leg wound had infection she placed the resident on contact precautions. RN-B confirmed R111 was not on contact precautions from 8/25/15, his return from the hospital, until RN-B implemented precautions on 9/1/15. RN-B stated that the 9/1/15 documentation was for staff to use precautions only during wound cares. R88 had a Clostridium difficile (C. difficile) infection, and the facility did not implement appropriate infection control precautions. Findings include: The Center for Disease Control (CDC) guidelines for health care facilities directed the following when caring for residents with a C. Difficile infection: Isolate patients with C. difficile immediately. Wear gloves and gowns when treating patients with C. difficile, even during short visits. Hand sanitizer does not kill C. difficile, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves. Clean room surfaces thoroughly on a daily basis while treating a patient with C. difficile and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing	F 441		

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F 441	Continued From page 92 disinfectant. R88's Admission Record identified diagnoses that included enterocolitis due to Clostridium difficile (a spore-forming bacteria that can cause swelling and irritation of the large intestine, or colon. This inflammation, known as colitis, can cause diarrhea, fever, and abdominal cramps). R88's admission Minimum Data Set (MDS) indicated R88 was cognitively intact, required extensive assistance of two staff for toileting, and was frequently incontinent of bowel. Laboratory results on 9/24/15, and 10/13/15, both identified the presence of C. difficile in R88's stool. On 11/9/15, at 3:42 p.m. registered nurse (RN)-C was interviewed, and stated R22 was on isolation precautions due to a C. difficile infection. RN-C stated staff were not required to gown and glove prior to entering R88's room, unless they were coming into direct contact with R88's stool. RN-C verified R88 had loose stools that day. On 11/10/15, at 7:34 a.m. nursing assistant (NA)-L was observed entering R88's room. There was a yellow sign on R88's door; it directed "stop contact precautions, wash hands, gown, glove. Visitors see nurse before entering". Outside the door was an isolation cart with gowns, gloves, masks and sanitizing wipes. NA-L had a coffeepot in her hands, knocked on the door and entered R88's room. NA-L did not wash her hands, or put on a gown or gloves. NA-L put the coffeepot on a bedside table next to R88. Housekeeper (H)-A then entered R88's room, and did not wash her hands, or gown or glove. H-A had a dry mop, and proceeded to dry mop the floor. NA-L proceeded to make R88's bed. H-A left the room without washing her hands, and placed the dry mop onto the housekeeping cart. NA-L left the room without washing her hands, and had a coffeepot in her hands when she left	F 441		

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the room. NA-L was interviewed and stated she did not gown or glove when she went into R88's room, because she just brought him fresh coffee, and made his bed. NA-L stated she had not washed her hands when leaving the room, she was on her way to do that now. H-A was interviewed and stated she did not gown or glove when going into R88's room, but she did use an alcohol based sanitizer when she left the room. At 7:57 a.m. H-A was observed with the dry mop still on her housekeeping cart. H-A stated she was supposed to take the soiled dry mop off her her cart, and replace it with a clean one, but she had not done this yet.
On 11/10/15, at 10:05 a.m. trained medication aide (TMA)-E was interviewed, and stated R88 did not have a dedicated stethoscope, thermometer or blood pressure cuff. TMA-A stated if these were used on R88, staff should clean them off with a disinfectant.

On 11/10/15, at 10:08 a.m. RN-B was interviewed, and stated she was the nurse responsible for the facility's infection control program. RN-B stated there was an isolation cart outside of R88's door, and she would expect staff to wash their hands with soap and water, not just using an alcohol based hand sanitizer when entering and leaving the room. RN-B stated she would expect nursing and housekeeping staff entering R88's room to have a "minimum" of gloves on, and she has asked them to gown and glove prior to entering the room, but "they don't." RN-B confirmed she had not done audits to determine whether or not staff were wearing gowns and gloves, or performing proper hand hygiene when entering R88's room. RN-B further stated the facility did not provide R88 with dedicated equipment at this time, it is something

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F 441	Continued From page 94 they should be doing, and the facility will start to do it soon. RN-B stated if staff were using the blood pressure cuff, stethoscope and thermometer on R88, they should be cleaning the equipment with a sanitizing wipe, but she hasn't educated them on it yet. In an observation on 11/10/15, at 10:29 a.m., certified occupational therapist assistant (COTA) was observed entering R88's room with a clipboard. The COTA did not gown or glove upon room entry, but did apply hand sanitizer. The COTA did not touch anything, but did use the door handle to close the door upon exit. The COTA did not wash or sanitize her hands after exiting the room. The COTA stated that she would take the clipboards to use in other rooms. On 11/12/15, at 7:14 a.m. RN-B was interviewed, and stated the sanitizing wipes on the isolation cart outside of R88's room did not kill spores. The facility policy and procedure on Clostridium Difficile undated, directed staff to wash hands with soap and water, alcohol gels or handrubs are not effective in removing or killing the spores . When possible, non-critical care equipment should be dedicated to the patient with C. difficile. Based on interview and document review, the facility failed to ensure Tuberculosis (TB) screening, including a two-step tuberculin skin test (TST) (a skin test to assist in identifying if an individual had been exposed to TB or was infected with TB), and a TB baseline symptom screening was completed upon employment and prior to providing cares for 9 of 10 direct care staff. This had the potential to affect all 159 residents residing in the facility. Findings include:	F 441		

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1001 ST LOUIS AVENUE DULUTH, MN 55802

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F 441	Continued From page 95 The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Setting, 2005 (MMWR) directed all health care workers must receive a baseline TB screening upon hire. The screening must include an assessment of the employees risk factors for TB, and any current TB symptoms. A two-step TST (tuberculin skin test) or a single interferon gamma release assay (IGRA), or a chest x-ray results must be maintained in the employee record. A review of employee tuberculosis (TB) screening and employee list indicated the following: * NA-N was hired 3/14/13. The first-step tuberculin skin test TST was administered that day. The second TST was not administered until 5/30/13. The second-step TST was administered late. * NA-O was hired 10/27/14. The first-step TST was administered on 6/3/15 and the second TST was administered 6/10/15. The baseline symptom screening was completed on 6/5/15. The screening was not prior to the start date. * NA-G was hired 10/15/15. The first-step TST was administered on 10/15/15. NA-G did not receive a second-step TST. The baseline symptom screening was completed on 10/15/15. * NA-M was hired on 10/26/15. The first-step TST was administered on 10/26/15. The second-step TST had not been administered. The baseline symptom screening was completed on 10/26/15. * NA-P was hired on 5/17/11. The first-step TST was administered on 5/17/11. The second-step TST had not been administered at that time. Another one-step TST was administered on	F 441		

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F 441	Continued From page 96 6/17/15 The baseline symptom screening was completed on 5/17/11. * NA-Q was hired on 12/26/12. The first-step TST was administered on 10/24/14. The second-step was administered on 12/17/14. The baseline symptom screening was undated. The TB screening was not completed at the time of hire. * NA-R was hired on 10/14/13. The first-step TST was administered on 10/11/13. There was no documentation of the second-step. NA-R received another one-step TST on 6/1/15. The second-step TST was read 5 days after administration, the TST is to be read 48-72 hours after administration. The baseline symptom screening was completed on 10/14/13 and 6/1/15. * NA-T was hired on 10/26/15. NA-T had received a TST on 9/21/15, prior to employment at facility. The first-step TST was administered on 10/26/15. The baseline symptom screening was completed on 10/26/15. * NA-U date of hire was listed as 7/23/15. There were no TST's or baseline symptom screening done for this date. There were 2 previous one-step TST results; one dated 11/4/10, and the other dated 12/2/14. A baseline symptom screening was completed with each TST. *NA-V was hired 12/3/07. A one-step TST was administered 10/24/14. Another one-step TST was administered 6/16/15. A baseline symptom screening was completed with each TST. During an interview 11/18/15, at 8:30 a.m., registered nurse (RN)-B stated the employee must have a negative TST before they can work with residents, and the second-step should be given within 21 days after the first. RN-B verified some of the new employees must have their	F 441	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Staff will be in- serviced on the Facility's Infection control Policies and Procedures, which includes the implementation of isolation precautions and ensuring complete hand washing. The Staff Development /Infection Control Coordinator will implement infection control precautions per CDC guidelines in a timely manner. And upon admission or readmission, or with any current resident if precautions are warranted. 4. Observation rounds will be conducted two (2) times per week times 12 weeks to monitor the facility's infection program to include isolation precautions and complete hand washing. Any negative occurrence will be addressed immediately.	

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F 441	Continued From page 97 TSTs repeated because they were late having their second-step TST administered. RN-B stated the employee is given a form that directs them when they need to come back either to have the first-step TST read, or have the second-step TST administered. RN-B stated she followed up with human resources. The undated facility policy and procedure for Tuberculosis Control Plan directed all qualified applicants for employment would be screened using a two-step TST or a blood test for tuberculosis.	F 441	The results of the observation rounds will be presented to the monthly QAPI committee to review and make recommendations. After three months the QAPI committee will make a recommendation as to the need to continue to monitor the facility wide infection control program. 5. The Director of Nursing/designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were well maintained for 8 of 15 resident rooms (rooms 121, 143, 151, 159, 160, 210, 212, 257) In addition, the facility failed to ensure a wheelchair was properly maintained for 1 of 1 residents (R129) reviewed for environmental concerns. Findings include: On 11/17/15, at 2:59 p.m. a tour of the facility was completed with the director of maintenance (DM)-B and the environmental director (ED)-A. During the tour, the following room maintenance	F 465	1. Resident room's # 121,143,151,159,160,210,212,257 and the wheelchair in room 129 were repaired, painted and or fixed to reflect a more homelike environment. 2. All resident rooms have the potential for not having a homelike environment.	

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F 465	Continued From page 98 and wheelchair concerns were identified and confirmed by both DM-B and ED-A. Room (RM) 121 had two 2 inch (in) gouges with sharp edges in the vinyl doorknob guard behind the main door. RM 143's bathroom had multiple scratches on the rim of the toilet. The caulking at the base of the toilet was cracked, peeled and dirty. There were four dime sized chips in the tiled wall in the bathroom. The built in closet had 6 in. long gash exposing the particleboard on the bottom right corner. RM 151's caulking at the base of the toilet was cracked, peeled and dirty. The bathroom also had a strong urine smell. RM 159's caulking at the base of the toilet was cracked, peeled and dirty. RM 160's bathroom sink has three cracks in the porcelain. RM 210's bathroom floor had yellow staining around the base of the toilet. Dirt was observed in the corners behind the toilet and below the sink. There were also dark splatters on the wall and floor near the toilet. RM 212's private room lacked a privacy curtain. RM 257's tiled bathroom floor had an area approximately 3 in. x 3 in. that was filled with cement.	F 465	3. The facility utilizes the Direct Supply "Tels" system, which allows all departments to alert the Maintenance department of resident rooms, resident environment and or the resident's equipment that need repair or attention.. An audit of ten (10) resident rooms will be conducted each week for 12 weeks to assure the rooms are maintained to reflect a more homelike environment. Any item or items needing repair, painting or fixing will be addressed immediately. This system will be ongoing throughout the year. The results of the audits will be presented to the monthly QAPI committee monthly for three (3) and quarterly thereafter for one year to assure a system of maintaining the resident rooms in a homelike environment.	

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F 465	Continued From page 99 R129's wheelchair's right-sided arm support was worn through the top layer exposing the cushion. After the tour on 11/17/15, at 3:33 p.m. DM-B stated he has not been currently performing routine maintenance rounds in the resident rooms since the ED-A started working in the facility. ED-A stated that he rounds every room in the facility monthly, however his checklist did not include maintenance specific tasks to look for and document for follow up. DM-B stated the facility does not have any room maintenance policies aside from housekeeping. The facility policy "Resident Restroom Cleaning" directed housekeepers to sweep, dust and mop the entire floor, moving any items that may be in the bathroom. The facility did not provide a policy on maintainence of resident's rooms, resident's environment or resident's equipment.	F 465	5.The Director of Maintenance/designee with oversight by the Administrator will be responsible. Completion date of 12-31-2015.	
F 494 SS=F	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the	F 494	1. No residents were affected by the alleged deficient practice. 2. All of the nursing assistant evaluations have been completed. Completion date of 12-30-2015	

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F 494	Continued From page 100 requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure performance reviews were completed for all nursing assistants in the past 12 months. This had the potential to affect all 159 residents residing in the facility. Findings include: A review of 15 employee files indicated the following employees did not have performance reviews completed in the past 12 months: Nursing assistant (NA)-D, NA-Q, NA-N, NA-Z, NA-R, NA-C, NA-V, and NA-W. During an interview on 11/18/15, at 9:04 a.m. the human resources director (HRD)-I stated no NA performance reviews were completed in the past year. The HRD-I stated the last reviews were done in 2013, by the previous company. During an interview on 11/18/15, at 12:06 p.m. the HRD-I verified no performance reviews were done in 2014, and that the evaluation dates found in the employee files were most likely accurate. HRD stated the expectation is that the performance reviews are done yearly.	F 494	3. The Administrator reviewed the federal requirements and the Standards of the State of Minnesota with the Director of Nursing and the Director of Human Resources regarding the requirement of nursing assistants having an annual evaluation. At the beginning of each month, HR will send out an evaluation form and a list of the CNA anniversary dates for that month. It will be the expectations that the Unit Managers complete the evaluation by the end of that month. 4. An audit will be completed monthly for three (3) months, then quarterly for one year to assure evaluations are completed per the State of Minnesota standard. Theses audits will be presented to the monthly QAPI committee to monitor the system of annual evaluations are being completed.	

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F 494	Continued From page 101 A policy and procedure for performance reviews was not provided.	F 494	5. The Director of Nursing /designee and the Director of Human Resources/ designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015.	
F 495 SS=F	483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure new employees receive appropriate orientation and training prior to providing direct care to residents. This has the potential to affect all 159 residents residing in the facility. Findings include: A review of employee training indicated nursing assistant (NA)-M, NA-AA, and NA-G had not received new employee orientation. The employee list indicated NA-M was hired on 10/26/15, and the schedule indicated she had been providing direct cares. NA-AA was hired on 9/4/15, and the schedule indicated he has been providing direct cares. NA-G was hired on	F 495	1. No residents were affected by the alleged deficient practice. 2. No residents were affected by the alleged deficient practice.	

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F 495	Continued From page 102 10/15/15, and the schedule indicated she had been providing direct cares. NA-T was hired on 10/26/15, and the schedule indicated he had been providing direct cares. During an interview on 11/18/15, at 8:30 a.m. registered nurse (RN)-B verified NA-M, NA-AA,NA-G, and NA-T had not attended new employee orientation and were scheduled to attend 12/9/15. RN-B stated new employees receive some information in their packet from human resources (HR) when they start. RN-B was not sure what information they receive from HR. RN-B verified she had not educated the above NAs regarding abuse prevention, dementia, or resident rights. During an interview on 11/18/15, at 12:06 p.m. the HR director (HRD)-I stated new employees received information regarding payroll, job description, code of conduct, and resident rights, privacy, and related employment information. HRD-I verified NAs do not receive information regarding abuse prevention or dementia. HRD stated the nurse educator does orientation monthly, but they are hiring NAs faster than education/orientation is held. The New Employee Orientation Training indicated Abuse and Neglect, Infection prevention and control, and dementia were to be included in the orientation. A facility policy and procedure for new employee orientation was not provided.	F 495	3. Employees have received the appropriate orientation and training prior to providing direct care to residents... All new staff have received the appropriate orientation prior to be assigned to care for staff. Completed 12-30-2015 4. An audit of personnel files will be conducted one (1) time per week times 12 weeks, then monthly for one year to monitor that all new staff have had the appropriate orientation prior to providing direct care. These audits will be presented to the monthly QAPI committee to review and assure a system of assuring new employees are the appropriate orientation prior to providing direct care. 5. The Director of Staff Development /designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015.	
F 496 SS=F	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING	F 496	1. No residents were affected by the alleged deficient practice.	

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F 496	Continued From page 103 Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility verified current certification/registration of a nursing assistant who provided direct care to residents. This had the potential to affect all 159 residents residing in the facility.	F 496		

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F 496	Continued From page 104 Findings include: The facility provided a list of all nursing assistants working in the facility and who were on the state registry. Nursing assistant (NA)-M was not included on the list provided by the facility that was checked with the registry. A review of the schedules, indicated NA-M began working with residents on 11/28/15, and worked with another NA until 10/31/15. NA-M was on the schedule independently one to two shifts 14 of 19 days between 10/31/15, and 11/18/15. During an interview on 11/18/15, at 7:41 a.m. the director of nursing (DON) stated she was not sure how often the NA registry is checked. During an interview on 11/18/15, at 12:16 p.m. the human resource director (HRD)-I verified NA-M was not on the nursing assistant registry and her certification had lapsed. HRD-I stated NA-M had been working as a nursing assistant in the facility. HRD-I verified a registry check was not done prior to employment for NA-M. During an interview on 11/18/15, at 1:36 p.m. the DON verified she was unaware that NA-M's registration/certification was not current until that morning. DON-F verified NA-M had been working as a nursing assistant in the facility and had not been under direct supervision 100% of the time. During an interview on 11/18/15, at 1:48 p.m. NA-M verified she had been working as a nursing assistant at the facility and had provided cares to residents while working independently and	F 496	2. All residents have the potential to be affected by the practice. 3. NA-M is current with her certification. All nursing assistant certifications have been verified as current. 4. An audit will be conducted each month for three (3) months and then quarterly for one year to monitor that all nursing assistant certifications are current. The results of the audits will be presented to the monthly QAPI committee to assure that no nursing assistant is allowed to provide direct care to a resident without a current certification.	

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F 496	Continued From page 105 unsupervised. The facility was unable to provide a policy and procedure for ensuring staff certification and licensing prior to employment.	F 496	5. The Director of Human resources/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015.	
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff received mandatory annual education and the appropriate hours of education to maintain the nursing assistant certifications. This had the potential to affect all 159 residents residing in the facility. Findings include: During a review of employee training hours for 17 nursing assistants (NA), 7 of the employees had been hired in the past year and had received or were scheduled to receive new employee orientation. The remaining NAs had been employed at the facility for greater than 12 months, and had received the following hours of training since 1/15: * NA-W had received 4.5 hours, including abuse prevention/reporting and general training. No dementia, infection prevention or control, resident rights, privacy training, or other mandatory	F 498	1. No residents were affected by the alleged deficient practice.	

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F 498	Continued From page 106 training was received. * NA-V had received 7.5 hours, including abuse prevention/reporting and general training. No dementia, infection prevention or control, resident rights, or privacy training, or other mandatory training was received. * NA-Z had received 1.0 hours, did not include mandatory training, such as abuse prevention/reporting, dementia, infection prevention or control, resident rights, privacy training, or other mandatory training. * NA-C had received 9.5 hours, including abuse prevention/reporting, infection prevention. No dementia, resident rights, or privacy training, or other mandatory training was received. * NA-R had received 1.5 hours, including abuse prevention and reporting. No dementia, infection prevention or control, resident rights, privacy training, or other mandatory training was received. * NA-Q had received 5.0 hours, did not include mandatory training such as abuse prevention/reporting, dementia, infection prevention or control, resident rights, privacy training, or other mandatory training. * NA-P had received 8.5 hours, including abuse prevention/reporting. No dementia, infection prevention or control, resident rights, privacy training, or other mandatory training was received. * NA-O had received 6.5 hours, including abuse prevention/reporting. No dementia, infection prevention or control, resident rights, privacy training, or other mandatory training was received. * NA-N had received 3.0 hours, did not include mandatory training such as, abuse prevention/reporting, dementia, infection prevention or control, resident rights, privacy	F 498		

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

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F 498	Continued From page 107 training, or other mandatory training. * NA-D had received 5.5 hours, including abuse prevention/reporting and infection prevention and control. No dementia, resident rights, privacy training, or other mandatory training was received. During an interview on 11/18/15, at 7:41 a.m. the director of nursing (DON) stated a new electronic training will be starting soon. The DON stated it is hard to expect the staff to attend training when they are at work, so with the electronic training, they will be able to do it at home and will get paid for that. During an interview on 11/18/15, at 8:30 a.m. registered nurse (RN)-B verified the staff listed above had not received 12 hours of mandatory training since at least 1/15. RN-B was unaware of the previous training received. RN-B stated the NAs were to receive 12 hours of training yearly. RN-B was not sure of the mandatory content of the training, but had a list that she was unable to locate. RN-B stated the NAs have been offered over 22 hours of education this year, and had been offered several opportunities throughout the year to obtain their 12 hours. RN-B stated she provided the nurse managers with the status of each employee and their training. RN-B verified that she had not followed up on the status for each employee. RN-B stated vulnerable adult training was offered in March, and the staff completed an educational packet with this information. If the employee missed the training, they had to do the make-up packet. If the employee had done the packet, it would have been included in the hours reported. RN-B stated they are planning to do electronic training and that will be assigned to each staff.	F 498	2. All residents have the potential to be affected by the alleged deficient practice. 3. Nursing assistants have received their 12 hour mandatory training. 4. An audit o will be completed each month for three (3) months then quarterly for one year to assure any nursing assistant requiring their 12 hour of mandatory education in a twelve month period of time will have completed their mandatory training/education.	

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F 498	Continued From page 108 A facility policy for staff education was requested but not provided.	F 498	5. The Director of Staff Development/designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015.	
F 500 SS=C	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the contract with physical therapy, occupational therapy, and speech therapy was current. This had the potential to affect all 159 residents residing in the facility. Findings include: The Therapy Services Agreement for physical therapy, occupational therapy, and speech therapy services dated 7/1/13, was between the	F 500	1. No residents were affected by the alleged deficient practice. 2. All residents may have the potential to be affected by the practice. 3. An updated contract for Therapy was obtained by 12-1-2015 4. All contracts will be reviewed quarterly at the QAPI committee to monitor that contracts remain timely and updated. On going.	

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F 500	Continued From page 109 previous owner of the facility and the therapy provider. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the contract would have to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility. A policy for contract renewals was not provided .	F 500	5. The Administrator/designee will be responsible. Completed 12-31-2015.	
F 502 SS=C	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the contract for laboratory services was current. This had the potential to affect all 159 residents residing in the facility. Findings include: The facility did not have a signed contract for laboratory services. The laboratory provider did submit a letter of agreement dated 12/23/13, for services to be provided for the facility. The letter of agreement was signed by the laboratory provider only, and not by the facility. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the contract would have	F 502	1 .No residents were affected by the alleged deficient practice 2. All residents may have the potential to be affected by the alleged deficient practice. 3. The laboratory contracts have been made current.	

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F 502	Continued From page 110 to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility. A policy for contract renewals was requested and not provided.	F 502	4. The Laboratory contract will be reviewed quarterly in the QAPI committee to monitor the date of the contract. On going. 5. The Administrator/ designee will be responsible. Completion date of 12-31-2015.	
F 508 SS=C	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the contract for radiology services were current. This had the potential to affect all 159 residents residing in the facility. Findings include: The Imaging and Radiology Service Agreement dated 12/2/09, was between a previous owner of the facility and the radiology provider. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the contract would have to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility.	F 508	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Radiology contract has made current. 4. The radiology contract will be reviewed quarterly at the QAPI committee to monitor the date of the contract. On going. 5. The Administrator/designee will be responsible. Completion date of 12-31-2015.	

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F 508	Continued From page 111 A policy for contract renewals was not provided .	F 508		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate medical records were completed for 5 of 5 residents (R15, R38, R61, R76, R109) reviewed for monthly pharmacist reviews. Findings include: R15's quarterly Minimum Data Set (MDS) dated 9/11/15, included diagnoses of diabetes mellitus and dementia. The MDS indicated R15 had been taking insulin, diuretics, antipsychotic and antianxiety medications. R15's had an admission date of 10/15/15, the pharmacy consultant verification of medication review for October 2015, was not filed in R15's	F 514	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the practice. 3. The pharmacy consultant reports will now be individualized and filed in the residents chart. 4. An audit will be completed each month for three (3) months to monitor the pharmacy consultant reports /recommendations have been filed in the resident's chart. These audits will be presented to the monthly QAPI committee for three months. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that the Consultant pharmacy reports are being filed in the residents' chart. 5. The Director of Nursing/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015.	

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F 514	Continued From page 112 chart. R38's admission MDS dated 10/26/15, included diagnoses of diabetes mellitus and dementia. The MDS indicated R38 had been taking insulin and antipsychotic medications. R38 had an admission date of 4/1/13, the pharmacy consultant verification of medication review for January, February, March, April, May, June, July, August, September and October 2015, were not filed in R38's chart. R61's admission MDS dated 10/29/15, included diagnoses of depression. The MDS indicated R61 had been taking an antidepressant medication. R61 had an admission date of 4/11/13, the pharmacy consultant verification of medication review for January, February, March, April, May, June, July, August, September and October 2015, were not filed in R38's chart. R76's quarterly MDS dated 8/13/15, included diagnoses of dementia, anxiety disorder, depression and post traumatic stress disorder. The MDS indicated R76 had been taking antipsychotic medications. R76 had an admission date of 10/15/09, the pharmacy consultant verification of medication review for January, February, March, April, May, June, July, August, September and October 2015, were not filed in R38's chart. R109's quarterly MDS dated 9/14/15, included diagnoses of anxiety disorder, depression, dementia and a psychotic disorder. The MDS indicated R109 had taken antipsychotic,	F 514		

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F 514	Continued From page 113 antianxiety and antidepressant medications. R109 had an admission date of 11/11/14, the pharmacy consultant verification of medication review for January, February, March, April, May, June, July, August, September and October 2015, were not filed in R38's chart. During interview on 11/18/15, at 9:44 a.m. the assistant director of nursing (ADON) stated the pharmacy consultant had started a new process with the October 2015, pharmacy consultant's medication review verification forms. The forms were now individualized by resident and they were kept in the ADON's office in a file, not in an individual resident's medical record. The ADON further stated that the pharmacy consultant's medication review verification forms were previously sent via e-mail and were not filed in the resident's medical record. The ADON verified she had to contact the consultant pharmacist to provide documentation of the medication review's prior to October of 2015. A policy on medical records was requested and not received.	F 514	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the practice. 3. The pharmacy consultant reports will now be individualized and filed in the residents chart. 4. An audit will be completed each month for three (3) months to monitor the pharmacy consultant reports /recommendations have been filed in the resident's chart. These audits will be presented to the monthly QAPI committee for three months. 5. The Director of Nursing/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015.	
F 519 SS=C	483.75(n) TRANSFER AGREEMENT WITH HOSPITAL In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when	F 519	1. No residents were affected by the alleged practice. 2. All residents have the potential to be affected by the practice.	

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F 519	Continued From page 114 transfer is medically appropriate, as determined by the attending physician; and medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions. The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a transfer agreement with at least one hospital was current. This had the potential to affect all 159 residents residing in the facility. Findings include: The Transfer Agreement between the facility and a hospital dated 5/24/15, was between a previous owner of the facility and hospital provider. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the contract would have to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility.	F 519		

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F 519	Continued From page 115 A policy for contract or agreement renewals was not provided.	F 519	3. The hospital transfer agreement has been updated. These will be reviewed quarterly to monitor compliance. On going. 4. The Administrator /designee will be responsible. Completion date of 12-31-2015.	

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F 000	INITIAL COMMENTS The facility plan of correction (POC) will serve as you allegation of compliance upon the department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint #H5227054 was completed. The complaint was unsubstantiated. An extended survey was conducted on 11/12-18/15. At the time of survey on 11/12/2015, an extended survey was initiated due to an Immediate Jeopardy at F323. The Immediate Jeopardy was removed on 11/18/2015. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to comprehensively assess and effectively implement interventions in order to minimize the risk of falls with serious injury or death for R61 who had frequent falls. The immediate jeopardy was removed on 11/18/15, at 10:30 a.m. after it was verified that the facility effectively implemented a removal plan.	F 000	OK 12/30/15	
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS	F 161	1. No residents were affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Don Barbut — TITLE: Administration — (X6) DATE: 12-31-2015

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

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F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS	F 161	1. No residents were affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Don Babbitt — TITLE: Administrator — (X6) DATE: 12-17-2015

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

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F 161	Continued From page 1 The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the surety bond was sufficient to cover the total amount in the resident fund accounts. This had the potential to impact 83 previous and current residents who had money in the account. Findings include: A review of the facility's surety bond (insurance that protects the resident personal funds in trust fund account held by the facility), revealed the amount of the surety bond was less than the total of the resident funds held by the facility. The surety bond dated 10/24/13, indicated the resident personal funds were protected up to a total of $39,000. The facility trust fund balance report dated 11/11/15, indicated 139 residents who now reside in the facility or who previously resided in the facility had an open trust fund account for a total of $58,829.27. 83 of 159 current residents had money in the trust fund. The surety bond was not sufficient to secure the total resident monies held by the facility. During an interview on 11/17/15, at 3:15 p.m. the administrator verified the surety bond was not	F 161	2. Residents may have the potential to be affected by the alleged deficient practice. 3. The facility purchased a new Surety Bond November 17, 2015, which covers the amount in the resident trust fund. 4. The facility will monitor the resident trust fund every month for three (3) months to monitor the Surety Bond covers the resident trust fund balance. If there would be a negative occurrence, the facility will take immediate action to cover the trust fund balance. 5. The results of the audits will be reported to the monthly QAPI committee for three months. 6. The Administrator/designee will be responsible.	

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

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F 161	Continued From page 2 sufficient to cover the resident fund balance . The facility policy and procedure for Resident Trust Account dated 7/2015, indicated a surety bond would be maintained on the resident trust fund account and would be renewed annually	F 161		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	1. Resident #46 was not affected by the alleged deficient practice as documented by Social Services. 2. All residents have the potential for being affected by the alleged deficient practice.	

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F 164	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident privacy during a pain assessment/medication pass for 1 of 1 residents (R46) reviewed for privacy. Findings Include: R46's Admission Record identified diagnoses that included chronic kidney disease stage 4, type 2 diabetes, and chronic pain due to trauma. The quarterly Minimum Data Set (MDS) dated 9/4/15, indicated R46 was cognitively intact and received scheduled pain medications. The physician's orders dated 11/13/15, directed R46 to receive oxycodone every four hours, as needed, for pain. On 11/12/15, at 8:55 a.m., trained medication aide (TMA)-B was observed at the medication cart in the hallway. While standing at the cart, TMA-B called loudly, "What's your pain?" to R46, who was in his room with the TV on. This could be heard by any resident, staff or visitor who was in the hallway. When asked if this method of asking about R46's pain maintained privacy, TMA-B replied, "I guess not", and continued to explain R46 is hard of hearing so she had to yell. In an interview on 11/13/15, at 9:52 a.m., registered nurse (RN)-A stated the facility expected licensed staff to ask about pain level in privacy. RN-A continued she would expect the nurse would go into a resident's room and have that conversation with the resident. RN-A also stated if the resident were hard of hearing, that is even more reason for the nurse to be at the resident's side.	F 164	3. Staff will be educated on the resident's right to privacy during cares. Completed 12-18-2015. 4. Observation rounds will be conducted two (2) times per week times 12 weeks to monitor the facility's system of respecting a resident's right to privacy. Any negative occurrence will be addressed with the staff member immediately. The observation round documentation will be presented to the monthly QAPI committee for review. After three months, the committee will recommend as to the need to continue to monitor that the facility demonstrates good practice on a resident's right to privacy is respected at all times.	

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

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F 164	Continued From page 4 The facility policy on Privacy undated, reviewed in 5/11, directed staff will speak with residents regarding their conditions in a private area. In addition, the facility's HIPAA and Confidentiality policy, dated 10/14, directed staff to lower their voice when discussing protected health information or move to a private area.	F 164	5. The Director of Nursing/designee will be responsible with oversight by the Administrator. Completed 12-31-2015.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt resolution of grievances, and feedback to residents, for 1 of 1 residents (R42), reviewed for grievances. R42's Admission record indicated diagnoses that included quadriplegia, type 2 diabetes, depression, and anxiety. R42's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated intact cognition. The MDS also indicated R42 required extensive assistance for transfers, bed mobility, dressing, eating, toileting and personal hygiene. R42's care plan dated 10/4/13, indicated R42 was at risk for injury/abuse due to mobility deficits, with the goal to not become a target of abuse, retaliation or receive injuries from another. Interventions included to observe for psychological, emotional and physical side effects.	F 166	1 .Resident #42 stated to the Director of Social Services that he was not affected by the alleged deficient practice. Weekly meetings between Social Services and resident # 42 have been initiated. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Administrator and Director of Social Services reviewed and revised the Policy regarding Resident Concerns. The Policy is revised to include documentation that the resident has been informed of the investigation and resolution of the concern. The Administrator and Director of Social services will review all resolutions.	

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F 166	Continued From page 5	F 166		

In an interview on 11/9/15, at 6:03 p.m., R42 stated he has made multiple complaints about a specific nursing assistant (NA) being very loud at night. R42 said every night this NA works, he gets woken up. R42 stated at the supper meal he just left, the NA didn't ask him a question directly, but asked another staff person to ask R42 a question. R42 stated this "attitude" all started when he made a complaint.

In the interview, R42 stated the facility social worker has said they're doing something about noise at night, but nothing has changed. R42 has requested that a NA not care for him, but has been told that the NA can't be taken off the unit and that if he won't have the NA in his room, then his cares won't get done.

During the interview, R42 said he was done complaining because all that happens is more attitude from nursing assistants. R42 said that when he recently complained, a nurse wrote up a behavior incident on him and then the nurse practitioner asked if he wanted to re-start antidepressant medication. R42 stated he is worried that if he says anything, he'll have to go back on his antidepressant.

In an interview on 11/13/15, at 11:07 a.m., the social service director (SSD) stated when a complaint is filed, they notify the Director of Nursing and the administrator; they report to the state agency if necessary, and make sure the resident is safe. Ultimately, the written complaint comes to the SSD and social services completes the follow-up and coordinates work with the appropriate department. The SSD stated residents can verbally complain and staff can

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F 166	Continued From page 6 write it on the grievance form. The social services department tracks complaints and reports to quality assurance (QA). The SSD stated some residents are care planned for making false accusations about staff, but the facility still investigates. The facility will care plan this only after a pattern is identified with a resident. During the 11/13/15, at 11:07 a.m., interview, the SSD stated that R42 did request to not have a staff person work with him, a long time ago, maybe in June. The SSD stated R42 will make these requests and then change his mind. The NA does not normally work with R42, but if two people are needed the NA will come to assist, unless R42 "says no." In an interview on 11/18/15, at 7:57 a.m., R42 stated he did talk to the facility social worker and the unit's nurse manager more than once about his concerns of loud NA's at night. R42 stated they did tell him they are "working on it" but he has gotten no other information about the status of the grievance. In an interview on 11/18/15, at 8:03 a.m., SSD stated the facility has a grievance process that typically begins with completion of a complaint form. Residents can report orally, but they prefer a written complaint because it is better for tracking purposes. SSD stated social services followed up on complaints and kept a log of concerns/grievances. SSD stated she had received one complaint on 10/22/15, by R42 of noise at night. SSD stated she talked to the night nurse about the complaint. SSD stated the night NA's happened to be working an evening, so she talked to them about	F 166		

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F 166	Continued From page 7 keeping noise down at night, acknowledging that it is their day, but it is the resident's night. SSD stated when she arrived in the morning, she will check in with the night nurse if anything was out of the ordinary. SSD stated she has not asked the night nurse about noise level recently and they have not audited night noise. SSD stated she had not received any other complaints from R42 regarding noise or other concerns. The facility resident concern policy, revised 5/2/15, directed concerns may be written or present orally. The policy further directed all concerns will be investigated and resolved within 30 days, except in extenuating circumstances that have been explained to and are acceptable to the complainant.	F 166	4. All resident concerns and the resolution that those concerns were presented to the resident will be reported at the monthly QAPI meeting for (3) three months. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that the facility informs the resident of the investigation and resolution of those concerns. 5.The Director of Social Services /designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225	1 .Residents # 96 and #90 were not affected by the alleged deficient practice. Social Services has initiated weekly meetings with resident # 90. Two staff members will be assigned to provide cares to resident #96. 2. All residents have the potential for being affected by the deficient practice.	

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F 225	Continued From page 8 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential mistreatment to the State Agency (SA) and thoroughly investigate allegations of potential mistreatment for 2 of 3 residents (R90, R96) reviewed for potential mistreatment. Findings include: R90 stated he had been verbally abused by a staff member, he had reported it to the facility, and the facility told him they couldn't do anything about it unless he put it in writing. R90's quarterly Minimum Data Set (MDS) dated 9/14/15, identified diagnoses that included cerebral vascular accident (CVA, commonly known as a stroke). The MDS also identify R90	F 225		

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F 225	Continued From page 9 had no behaviors, was continent of urine, and required extensive staff assistance with bed mobility, personal hygiene and toileting. The care plan dated 1/8/14, indicated R90 used a condom catheter at night, and used the urinal with staff assistance every two hours and as needed. On 11/10/15, at 12:45 p.m. R90 stated (a while ago) his condom catheter had come off during the night. Nursing assistant (NA)-N came into his room, and when he asked her to leave the condom catheter off, he would use the urinal, she became angry. NA-N stated she didn't have time to change him if he became wet (with urine). R90 described her behavior as loud, rude and snotty. R90 stated he reported NA-N's verbal abuse the following day. On 11/12/15, at 12:24 p.m. family member (F)-A stated she went with R90 to report NA-N's verbal abuse to staff the following day. F-A stated they reported to registered nurse (RN)-G, who told them a resident's report of verbal abuse by a staff member must be put in writing, or the facility was unable to do anything about it. On 11/12/15, at 7:10 a.m. the director of nursing (DON) verified there was no mistreatment report for R90's report of verbal abuse by NA-N. On 11/12/15, at 4:30 p.m. RN-G was interviewed and stated she remembered R90 and F-A reporting verbal abuse by NA-N. RN-G stated she reported it to the DON, and was told either by the DON or the social worker R90 that F-A needed to fill out a grievance form. RN-G further stated the nursing assistant union was strong, and a complaint had to be in written form by the resident. At 5:48 p.m. RN-G stated she gave R90's completed grievance form to the DON.	F 225		

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F 225	Continued From page 10 On 11/12/15, at 5:52 p.m. the DON was interviewed, and stated R90 and F-A filled out a grievance form regarding alleged verbal abuse by NA-N. The DON stated she did not report R90's allegation of verbal abuse to the state agency, and she did not investigate. "It was a 'he said she said' " the DON verbalized, "I have a union here," and she instructed NA-N not to go into R90's room again. On 11/13/15, at 2:10 p.m. the director of human resources (HR)-I stated she did not receive a grievance form completed by R90 and F-A, and there was no documentation in NA-N's file indicating any type of discipline regarding R90's complaint of alleged verbal abuse. On 11/13/15, at 2:16 p.m. the director of social services (SW)-B stated she did not have a grievance form completed by R90 and F-A. On 11/13/15, at approximately 2:15 p.m. the facility provided a copy of R90 and F-A's grievance form. The grievance form was dated 7/29/15, and indicated the following: "Resident's (sic) rang for staff on NOC (night) shift to come in as condom catheter was falling off. Staff (NA-N) was CNA (certified nursing assistant). Resident asked to have condom cath removed and he would use urinal rest of night. Staff responded 'no, I don't want you to piss the bed' and demanded resident have condom cath put back on." The form was signed by RN-G and dated 7/30/15, and the DON and administrator were notified on 7/30/15. The facility policy and procedure on Abuse Prevention Plan undated, directed the administrator must be informed immediately of all	F 225		

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F 225	Continued From page 11 incidents. The Abuse Prevention Plan defined verbal abuse as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or their families. The policy further directed that all incidents are to be reported, documented and investigated internally. 2. R96 had diagnoses of physiological condition, low back pain, generalized arthritis. The quarterly Minimum Data Set (MDS) dated 10/19/15, identified R96 had no cognitive impairment and required extensive limited assistance from one person for activities of daily living (ADL)'s. The MDS also identified R96 as having no behaviors. R96's care plan dated 11/10/13, indicated "Resident is a vulnerable Adult, at risk for injury/abuse from others due to cognitive deficits. Potential for retaliation related to Bipolar Disorder. Resident also noted to give money away." Also "[R96] has potential to demonstrate verbally abusive behaviors." An applicable intervention to this was to give R96 as many choices as possible. An Interview on 11/10/15, at 12:50 p.m. R96 said "One time I was abused. It was a nurse assistant. I was sitting on the toilet with my sweater on. She wanted to take the sweater off and I said no but she took it off anyway. She fractured my thumb. When I told her she was hurting me she said 'I don't give a fuck'. I told everyone, she was gone as long as my thumb	F 225	3. Staff were inserviced on the Abuse, Neglect, and Mistreatment Policy. The Administrator reviewed the policy and procedure with the Director of social services and the DON reviewing with them the procedures and expectations for a thorough investigation. The Administrator directed the Director of Social Services to resume primary responsibility for conducting the investigation relating to any allegation of abuse , neglect or mistreatment o the resident. Any alleged abuse, neglect or mistreatment will be reported to the proper State agencies.	

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F 225	Continued From page 12 was healing. That isn't much of a penalty for hurting me. Everyone that knows me know I don't need to be treated like that, I cooperate". An Interview on 11/12/2015, at 1:50 p.m. the director of nurses (DON) said R96 kept telling them different events that had happened to her . R96 had a "tussle" in the smoking area, a fall and this event. The DON said no other staff received a report. The DON said the next day R96 reported nursing assistant (NA)-T grabbed her finger. The DON said she investigated it right away but did not have a through investigation regarding this issue. The report dated 06/30/15, indicated "The resident was interviewed several times, including by this writer. She told different stories of event each time. She had forgotten that she fell, or that the day prior to the report that another resident grabbed something from that same hand and that she had complained of pain at the time as well. Bruise is healing. The staff in question was also interviewed by this writer, and stated that there was no incident of her bumping or grabbing the resident's hand. She had helped her remove a shirt, and a bit later offered help with cares which resident refused . Resident has multiple dx [diagnosis] and has been angry that she needs staff supervision for her smoking There is no findings of abuse in this case." Under incident description "The resident reports that her hand is sore, and that an aide last evening hurt her hand during cares. Employee suspended pending investigation, and care can changed that 2 staff be in the room during cares. Investigation ongoing." There is no further investigation.	F 225		

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 13 An interview with registered nurse (RN)-A on 11/17/15, at 11:13 a.m. said she (R96) reports abuse to us regularly. RN-A said there is a correlation between not R96 getting her way and making reports of abuse. An interview on 11/17/2015, at 11:25 a.m. with social services (SS)-B stated she hasn't been completing the vulnerable adult (VA) report for 9 months to a year. SS-B said it was transitioned to nursing at that time, but in the last couple weeks was being transitioned back to the social services department again. SS-B said she had nothing to do with R96's VA report from July or the investigation. An interview with DON on 11/17/2015, at 3:01 p.m. said she does not have any further investigation of the broken finger. The DON said this is a she said/she said and R96 has a lot of diagnoses that make her unreliable. A final radiology report dated 7/1/15, indicated "There are likely degenerative in etiology, however small avulsed fracture fragment is not completely excluded". A physician office visit dated 7/8/15, indicated "There is dark purple ecchymosis present on the thenareminence, the volar wrist, and the dorsal thumb". Nursing progress notes were requested for this event but were not received.	F 225	4. All allegations – and the investigations- of abuse, neglect and mistreatment will be presented to the QAPI monthly meeting every month for three (3) months to monitor the thoroughness of the investigations. After three months the QAPI committee will make a recommendation as to the need to monitor that the facility has properly investigated and reported all alleged abuse , neglect and or mistreatment. 5. The Director of Social Services/designee with oversight from the Administrator will be responsible. Completion date of 12-31-2015.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226	1. Residents # 96 and #90 were not affected by the affected deficient practice. Social services has initiated weekly meetings with Resident #90. Two staff members will be assigned to provide cares to resident #96.	

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F 226	Continued From page 14 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their abuse policy to ensure immediate reporting of allegations of potential mistreatment to the State Agency (SA) and thoroughly investigate allegations of potential mistreatment for 2 of 3 residents (R90, R96) reviewed for potential mistreatment. Findings include: R90 stated he had been verbally abused by a staff member, and the facility failed to report to the SA, and thoroughly investigate. The facility policy and procedure on Abuse Prevention Plan undated, directed the administrator must be informed immediately of all incidents. The Abuse Prevention Plan defined verbal abuse as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or their families. The policy further directed that all incidents are to be reported, documented and investigated internally. R90's quarterly Minimum Data Set (MDS) dated 9/14/15, identified diagnoses that included cerebral vascular accident (CVA, commonly known as a stroke). The MDS also identify R90	F 226	2. All residents have the potential for being affected by the alleged deficient practice. 3. Staff were inserviced on the Abuse, Neglect, and Mistreatment Policy. Completed 11-18-2015. The Administrator reviewed the Mistreatment Policy and Procedure with the Director of Nursing and the Director of Social Services and the procedures and expectations for a thorough investigation. The Administrator directed the Director of Social Services to resume primary responsibility for conducting the investigation relating to any alleged abuse, neglect and or mistreatment. Completed 12-4-2015. 4. All allegations and the subsequent investigations will be presented at the monthly QAPI meeting for three months to monitor that the faculty followed its Policy on Mistreatment. After three months the QAPI committee will make a recommendation as to the need to monitor that the facility has properly investigated and reported all alleged abuse , neglect and of mistreatment. 5. The Director of social services with oversight from the Administrator will be responsible. Completion date of 12-3-2015	

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F 226	Continued From page 15 had no behaviors, was continent of urine, and required extensive staff assistance with bed mobility, personal hygiene and toileting. The care plan dated 1/8/14, indicated R90 used a condom catheter at night, and used the urinal with staff assistance every two hours and as needed. On 11/10/15, at 12:45 p.m. R90 stated (a while ago) his condom catheter had come off during the night. Nursing assistant (NA)-N came into his room, and when he asked her to leave the condom catheter off, he would use the urinal, she became angry. NA-N stated she didn't have time to change him if he became wet. R90 described her behavior as loud, rude and snotty. R90 stated he reported NA-N's verbal abuse the following day. On 11/12/15, at 12:24 p.m. family member (F)-A stated she went with R90 to report NA-N's verbal abuse to staff the following day. F-A stated they reported to registered nurse (RN)-G, who told them a resident's report of verbal abuse by a staff member must be put in writing, or the facility was unable to do anything about it. On 11/12/15, at 7:10 a.m. the director of nursing (DON) verified there was no mistreatment report for R90's report of verbal abuse by NA-N. On 11/12/15, at 4:30 p.m. RN-G was interviewed and stated she remembered R90 and F-A reporting verbal abuse by NA-N. RN-G stated she reported it to the DON, and was told either by the DON or the social worker R90 that F-A needed to fill out a grievance form. RN-G further stated the nursing assistant union was strong, and a complaint had to be in written form by the resident. At 5:48 p.m. RN-G stated she gave R90's completed grievance form to the DON.	F 226		

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F 226	Continued From page 16 On 11/12/15, at 5:52 p.m. the DON was interviewed, and stated R90 and F-A filled out a grievance form regarding alleged verbal abuse by NA-N. The DON stated she did not report R90's allegation of verbal abuse to the state agency, and she did not investigate. "It was a 'he said she said' " the DON verbalized, "I have a union here," and she instructed NA-N not to go into R90's room again. On 11/13/15, at 2:10 p.m. the director of human resources (HR)-I stated she did not receive a grievance form completed by R90 and F-A, and there was no documentation in NA-N's file indicating any type of discipline regarding R90's complaint of alleged verbal abuse. On 11/13/15, at 2:16 p.m. the director of social services (SW)-B stated she did not have a grievance form completed by R90 and F-A. On 11/13/15, at approximately 2:15 p.m. the facility provided a copy of R90 and F-A's grievance form. The grievance form was dated 7/29/15, and indicated the following: "Resident's (sic) rang for staff on NOC (night) shift to come in as condom catheter was falling off. Staff (NA-N) was CNA (certified nursing assistant). Resident asked to have condom cath removed and he would use urinal rest of night. Staff responded 'no, I don't want you to piss the bed' and demanded resident have condom cath put back on." The form was signed by RN-G and dated 7/30/15, and the DON and administrator were notified on 7/30/15. R96 had diagnoses of physiological condition, low back pain, generalized arthritis. The quarterly Minimum Data Set (MDS) dated 10/19/15,	F 226		

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F 226	Continued From page 17 identified R96 had no cognitive impairment and required extensive limited assistance from one person for activities of daily living (ADL)'s. The MDS also identified R96 as having no behaviors. An interview on 11/10/15, at 12:50 p.m. R96 said "One time I was abused. It was a nurse assistant. I was sitting on the toilet with my sweater on. She wanted to take the sweater off and I said no but she took it off anyway. She fractured my thumb. When I told her she was hurting me she said 'I don't give a fuck'. I told everyone, she was gone as long as my thumb was healing. That isn't much of a penalty for hurting me. Everyone that knows me know I don't need to be treated like that, I cooperate." An interview on 11/12/2015, at 1:50 p.m. the director of nurses (DON) said R96 kept telling them different events that happened to her . R96 had a 'tussle' in the smoking area, a fall and this event. The DON said no other staff received a report. The DON said the next day R96 reported nursing assistant (NA)-T grabbed her finger. The DON said she investigated it right away, but did not have a through investigation regarding this issue. The report dated 06/30/15, indicated "The resident was interviewed several times, including by this writer. She told different stories of event each time. She had forgotten that she fell, or that the day prior to the report that another resident grabbed something from that same hand and that she had complained of pain at the time as well. Bruise is healing. The staff in question was also interviewed by this writer, and stated that there was no incident of her bumping or grabbing the resident's hand. She	F 226		

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F 226	Continued From page 18 had helped her remove a shirt, and a bit later offered help with cares which resident refused . Resident has multiple dx [diagnosis] and has been angry that she needs staff supervision for her smoking. There is no findings of abuse in this case." Under incident description "The resident reports that her hand is sore, and that an aide last evening hurt her hand during cares. Employee suspended pending investigation, and care can changed that 2 staff be in the room during cares. Investigation ongoing." There is no further investigation. An interview on 11/17/2015, at 11:25 a.m. with social services (SS)-B who said she hasn't been doing the vulnerable adult (VA) for 9 months to a year. She said it was transitioned to nursing at that time but in the last couple weeks was being transitioned back to the social services department again. SS-B said she had nothing to do with R96's VA report from July or the investigation. An interview with DON on 11/17/2015, at 3:01 p.m. said she did not have any further investigation of R96's broken finger. The DON said this is a she said/she said and R96 has a lot of diagnosis' that make her unreliable. A final radiology report dated 7/1/15, indicated "There are likely degenerative in etiology, however small avulsed fracture fragment is not completely excluded". A physician office visit dated 7/8/15, indicated "There is dark purple ecchymosis present on the thenareminence, the volar wrist, and the dorsal thumb".	F 226		

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F 226	Continued From page 19 Nursing progress notes were requested but were not received. R96's care plan dated 11/10/13 indicated "Resident is a vulnerable Adult, at risk for injury/abuse from others due to cognitive deficits. Potential for retaliation related to Bipolar Disorder. Resident also noted to give money away." Also "[R96] has potential to demonstrate verbally abusive behaviors." An applicable intervention to this was to give R96 as many choices as possible. An interview with registered nurse (RN)-A on 11/17/15, at 11:13 a.m. said she (R96) reports abuse to us regularly. RN-A said there is a correlation between R96 not getting her way and making reports of abuse.	F 226	1 .Resident # 49 has had no negative outcomes from the alleged deficient practice. Social Services purchased additional items of clothing for R49, which she has shown acceptance. 2. Residents who do not have the ability to make choices or do not have the ability to communicate likes and dislikes or needs have the potential to be affected by the alleged deficient practice. 3. Residents will be assessed which may include but not limited to making choices concerning clothing, grooming, name they preferred to be called, and or appropriate conversation with resident, etc. staff will be in-serviced on areas that relate to dignity, dignity related to resident care with resident interaction. Residents found to have needs or issues identified via assessment are assisted to assure that needs are met in n dignified method. Observation rounds will be conducted two times per week for 12 weeks to monitor that residents are appropriately dressed, groomed and that staff interaction are appropriate. Any negative occurrence will be addressed immediately.. Staff will be in serviced on the resident's right to be dressed in a dignified manner and promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that 1 of 1 residents (R49) was dressed in a dignified manner, ensuring that her back, shoulder and legs were covered and ensuring that her incontinent product was not visible. Findings include:	F 241		

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F 241	Continued From page 20 R49's admission record indicated diagnoses that included failure to thrive, depression, restlessness and agitation and diabetes. R49's annual Minimum Data Set (MDS), dated 7/8/15, indicated R49 had severely impaired cognition, required extensive assistance with bed mobility, transfers, dressing, eating, toileting and personal hygiene, and was frequently incontinent of bladder and bowel. On 11/9/15, at 3:46 p.m., R49 was observed in the second floor dining room wearing a top that snapped up the back. The shirt was not fully snapped and R49's lower back and green incontinent product were visible. On 11/13/15, at 12:48 p.m., R49 was sitting in the second floor dining room with a tab alarm pulling down the right side of her brown shirt collar so that R49's entire right shoulder was visible. When asked if R49 usually wore shirts off-shoulder, Nursing Assistant (NA)-F stated, "Not usually". During the observation, R49 spilt her hot chocolate on her shirt, pants and on to the floor. On 11/13/15, at 1:30 p.m., shortly after the above observation, R49 was observed sitting in her wheelchair in front of the second floor nursing station. R49 was no longer wearing the brown shirt or pants, but had on a long shirt, or dress, that snapped down the back. This piece of clothing only went half-way down R49's thighs, leaving her knees and lower legs uncovered. Because R49's lower legs were uncovered, knee-high nylons and a wander guard were also visible.	F 241	4.. Observation rounds will be conducted two (2) times per week for 12 weeks to monitor that residents are dressed and groomed in a dignified manner. Any negative occurrence will be addressed immediately. The observation round documentation will be presented to the monthly QAPI committee for three months to monitor the facility's system of having the resident's dressed and groomed in a dignified manner. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that the facility consistently practices that the resident's right to be dressed and groomed; that the facility promotes care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition fo their individuality. 5. The Administrator/designee will be responsible. Completed 12-18-2015.	

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F 241	Continued From page 21 The facility policy titled Quality of Life-Dignity dated 10/09, directed staff shall promote, maintain and protect resident privacy, including bodily privacy.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor frequency of bathing choices for 1 of 3 residents (R146) reviewed for choices. Findings include: On 11/9/15, at 2:49 p.m. family member (F)-B stated R146 would like to be bathed daily, and had bathed daily prior to admission to the facility. F-B stated he had given this information to staff, and the facility responded by telling him R146 is bathed twice a week. R146 was present during the interview, and nodded her head in agreement. R146's Admission Record identified diagnoses that included Down's syndrome and acute respiratory failure. The Minimum Data Set (MDS) dated 8/13/15, indicated R146 had severe cognitive decline, and required extensive assist	F 242	1. A family care conference was held on 12-9-2015. Resident # 146 's family would like two showers per week and changed from pm to am shift. However, the resident has discharged. 2. All residents have the potential to be affected by the alleged deficient practice. 3.. The Interdisciplinary Team was reeducated on F-242 regarding a Resident having the right for self-determination and choices in their plan of care. Completed 12-31-2015	

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F 242	Continued From page 22 with bathing. On 11/17/15, at 9:48 a.m. registered nurse (RN)-C stated the facility assigned residents a weekly bath day upon admission, and will provide 1 or 2 baths a week. RN-C stated R146 was bathed twice a week, however she was unsure if the facility had asked R146 or her family member her preference for more then one or two baths a week, and was unsure if they asked about her previous bathing routine. On 11/18/15, at 12:04 p.m. the director of nursing (DON) was interviewed and stated she would expect the facility honor resident choices for bathing frequency. The facility policy and procedure on Quality of Life - Accommodation of Needs dated 10/09, directed the resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.	F 242	4. The resident's right for self-determination and choices will be discussed with the resident and of guardian upon each admission. And The Interdisciplinary Team will review each resident's right to self-determination and choices in their plan of care at each quarterly care conference. Initiated 12-1-2015. 5. An audit will be completed each month for the next three months to monitor that choices are offered and documented in the Plan of care. Audits will be presented to the monthly QAPI committee for three months and then quarterly for the next year to monitor that a system assuring self-determination and resident choice is functioning.. 6. The Director of Social Services / designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	1 .Residents #152, who was on Hospice at the time of his skin issue, expired 7-2-2015. Resident #158, who is on Hospice has MD documentation that weight loss is unavoidable;, however resident does eat meals in her room where staff offer choices and encourage resident to eat. Resident # 61 has scheduled pain medication and documented as effective.	

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F 280	Continued From page 23 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revised the plan of care to include the moderate to severe pain assessment for 1 of 1 (R61) reviewed for pain from post tramatic head injury requirein gsurgical interventlon and acetabulum fracture, In addition, dietician's recommendations for 1 of 4 residents (R65) reviewed for dietary concerns and in addition, the facility did not update the plan of care for 1 of 1 residents (R152) reviewed in need of pressure ulcer prevention/treatment. Findings include: R61's care plan dated 11/3/15, indicated "Potential for pain r/t [related to] steatohepatitis (fatty liver), osteoarthritis, diabetes, cardiac issues, history of CVA [cerebral vascular accident], compression fracture in back, dermatitis in anal area and buttocks". There is no mention in the above care plan of the post surgical pain or the fractured acetabulum pain. R61's admission record indicated a diagnosis of	F 280		

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

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atrial fibrillation, depression, hypertension, diabetes mellitus, coronary artery disease. R61's admission Minimum Data Set (MDS) dated 10/29/15, indicated R61 was severely cognitively impaired, had no behavior problems, and felt sad in the past seven days. The MDS identified R61 had pain, and received pain medication daily, and was at risk of falls, and had a history of two or more falls without injury. and a fall with injury.

Pain assessments dated 9/8/15, 10/29/15 and 11/10/15, were analyzed and R61 went from not being awaken from the pain in the night to being awaken in the night from the pain. The pain was rated moderate to severe on all. The assessment dated 9/8/15, indicated R61 only needing pain medication every 3-4 days, but the two dated 10/29/15, and 11/10/15 both indicated daily pain and pain medications needed.

An interview on 11/12/2015, at 7:03 a.m. R61 said I'm okay but my legs hurt.

An observation of R61 on 11/12/2015, at 10:38 a.m. lying in his bed with his knees up and a pillow under them. When asked he rated his pain at a 8/10 (on a verbal scale where 1 was no pain and 10 was the most pain he has ever had).

An Interview with Registered nurse (RN)-A on 11/16/2015 at 4:07 p.m. stated she has seen R61 in a lot of pain and agreed he does not have pain control. She said she has seen him grimace in pain. She said all the staff should be using the same pain scale and she realized they are not. She will get all staff using the same pain scale . She said they do not us any non pharmaceutical pain interventions and they should.. She also said she spoke with the pharmacist, he reviewed

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F 280	Continued From page 25 R61's medications and the medical doctor will review the medications. The medical doctor scheduled a pain medication because of the facilities request. We realize since you have been here he doesn't have good pain control and his pain may be affecting his relentlessness and requested a regular pain medication. His new pain order is for oxycodone 10 mg 3 times daily. The medical doctor also reviewed his other medications. RN-A also said R61 does not have any behaviors. R152 did not have a comprehensive care plan developed to minimize the risk of development and promote healing of pressure ulcers. According to the undated face sheet, R152 was admitted on 5/28/15, with metastatic neuroendocrine carcinoma, inferior vena cava obstruction and significant nutritional deficits. A Care Area Assessment dated 6/5/15, identified R152 had the "potential" to develop pressure ulcers. The care plan dated as initiated on 6/5/15, identified a goal of having intact skin. The interventions identified included following facility protocols and policies and weekly treatment documentation. There were no individualized interventions in place to minimize the identified potential for skin breakdown. A progress note dated 5/28/15 revealed R152 had mepiplex on his coccyx at the time of admission for "preventative measures." A physician order dated 6/17/15, identified mepiplex (foam dressing) to the coccyx. On 6/19/15 a physician order directed staff to place an Optifoam dressing (an absorbent all in one wound dressing with a moisture barrier on the outside) to the skin breakdown on the right buttock. A	F 280		

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6/19/15, progress note identified skin breakdown noted on the right buttock measuring 2 centimeter (cm) by 2 cm. A weekly skin assessment completed 6/20/15, identified the skin was intact but then identified "skin broken at coccyx" with no further assessment. R152 expired on 7/5/15.

On 11/17/15, at 12:55 p.m. Registered Nurse (RN)-A stated there was no further care planning for R152. RN-A stated the care plan hadn't been finalized for R152 yet.

On 11/18/15 at 8:35 a.m. the director of nursing (DON) stated she recalled R152. The DON stated she believed R152 "never really opened up." The DON stated she would have to look at R152's record and would provide additional information. On 11/18/15 at 10:00 a.m. the DON provided copies of documentation and stated it was "everything we have on the wounds." Upon review of the documents, there was no additional information provided, including no other care planning content.

R158's significant change Minimum Data Set (MDS) dated 9/30/15, indicated R158 had moderate cognitive impairments. The MDS indicated R158 was independent with eating after set- up with a 5% decline in weight loss indicated. The MDS included diagnoses of cancer and dementia.

R158's care plan dated 10/9/15, indicated R158 was at risk for nutrition secondary to fluid restrictions, weight loss and infection problems. Interventions included:
- provide and serve diet as ordered
- monitor intake and record every meal
- weigh weekly on shower day

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R158's physician orders dated 11/10/15, included an order for a regular diet. The physician orders lacked an order for a nutritional supplement.

R158's Weights and Vitals Summary included the following weights:
- 11/7/15 119 pounds (lbs) -10% weight change
- 10/2/15 123 lbs -5% weight change
- 9/25/15 123.6 lbs
- 9/15/15 134.4 lbs
- 9/14/15 135.6 lbs
- 8/26/15 133 lbs
- 8/25/15 131.9 lbs

R158's meal intake record from 9/15/15, to 11/1/15, indicated the following meal intake percentages:

- 31 meals at 0% -25%
- 48 meals at 26% -50%
- 55 meals at 51% - 75%
- 27 meals at 76% - 100%

The medical record lacked evidence of a nutritional reassessment with a revision to the care plan.

On 11/17/15, at 8:03 a.m. R158 was observed eating in the dining room for the breakfast meal. R158 was served hot cereal, eggs, toast, a cup of frozen orange juice and a cup of coffee. During the observation R158 asked for more coffee and and was served a total of 3 cups during breakfast. R158 was being encouraged to eat throughout the meal and was assisted to put jelly on her toast, staff did not offer to place brown sugar or raisins on her hot cereal. During the meal R158 stated "I don't do eggs" when

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F 280	Continued From page 28 encouraged by the staff member to eat. The staff member did not offer R158 anything else to eat. R158 ate 75% of hot cereal, bites of eggs and her toast, leaving the crust. R158 consumed 3 cups of coffee, 1/2 of her milk and no orange juice. R158 stated "I've had enough." On 11/17/15, at 12:23 p.m. R158 was observed eating independently in the dining room for the lunch meal. R158 was served a cup of oranges with whipped topping, taco hotdish, mexican corn, 8 ounces (oz) of milk and 8 oz of coffee R158 ate 100% of the oranges and whipped topping and only bites of the taco hotdish and mexican corn. R158 drank 100% of her milk and coffee. During the observation R158 was busy playing with her dining room ticket and would frequently pick up her fork and not take a bite of food and then put the fork back down. R158 then pushed herself from the dining room table and propelled herself back to her room via her wheelchair. When interviewed on 11/18/15, at 9:05 a.m. the registered dietician (RD) stated residents are to be weighed monthly at a minimum and weights and food intakes are reviewed monthly by the dietician. The RD further stated if there is a decline in weight and food intake the resident would be reassessed for interventions to prevent further weight loss. The RD stated that R158 was a difficult case as she was on hospice care, however stated R158 is not actively in the dying process. Upon review of the RD's spreadsheet compared to the weights in the medical record the RD stated R158 was not looked at for a decline in weight do to the RD Inputting R158's weight of 123.6 lbs dated 9/25/15, as the residents weight to compare subsequent weights to, rather than the admission weight of 131.9 lbs	F 280	2. all residents have the potential to have issues with care planning. 3. .IDT members and licensed staff will complete in-service on care planning including updates as needed for change of status or condition, to be completed by 12/18/15. Care plans will be reviewed quarterly and discussed with resident and or family, and updated as needed; care plans are reviewed updated as needed with any change in condition such as, but not exclusively, falls, skin issues, changes in mentation or ADL status.; the Nurse Managers will recheck that care plans and care sheets are updated with above changes. 4.The DON will be responsible and report results of nurse manager findings to the QAPI committee for three months. After three months the nurse mangers will report any care plan issues to the DON and further education will be provided to staff as needed. 5.The Director of Nursing /designee will be responsible. Correction will be completed on or before 12-31-2015.	

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F 280	Continued From page 29 dated 8/25/15. The RD stated that she had missed the weight in her review and should have been reassessed for possible interventions.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow intervention on the care plan to prevent pressure ulcers for 1 of 4 residents (R22) reviewed for pressure ulcers. R22's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R22 had severe cognitive impairments and required extensive assistance with bed mobility and total assistance with transfers. The MDS included diagnoses of diabetes mellitus, hemiparesis and cerebral palsy. The MDS indicated R22 had a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), that was unhealed and was not present at the time of the previous assessment. R22's care plan dated 9/22/15, indicated the resident had a pressure ulcer to the right ischium (forms the lower and back part of the hip bone), Interventions included: - administer medications as ordered - administer treatments as ordered and monitor for effectiveness. - weekly skin assessment by a nurse, with	F 282	1 .Resident # 22 is followed by the WCC nurse; the wound has decreased in size and remains free of symptoms of infection. Resident has documented history of refusing re-positioning, which results in periodic skin issues. Staff continues to encourage resident to re-position. 2. All residents would be considered at risk for deficient practice. 3. Nursing staff will be re-educated on skin care with emphasis on prevention. Charge nurses are placing a laminated card under the resident with instruction to turn return to nurse and keeping a log on the unit to track repositioning. 4. Nurse mangers will collect the logs and present their report to the monthly QAPI committee for three months. After three months the QAPI committee will make a recommendation as to the need to continue to monitor or develop further interventions as needed. The Director of Nursing/designee will be responsible Completion date of 12-31-2015.	

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F 282	Continued From page 30 changes reported to the MD - skin risk assessment, Braden [assessment for predicating pressure ulcer risk] and tissue tolerance [assessment for repositioning schedule] quarterly and as needed (PRN) - monitor nutritional status, serve diet as ordered - moisturizer applied twice daily and PRN to skin, do not massage over bony prominences - weight bearing assist from staff for significant repositioning every two hours and PRN in wheelchair and bed, resident has a history of refusing. - requires an alternating air mattress on his bed and cushion in wheelchair. R22's medical record lacked evidence of a comprehensive skin risk assessment, to be done quarterly and PRN per the care plan. R22's medical record lacked a Tissue Tolerance Assessment, to be done quarterly and PRN per the care plan. The medical record lacked any assessments related to tissue profusion. R22's medical record lacked evidence of consistent weekly skin assessments since June of 2015. The following skin assessments after June of 2015 were dated 7/1/15, 8/19/15, 10/21/15, and 11/11/15. Review of the medical recorded indicated the stage 2 pressure ulcer was discovered on 9/2/15, and measured 4.5 centimeters (cm) x 0.5 cm x a depth of less than 0.1 cm. "Wound base was 90% red with 10% yellow tissue and was moist in appearance. No exudate, no odor. Surrounding tissue intact, pink and blanched. Writer applied foam border dressing and will seek physician orders. Interventions in place include alternating pressure mattress and wheel chair cushion."	F 282		

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F 282	Continued From page 31 When interviewed on 11/17/15, at 2:19 a.m. registered nurse (RN)-B stated that the nurses do a quarterly Braden Scale and weekly skin observation on residents, but they do not use a Tissue Tolerance assessment and added she has never seen that type of assessment since starting in the facility. RN-B verified that the weekly skin observations were not completed weekly as care planned for. When interviewed on 11/17/15, at 2:38 p.m. RN-H stated the facility does not use a Tissue Tolerance assessment for assessing for appropriate individualized repositioning schedules. When interviewed on 11/18/15, at 10:20 a.m. the director of nursing (DON) stated that all residents are on a every 2 hours repositioning schedule and that the nurses utilize the Braden Scale to determine an appropriate repositioning schedule for residents. The DON further stated that R22 was repositioned timely according to his care plan. The DON stated the facility does not use a specific tool to assess for tissue profusion. The DON further stated that weekly skin observations should be completed and documented.	F 282		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 285		

Don Babbitt Administrator
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F 285	Continued From page 32 (i) Mental illness as defined in paragraph (m)(2)(I) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (II) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (II) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess programming needs	F 285	1. The facility did receive a Level II PASSR for resident #146 and no outside resources/interventions were required for the resident. 2. Four residents were identified in the facility requiring a Level II PASSR. None of the residents required outside resources/interventions. 3. The Administrator reviewed the Standards for Level II residents requiring programming needs with the Director of Social Services. The Director of Social Services will include a specialized plan if care for all Level II residents identified in the Level II PASSR requiring special programming.	

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F 285	Continued From page 33 based on the Level II Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 1 residents (R146) reviewed with a developmental disability. Findings include: R146's Admission Record identified diagnoses that included Down's syndrome. The care plan dated 8/17/15, lacked indication of active treatment needs. R146's Level II PASRR dated 8/10/15, indicated R146 had a developmental disability, and required convalescent care from 8/6/15, to 10/6/15. The Level II PASRR further identified R146 required active treatment, and the facility assured active treatment needs will have been specified in R146's individual service plan, and would be met while R146 resided in the nursing facility. On 11/13/15, the facility was requested to provide a copy of R146's Level II PASRR. On 11/17/15, social worker (SW)-A provided a copy of R146's Level II PASRR, and stated the facility had just received a copy of it from the county via fax. SW-A verified the facility had not reviewed R146's Level II PASRR previous to this time. On 11/18/15, at 8:24 a.m. SW-A stated the facility was meeting R146's active treatment by having R146 participate in the facility activity programs. On 11/18/15, at 9:41 a.m. SW-A stated it was the county's responsibility to ensure the facility received the Level II PASRR, and the facility was currently waiting for R146 to be assigned a county worker. SW-A further stated R146 participates in many of the facility activities, and	F 285	An audit of all residents and all new admissions requiring a Level II screen and assed as needing special programming will be conducted every month to monitor that specialized plans of care have been developed for these residents. 4. the audits will be presented to the monthly QAPI committee for three months. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that Level II residents have the PASSR and specialized care plan. Completion date of 12-31-2015.	

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F 285	Continued From page 34 she spends a lot of time in her room. A policy and procedure on Level II PASRR evaluations was requested, but not provided.	F 285		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pain and implement interventions to relieve moderate to severe pain following lumbar (low back) and acetabulum (ball of femur) fractures for 1 of 1 residents (R61) reviewed for pain. This deficient practice caused actual harm to R61. In addition, the facility failed to provide coordination of care between the facility and the hospice agency for 1 of 1 residents (R109) reviewed for hospice. The facility also failed to provide services to a resident as directed by the physician for 1 of 1 residents (R143). Findings include: R61's admission record identified multiple diagnoses including traumatic subdural hematoma, lumbar compression fracture and hip fracture. R61's admission Minimum Data Set	F 309		

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F 309	Continued From page 35 (MDS) dated 10/29/15, indicated R61 was severely cognitively impaired and had no behavior problems. The MDS identified R61 had pain and received pain medication daily, and was at risk of falls with a history of falls with injury. The MDS further identified R61 required extensive assistance of one staff for activities of daily living (ADLs) and had not ambulated the past seven days. Pain assessments were completed 9/8/15, 10/29/15 and 11/10/15. R61 was awakened at night from the pain. The pain was rated moderate to severe on all. The most recent assessment dated 11/10/15, identified daily pain and pain medications needed. The Care Area Assessment (CAA) dated 10/29/15, indicated verbal behaviors such as moaning, groaning, and crying to demonstrate pain. The characteristics, frequency and intensity of the pain was not completed. R61's care plan dated 11/3/15, identified a potential for pain. The care plan directed pain medications as ordered, monitor for and report changes in routine or appetite and verbal/non-verbal complaints of pain. The care plan did not include any non-pharmacological interventions to help alleviate pain. The Medication Administration Record for 8/15, 9/15, 10/15, and 11/15 were reviewed. R61 started receiving oxycodone every three hours as needed (PRN) on 10/22/15, until 11/16/15, (during survey) when the medication order was change to provide pain medication at scheduled times. The oxycodone was given 9 times in 10/15, of the 60 potential opportunities for PRN doses, and was given 26 times in 11/15, of the 96 potential	F 309	Mon-Fri and the nurse managers review any resident changes or /issues. Any issues with follow through are addressed with staff immediately, education is provided as needed. 4.The DON reports any issues to the QAPI monthly. After three months the QAPI committee will make a recommendation as to the need for reeducation or revisions to the process. Completion date of 12-31-2015.	

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 309	Continued From page 36 opportunities for PRN doses which could have been provided. An observation of R61 on 11/12/2015, at 10:38 a.m. lying in his bed with his knees up and a pillow under them. When asked he rated his pain at a 8/10 (a verbal pain scale where 1 was no pain and 10 was the most pain he has ever had). An interview on 11/9/15 at 1:00 p.m. with physical therapist (PT)-A identified they had started seeing R61 10/22/15, to 10/30/15, and restarted 11/3/15 to current. She said when he came back from the hospital after his subdural hematoma in 9/15, he had orders for all three disciplines (physical, occupational, speech) to assess and treat him. PT-A stated they use a Wong-Baker pain scale (facial pictures) with R61 to measure his pain. PT-A continued to state after the 10/22/15, referral they only saw him for eight days. They attempted to ambulate him but he could not ambulate. He could only ambulate 3-4 steps from bed to chair with a walker. PT-A said, "He was in a lot of pain cause of his back [lumbar fracture]." The next request for therapy services was on 11/3/15, after returning from the hospital with the hip fracture from another fall. R61's orders were for weight bearing as tolerated and all three disciplines evaluated him. They tried a TENS unit (transcutaneous electrical nerve stimulation) for his pain. R61 rated his pain at a 10/10 and you could tell by his facial expressions if he was in pain. An interview on 11/12/15, at 8:50 a.m. physical therapy assistant (PTA)-A asked R61 to rate his pain using the Wong-Baker faces pain scale. R61 rated his pain a 10/10. PTA-A said she always utilized that pain scale. PTA-A verified he was	F 309		

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F 309	Continued From page 37 given pain medication at 8:13 a.m.. PTA-A indicated she evaluated R61's wheelchair on 11/9/15. She stated the leg of the wheelchair was too short for R61. She could not explain why the leg rest had not been adjusted for R61. PTA-A put R61's leg on a stool and R61 hollered out in pain. PTA-A told PT-D that his leg kept falling off the leg rest as the leg rest on the wheelchair was too short for him. R61 moaned and whimpered the whole time PTA-A was moving his leg. R61 repeatedly said "it hurts" and "ouch, ouch, ouch." At 8:54 a.m. PTA-A asked R61 what his pain level was and he said 10/10. PTA-A was not able to continue the therapy on his legs so she used a balloon to play ball. A subsequent interview on 11/12/15, at 9:02 a.m. PTA-A said R61 has not been able to move his leg due to pain. PTA-A stated he was weight bearing as tolerated but can't walk due to his pain level. She said she usually walks people sooner after an injury but has not walked him due to "extreme pain." She said she didn't ask if they gave him something for pain. She said it is important to have scheduled pain medications. Interview on 11/12/15, at 10:11 a.m. nursing assistant (NA)-H stated R61 cried out in pain a lot because of his back and hip injury. He said the pillow between R61's legs in bed was because he wouldn't straighten his leg out. She went on to say R61's wheelchair did not fit him and the wheelchair hurt him. An interview on 11/12/15, at 10:38 a.m. while R61 was lying in bed, this writer asked R61 to rate his pain and he rated his pain at an "8/10". On 11/12/15, at 12:45 p.m. PT-A stated her expectation was a resident would get a pain	F 309		

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F 309	Continued From page 38 medication when they are in pain. She said R61 rated his pain as 10/10. PT-A said if the resident is still able to move and transfer they go ahead with therapy. PT-A said he used the sliding board to the Nu Step but R61 grimaced in pain. PT-A said there were no non pharmacological interventions used for R61's pain today. She didn't know why the TENS was not put on him. PT-A said when physical therapy did an evaluation on 11/6/15, post fall with injury, she said they changed his wheelchair because it didn't fit him well. PT-A was aware his wheelchair leg didn't fit him well and his leg kept sliding off the leg of the wheelchair. She said they put a calf pad in place that morning after the discussion with PTA-A. An interview on 11/13/15, at 8:47 a.m. occupational therapy (OT)-K asked R61 to rate his pain and he rated it at a 6/10 located near his left hip. She told him she would tell the nurse. NA-G said on 11/13/15, at 2:28 p.m. that she normally works another hall but "I know he is always in pain and yelling in pain." An interview on 11/13/15, at 2:29 p.m. trained medication assistant (TMA)-K said she used a pain scale called pain AD. She said it uses breathing, negative vocalization, facial expression, body language and consolable to determine pain level. She didn't know what others used to determine pain levels. The order was for oxycodone 5 mg (milligram) 1 - 2 tablets every 3 hours for pain PRN. She said if R61 had a pain level of 1-5 /10 she gave 1 tablet. If he had a pain level of 6-10 /10 she give 2 tablets. An interview with registered nurse (RN)-A on 11/16/15, at 4:07 p.m. stated she has seen R61 in	F 309		

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F 309	Continued From page 39 a lot of pain and agreed he did not have adequate pain control. She said she has seen him grimace in pain. RN-A stated all staff should be using the same pain scale and they are not. She said they do not us any non pharmacological pain interventions and "we should." RN-A stated since survey started R61 doesn't have good pain control. She further stated R61's pain may be affecting his restlessness so staff requested a regular pain medication. His new pain order is for oxycodone 10 mg 3 times daily. A progress note dated 10/24/15, at 1:11 a.m. identified R61 was restless and climbing out of bed several times. When asked if he had pain and wanted a pain pill R61 said yes. An observation on 11/17/15, at 9:05 a.m. PT-M said the TENS unit blocks the nerve synapse. She said it is a 15 minute treatment. PT-M indicated R61 had horrible pain some day's. PT-M stated therapy used a Wong Baker pain scale. R61 rated his pain as "a lot" on the Baker Wong scale before he started physical therapy . While PT-M was working with his left leg, R61 was saying his right side hurt. PT-M did not ask a nurse if he had his pain medication before therapy and did not apply the TENS unit. An interview on 11/17/15, at 7:55 a.m. RN-H stated she didn't use a pain scale. She just asked the resident if their pain was mild, moderate or severe. The last time she asked R61 about his pain, he said it was moderate. She said she was not aware of any standardized method in the facility, for pain management assessments. Interview with the DON on 11/18/15 at 7:58 a.m. identified R61 was placed on some	F 309		

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F 309	Continued From page 40 non-pharmocological interventions for pain on 11/17/15. "We saw that as a need for him." A facility policy titled: PAIN ASSESSMENT PROTOCOL reviewed 11/02, indicated. "It is the policy of Bayshore to provide for the optimum quality of life for every resident. Quality of Life includes individualized management of pain. Management of pain includes accurate assessment, pharmacological and non-pharmacological methods, and physical and psychosocial interventions." R109 received hospice services, and the facility failed to provide coordination of care. Findings include: R109's Admission Record identified diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 9/14/15, indicated R109 had severe cognitive impairment, and required extensive to total assistance of staff with bed mobility, transfers, dressing, eating, mobility, personal hygiene, bathing and toileting. R109 began receiving hospice services on 12/2/15, for end of life services due to the diagnosis of Alzheimer's disease. The most recent certification by the hospice agency was 9/17/15, and at that time it was determined he would receive skilled nursing services once a week for nine weeks, and nursing assistant (NA) services twice a week for nine weeks. On 11/12/15, at 1:27 p.m. nursing assistant (NA)-K was interviewed, and stated the hospice NA came to the facility two or three times a week. NA-K stated they came at different times of the week, and different times of the day. NA-K stated	F 309		

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F 309	Continued From page 41 the facility was unaware of when the hospice NA was going to be at the facility to care for R109. On 11/17/15, at 9:36 a.m. registered nurse (RN)-C was interviewed, and stated the hospice NA schedule was "sporadic" and "they just come." RN-G stated the facility does not have the hospice NA-s schedule, and they do not call the facility prior to coming out. RN-G further stated the hospice NA's have their own schedule, and the facility does not know when they are coming. On 11/18/15, at 11:57 a.m. the director of nursing (DON) was interviewed and stated she assumed the facility was aware of the hospice NA visit schedule. The facility policy and procedure on Hospice Program dated 2/14, directed when a resident participates i the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed. R143 did not receive timely and accurate assessments of clinical changes with corresponding physician updates as needed. According to his admission face sheet, R143 was admitted on 7/13/15, with a short term admission plan for rehabilitation services. The resident diagnosis report dated 7/13/15, identified multiple diagnoses including right below the knee ambulation (RBKA), diabetes and hypertension. Admission orders for R143 on 7/13/15, included full code status; accucheck (blood sugar) four times a day, call if results >250 milligrams/deciliter mg/dL or <70 mg/dL; daily weights - if resident gains more than 3# overnight	F 309		

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F 309	Continued From page 42	F 309		

or 5# or more in one week - call MD; and multiple medications. R143's admission weight was 233 pounds. R143's admission Minimum Data Set dated 7/20/15, identified he needed extensive to full assistance with cares and was moderately confused. In addition, it identified R143 did not have a shortened life expectancy.

On 7/14/15 at 12:22 p.m. the Medication Administration Record (MAR) identified a blood sugar (BS) of 297 mg/dL R143's daily weight was 229 pounds. There was no assessment for hyperglycemia (high BS) and the physician was not updated as ordered. R143 was on no medications to assist with blood sugar management.

No weight was obtained on 7/15/15. On 7/16-17/15 R143 weighed 230 pounds. There was no weight obtained on 7/18/15. On 7/19/15 R143 weighed 231 pounds. On 7/20/15 no weight was obtained.

On 7/21/18 a fax was sent to the primary physician identifying "Many abnormal values" for labs. There was no further assessment information documented or relayed to the physician. The physician responded indicating the low hemoglobin was "the only critical one". The physician then ordered medications changes and to check stool for occult blood, orthostatic blood pressure - tell me if >20 millimeter systolic drop - will see him on 7/23/15. On 7/21/15 at 10:58 p.m. R143 had a BS of 277 mg/dL. The physician was not updated and there was no assessment for hyperglycemia.

On 7/22/15 another fax was sent to the physician identifying increased swelling to the scrotum and

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F 309	Continued From page 43 right side of penis. The daily weight had not been obtained and there was no assessment to correspond with this identified problem. At 2:00 p.m. R143 had a BS of 260 mg/dL. The physician was not updated and there was no assessment for hyperglycemia. There was no daily weight on 7/23/15. In addition on 7/2315 at 5:51 a.m. R143's blood pressure was 217/93. His previously documented blood pressures had never gone above 166/80. No other assessment was completed and the physician was not updated. Another fax was sent to the physician on 7/24/15 identifying on 7/19/15 R143's weight was 231.5 pounds and today was 242.3 pounds. It further identified R143 had a notable increase in edema of legs, scrotum, hands/arms. There was no further assessment obtained or provided. On 7/24/15 the physician ordered labs and medication changes and requested the facility fax the results of the stool occult and orthostatic blood pressures. In addition the physician ordered a chest x-ray (CXR), and electrocardiogram (ECG). Although the orders were written on 7/24/15 they were not transcribed until 7/25/15. The blood for the lab work was no collected until 7/28/15. Interview with RN-A on 11/17/15 at 1:10 p.m. revealed she did not know why the transcription and implementation of the new physician orders had been delayed. On 7/2515 the ECG identified "possible coronary ischemia." There was no evidence the physician was informed. The CXR dated 7/25/15 identified a "pulmonary edema pattern" which was faxed to the physician on 7/26/15. There was no daily weight obtained 7/25/15. On 7/26/15 the occult stools came back positive. There was no evidence it was faxed to the physician. Although it was stamped "Faxed" the area for	F 309		

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F 309	Continued From page 44 date/time/initials was blank. Interview with Registered Nurse (RN)-A on 11/15 at 1:10 p.m. indicated there was no indication in the record the physician had been notified of the occult stool results. On 7/26/15 R143's weight was 258.5 pounds for a total gain of pounds 25 since admission on 7/13/15. No further assessments were completed and no further physician updates were provided. On 7/29/15 at 2:00 a.m. progress notes identified a caregiver answered the call light. He stated his back hurt wanted to be turned on his side. While the caregiver was talking to the resident he became cyanotic and unresponsive. A code blue was called and cardiopulmonary resuscitation was provided until paramedics arrived. R143 was determined to be expired at 3:05 a.m. Interview with RN-A on 11/17/15 at 1:10 p.m. indicated there had been no assessments of R143's condition. RN-A stated the physician was not updated with the blood sugars and nothing was being monitored for those changes. RN-A stated the facility had begun monitoring for hyper/hypoglycemia every shift but that had not been initiated here. RN-A further stated she recalled the physician being updated on some weights but "just not every day." RN-A stated she would have to "believe we notified him." However, she also stated it was "unusual and suspicious" that there was nothing documented and no further orders had the physician been updated. RN-A stated she remembered [R143] and was aware of "some of the problems but I can't say I was updated on all of them." RN-A acknowledged that as she reviewed things she would have "gone forward and updated the physician." She further said she would have sent R143 to the	F 309	1. No residents were affected by the alleged deficient practice of failing to coordinate care with Hospice. 2. All Hospice residents may be affected by the alleged deficient practice. 3. An interdisciplinary meeting was held with Hospice on 12-9-2015 regarding coordination of care. Meetings are scheduled every two weeks. Hospice is providing schedules of the nursing assistant visits every Monday.	

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F 309	Continued From page 45 emergency room had she received no response from the physician. Interview with the residents physician (P)-A on 11/17/15 at 2:45 p.m. indicated he had seen R143 on 7/24/15. He had been updated in R143's weight gain and he suspected ascites (fluid in the abdominal cavity) and fluid overload. P-A further indicated R143 had multiple co-morbidities and the facility had not received a lot of information at the time of this resident's admission. Based on the results received from the tests ordered on 7/24/15, "things looked terrible," going on to say R143 had the fluid overload, ascites, and pancytopenia (deficiency of all three cellular components of the blood - red cells, white cells, and platelets). P-A went on to say he believed R143 had bone marrow issues that would have required very aggressive tests to determine what the issues were followed by very aggressive treatment. When interviewed on 11/18/15 at 11:36 a.m. the director of nursing (DON) stated she did not have a quality review process for the care provided in death records. The DON stated when she reviewed a death record she reviewed for notifications but "since I've been here there hasn't been a question of wrongful death." The DON further stated that the majority of deaths were "hospice or expected" and no physician had ever questioned a death so death records weren't reviewed. The DON stated R143 was refusing things and it was difficult to get him to cooperate .	F 309	4. Minutes of the biweekly meeting with Hospice will be reviewed at the monthly QAPI committee to assure coordination of care is continuing. 5. The Director of Nursing/designee is responsible. 1 .Resident # 143 expired 7-29-2015. 2 .All residents have the potential to be affected by the alleged deficient practice. 3 .License staff will be in-serviced on providing services as directed by a physician. 4. The facility will audit two (2) resident charts per week times twelve weeks to monitor license staff are providing services as directed by a physician. Any negative occurrence will be immediately reported to the Director of Nursing. These audits will be presented to the monthly QAPI for three months for review and recommendations. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that the license staff are providing services as directed by the Physician. 5. The Director of Nursing /designee will be responsible. Completion date of 12-31-2015	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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F 314	Continued From page 46 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services to prevent and promote healing of pressure ulcers for 2 of 4 residents (R22 and R152) reviewed for pressure ulcers. Findings Include: R22's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R22 had severe cognitive impairments and required extensive assistance with bed mobility and total assistance with transfers. The MDS included diagnoses of diabetes mellitus, hemiparesis and cerebral palsy. The MDS indicated R22 had a stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), that was unhealed and was not present at the time of the previous assessment. The skin Care Area Assessment (CAA) dated 1/21/15, indicated that R22 was at risk for developing pressure ulcers due to impaired mobility, incontinence, needed extensive assistance with positioning and had a history of healed pressure ulcers.	F 314	1. Resident #22 is followed by the WCC nurse, the wound has decreased in size, and remains free of signs and symptoms of infection. Resident has history of refusing repositioning, which results in occasional skin issues. Staff continue to encourage repositioning. 2. All residents would be considered at risk for alleged deficient practice. 3. The Nursing staff were reeducated on skin with a focus on prevention of development of wounds. Charge nurses are placing a laminated card under residents with instructions to return to nurse and keeping a log on the Unit to track repositioning. 4. Nurse managers will collect the logs and report to the monthly QAPI committee. After three months the QAPI committee will make a recommendation as to the need to continue to monitor the repositioning program. 5. The Director of Nursing/designee with	

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F 314	Continued From page 47 R22's care plan dated 9/22/15, indicated the resident had a pressure ulcer to the right ischium (forms the lower and back part of the hip bone), interventions included: - administer medications as ordered - administer treatments as ordered and monitor for effectiveness. - weekly skin assessment by a nurse, with changes reported to the MD - skin risk assessment, Braden [assessment for predicating pressure ulcer risk] and tissue tolerance [assessment for repositioning schedule] quarterly and as needed [PRN] - monitor nutritional status, serve diet as ordered - moisturizer applied twice daily and PRN to skin, do not massage over bony prominences - weight bearing assist from staff for significant repositioning every two hours and PRN in wheelchair and bed, resident has a history of refusing. - requires an alternating air mattress on his bed and cushion in wheelchair. R22's medical record lacked evidence of a comprehensive skin risk assessment, to be done quarterly and PRN per the care plan. R22's Braden Scale dated 9/22/15, indicated R22 was at a low risk for developing pressure ulcers. R22's medical record lacked a Tissue Tolerance Assessment, to be done quarterly and PRN per the care plan. The medical record lacked any assessments related to tissue profusion. R22's medical record lacked evidence of consistent weekly skin assessments since June of 2015. The following skin assessments after	F 314	Oversight from the Administrator will be responsible. Completion date of 12-31-2015,	

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F 314	Continued From page 48 June of 2015 were dated 7/1/15, 8/19/15, 10/21/15, and 11/11/15. Review of the medical recorded indicated the stage 2 pressure ulcer was discovered on 9/2/15, and measured 4.5 centimeters (cm) x 0.5 cm x a depth of less than 0.1 cm. "Wound base was 90% red with 10% yellow tissue and was moist in appearance. No exudate, no odor. Surrounding tissue intact, pink and blanched. Writer applied foam border dressing and will seek physician orders. Interventions in place include alternating pressure mattress and wheel chair cushion." Skin/Wound Noted charted weekly from 9/22/15-11/10/15 with required wound descriptions. The medical record lacked any evidence of a re-assessment of the residents current pressure ulcer interventions or an analysis to the cause of the current pressure ulcer. A fax was sent to the physician on 9/29/15 regarding the current treatment of a foam dressing not staying in place. The physician responded and ordered a thin hydrocolloid dressing to be changed every 3 days. Review of the medical record lacked evidence that the wound or dressing with surrounding skin were observed daily. When interviewed on 11/17/15, at 7:14 a.m. nursing assistant (NA)-D stated that R22 was to be repositioned every 2 hours and needed assistance to reposition. NA-D stated that R22 has a roho cushion in his wheelchair and an alternating air pressure reducing mattress on his bed. NA-D was not aware of any changes to	F 314		

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F 314	Continued From page 49 R22's care plan since the development of the stage 2 pressure ulcer. When interviewed on 11/17/15, at 2:19 a.m. registered nurse (RN)-B stated she does the weekly measuring and assessments of the wounds in the facility. RN-B verified R22 developed a stage 2 pressure ulcer to his right ischium on 9/22/15, and the pressure ulcer has improved. RN-B described that the nurses do a quarterly Braden Scale and weekly skin observation on residents, but they do not use a Tissue Tolerance assessment and added she has never seen that type of assessment since starting in the facility. RN-B could not provide documentation of an analysis of why R22 had developed a pressure a ulcer. When asked what new interventions had been implemented for R22 RN-B stated that she thought he was seen by therapy but after reviewing the medical record could not provide a date or information regarding any therapy R22 had received. RN-B further stated that residents are always care planned for repositioning every 2 hours unless the frequency is required to be less. RN-B could not state or provide documentation on how R22 was assessed for an every 2 hour repositioning schedule. During the interview RN-B verified that the weekly skin observations were not completed weekly as care planned for. RN-B also stated that all wounds are discussed in the weekly weight loss and skin team meeting. R22's medical record lacked any documentation related to the weight loss and skin team meeting discussions. On 11/17/15, at 2:38 p.m. RN-H stated the facility does not use a Tissue Tolerance assessment for	F 314		

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F 314	Continued From page 50 assessing for appropriate individualized repositioning schedules. RN-H stated the facility gets instructions on admission from the hospital on the repositioning frequency a resident needs or from physical or occupational therapy. When interviewed on 11/18/15, at 7:43 a.m. the occupational therapist (OT) stated R22 was seen from 7/30/15 through 8/21/15 prior to the development of the current pressure ulcer. The OT stated R22 was assessed for wheelchair positioning to aid in independent eating. The OT stated R22 had a cushion removed from his wheelchair that had been placed on top of his roho cushion and they adjusted the back of his wheelchair to decrease leaning. The OT stated she was made aware of R22's development of a stage 2 pressure ulcer but did not pick him up for therapy as there isn't anything more therapy could do for R22. The OT further stated that the therapy department can do pressure mapping if requested and ordered but they do not do routine screening for tissue profusion and added that it is a nursing assessment. When interviewed on 11/18/15, at 8:23 a.m. RN-C replied "That's a really good question," when asked how a resident is assessed for appropriate repositioning schedules. RN-C reviewed R22's record and confirmed that R22's record lacked a comprehensive risk assessment and tissue tolerance assessment. RN-B stated she was taught to use the Braden Scale, then confirmed the Braden is not a comprehensive risk assessment. On 11/18/15, at 9:35 a.m. R22's wound was observed to be a stage 2 pressure ulcer to the	F 314		

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F 314	Continued From page 51 right ischium. The wound bed was beefy red, without slough or odor. The edges of the wound were intact and the surrounding tissue blanched. Registered nurse (RN)-B stated the measurements had not changed since 11/17/15 when she did her weekly rounds. The wound had measured 2.4 cm x 1.2 cm x a depth of less than 0.1 cm. When interviewed on 11/18/15, at 10:20 a.m. the director of nursing (DON) stated that all residents are on a every 2 hours repositioning schedule and that the nurses utilize the Braden Scale to determine an appropriate repositioning schedule for residents. The DON further stated that R22 was repositioned timely according to his care plan. The DON stated the facility does not use a specific tool to assess for tissue profusion. The DON further stated weekly skin observations should be completed and documented. The undated facility Skin and Wound Manual indicated assessment of potential skin problems are completed upon admission, weekly, readmission and daily for high risk patient/residents. Requested a policy on the prevention of pressure ulcers and the facility did not provide one. R152 did not receive services to minimize the risk of development and promote healing of pressure ulcers. According to the undated face sheet, R152 was admitted on 5/28/15, with metastatic neuroendocrine carcinoma, inferior vena cava obstruction and significant nutritional deficits. A Care Area Assessment dated 6/5/15, identified R152 had the "potential" to develop pressure	F 314		

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F 314	Continued From page 52 ulcers. The care plan dated as initiated on 6/5/15, identified no individualized interventions for R152 but did identify it would follow facility protocols and policies. A progress note dated 5/28/15 revealed R152 had mepiplex on his coccyx at the time of admission for "preventative measures." The Braden skin risk assessment of 5/28/15, identified R152 to be at low risk for skin breakdown. A physician progress note dated 6/2/15, indicated no skin breakdown. A physician order dated 6/17/15, identified mepiplex (foam dressing) to the coccyx - change dressing every 4-7 days and as needed (PRN) - float heels and remind [R152] to reposition every 2 hours. There was no documentation in the record to correspond with the need for the new physician's order. On 6/19/15 a physician order directed staff to place an Optifoam dressing (an absorbent all in one wound dressing with a moisture barrier on the outside) to the skin breakdown on the right buttock. A 6/19/15, progress note identified skin breakdown noted on the right buttock measuring 2 centimeter (cm) by 2 cm. A weekly skin assessment completed 6/20/15, Identified the skin was intact but then in a section for skin issues the weekly note identified "skin broken at coccyx" with no further assessment. There was no further wound documentation for R152. R152 expired on 7/5/15. On 11/17/15, at 12:55 p.m. Registered Nurse (RN)-A stated there was no further documentation available on R152's skin status. RN-A further stated the facility identified a need to	F 314		

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F 314	Continued From page 53 Improve their skin care and had one of the nurses take specialized wound care training. RN-A identified the facility policy was to complete weekly skin assessments and update the practitioners as needed. RN-A stated the care plan hadn't been finalized for R152 yet. On 11/18/15 at 8:35 a.m. the director of nursing (DON) stated she recalled R152. The DON stated she believed R152 "never really opened up." The DON further stated the dressings in place were for "protection" due to R152's high risk for skin break down. She clarified that dressings are used "all the time" for hospice residents. The DON stated she would have to look at R152's record and would provide additional information. On 11/18/15 at 10:00 a.m. the DON provided copies of documentation and stated it was "everything we have on the wounds." The DON believed it to be "all the documentation we need." Upon review of the documents, there was no additional information provided.	F 314	3. Nurse Managers will audit weekly that skin checks are completed timely for three months. Observations rounds will be conducted by the nurse managers and staff development to monitor that turning schedules are being performed per the resident's plan of care. 4. Audit outcomes will be discussed at QAPI for three months to determine if further education is needed. 5. The Director of Nursing/designee will be responsible. Completion date of 12-31-2015.	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 323		

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F 323	Continued From page 54 review, the facility failed to ensure comprehensive assessments were completed and individualized interventions were developed and implemented to minimize the risk for falls for 1 of 2 residents (R61) reviewed for falls. The facility failed to evaluate the causative factors of resident falls to determine the efficacy of current interventions and if new interventions were appropriate. The facility's failure resulted in an immediate jeopardy, with actual harm (hip fracture) for R61. In addition, the facility failed to ensure side rails were appropriately secured for 1 of 1 residents (R42), reviewed for side rails. The immediate jeopardy began on 10/22/15, when R61 returned from the hospital following a significant fall with subdural hematoma. R61 experienced a significant change in condition following that hospitalization. Upon return, the facility failed to assess R61's multiple changes including fall risk in order to assist in developing appropriate individualized interventions to minimize the risk for ongoing falls. The director of nursing (DON) was notified of the immediate jeopardy (IJ) for R61 on 11/12/15, at 6:23 p.m. The immediate jeopardy was removed on 11/18/15, at 10:30 a.m. but noncompliance remained at the lower scope and severity of a G, which indicated actual harm that was not immediate jeopardy due to fractured hip. Findings include: R61's admission record indicated multiple diagnoses including atrial fibrillation, hypertension, and diabetes mellitus. R61 experienced multiple falls, some of which resulted in significant injury. The facility did not evaluate the causative factors of the fall, the efficacy of	F 323	1. Resident #42 owns his own bed. Resident #42 was interviewed regarding the use of the side rails. Resident is unable to turn self or reach side rails due to disease and severe upper extremity contractures. Resident states he only uses the side rail on one side of the bed and only with staff present assisting with turns. The opposite side rail was removed, which eliminates the safety issue. Resident #61 does not have a side rail – only an assist bar, with no history of loosening. 2. The bariatric beds have been identified with side rails and would have the potential to be affected, however there has never been an issue identified with our current side rails becoming loose.	

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F 323	Continued From page 55	F 323		

interventions and the need for additions to the individualized interventions to assist in minimizing the risk for ongoing falls.

R61's quarterly Minimum Data Set (MDS) dated 9/8/15, identified he was cognitively intact and independent when ambulating in his room and in the hallway. On 9/21/15 he was admitted to the hospital with a subdural hematoma and fractured back following a fall. R61 returned from the hospital on 10/22/15. R61's MDS dated 10/29/15, indicated R61 was severely cognitively impaired and had no behavior problems. The MDS further identified R61 required extensive assistance of one staff for activities of daily living (ADLs). The MDS also identified R61's balance during transfers was not steady, but he was able to stabilize without assistance. The MDS identified R61 had pain, received pain medication daily, was at risk of falls, and had a history of falls with injury.
R61's Fall Care Area Assessment (CAA) dated 11/2/15, indicated R61 was at high risk for falls with a history of falls in the past. The Fall CAA did not address individualized interventions in place, their efficacy or the need for changes.

R61 had multiple Fall Risk Assessments completed, most recently on 11/12/15, however, they were checklists containing data which did not comprehensively assess R61's fall risk to ensure appropriate interventions were implemented. The data gathered indicated R61 was at a high risk for falls, had decreased coordination, used assistive devices, and had multiple falls.

R61's care plan initiated on 1/13/14, indicated he was a high risk for falls related to impaired balance and cognition, history of CVA (cerebral

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F 323	Continued From page 56 vascular accident), incontinence, diabetes and multiple falls with injuries. The identified goal was "The resident will be free of minor injury through the review date." R61's care plan dated 11/9/15, identified the following interventions: call light within reach and encourage use, prompt response to call lights, ensure appropriate footwear in use, PT as ordered, activities for diversion/distraction, TAB alarm in bed and wheelchair (w/c), pressure alarm in bed, transfer with assist of 1, gait belt and back brace. The care plan was revised on 11/9/15, following multiple observations of a motion sensor alarm not being appropriately implemented. Observation on 11/9/15, at 5:05 p.m. identified R61 lying in bed with his call light on the overbed table. The overbed table was approximately three feet away from R61's reach and the motion alarm was turned off. The TAB alarm was attached to him. Registered nurse (RN)-M verified the motion alarm was turned off and the call light was out of reach. RN-M turned the motion alarm on and identified it was not functioning. RN-M changed the batteries and was able to get the alarm to work. On 11/9/15, at 5:20 p.m. the motion alarm was found turned off. RN-A came in with R61's meal tray and left the room with out turning the alarm on. When asked to verify the motion alarm was turned off she stated it was. RN-A further stated the alarm was a problem as it was always sounding "so we don't turn it on all the time." On 11/9/15, at 6:20 p.m. R61's motion alarm was found to be turned off. This was verified by RN-A. RN-A turned the alarm back on again.	F 323		

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F 323	Continued From page 57 Review of R61's progress note dated 8/22/15, at 2:13 a.m. identified the resident self reported a fall. R61 stated he was walking around the bed in his room and tripped on the bed. R61 stated he hit his head and also complained of slight shoulder pain. Another progress note dated 9/21/15, at 3:51 p.m. identified R61 had fallen and hit his head. R61 was sitting on the edge of the bed and stated he hit his head. R61 stated he was in the bathroom when he fell and hit the back of his head on the doorknob of the bathroom door. R61 was not utilizing his walker at the time of the fall. R61 complained of dizziness, ringing in ears, and pain on palpation to back of head. R61 stated he was dizzy, his legs gave out, and he fell. The on call physician directed staff to monitor for any neurological changes and increased pain to head or back. On 9/22/15 at 7:15 a.m. R61 continued to complained of ringing in ears, dizziness, and a headache. R61 had increased back pain and was unable to roll or sit up in bed or ambulate. His blood pressure dropped to 94/53 and pulse was 53. R61 was sent to the emergency room and was admitted with a subdural hematoma (brain bleed) and fractured back. A progress note dated 10/22/15, at 1:47 p.m. indicated R61 returned form the hospital. On 10/24/15, at 1:11 a.m. a medication administration note indicated R61 was restless and climbing out of bed multiple times. R61 was up walking alone going through his closet. The alarm was off and did not sound. A nursing note dated 10/25/15, at 10:59 p.m. identified R61 was on neurological checks due to	F 323		

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F 323	Continued From page 58 a fall in the morning. R61 was up walking in the hallway looking for his dogs. R61 was unsteady on his feet. He had 3 alarms in place, however, he had one alarm tucked in his pants pocket, one alarm wrapped up in a blanket, and the third alarm did not sound. A progress note dated 10/29/15, at 6:18 p.m. identified R61 was found on the floor in the middle of the room. Although R61 had 2 TAB alarms and a motion alarm on the floor, none of the alarms sounded. The nursing progress note dated 10/31/15, at 9:22 a.m. indicated R61 was unable to bear weight on his right lower extremity (RLE) and was complaining of pain. Staff reported R61 complained on 10/30/15 as well. R61 had significant pain when up in the wheelchair. R61 was sent to the emergency room and was admitted with a right acetabulum (head/ball of the femur) fracture. R61 returned to the facility on 11/3/15 with a plan for non-surgical management of the hip fracture. On 11/12/15, at 2:45 p.m. R61 was observed by the surveyor to be sitting on the foot pedals of his wheelchair. R61 was in his room with his door closed. No alarms were sounding when he was discovered on his foot pedals. After being called to the room, LPN-A and RN-B agreed there were no alarms sounding and there was no call light within reach. An incident note dated 11/12/15, at 11:31 p.m. indicated R61 slid out of his wheelchair and was being held onto by RN-B. R61 slid out of his chair and was not quite on the ground. R61 stated he wanted to go to bed, and was trying to get there	F 323		

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F 323	Continued From page 59 when he slid off his chair. RN-B and licensed practical nurse (LPN)-A returned R61 to bed with the mechanical lift. R61's falls were reviewed with the director of nursing (DON) on 11/12/15, at 3:58 p.m. and the DON indicated the fall of 8/22/15, was a slip off the recliner with no injury. The DON stated R61 was independent with ambulation at that time so there were no specific interventions for falls at that time. The DON stated the next fall was on 9/21/15, when R61 fell in his bathroom, got himself up and went to the side of the bed. The DON said R61 self-reported the fall. R61 was not using his walker and there was no obvious injury. R61 reported he hit the back of his head on the bathroom door knob. The DON stated she wasn't sure when the TAB alarm was placed on R61. Other interventions in place at that time included: physical therapy (PT) to evaluate, call light within reach, appropriate foot wear, and transfer with assist of one, gait belt, and back brace on. The DON indicated when R61 fell on 10/25/15, at 10:30 a.m. he was found crawling toward his roommate's bed. The fall was unwitnessed. The DON stated R61 had gripper socks on at the time and he was confused. The DON identified a motion sensor alarm was added at that time. The DON further stated between this fall and the one on 10/29/15, alarms were the only additional interventions. The DON also indicated staff was "trying to manage his pain" as they felt the restlessness may have been related to his difficulty expressing pain. The DON stated R61 also fell on 10/29/15, at	F 323		

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F 323	Continued From page 60 6:30 a.m. None of the alarms were sounding when R61 was found. The TAB alarm was wrapped up in his blanket. The DON said there were no new interventions at that time. The DON stated she did not believe the hip fracture was a result of the fall because R61 did not report the problem until 2 days after the fall. The DON went on to say when R61 was found on the pedals of his wheelchair on 11/12/15, she did not believe that was a fall. The DON stated R61 slipped off the chair. However, the DON could not explain how R61 slipped out of the wheelchair. When asked about reviewing the specific fall interventions, the DON invited the nurse manager over to answer specific questions. RN-A stated after the 11/12/15, incident she placed a pressure pad alarm in R61's wheelchair with dycem (non-skid sheet) on the top and bottom of the pressure pad. RN-A also said they asked for a pharmacist review of R61's medications. A request was also sent to therapy for a reassessment. RN-A was informed about the alarms not sounding and indicated she was not aware there had been issues. When asked about an interdisciplinary team comprehensive assessment of the falls to determine the root cause of the falls, the efficacy of current interventions and identify other interventions that may be appropriate to minimize R61's risk for falls, both the DON and RN-A stated they had not done that. An interview on 11/9/15, at 1:00 p.m. with physical therapist (PT)-A identified they saw R61 from 10/22/15, to 10/30/15, and again 11/3/15, to current. PT-A said when they saw him back in 3/15, he was discharged as independent with a 4	F 323		

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F 323	Continued From page 61 wheeled walker (WW). PT-A stated when R61 came back from the hospital following his subdural hematoma in 10/15, he had orders for all three disciplines (physical, occupational, and speech) to assess and treat. PT-A stated therapy staff saw R61 for eight days. Staff attempted to ambulate him but he could not ambulate. PT-A stated R61 had a lot of pain due to his back fracture. PT-A stated the next request for therapy services was on 11/3/15, after returning from the hospital with the acetabulum fracture from another fall. R61's orders were for weight bearing as tolerated. Therapy staff utilized an TENS (Transcutaneous Electrical Nerve Stimulation) unit for his pain. PT-A stated R61 rated his pain at a 10/10 and staff could tell by R61's facial expressions when he was in pain. A subsequent interview on 11/12/15, at 12:45 p.m. PT-A stated physical therapy did an evaluation on 11/6/15, post fall with injury, she said they changed his wheelchair at that time because it didn't fit him well. PT-A was aware leg kept sliding off the leg of the wheelchair. She said they put a calf pad in place that morning. After notification of the IJ on 11/13/15, updated interventions for R61's fall care plan included the following interventions. However, the interventions were not observed to be implemented right away, or staff were not knowledgeable about the changes. Anticipate and meet the resident's needs. Do not leave the resident unattended when up in w/c. Follow facility fall protocol. Hoyer lift with assist of two staff for all transfers . Review information on past falls and attempt to determine cause of falls. Record potential root	F 323		

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F 323	Continued From page 62 causes. Alter any potential causes if possible. Educate resident/family caregivers/IDT Provide diversion and distraction such as news, music, socials and special events. Offer a snack (food and drink) when restless, states he's hungry or unable to sleep and monitor effectiveness. PT evaluate and treat as ordered. The resident uses TAB electronic alarm in bed and w/c. Pressure alarm in bed and w/c. Dycem on top and bottom of pressure mat in w/c. During an interview on 11/13/15, at 8:17 a.m. trained medication assistant (TMA)-K stated R61 had one pressure alarm in his chair and a pressure alarm in his bed. An observation on 11/13/15, at 10:00 a.m. R61 was sitting by the nurses station in the hallway with his TAB alarm on but not in attendance at the nearby activities program. During interview on 11/13/15, at 11:28 a.m. activities (A)-A said R61 went to activities but didn't attend much since returning from the hospital. A-A said they do 1:1's. She said if the documentation identified R61 as unavailable, he was usually in bed in a lot of pain or not feeling well. An interview on 11/13/15, at 2:25 p.m. nursing assistant (NA)-A said they did not receive report on any changes to R61's care. NA-G said on 11/13/15, at 2:28 p.m. they work on the other hall but, "I know he is always in pain and yelling in pain." An interview on 11/13/15, at 2:37 p.m. RN-F said	F 323		

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F 323	Continued From page 63	F 323		

she was told he was on fall precautions, so he has alarms in his chair and a TAB alarm. She was not aware of any new plan of care since yesterday.

An interview on 11/13/15, at 11:06 a.m. with family member (FM)-K indicated when R61 fell in September he slipped and fell in the bathroom. R61 told FM-K he was tired of waiting so long to get help. FM-K stated prior to his head injury, R61's mind was clear.

An interview on 11/16/15 at 3:43 p.m. NA-G stated, "I didn't know he fell. He is in a lot of pain. He has a back brace and is a full mechanical lift." NA-G further stated she hadn't been informed of any changes in his plan of care in the last couple days NA-G was aware he had alarms on his chair and his bed.

During an interview with RN-D on 11/16/15, at 3:47 p.m. stated the changes in R61's plan of care included: alarms in the wheelchair and bed, and when up he needs to be in the dining room or by the nurses station. R61 had a TAB alarm in his wheelchair and a pressure alarm in his bed. There was education for staff of the changes and staff signed after receiving the education .

An interview with RN-A on 11/16/15, at 4:07 p.m. stated staff placed a pressure pad and and a TAB alarm in his bed and wheelchair. R61 was not to be left unattended while in the wheelchair. He is to be engaged in activities. The pharmacist reviewed R61's medications and the medical doctor will as well. The physician ordered a scheduled a pain medication. RN-A further stated she has seen R61 in a lot of pain and agreed he did not have adequate pain control. She said she

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F 323	Continued From page 64 has seen him grimace in pain. RN-A stated all staff should be using the same pain scale and they are not. She said they do not us any non pharmacological pain interventions and "we should." RN-A stated since survey started R61 doesn't have good pain control. She further stated R61's pain may be affecting his restlessness so staff requested a regular pain medication. His new pain order is for oxycodone 10 mg 3 times daily. Interview on 11/16/15, at 4:28 p.m. with the DON indicated they changed the process of reviewing falls to include a weekly IDT meeting, including PT, to review all high risk fall residents. The new committee will review falls to ensure interventions are in place and all of residents were reviewed for fall risks. An interview on 11/17/15, at 8:35 a.m. A-A stated she had him in 3-4 activities a week. She said R61 will be visited 3-4 times a week. This plan started on 11/13/15. Before then, A-A had R61 do things independently, now he will have more planned 1:1's. The team planned to have weekly fall meetings and she will attend those meetings. An observation on 11/17/15, at 9:05 a.m. PT-M was doing therapy for R61. When he was asked about his wheelchair leg being too short, she agreed and said "the right leg could be lengthened a little." The w/c leg was lengthened at that time. An interview on 11/17/15, at 11:05 a.m. NA-J said the DON was on the unit and educated everyone on what to do for R61's falls.	F 323		

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F 323	Continued From page 65 An interview on 11/17/15, at 12:24 p.m. RN-A said the pharmacist and medical doctor's recommendations regarding R61's falls were in place. An interview on 11/17/15, at 12:39 p.m. RN-F said she had accident investigation training when she started but not with in the last couple months. The immediate jeopardy that began on 10/22/15, was removed on 11/18/15, when the facility implemented the following interventions to minimize the risk of falls for R61. However, noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy for R61. Actions taken to remove the IJ, which were verified through observation, interview and record review were as follows: 1. Comprehensive fall risk assessment was completed. 2. Physician orders for a Basic Metabolic Profile (BMP) and urinalysis were completed. 3. R61 was not left alone in his room during observations. 4. R61 was included in more activities and 1:1 sessions. 5. Alarms were in place in the wheelchair and in bed. 6. NA care sheets were changed and signed by the NAs. 7. Care plan was updated. 8. The medication and treatment administration records were updated as ordered. 9. The pharmacist and physician's recommendations were completed as ordered. 10. Weekly IDT meeting related to resident falls	F 323		

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F 323	Continued From page 66 was implemented. 11. Fall risk assessments will be done quarterly with high risk residents being focused on at the weekly IDT meeting. On 11/13/15 at 2:01 p.m. the DON confirmed the undated Root Cause Analysis Authors was the fall prevention policy. The policy identified, "During the daily standup meeting falls are discussed focusing on safety, fall risk, fall management, devices, care plan adjustments and updates to group sheets that direct the non-license staff care." The facility policy entitled, "Alarms for Bed and Chair" reviewed 10/14 indicated, "Alarms do not substitute for proper care and supervision." R42's right side rail was not secured to prevent movement to the side rail. R42's quarterly MDS dated 9/25/15, indicated R42 was cognitively intact and needed extensive assistance with bed mobility. The MDS included multiple diagnoses including quadriplegia. R42's care plan dated 10/1/15, indicated R42 used side rails as ordered by the physician for safety while in bed and to assist with bed mobility. The care plan directed staff to observe for injury or entrapment related to side rail use. On 11/10/15, at 9:28 a.m. and 11/12/15, at 7:45 a.m. R42's right side rail was not secured. When checking for the function of the right side rail it moved freely up and down at an angle. When pulling on the side rail a gap occurred that could entrap a body part, creating a potential hazard to R42.	F 323	1. A. All safety interventions for residents have been added to TAR for licensed staff to assess and to document that those interventions are in place and working properly. B. Safety care plans have been reviewed along with CNA care sheets for appropriate interventions by 12/18/15. C. A new fall assessment was done for all current residents. Completed 11/13/15. D. All residents will have a fall assessment on admission or readmission, quarterly and following any fall or significant change. This is ongoing. E. the Director of Nursing/designee is notified immediately of any fall. F. Interventions are reviewed and revised as necessary G. IDT meets Monday through Friday assessing any new falls, review and recommend interventions as necessary, and will update care plan as needed. H IDT meets weekly to discuss all residents considered high risk for falls, care plans reviewed, effectiveness discussed and updated as needed.	

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F 323	Continued From page 67 On 11/12/15, at 7:45 a.m. R42 verified that the right side rail was too loose for him and he had reported it to staff the day on 11/11/15. On 11/17/15, at 7:21 a.m. the right side rail was observed to be tightened up. There was no longer a gap. When interviewed on 11/17/15, at 9:24 a.m. NA-D stated that the side rails become loose at times and when R42 reports he did not feel safe, staff put in a maintenance ticket to have it tightened. NA-D verified that the right side rail had been tightened, but was not sure when. When interviewed on 11/17/15, at 3:43 p.m. the director of maintenance (DM)-B stated the side rails for R42's were the correct rails for the bed. He added, they do loosen up with use. DM-B stated the facility does not have a process in place to routinely check the safety and function of side rails. The facility policy Bed Safety dated 12/07, directed maintenance staff to inspect all bed equipment to try and prevent deaths/injuries from the beds and equipment including sides rails .	F 323	I. any side rails will be checked weekly to determine that they are properly attached to bed by maintenance. II. Nursing staff will be inserviced on fall, and fall prevention DON will review all falls and fall follow up to assure above is completed. 4. DON will report to QAPI monthly to determine any trends, patterns or issues with current fall policy. This will be on going. 5. The Director of Nursing/designee will be responsible. Completion date of 12-31-2015.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325	1. Resident # 158 was not affected by the alleged deficient practice. Resident is currently stable, MD has determined that resident's weight loss is unavoidable related to cancer diagnoses 2. All residents have the potential to be affected by the alleged deficient practice.	

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F 325	Continued From page 68 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to recognize and act upon a significant weight decline for 1 of 3 residents (R158) reviewed for nutrition. Findings Include: R158's significant change Minimum Data Set (MDS) dated 9/30/15, indicated R158 had diagnoses of cancer and dementia. The MDS further identified R158 had moderate cognitive impairments, and was independent with eating after set-up assistance, and a 5% decline in weight loss was indicated. R158's Dietary/Nutritional Assessment dated 9/8/15, indicated R158 had an average intake of 75% of food at meals with regular portions being served. The assessment also indicated that R158 had vision impairments and was a low nutritional risk at this time. Nutritional interventions included observe for weight changes. R158's Nutrition Care Area Assessment (CAA) dated 9/30/15, indicated R158 was a nutritional risk due to a poor memory, inability to perform activities of daily living without significant physical assistance and weight loss. The goal listed on the CAA was symptom relief or palliative measure and a care plan would be developed.	F 325		

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F 325	Continued From page 69 R158's care plan dated 10/9/15, indicated R158 was at risk for nutrition secondary to fluid restrictions, weight loss and infection problems. Interventions included: - provide and serve diet as ordered - monitor intake and record every meal - weigh weekly on shower day R158's physician orders dated 11/10/15, included an order for a regular diet. The physician orders lacked an order for a nutritional supplement. R158's Weights and Vitals Summary included the following weights: - 11/7/15 119 pounds (lbs) -10% weight change - 10/2/15 123 lbs -5% weight change - 9/25/15 123.6 lbs - 9/15/15 134.4 lbs - 9/14/15 135.6 lbs - 8/26/15 133 lbs - 8/25/15 131.9 lbs R158's meal intake record from 9/15/15, to 11/1/15, indicated the following meal intake percentages: - 31 meals at 0% -25% - 48 meals at 26% -50% - 55 meals at 51% - 75% - 27 meals at 76% - 100% The medical record lacked evidence of a nutritional reassessment. On 11/17/15, at 8:03 a.m. R158 was observed eating in the dining room for the breakfast meal. R158 was served hot cereal, eggs, toast, a cup of frozen orange juice and a cup of coffee. During the observation R158 asked for more coffee and	F 325		

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F 325	Continued From page 70 and was served a total of 3 cups during breakfast. R158 was being encouraged to eat throughout the meal and was assisted to put jelly on her toast, staff did not offer to place brown sugar or raisins on her hot cereal. During the meal R158 stated "I don't do eggs" when encouraged by the staff member to eat. The staff member did not offer R158 an alternative food. R158 ate 75% of hot cereal, bites of eggs and her toast, leaving the crust. R158 consumed 3 cups of coffee, 1/2 of her milk and no orange juice. R158 stated "I've had enough." On 11/17/15, at 12:23 p.m. R158 was observed eating independently in the dining room for the lunch meal. R158 was served a cup of oranges with whipped topping, taco hotdish, Mexican corn, 8 ounces (oz) of milk and 8 oz of coffee. R158 ate 100% of the oranges and whipped topping and only bites of the taco hotdish and Mexican corn. R158 drank 100% of her milk and coffee. During the observation R158 was busy playing with her dining room ticket and would frequently pick up her fork and not take a bite of food and then put the fork back down. R158 then pushed herself from the dining room table and propelled herself back to her room via her wheelchair. When interviewed on 11/18/15, at 9:12 a.m. nursing assistant (NA)-L stated that every meal is documented into the computer kiosk. NA-L also stated R158's intake is reported to the nurse on every shift for further documentation regardless of how much R158 ate at the meal. When interviewed on 11/18/15, at 8:41 a.m. registered nurse (RN)-C stated the dietician determined if a nutritional supplement is implemented. RN-C stated that R158 did not	F 325		

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F 325	Continued From page 71 have an order for a nutritional supplement. When interviewed on 11/18/15, at 9:05 a.m. the registered dietician (RD) stated residents are to be weighed monthly at a minimum, and resident's weights and food intakes are reviewed monthly by the dietician. The RD further stated if a resident has a decline in weight and food intake, the resident would be reassessed for interventions to prevent further weight loss. The RD stated R158 was a difficult case, as she was on hospice care, however, the RD stated R158 was not actively in the dying process. Upon review of the RD's personal spreadsheet of residents weight the RD stated R158 was not looked at for a decline in weight as the RD reported she entered R158's starting weight as 123.6 lbs dated 9/25/15. The RD stated the starting weight should have been her admission weight of 131.9 lbs dated 8/25/15. The RD stated that she had missed the weight in her review and should have been reassessed for possible interventions. The facility policy on Weight Assessment and Intervention undated directed the dietician to review the monthly weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met.	F 325	3. The Registered Dietician will follow the weight assessment and intervention guidelines.. This will be ongoing. Registered dietician will continue to work with nursing staff regarding weight frequency and follow-up. This will be ongoing. Weights will be taken weekly. 4. Registered dietician will review weights weekly to determine any significant changes, and will communicate with the IDT to determine appropriate interventions. Will continue to work with Wound and weight committee weekly.. Registered dietitian will report to QAPI monthly on all significant findings. 5. The RD/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 333	1. Resident #109 has had no ill effects from alleged deficient practice. 2. All residents would be considered at risk from alleged deficient practice.	

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F 333	Continued From page 72 by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R109) was free from a significant medication error. Findings include: R109's Admission Record identified diagnoses that included Alzheimer's disease. On 12/2/14, R109 was place on hospice services for end of life services due to Alzheimer's disease. The physician's orders on 12/28/14, directed morphine sulfate solution, give 2 milligrams (mg) by mouth every 1 hour as needed for shortness of breath pain (2 mg equals 0.1 milliliters [ml]). A review of R109's progress notes indicated the following: On 1/1/15, an entry indicated per the trained medication aide (TMA) and the nursing supervisor on day shift, and after researching the narcotics record book, it was discovered on 12/28/15, R109 received an incorrect dose of liquid morphine. R109 was prescribed 2 mg, and 2 mg was the equivalent of 0.1 milliliters (ml). R109 was given 2 ml, 20 times the amount ordered. On 11/17/15, at 9:42 a.m. registered nurse (RN)-C was interviewed, and stated she was not working at that time, and was unaware of the medication error. On 11/18/15, at 11:23 a.m. the director of nursing (DON) was interviewed and stated she reviewed medication errors at the Quality Assurance (QA) meeting. The DON was unaware of R109's medication error.	F 333		

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F 333	Continued From page 73 The facility was requested to provide a copy of the medication error investigation form. On 11/17/15, at 12:40 p.m. the admissions coordinator (AC)-H stated she was unable to find the medication error investigation. The facility policy and procedure on Adverse Consequences and Medication Errors dated 2/14, indicated a medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with the physician's orders. The policy directed the interdisciplinary team to review the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis.	F 333	3 .Licensed staff and TMAs will complete medication administration reeducation by 12/18/15. The transcription process is currently being audited for all new admission and readmissions. This is on going. All medication errors will be reviewed by Nurse Managers and DON, corrective reeducation will be done as soon as review is complete. This is ongoing. 4.. Medication error trends and or patterns will be reported to monthly QAPI committee.. This will be on going. The transcription process is being reported to the monthly QAPI committee. This will be ongoing. 5. The Director of Nursing /designee will be responsible. Completion date of 12-31-2015.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice.	

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F 356	Continued From page 74 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the nurse staff posting included the actual hours worked for partial shifts. This had the potential to affect all 159 residents residing in the facility. Findings include: A review of the direct care staff posting and the facility staffing schedule from 11/2/15, through 11/16/15, indicated partial shifts were worked by staff on 13 of 15 days. The direct care staff postings for each date did not specify the actual hours worked during the partial shifts. During an interview on 11/18/15, at 7:41 a.m. the director of nursing (DON), verified partial shifts were not included on the nurse staff posting . During an observation on 11/9/15, at 12:29 p.m. the staff posting to the left of the front desk could not be viewed by anyone seated in a regular wheelchair.	F 356	3. The posting of actual nursing hours was lowered so as to be at a level height for wheelchair residents. Hours posted include actual hours worked, which include partial shifts. 4. An audit will be conducted two (2) times per week times 12 weeks to monitor that actual hours , including partial shifts are recorded and posted on the nurse staff posting. Audits will be presented to the monthly QAPI committee to assure compliance with posting of actual hours worked.. After three months the QAPI committee will make a recommendation as to the need to continue to monitor the posting of hours. 5. the Administrator/designee will be responsible. Completion date of 12-31-2015.	

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F 356	Continued From page 75 On 11/18/15, at 1:58 p.m. the DON verified the staff posting was 59 inches from the floor to bottom of staff posting, and was not at a height that was accessible for anyone seated in a regular wheelchair to easily read.	F 356	5. The Administrator/designee will be responsible.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were promptly addressed for 2 of 5 residents (R38, R109) reviewed for unnecessary medications. Findings include: R38's admission record indicated diagnoses that included colostomy, adjustment disorder with mixed anxiety and depression, diabetes, dementia, delusional disorders, and brief psychotic disorder. R38's quarterly Minimum Data Set (MDS) dated 9/11/15, indicated she had moderate cognitive impairment, and exhibited no moods or behaviors.	F 428	1. Resident #38 has had no adverse or ill effects due to the alleged deficient practice. Resident #38 is less anxious and has minimal attempts at trying to remove her ostomy bag with current medications. Appetite is improved and she is participating in activties. Resident # 109 has had no adverse of ill effects due to the alleged deficient practice. Resident is demonstrating less grimacing, less moaning, less arching and less grinding of teeth, which has improved his quality of life. 2. All residents have the potential to be affected by the deficient practice.	

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F 428	Continued From page 76 R38's order summary report, dated 11/18/15, indicated R38 received sertraline HCl (Zoloft) (an antidepressant medication), 200 milligrams (mg) by mouth in the morning for anxiety with obsessive compulsive disorder (OCD) related to adjust disorder with mixed anxiety and depressed mood; the start date was 8/15/14. The order report also indicated R38 received quetiapine fumarate (an antipsychotic medication), 50 mg twice a day for paranoia related to delusional disorder with a start date of 8/16/13. In addition, R38's order summary indicated lorazepam (an antianxiety medication) 0.5 mg by mouth as needed for anxiety related to delusional disorder and 0.25 mg by mouth two times a day for anxiety related to adjustment disorder with mixed anxiety and depressed mood. R38's care plan indicated R38 had a behavior problem related to loosening her colostomy bags multiple times a day, and she exhibited hoarding type behaviors. The care plan also indicated R38 had a mood problem related to paranoia, dementia, delusions, and cognitive impairment. The care plan directed staff to observe/record/report to the physician any acute episodes or feelings of sadness, loss of pleasure and interest in activities, and to have positive interactions with resident at times other than when she is receiving medical care. A 6/19/15, Consultant Pharmacist's Medication Review form indicated an irregularity regarding R38's sertraline (Zoloft) medication. The irregularity comment stated: yearly risk versus benefit analysis/documentation is required for all psychotropic medications. This medication was last increased about 1 year ago. The comment	F 428		

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F 428	Continued From page 77 noted that R38 has a past history of focusing on her ostomy bag. Since starting this medication, that has improved, therefore, no further reduction is recommended at this time-still risk vs. benefit analysis/documentation is required by CMS. The suggested course of action was to provide a risk versus benefit statement and clinical rationale for continuation of the Zoloft as ordered. A hand written note dated 7/11/15, on the follow-up action section read to defer to the consultant psychiatrist. The signature is not legible. The 10/20/15, consultant pharmacist irregularity comment requested a risk versus benefit statement for the sertraline medication, including clinical rationale for continuation, per CMS guidelines. Under the follow-up or action taken section "rejected" is circled and a 10/29/15, hand written note indicated: reduction not indicated at this time. Benefits currently outweigh risks. The signature is not legible; however, in an interview on 11/17/15, at 2:07 p.m., registered nurse (RN)-G stated that the signature is that of the consultant psychiatrist's nurse practitioner. R38 was observed and interviewed on 11/9/15, at 3:20 p.m., sitting calmly on the edge of her bed. R38 made eye contact, answered questions and interacted appropriately throughout the interview. R38 was observed on 11/12/15, at 6:55 a.m. and again at 8:10 a.m., calmly sitting in the second floor dining room with a beverage in front of her. On 11/12/15, at 8:53 a.m. R38 was in the doorway of her room with a smile on her face. On 11/12/15, at 12:24 and again at 12:45 p.m. R38 was observed in the dining room on 11/15/15, at 8:00 a.m. with a beverage, waiting for breakfast to be served. On 11/17/15, R38 was	F 428		

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F 428	Continued From page 78 observed sitting with two others at the dining room table with beverages, waiting for breakfast. In an interview on 11/17/15, at 8:44 a.m. R38 stated she doesn't know her medication, but her brother is her responsible party. R38 stated she doesn't feel like she has any side effects from her medications, but feels that they help her. In an interview on 11/17/15, at 8:56 a.m. nursing assistant (NA)-J stated R38 does hoard sugar, gowns, towels and other items; R38 also pulls her colostomy bag off. NA-J stated R38 required set-up and stand-by assist with personal hygiene, but is independent with other cares. NA-J also stated they have not been told to watch for anything else. In an interview on 11/17/15, at 2:00 p.m. registered nurse (RN)-A stated the initials on the June 2015, medication review form are the nurse practitioner's who rounds at the facility. In an interview on 11/17/15, at 2:07 p.m. RN-G stated R38 just started visits with the consultant psychiatrist in October. RN-G stated the June 2015, response referred R38 to this consultant psychiatrist, who did not see R38 until October. RN-G stated the hand-written note in October was from the consultant psychiatrist's nurse practitioner. RN-G stated they (the consultant psychiatrist and the nurse practitioner) don't type up a formal risk versus benefit when it's requested from a physician. RN-G also stated they don't review it with residents. A rounding form indicated that the consultant psychiatrist rounded on R38 on 10/29/15.	F 428	3. The following systems will implemented by 12-31-2015 Pharmacist makes recommendations and emails to ADON along with DON ADON prints off recommendations, signs, and distributes to appropriate nurse managers Nurse Managers fax appropriate recommendations to providers or places in rounding book for Eldercare and Dr. Gish residents. . Nurse Managers follow through on nursing recommendations from pharmacist As recommendations are addressed by provider and nursing, a copy is made this copy is given back to ADON. Original is placed in resident chart and copy stays with ADON ADON uses the "nursing drug report" emailed by consultant pharmacist to check off recommendations that have come back from the nurse manager and ensures that the provider response is appropriate.	

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F 428	Continued From page 79 In an interview on 11/18/15, at 10:23 a.m., the consultant pharmacist stated he cannot account for the lapse of time between June and October when no action was taken. The consultant pharmacist stated that in his opinion the brief risk versus benefit on the October form was an adequate risk versus benefit and that the psychiatrist often puts a more detailed description in his notes, which would not yet be available in the medical record. No additional information was received from the facility. R109 had recommendations from the consultant pharmacist, and the facility did not act upon them. R109's Admission Record identified diagnoses that included Alzheimer's disease, anxiety disorder, depression, hypertension, gout and arthritis. The quarterly Minimum Data Set (MDS) dated 9/14/15, indicated R109 had severe cognitive impairment, and required extensive to total assistance of staff with bed mobility, transfers, dressing, eating, mobility, personal hygiene, bathing and toileting. R109's physician's orders indicated the following: Ativan (an antianxiety medication) 1 milligram (mg) twice a day. Risperdal (an antipsychotic medication) 1 mg/ml (milliliter) 0.1 mg daily. Zoloft (an antidepressant medication) 25 mg at bedtime. On 8/25/15, the consultant pharmacist gave the following recommendation: please provide documentation of the lowest effective dose for the Ativan, Risperdal, and Zoloft as well as how these medications improve the residents quality of life. On 10/9/15, R109's physician responded with the following: trial reduction of both Zoloft and	F 428	ADON and consultant pharmacist will review questionable responses and decide if further clarification is needed. Pharmacist will also review past due recommendations by reviewing the pending recommendation report with the ADON. Decision will be made at that time as to readdress with provider or Medical Director 4. Any negative occurrence will be reported to the consulting pharmacist immediately. Any issues with follow up with physicians will be discussed at the monthly QAPI committee. Any on going issues with the MD responses the Facility will contact the Medical Director to facilitate having the attending physician respond back more timely. System will be on going. 5. The Director of Nursing/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015	

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F 428	Continued From page 80 Risperdal. Question effectiveness, question if experiencing symptoms. The physician's response lacked documentation of how these medications improved R109's quality of life. On 11/17/15, at 8:03 a.m. registered nurse (RN)-G was interviewed, and stated the consultant pharmacist comes to the facility monthly, and she reviews the recommendations with him. On 11/18/15, at 11:59 a.m. the director of nursing (DON) was interviewed, and stated the assistant director of nursing reviews the consultant pharmacist recommendations with him, and the DON was told there was not a problem with them. The facility was unable to provide a policy and procedure on consultant pharmacist's recommendations.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential for being affected by the alleged deficient practice.	

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F 431	Continued From page 81 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure insulin was stored at the required temperatures in 1 of 4 medication refrigerators. In addition, the facility failed to provide security of insulin pens located on the first floor nurses station. Findings include: On 11/13/15, at 9:25 a.m. the Morning Light West medication refrigerator temperature was observed to be 32 degrees Fahrenheit (F) on one thermometer and 29 degrees F on another thermometer. The built in freezer had a large amount of frost build up on the outside extending into the refrigerator. A review of the temperature log indicated the acceptable range was 36-46 degrees F, and the temperature had been within	F 431		

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range for the last 13 days. The temperature log indicated the facility checked the medication refrigerator temperatures once daily. Licensed practical nurse (LPN)-C verified the frost build up and the temperature was 32 degrees F on one thermometer and 29 degrees F on the other.

The manufacturer's package inserts for the insulin stored in the medication refrigerator directed the following:

Unopened Novolog should be stored in a refrigerator between 36 degrees F and 46 degrees F
Unopened Lantus should be stored in refrigerator at 36 degrees F and 46 degrees F
Unopened Humulin N should be stored in the refrigerator and should be discarded if it has been frozen
Unopened Humalog should be stored in refrigerator at 36 degrees F and 46 degrees F

The refrigerator contained the following unopened resident insulin (medication to control diabetes) pens:

R1 7 Lantus pens
R142 3 Lantus pens
R87 1 Lantus pen and 2 Humalog pens
R9 2 lantus pens and 12 Novolog pens
R7 1 Humulin N pen

R1's signed physician orders dated 10/14/15, included a diagnosis of type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene. The physician orders directed staff to inject subcutaneously 27 units of Lantus solution daily at bedtime.

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F 431	Continued From page 83 R142's signed physician orders dated 11/10/15, included a diagnosis of type 2 diabetes without complications. The physician orders directed staff to inject subcutaneously 10 units of Lantus solution two times daily. R87's signed physician orders dated 10/8/15, included a diagnosis of type 2 diabetes without complications. The physician orders directed staff to inject subcutaneously 4 units of Humalog solution in the morning in addition to a sliding scale dose up to 8 units daily. The physician orders also directed staff to inject subcutaneously 10 units of Lantus solution at bedtime. R9's signed physician orders dated 11/5/15, included a diagnosis of type 2 diabetes mellitus with diabetic neuropathy. The physician orders directed staff to inject subcutaneously 10 units of Novolog solution every evening with supper and inject 17 units two times daily. The physician orders also directed staff to inject subcutaneously 10 units of Lantus solution every 12 hours. R7's signed physician orders dated 11/10/15, included a diagnosis of type 2 diabetes mellitus without complications. The physician orders directed staff to inject subcutaneously 20 units of Humulin solution daily at bedtime and to inject 25 units subcutaneously one time daily. When interviewed on 11/13/15, at 9:47 a.m. registered nurse (RN)-B stated she will pull the insulin from the medication refrigerator and contact the pharmacy consultant for instructions. When interviewed on 11/18/15, at 9:50 a.m. RN-B verified the insulin pens were destroyed and had been reordered. RN-B stated that a maintenance	F 431		

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F 431	Continued From page 84 ticket has been placed for the medication refrigerator. When interviewed on 11/18/15, at 10:20 a.m. the director of nursing (DON) stated that the Insulin pens were reordered and a new medication refrigerator was on order. The DON further stated the medication refrigerators in the facility are getting old. The facility policy Storage of Medications dated 4/14, directed medications requiring refrigeration or temperatures between 36 degrees F and 46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring. On 11/12/15, at 8:15 a.m. Novolog and Lantus insulin pens were observed at the first floor nurse's station, near the open door. The Novolog insulin pen had approximately 70 units of insulin in it, and the Lantus insulin pen had approximately 130 units of insulin in it. During continuous observation from 8:15 a.m. through 8:45 a.m. the insulin pens remained on the desk, and staff and residents were passing by the open door. At 8:45 a.m. registered nurse (RN)-D picked up both insulin pens, and stated she left them on the desk because she was going to administer it after breakfast. RN-D stated it was not normal practice to leave insulin pens unsecured. On 11/18/15, at 12:09 p.m. the director of nursing (DON) stated insulin pens should not be left lying out unsecured.	F 431	3. The medication refrigerators were replace with new refrigerators. The License staff were reeducated documenting refrigerator temps on a daily basis; the License staff and TMAs were reeducated on the proper storage of medications which included insulin pens. Completed 12-18- 2015. 4. An audit will be conducted one (1) times per week times 12 weeks to monitor the refrigerator temperatures for the proper storage of medications in the refrigerators. Observation rounds will be conducted one (1) times per week times 12 weeks to monitor proper storage of medications including insulin pens by nurse managers. Any negative occurrence will be addressed immediately. This documentation will be presented to the monthly QAPI committee to monitor the proper storage of medications. After three months the QAPI committee will make a recommendation as to the need monitor that the temperature logs are being documented daily. Refrigerator temperature logs will be collected weekly and placed in a three ring binder. Logs will be kept for one year. 5. The Director of Nursing/ designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 85 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 441		

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F 441	Continued From page 86 review, the facility failed to implement an infection control surveillance plan to identify, document and monitor resident infections. In addition, the facility failed to ensure appropriate hand washing and gloving practices were provided during cares for 1 of 1 residents (R49) observed during cares. In addition, the facility failed to implement contact precautions for 1 of 1 residents (R111) diagnosed with methicillin resistant staphylococcus aureus (MRSA) infection. The facility also failed to implement contact precautions for 1 of 1 residents (R88) diagnosed with clostridium-difficile (C-Diff) infection. These practices had the potential to affect all 159 residents in the facility. Findings include: In an interview on 11/17/15, at 2:47 p.m., RN-B stated three residents currently were currently on isolation precautions. RN-B stated she hasn't formally audited implementation of precautions for these residents. RN-B stated she expects all staff to see the door sign (directing all people to check with the nurse before entering) and ask the nurse what precautions they need to take before entering a room. In the interview on 11/17/15, at 2:47 p.m., RN-B stated each nursing station recorded what residents had infectious symptoms: loose stools, temperatures, coughing. RN-B also looked at residentprogress notes daily and attended a daily morning report in order to gather information related to potential infections. RN-B stated she educated staff to "foam in and foam out" of rooms. If a resident had C-Diff, then they are to wash their hands with soap and water	F 441		

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and also put on gloves. If she saw a concern she would talk to individual staff and then let their manager know.

RN-B stated she had done a full infection prevention and control class at the end of September, teaching 5 or 6 classes. If a staff person could not attend, they were to review a packet of the presentation and sign off. RN-B hds not reviewed to determine if all staff have received this education.

In an interview on 11/17/15, at 3:38 p.m., the Occupational Therapist (OT)-D stated the evaluating therapist would find out during an intial evaluation meeting with a resident if that resident was on precautions. OT-D stated that the information will "trickle down" to other therapists. OT-D stated if a resident became infectious while in the facility, nursing would inform her in some way and she would inform her staff the best she can, usually on a one-by-one basis.

OT-D stated there were a lot of new therapy staff; new to the facility and to the profession, and there was a lot of uncertainty around implementation of infection precautions. OT-D stated she had re-educated her staff to wash hands, and gown and glove prior to working with infected residents in their room. OT-D stated therapists use sani-wipes (a disinfectant) to wipe down all therapy equipment and wheelchair handles when an infectedresident is done with their therapy session.

In the interview on 11/17/15, at 2:47 p.m., RN-B advised staff if they are just going in and out of the room, they should put on gloves; if they are coming in contact with any surface in the room,

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F 441	Continued From page 88 they should also use gloves. RN-B stated housekeeping is not her area, so she doesn't train housekeeping staff on infection control . She stated that putting a mop back on the housekeeping cart to use in another room should not be done. RN-B stated she has not done any resident or infection-specific training across other departments. In an interview on 11/18/15, at 7:42 a.m., Maintenance (M)-A stated housekeeping staff are to remove a soiled dust mop and get it laundered after using it in a room with precautions. M-A stated staff are not to use the dust mop in additional rooms. In an interview on 11/18/15, at 8:42 a.m., RN-B stated she reviewed all resident progress notes daily upon her arrival in the facility to determine if there were any infection control related issues. RN-B stated staff were to inform her if anyone is on antibiotic therapy. RN-B stated she gathered information on resident's with infections by reading a daily log where nurses record resident specific information, a nurse manager would tell her or she would read it in the progress notes. R49 did not receive complete hand hygiene during daily cares. R49 ' s admission record indicated diagnoses that included failure to thrive, depression, restlessness and agitation and diabetes. R49 ' s annual Minimum Data Set (MDS), dated 7/8/15, indicated R49 had severely impaired cognition, required extensive assistant with bed mobility, transfers, dressing, eating, toileting and personal hygiene and was frequently incontinent of bladder and bowel.	F 441		

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During an observation of R49's cares on 11/12/15, at 8:31 a.m., nursing assistants (NA)-F and NA-G were observed to change gloves without using hand sanitizer or handwashing in between glove changes.

According to NA-G, R49's incontinent product was saturated with urine and R49 had also had a bowel movement. NA-F and NA-G took turns cleaning BM off of R49 with disposable wet wipes. After cleaning R49's perineal area, NA-G and NA-F took off their gloves and without handwashing or hand sanitizer, donned new gloves. NA-F then took a wet washcloth and washed under R49's breasts and her armpits. NA-G tied up the garbage with the soiled incontinent product and wet wipes and placed it on the floor.NA-G then brought a stand lift into the room, removed her gloves and used hand-sanitizer.

In an interview on 11/17/15, at 2:47 p.m., registered nurse (RN)-B stated that she hasn't monitored hand washing formally. She did do a few audits in July of 2015, but hasn't monitored hand-washing formally.

The facility's undated Infection Prevention and Control Program section on Glove Use (page 48-49) specified hand hygiene to be completed before donning and after removing gloves.

R111 had a methicillin resistant staphylococcus aureus (MRSA) infection and the facility did not implement appropriate infection control precautions.

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

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F 441	Continued From page 90 R111 Admission Record identified diagnoses that included methicillin resistant staphylococcus aureus infection, peripheral vascular disease, and aneurysm of artery of a lower extremity. R111's admission minimum data set (MDS), dated 8/31/15, indicated he was cognitively intact and had surgical wounds. An 11/15/15 progress note indicated a blister to R111's left heel. The note continued that the blister had popped with yellowish/red drainage. The area was cleaned with wound cleaner and applied a non-stick pad and wrapped. 11/16/15 physician orders for wound care directed staff to clean the wound, apply telfa and tegaderm dressing daily. Review of R111's Interagency Referral Form (IAR) dated 8/25/15, identified MRSA as a high priority, and present, on the first page of the form. In addition the IAR indicated R11 was on a new medication sulfamethoxazole-trimethoprim (an antibiotic) for 14 days after discharge. In an observation on 11/15/15, at 7:04 a.m., R111's room had an infection control station outside the room, but no sign on the door directing staff or visitors to check with the nurse before entering. An observation on 11/17/15, at 9:47 a.m., revealed there was still no sign on R111's door. RN-B had a sign put on R11's door on 11/17/15 at 10:58 a.m. On 11/15/15, at 7:04 a.m., nursing assistant (NA)-H and NA-N entered R111's room with gloves on, but no gowns. Upon exiting the room at 7:50 a.m., NA-N was observed to use purple (MRSA-killing) wipes to wipe down the surfaces of the Hoyer lift.	F 441		

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F 441	Continued From page 91 In an interview on 11/17/15, at 2:47 p.m., RN-B stated CDC guidelines were used to determine which isolation precautions are put in place. She did not know if all three of R111's wounds had been cultured and if not, the reasoning behind why they weren't. RN-B stated, "I'd have to check." No further clarification was provided. RN-B also stated any nurse can implement precautions, they don't have to wait for orders In an interview on 11/18/15, at 8:42 a.m., RN-B stated R111 had returned from the hospital on 8/25/15. RN-B stated as soon as she found out R111's leg wound had infection she placed the resident on contact precautions. RN-B confirmed R111 was not on contact precautions from 8/25/15, his return from the hospital, until RN-B implemented precautions on 9/1/15. RN-B stated that the 9/1/15 documentation was for staff to use precautions only during wound cares. R88 had a Clostridium difficile (C. difficile) infection, and the facility did not implement appropriate infection control precautions. Findings include: The Center for Disease Control (CDC) guidelines for health care facilities directed the following when caring for residents with a C. Difficile infection: Isolate patients with C. difficile immediately. Wear gloves and gowns when treating patients with C. difficile, even during short visits. Hand sanitizer does not kill C. difficile, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves. Clean room surfaces thoroughly on a daily basis while treating a patient with C. difficile and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing	F 441		

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F 441	Continued From page 92 disinfectant. R88's Admission Record identified diagnoses that included enterocolitis due to Clostridium difficile (a spore-forming bacteria that can cause swelling and irritation of the large intestine, or colon. This inflammation, known as colitis, can cause diarrhea, fever, and abdominal cramps). R88's admission Minimum Data Set (MDS) indicated R88 was cognitively intact, required extensive assistance of two staff for toileting, and was frequently incontinent of bowel. Laboratory results on 9/24/15, and 10/13/15, both identified the presence of C. difficile in R88's stool. On 11/9/15, at 3:42 p.m. registered nurse (RN)-C was interviewed, and stated R22 was on isolation precautions due to a C. difficile infection. RN-C stated staff were not required to gown and glove prior to entering R88's room, unless they were coming into direct contact with R88's stool. RN-C verified R88 had loose stools that day. On 11/10/15, at 7:34 a.m. nursing assistant (NA)-L was observed entering R88's room. There was a yellow sign on R88's door; it directed "stop contact precautions, wash hands, gown, glove. Visitors see nurse before entering". Outside the door was an isolation cart with gowns, gloves, masks and sanitizing wipes. NA-L had a coffeepot in her hands, knocked on the door and entered R88's room. NA-L did not wash her hands, or put on a gown or gloves. NA-L put the coffeepot on a bedside table next to R88. Housekeeper (H)-A then entered R88's room, and did not wash her hands, or gown or glove. H-A had a dry mop, and proceeded to dry mop the floor. NA-L proceeded to make R88's bed. H-A left the room without washing her hands, and placed the dry mop onto the housekeeping cart. NA-L left the room without washing her hands, and had a coffeepot in her hands when she left	F 441		

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the room. NA-L was interviewed and stated she did not gown or glove when she went into R88's room, because she just brought him fresh coffee, and made his bed. NA-L stated she had not washed her hands when leaving the room, she was on her way to do that now. H-A was interviewed and stated she did not gown or glove when going into R88's room, but she did use an alcohol based sanitizer when she left the room. At 7:57 a.m. H-A was observed with the dry mop still on her housekeeping cart. H-A stated she was supposed to take the soiled dry mop off her her cart, and replace it with a clean one, but she had not done this yet.
On 11/10/15, at 10:05 a.m. trained medication aide (TMA)-E was interviewed, and stated R88 did not have a dedicated stethoscope, thermometer or blood pressure cuff. TMA-A stated if these were used on R88, staff should clean them off with a disinfectant.

On 11/10/15, at 10:08 a.m. RN-B was interviewed, and stated she was the nurse responsible for the facility's infection control program. RN-B stated there was an isolation cart outside of R88's door, and she would expect staff to wash their hands with soap and water, not just using an alcohol based hand sanitizer when entering and leaving the room. RN-B stated she would expect nursing and housekeeping staff entering R88's room to have a "minimum" of gloves on, and she has asked them to gown and glove prior to entering the room, but "they don't." RN-B confirmed she had not done audits to determine whether or not staff were wearing gowns and gloves, or performing proper hand hygiene when entering R88's room. RN-B further stated the facility did not provide R88 with dedicated equipment at this time, it is something

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F 441	Continued From page 94 they should be doing, and the facility will start to do it soon. RN-B stated if staff were using the blood pressure cuff, stethoscope and thermometer on R88, they should be cleaning the equipment with a sanitizing wipe, but she hasn't educated them on it yet. In an observation on 11/10/15, at 10:29 a.m., certified occupational therapist assistant (COTA) was observed entering R88's room with a clipboard. The COTA did not gown or glove upon room entry, but did apply hand sanitizer. The COTA did not touch anything, but did use the door handle to close the door upon exit. The COTA did not wash or sanitize her hands after exiting the room. The COTA stated that she would take the clipboards to use in other rooms. On 11/12/15, at 7:14 a.m. RN-B was interviewed, and stated the sanitizing wipes on the isolation cart outside of R88's room did not kill spores. The facility policy and procedure on Clostridium Difficile undated, directed staff to wash hands with soap and water, alcohol gels or handrubs are not effective in removing or killing the spores . When possible, non-critical care equipment should be dedicated to the patient with C. difficile. Based on interview and document review, the facility failed to ensure Tuberculosis (TB) screening, including a two-step tuberculin skin test (TST) (a skin test to assist in identifying if an individual had been exposed to TB or was infected with TB), and a TB baseline symptom screening was completed upon employment and prior to providing cares for 9 of 10 direct care staff. This had the potential to affect all 159 residents residing in the facility. Findings include:	F 441		

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	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1001 ST LOUIS AVENUE DULUTH, MN 55802

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F 441	Continued From page 95 The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Setting, 2005 (MMWR) directed all health care workers must receive a baseline TB screening upon hire. The screening must include an assessment of the employees risk factors for TB, and any current TB symptoms. A two-step TST (tuberculin skin test) or a single interferon gamma release assay (IGRA), or a chest x-ray results must be maintained in the employee record. A review of employee tuberculosis (TB) screening and employee list indicated the following: * NA-N was hired 3/14/13. The first-step tuberculin skin test TST was administered that day. The second TST was not administered until 5/30/13. The second-step TST was administered late. * NA-O was hired 10/27/14. The first-step TST was administered on 6/3/15 and the second TST was administered 6/10/15. The baseline symptom screening was completed on 6/5/15. The screening was not prior to the start date. * NA-G was hired 10/15/15. The first-step TST was administered on 10/15/15. NA-G did not receive a second-step TST. The baseline symptom screening was completed on 10/15/15. * NA-M was hired on 10/26/15. The first-step TST was administered on 10/26/15. The second-step TST had not been administered. The baseline symptom screening was completed on 10/26/15. * NA-P was hired on 5/17/11. The first-step TST was administered on 5/17/11. The second-step TST had not been administered at that time. Another one-step TST was administered on	F 441		

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F 441	Continued From page 96 6/17/15 The baseline symptom screening was completed on 5/17/11. * NA-Q was hired on 12/26/12. The first-step TST was administered on 10/24/14. The second-step was administered on 12/17/14. The baseline symptom screening was undated. The TB screening was not completed at the time of hire. * NA-R was hired on 10/14/13. The first-step TST was administered on 10/11/13. There was no documentation of the second-step. NA-R received another one-step TST on 6/1/15. The second-step TST was read 5 days after administration, the TST is to be read 48-72 hours after administration. The baseline symptom screening was completed on 10/14/13 and 6/1/15. * NA-T was hired on 10/26/15. NA-T had received a TST on 9/21/15, prior to employment at facility. The first-step TST was administered on 10/26/15. The baseline symptom screening was completed on 10/26/15. * NA-U date of hire was listed as 7/23/15. There were no TST's or baseline symptom screening done for this date. There were 2 previous one-step TST results; one dated 11/4/10, and the other dated 12/2/14. A baseline symptom screening was completed with each TST. *NA-V was hired 12/3/07. A one-step TST was administered 10/24/14. Another one-step TST was administered 6/16/15. A baseline symptom screening was completed with each TST. During an interview 11/18/15, at 8:30 a.m., registered nurse (RN)-B stated the employee must have a negative TST before they can work with residents, and the second-step should be given within 21 days after the first. RN-B verified some of the new employees must have their	F 441	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Staff will be in- serviced on the Facility's Infection control Policies and Procedures, which includes the implementation of isolation precautions and ensuring complete hand washing. The Staff Development /Infection Control Coordinator will implement infection control precautions per CDC guidelines in a timely manner. And upon admission or readmission, or with any current resident if precautions are warranted. 4. Observation rounds will be conducted two (2) times per week times 12 weeks to monitor the facility's infection program to include isolation precautions and complete hand washing. Any negative occurrence will be addressed immediately.	

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F 441	Continued From page 97 TSTs repeated because they were late having their second-step TST administered. RN-B stated the employee is given a form that directs them when they need to come back either to have the first-step TST read, or have the second-step TST administered. RN-B stated she followed up with human resources. The undated facility policy and procedure for Tuberculosis Control Plan directed all qualified applicants for employment would be screened using a two-step TST or a blood test for tuberculosis.	F 441	The results of the observation rounds will be presented to the monthly QAPI committee to review and make recommendations. After three months the QAPI committee will make a recommendation as to the need to continue to monitor the facility wide infection control program. 5. The Director of Nursing/designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were well maintained for 8 of 15 resident rooms (rooms 121, 143, 151, 159, 160, 210, 212, 257) In addition, the facility failed to ensure a wheelchair was properly maintained for 1 of 1 residents (R129) reviewed for environmental concerns. Findings include: On 11/17/15, at 2:59 p.m. a tour of the facility was completed with the director of maintenance (DM)-B and the environmental director (ED)-A. During the tour, the following room maintenance	F 465	1. Resident room's # 121,143,151,159,160,210,212,257 and the wheelchair in room 129 were repaired, painted and or fixed to reflect a more homelike environment. 2. All resident rooms have the potential for not having a homelike environment.	

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F 465	Continued From page 98 and wheelchair concerns were identified and confirmed by both DM-B and ED-A. Room (RM) 121 had two 2 inch (in) gouges with sharp edges in the vinyl doorknob guard behind the main door. RM 143's bathroom had multiple scratches on the rim of the toilet. The caulking at the base of the toilet was cracked, peeled and dirty. There were four dime sized chips in the tiled wall in the bathroom. The built in closet had 6 in. long gash exposing the particleboard on the bottom right corner. RM 151's caulking at the base of the toilet was cracked, peeled and dirty. The bathroom also had a strong urine smell. RM 159's caulking at the base of the toilet was cracked, peeled and dirty. RM 160's bathroom sink has three cracks in the porcelain. RM 210's bathroom floor had yellow staining around the base of the toilet. Dirt was observed in the corners behind the toilet and below the sink. There were also dark splatters on the wall and floor near the toilet. RM 212's private room lacked a privacy curtain. RM 257's tiled bathroom floor had an area approximately 3 in. x 3 in. that was filled with cement.	F 465	3. The facility utilizes the Direct Supply "Tels" system, which allows all departments to alert the Maintenance department of resident rooms, resident environment and or the resident's equipment that need repair or attention.. An audit of ten (10) resident rooms will be conducted each week for 12 weeks to assure the rooms are maintained to reflect a more homelike environment. Any item or items needing repair, painting or fixing will be addressed immediately. This system will be ongoing throughout the year. The results of the audits will be presented to the monthly QAPI committee monthly for three (3) and quarterly thereafter for one year to assure a system of maintaining the resident rooms in a homelike environment.	

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F 465	Continued From page 99 R129's wheelchair's right-sided arm support was worn through the top layer exposing the cushion. After the tour on 11/17/15, at 3:33 p.m. DM-B stated he has not been currently performing routine maintenance rounds in the resident rooms since the ED-A started working in the facility. ED-A stated that he rounds every room in the facility monthly, however his checklist did not include maintenance specific tasks to look for and document for follow up. DM-B stated the facility does not have any room maintenance policies aside from housekeeping. The facility policy "Resident Restroom Cleaning" directed housekeepers to sweep, dust and mop the entire floor, moving any items that may be in the bathroom. The facility did not provide a policy on maintainence of resident's rooms, resident's environment or resident's equipment.	F 465	5.The Director of Maintenance/designee with oversight by the Administrator will be responsible. Completion date of 12-31-2015.	
F 494 SS=F	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the	F 494	1. No residents were affected by the alleged deficient practice. 2. All of the nursing assistant evaluations have been completed. Completion date of 12-30-2015	

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F 494	Continued From page 100 requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure performance reviews were completed for all nursing assistants in the past 12 months. This had the potential to affect all 159 residents residing in the facility. Findings include: A review of 15 employee files indicated the following employees did not have performance reviews completed in the past 12 months: Nursing assistant (NA)-D, NA-Q, NA-N, NA-Z, NA-R, NA-C, NA-V, and NA-W. During an interview on 11/18/15, at 9:04 a.m. the human resources director (HRD)-I stated no NA performance reviews were completed in the past year. The HRD-I stated the last reviews were done in 2013, by the previous company. During an interview on 11/18/15, at 12:06 p.m. the HRD-I verified no performance reviews were done in 2014, and that the evaluation dates found in the employee files were most likely accurate. HRD stated the expectation is that the performance reviews are done yearly.	F 494	3. The Administrator reviewed the federal requirements and the Standards of the State of Minnesota with the Director of Nursing and the Director of Human Resources regarding the requirement of nursing assistants having an annual evaluation. At the beginning of each month, HR will send out an evaluation form and a list of the CNA anniversary dates for that month. It will be the expectations that the Unit Managers complete the evaluation by the end of that month. 4. An audit will be completed monthly for three (3) months, then quarterly for one year to assure evaluations are completed per the State of Minnesota standard. Theses audits will be presented to the monthly QAPI committee to monitor the system of annual evaluations are being completed.	

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F 494	Continued From page 101 A policy and procedure for performance reviews was not provided.	F 494	5. The Director of Nursing /designee and the Director of Human Resources/ designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015.	
F 495 SS=F	483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure new employees receive appropriate orientation and training prior to providing direct care to residents. This has the potential to affect all 159 residents residing in the facility. Findings include: A review of employee training indicated nursing assistant (NA)-M, NA-AA, and NA-G had not received new employee orientation. The employee list indicated NA-M was hired on 10/26/15, and the schedule indicated she had been providing direct cares. NA-AA was hired on 9/4/15, and the schedule indicated he has been providing direct cares. NA-G was hired on	F 495	1. No residents were affected by the alleged deficient practice. 2. No residents were affected by the alleged deficient practice.	

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F 495	Continued From page 102 10/15/15, and the schedule indicated she had been providing direct cares. NA-T was hired on 10/26/15, and the schedule indicated he had been providing direct cares. During an interview on 11/18/15, at 8:30 a.m. registered nurse (RN)-B verified NA-M, NA-AA,NA-G, and NA-T had not attended new employee orientation and were scheduled to attend 12/9/15. RN-B stated new employees receive some information in their packet from human resources (HR) when they start. RN-B was not sure what information they receive from HR. RN-B verified she had not educated the above NAs regarding abuse prevention, dementia, or resident rights. During an interview on 11/18/15, at 12:06 p.m. the HR director (HRD)-I stated new employees received information regarding payroll, job description, code of conduct, and resident rights, privacy, and related employment information. HRD-I verified NAs do not receive information regarding abuse prevention or dementia. HRD stated the nurse educator does orientation monthly, but they are hiring NAs faster than education/orientation is held. The New Employee Orientation Training indicated Abuse and Neglect, Infection prevention and control, and dementia were to be included in the orientation. A facility policy and procedure for new employee orientation was not provided.	F 495	3. Employees have received the appropriate orientation and training prior to providing direct care to residents... All new staff have received the appropriate orientation prior to be assigned to care for staff. Completed 12-30-2015 4. An audit of personnel files will be conducted one (1) time per week times 12 weeks, then monthly for one year to monitor that all new staff have had the appropriate orientation prior to providing direct care. These audits will be presented to the monthly QAPI committee to review and assure a system of assuring new employees are the appropriate orientation prior to providing direct care. 5. The Director of Staff Development /designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015.	
F 496 SS=F	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING	F 496	1. No residents were affected by the alleged deficient practice.	

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F 496	Continued From page 103 Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility verified current certification/registration of a nursing assistant who provided direct care to residents. This had the potential to affect all 159 residents residing in the facility.	F 496		

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F 496	Continued From page 104 Findings include: The facility provided a list of all nursing assistants working in the facility and who were on the state registry. Nursing assistant (NA)-M was not included on the list provided by the facility that was checked with the registry. A review of the schedules, indicated NA-M began working with residents on 11/28/15, and worked with another NA until 10/31/15. NA-M was on the schedule independently one to two shifts 14 of 19 days between 10/31/15, and 11/18/15. During an interview on 11/18/15, at 7:41 a.m. the director of nursing (DON) stated she was not sure how often the NA registry is checked. During an interview on 11/18/15, at 12:16 p.m. the human resource director (HRD)-I verified NA-M was not on the nursing assistant registry and her certification had lapsed. HRD-I stated NA-M had been working as a nursing assistant in the facility. HRD-I verified a registry check was not done prior to employment for NA-M. During an interview on 11/18/15, at 1:36 p.m. the DON verified she was unaware that NA-M's registration/certification was not current until that morning. DON-F verified NA-M had been working as a nursing assistant in the facility and had not been under direct supervision 100% of the time. During an interview on 11/18/15, at 1:48 p.m. NA-M verified she had been working as a nursing assistant at the facility and had provided cares to residents while working independently and	F 496	2. All residents have the potential to be affected by the practice. 3. NA-M is current with her certification. All nursing assistant certifications have been verified as current. 4. An audit will be conducted each month for three (3) months and then quarterly for one year to monitor that all nursing assistant certifications are current. The results of the audits will be presented to the monthly QAPI committee to assure that no nursing assistant is allowed to provide direct care to a resident without a current certification.	

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F 496	Continued From page 105 unsupervised. The facility was unable to provide a policy and procedure for ensuring staff certification and licensing prior to employment.	F 496	5. The Director of Human resources/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015.	
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff received mandatory annual education and the appropriate hours of education to maintain the nursing assistant certifications. This had the potential to affect all 159 residents residing in the facility. Findings include: During a review of employee training hours for 17 nursing assistants (NA), 7 of the employees had been hired in the past year and had received or were scheduled to receive new employee orientation. The remaining NAs had been employed at the facility for greater than 12 months, and had received the following hours of training since 1/15: * NA-W had received 4.5 hours, including abuse prevention/reporting and general training. No dementia, infection prevention or control, resident rights, privacy training, or other mandatory	F 498	1. No residents were affected by the alleged deficient practice.	

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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 498	Continued From page 106 training was received. * NA-V had received 7.5 hours, including abuse prevention/reporting and general training. No dementia, infection prevention or control, resident rights, or privacy training, or other mandatory training was received. * NA-Z had received 1.0 hours, did not include mandatory training, such as abuse prevention/reporting, dementia, infection prevention or control, resident rights, privacy training, or other mandatory training. * NA-C had received 9.5 hours, including abuse prevention/reporting, infection prevention. No dementia, resident rights, or privacy training, or other mandatory training was received. * NA-R had received 1.5 hours, including abuse prevention and reporting. No dementia, infection prevention or control, resident rights, privacy training, or other mandatory training was received. * NA-Q had received 5.0 hours, did not include mandatory training such as abuse prevention/reporting, dementia, infection prevention or control, resident rights, privacy training, or other mandatory training. * NA-P had received 8.5 hours, including abuse prevention/reporting. No dementia, infection prevention or control, resident rights, privacy training, or other mandatory training was received. * NA-O had received 6.5 hours, including abuse prevention/reporting. No dementia, infection prevention or control, resident rights, privacy training, or other mandatory training was received. * NA-N had received 3.0 hours, did not include mandatory training such as, abuse prevention/reporting, dementia, infection prevention or control, resident rights, privacy	F 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1801 ST LOUIS AVENUE DULUTH, MN 55802

(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 498	Continued From page 107 training, or other mandatory training. * NA-D had received 5.5 hours, including abuse prevention/reporting and infection prevention and control. No dementia, resident rights, privacy training, or other mandatory training was received. During an interview on 11/18/15, at 7:41 a.m. the director of nursing (DON) stated a new electronic training will be starting soon. The DON stated it is hard to expect the staff to attend training when they are at work, so with the electronic training, they will be able to do it at home and will get paid for that. During an interview on 11/18/15, at 8:30 a.m. registered nurse (RN)-B verified the staff listed above had not received 12 hours of mandatory training since at least 1/15. RN-B was unaware of the previous training received. RN-B stated the NAs were to receive 12 hours of training yearly. RN-B was not sure of the mandatory content of the training, but had a list that she was unable to locate. RN-B stated the NAs have been offered over 22 hours of education this year, and had been offered several opportunities throughout the year to obtain their 12 hours. RN-B stated she provided the nurse managers with the status of each employee and their training. RN-B verified that she had not followed up on the status for each employee. RN-B stated vulnerable adult training was offered in March, and the staff completed an educational packet with this information. If the employee missed the training, they had to do the make-up packet. If the employee had done the packet, it would have been included in the hours reported. RN-B stated they are planning to do electronic training and that will be assigned to each staff.	F 498	2. All residents have the potential to be affected by the alleged deficient practice. 3. Nursing assistants have received their 12 hour mandatory training. 4. An audit o will be completed each month for three (3) months then quarterly for one year to assure any nursing assistant requiring their 12 hour of mandatory education in a twelve month period of time will have completed their mandatory training/education.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 498	Continued From page 108 A facility policy for staff education was requested but not provided.	F 498	5. The Director of Staff Development/designee will be responsible with oversight by the Administrator. Completion date of 12-31-2015.	
F 500 SS=C	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the contract with physical therapy, occupational therapy, and speech therapy was current. This had the potential to affect all 159 residents residing in the facility. Findings include: The Therapy Services Agreement for physical therapy, occupational therapy, and speech therapy services dated 7/1/13, was between the	F 500	1. No residents were affected by the alleged deficient practice. 2. All residents may have the potential to be affected by the practice. 3. An updated contract for Therapy was obtained by 12-1-2015 4. All contracts will be reviewed quarterly at the QAPI committee to monitor that contracts remain timely and updated. On going.	

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F 500	Continued From page 109 previous owner of the facility and the therapy provider. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the contract would have to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility. A policy for contract renewals was not provided .	F 500	5. The Administrator/designee will be responsible. Completed 12-31-2015.	
F 502 SS=C	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the contract for laboratory services was current. This had the potential to affect all 159 residents residing in the facility. Findings include: The facility did not have a signed contract for laboratory services. The laboratory provider did submit a letter of agreement dated 12/23/13, for services to be provided for the facility. The letter of agreement was signed by the laboratory provider only, and not by the facility. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the contract would have	F 502	1 .No residents were affected by the alleged deficient practice 2. All residents may have the potential to be affected by the alleged deficient practice. 3. The laboratory contracts have been made current.	

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F 502	Continued From page 110 to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility. A policy for contract renewals was requested and not provided.	F 502	4. The Laboratory contract will be reviewed quarterly in the QAPI committee to monitor the date of the contract. On going. 5. The Administrator/ designee will be responsible. Completion date of 12-31-2015.	
F 508 SS=C	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the contract for radiology services were current. This had the potential to affect all 159 residents residing in the facility. Findings include: The Imaging and Radiology Service Agreement dated 12/2/09, was between a previous owner of the facility and the radiology provider. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the contract would have to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility.	F 508	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Radiology contract has made current. 4. The radiology contract will be reviewed quarterly at the QAPI committee to monitor the date of the contract. On going. 5. The Administrator/designee will be responsible. Completion date of 12-31-2015.	

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F 508	Continued From page 111 A policy for contract renewals was not provided .	F 508		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate medical records were completed for 5 of 5 residents (R15, R38, R61, R76, R109) reviewed for monthly pharmacist reviews. Findings include: R15's quarterly Minimum Data Set (MDS) dated 9/11/15, included diagnoses of diabetes mellitus and dementia. The MDS indicated R15 had been taking insulin, diuretics, antipsychotic and antianxiety medications. R15's had an admission date of 10/15/15, the pharmacy consultant verification of medication review for October 2015, was not filed in R15's	F 514	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the practice. 3. The pharmacy consultant reports will now be individualized and filed in the residents chart. 4. An audit will be completed each month for three (3) months to monitor the pharmacy consultant reports /recommendations have been filed in the resident's chart. These audits will be presented to the monthly QAPI committee for three months. After three months the QAPI committee will make a recommendation as to the need to continue to monitor that the Consultant pharmacy reports are being filed in the residents' chart. 5. The Director of Nursing/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015.	

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F 514	Continued From page 112 chart. R38's admission MDS dated 10/26/15, included diagnoses of diabetes mellitus and dementia. The MDS indicated R38 had been taking insulin and antipsychotic medications. R38 had an admission date of 4/1/13, the pharmacy consultant verification of medication review for January, February, March, April, May, June, July, August, September and October 2015, were not filed in R38's chart. R61's admission MDS dated 10/29/15, included diagnoses of depression. The MDS indicated R61 had been taking an antidepressant medication. R61 had an admission date of 4/11/13, the pharmacy consultant verification of medication review for January, February, March, April, May, June, July, August, September and October 2015, were not filed in R38's chart. R76's quarterly MDS dated 8/13/15, included diagnoses of dementia, anxiety disorder, depression and post traumatic stress disorder. The MDS indicated R76 had been taking antipsychotic medications. R76 had an admission date of 10/15/09, the pharmacy consultant verification of medication review for January, February, March, April, May, June, July, August, September and October 2015, were not filed in R38's chart. R109's quarterly MDS dated 9/14/15, included diagnoses of anxiety disorder, depression, dementia and a psychotic disorder. The MDS indicated R109 had taken antipsychotic,	F 514		

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F 514	Continued From page 113 antianxiety and antidepressant medications. R109 had an admission date of 11/11/14, the pharmacy consultant verification of medication review for January, February, March, April, May, June, July, August, September and October 2015, were not filed in R38's chart. During interview on 11/18/15, at 9:44 a.m. the assistant director of nursing (ADON) stated the pharmacy consultant had started a new process with the October 2015, pharmacy consultant's medication review verification forms. The forms were now individualized by resident and they were kept in the ADON's office in a file, not in an individual resident's medical record. The ADON further stated that the pharmacy consultant's medication review verification forms were previously sent via e-mail and were not filed in the resident's medical record. The ADON verified she had to contact the consultant pharmacist to provide documentation of the medication review's prior to October of 2015. A policy on medical records was requested and not received.	F 514	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the practice. 3. The pharmacy consultant reports will now be individualized and filed in the residents chart. 4. An audit will be completed each month for three (3) months to monitor the pharmacy consultant reports /recommendations have been filed in the resident's chart. These audits will be presented to the monthly QAPI committee for three months. 5. The Director of Nursing/designee will be responsible with oversight from the Administrator. Completion date of 12-31-2015.	
F 519 SS=C	483.75(n) TRANSFER AGREEMENT WITH HOSPITAL In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when	F 519	1. No residents were affected by the alleged practice. 2. All residents have the potential to be affected by the practice.	

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F 519	Continued From page 114 transfer is medically appropriate, as determined by the attending physician; and medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions. The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a transfer agreement with at least one hospital was current. This had the potential to affect all 159 residents residing in the facility. Findings include: The Transfer Agreement between the facility and a hospital dated 5/24/15, was between a previous owner of the facility and hospital provider. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the contract would have to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility.	F 519		

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F 519	Continued From page 115 A policy for contract or agreement renewals was not provided.	F 519	3. The hospital transfer agreement has been updated. These will be reviewed quarterly to monitor compliance. On going. 4. The Administrator /designee will be responsible. Completion date of 12-31-2015.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION 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 Bayshore Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	POC ok 12-22-15 RECEIVED DEC 18 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Don Babbitt	Administrator	12-15-2015

see page 2 for signature

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 Or by email to: Marian.Whitney@state.mn.us or 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 Bayshore Health Center is a 2-story building with a no basement. The original building was constructed in 1969 with an addition in 1978. The original building buildings and additions are all Type II (111) construction, therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 139 beds and had a census of 108 at the time of the survey.	K 000		

Don Barbeau Administrator 12-15-2015

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	1. The soiled utility room door 175A and the 1 Center door were both repaired. 2. The doors were repaired by 12-1-2015. 3. Environmental rounds were initiated on 12-14 2015 to monitor our process for assuring all doors in the Facility function properly. Rounds will be conducted two (2) times per week times 12 weeks to monitor compliance. 4. The results of the documentation will be presented to the monthly QAPI committee for review and recommendations. 5. The Director of Maintenance will be responsible with oversight by the Administrator.	

This STANDARD is not met as evidenced by:
Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in

accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors.

Findings include:

On facility tour between 2:00 PM to 5:00 PM on 11/12/2015, observation revealed, that Soiled Utility rooms 175A and in 1 Center did not

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	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	**1601 ST LOUIS AVENUE DULUTH, MN 55802**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 positively latch into the frame. This deficient condition was verified by the Maintenance Supervisor.	K 029		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 2:00 PM to 5:00 PM on 11/12/2015, it was revealed during the review of the	K 067	1. The smoke and fire damper testing and subsequent documentation was completed on 12-1-2015. 2. The maintenance record/documentation will be presented to the monthly QAPI committee for review. 3. The Director of Maintenance will be responsible with over sight from the Administrator.	

facility's fire and smoke damper test/inspection documentation and interview with the Maintenance Supervisor, that the facility could not provide any documentation for the smoke and fire damper testing at the time of the inspection.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/12/2015**

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BAYSHORE RESIDENCE & REHAB CTR	**1601 ST LOUIS AVENUE DULUTH, MN 55802**

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K 067	Continued From page 4 This deficient condition was verified by the Maintenance Supervisor.	K 067		
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was not limiting storage near electrical devices in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors of the facility. Findings include: On facility tour between 2:00 PM to 5:00 PM on 11/12/2015, observations revealed that in Room 253 the facility failed to limit the use of extension cords. This deficient condition was verified by the Maintenance Supervisor.	K 147	1. The extension cords were removed from room 235 by 12-1-2015. 2. Observation rounds will be conducted two (2) times per week times 12 weeks to monitor the facility follows its policy of restricing the use of extension cords in resident rooms. 3. This documentation will be presented to the monthly QAPI committee for review. 4. The Director of Maintenance will be responsible with oversight by the Administrator.	

K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1	K 154		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/12/2015**

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K 154	Continued From page 5 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 2:00 PM to 5:00 PM on 11/12/2015, during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire sprinkler system out of service policy. This deficient condition was verified by the Maintenance Supervisor.	K 154	1. The Automatic Fire System out of Service Policy or the "Fire Watch" Policy was revised and updated per the regulations by the Director of Maintenance. Completed 12-1-2015. 2. Fire and Life Safety policies will be reviewed at the monthly QAPI committee for three (3) months. 3. The Director of Maintenance will be responsible with oversight by the Administrator.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period,	K 155		

the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/12/2015**

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K 155	Continued From page 6 returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 2:00 PM to 5:00 PM on 11/12/2015, during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire alarm system out of service policy. This deficient condition was verified by the	K 155	1. The Automatic Fire System out of Service policy or "Fire Watch" policy was revised and updated per the regulations by the Director of Maintenance. Completed 12-1-2015 2. Fire and Life Safety policies will be reviewed at the monthly QAPI committee for three (3) months. 3. The Director of Maintenance will be responsible wit oversight by the Administrator.	