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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H2M4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00288

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245405**

2. STATE VENDOR OR MEDICAID NO.
(L2) **924240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HERITAGE LIVING CENTER**
(L4) **619 WEST SIXTH STREET**
(L5) **PARK RAPIDS, MN** (L6) **56470**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/12/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12. Total Facility Beds **64** (L18)

13. Total Certified Beds **64** (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
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 08/14/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/14/2018 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
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
07/31/2018
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245405

August 14, 2018

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, MN 56470

Dear Mr. Hansen:

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.

Effective August 1, 2018 the above facility is recommended for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds located in rooms .

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 14, 2018

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, MN 56470

RE: Project Number S5405029

Dear Mr. Hansen:

On July 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 22, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 1, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 1, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 22, 2018, effective August 1, 2018 and therefore remedies outlined in our letter to you dated July 11, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00288

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(L3) **HERITAGE LIVING CENTER**
(L4) **619 WEST SIXTH STREET**
(L5) **PARK RAPIDS, MN** (L6) **56470**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/22/2018** (L34)

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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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13. Total Certified Beds **64** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date:
Lyla Burkman, Unit Supervisor 07/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/30/2018 (L20)

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

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

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01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

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25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 11, 2018

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, MN 56470

RE: Project Number S5405029

Dear Mr. Hansen:

On June 22, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 electronically attached CMS-2567 whereby corrections are required.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - **your right to request an informal reconsideration to dispute the attached deficiencies.**

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" 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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 1, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 1, 2018 the following remedy will be imposed:

• Civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 22, 2018 (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 December 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING ______ B. WING ______	06/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 18 through June 21, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 18 through June 22, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 554		7/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/18/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING ______ B. WING ______	06/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

(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 554	Continued From page 1 Based on observation, interview and document review, the facility failed to ensure an assessment for safe self-administration of medications was completed for 1 of 1 resident (R36) observed to self-administer medication via nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs). Findings include: R36's 14 day Minimum Data Set (MDS) dated 5/12/18, indicated R36 had no cognitive impairment and diagnoses which included heart failure, pneumonia, chronic obstructive pulmonary disease (COPD) and respiratory failure. R36's Order Summary Report dated 5/3/18, included orders for ipratropium-albuterol solution 0.5-2.5 (3) milligram (mg)/3 milliliters (ml) one vial inhale orally four times a day for bronchospasms. In addition, R36 had another order for ipratropium-albuterol solution one vial every four hours as needed (PRN) for lung congestion. There was no order indicating R36 may self-administer nebulizer treatments. R36's care plan provided on 6/22/18, indicated R36 had shortness of breath (SOB) related to recent pneumonia and received oxygen therapy due to SOB with exertion, coronary artery disease, severe edema and recent pneumonia. The medication administration focus area indicated medications were to be given by nursing staff except R36 may self-administer nebulizer treatments after set-up. R36's Medication Administration Record (MAR) for June 2018, reviewed 6/22/18, indicated R36 had received ipratropium-albuterol solution -.5-2.5	F 554	It is the policy and procedure of HLC to do an assessment for each resident who wishes to self-administer medications to ensure safe administration. 1. Corrective Action: a.) R36 self-administration assessment was completed on 06/22/18. b.) Assessment results were taken to IDT meeting and reviewed on 06/23/18. c.) Care plan updated on 06/23/18. d.) Physician order renewed for the self-administration of nebulizer medication. 2. Correction as it relates to other residents: a.) Chart reviews completed on each resident currently self-administering their own medications to ensure assessment, care plan and physician orders were all up to date. b.) Policy and Procedure shared with nursing staff and IDT. 3. Reoccurrence will be prevented by; a.) Reviewing quarterly at care conference each individual residents desire to self administer medications and ensuring the proper documentation is in place. b.) RN Unit Managers educated on the correct place to chart review with care conference. c.) QA will be done for 90 days and results shared at QAPI meeting to determine if any further action is needed. 4. Plan of Correction will be monitored by: DON, IDT , Unit Managers 5. Date of Correction: 07/19/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING ______ B. WING ______	06/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	**619 WEST SIXTH STREET PARK RAPIDS, MN 56470**

(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 554		F 554		

Continued From page 2
(3) mg/3ml 1 vial inhale orally four times per day for bronchospasms. The MAR indicated R36 may self-administer after nursing set-up. R36 had not received any PRN ipratropium-albuterol solution.

R36's most recent Self-Administration of Medication (SAM) assessment dated 9/19/17, indicated R36 did not wish to self administer medications therefore nursing would administer the medications.

On 6/20/18, at 8:57 a.m. R36 was observed sitting in his recliner, asleep. The nebulizer machine was running and R36 had the nebulizer mask on his face.
-At 9:09 a.m. the administraiton of the nebulizer was complete, however the machine continued to run and the face mask remained on. R36 remained asleep.
-At 9:22 a.m. R36 remained asleep with the mask on his face and the nebulizer machine running.
-At 9:33 a.m. R36 awoke, removed the nebulizer mask and placed oxygen tubing to his nares.

On 6/20/18, at 1:19 p.m. R36 was not in his room. One inch of clear liquid was observed in the nebulizer medication chamber.
-At 1:48 p.m. R36 remained away from room. The liquid remained in the nebulizer medication chamber.
-At 2:02 p.m. R36 was in his room. Nursing assistant (NA)-B, who is also a trained medication aide (TMA), stated R36 was capable of administering his own nebulizer after set-up by nursing and R36 liked to administer them after his meals. NA-B proceeded to enter R36's room and confirmed the liquid in the nebulizer was his noon nebulizer medication which had been set-up but

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

(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 554	Continued From page 3	F 554		

not yet administered. NA-B began the treatment at this time.

On 6/21/18, at 9:37 a.m. R36 was observed seated in the recliner with the nebulizer treatment running and the mask on his face.
-At 9:38 a.m. licensed practical nurse (LPN)-C stated R36 was able to self-administer his nebulizer treatments after set-up by nursing. LPN-C did not know if a SAM assessment had been completed.

On 6/22/18, at 8:24 a.m. registered nurse (RN)-A stated he had only worked at the facility a short time and was not aware R36's SAM assessment dated 9/19/17, which indicated R36 resident did not wish to self administer medications and that nursing would administer them.

On 6/22/18, at 2:30 p.m. the director of nursing (DON) stated it was her expectation for staff to follow the facility's policy and procedure for completing medication SAM assessments. The DON stated R36 had not used the nebulizer prior to the end of April 2018, and thought R36's assessment was missed due to turnover of new staff. The DON indicated she had completed R36's SAM assessment this morning.

The facility's Self Administration of Medications policy and procedure revised 2/20/18, indicated the RN Manager coordinated assessments with the interdisciplinary team (IDT). The IDT assessed the resident's cognitive, physical and visual ability to carry out this responsibility. The facility may require that drugs be administered by the nurse until the IDT had the opportunity to obtain information necessary to complete an assessment and update the care plan. Nursing

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F 554	Continued From page 4 obtained an order from the physician for self-administration of medications. Review of the process of self-administration of medications occurred at the quarterly care conference, and as needed.	F 554		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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:	F 609		8/1/18

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F 609	Continued From page 5 Based on interview and document review, the facility failed to report a burn of unknown origin for 1 of 2 residents (R21) reviewed for injuries of unknown origin. Findings include: R21's admission record dated 6/22/18, indicated R21's diagnoses included dementia with behavioral disturbances, visual loss of left eye, anxiety, and weakness. R21's quarterly Minimum Data Set (MDS) indicated R21 had moderate cognitive impairment, highly impaired vision, and required extensive staff assitance to perform activities of daily living with the exception of eating which R21 required set up help. R21's incident progress note dated 3/9/18, at 12:49 p.m. indicated staff reported R21 had a red open area on his left thigh. The area appeared to be a burn measuring 11 centimeters (cm) by 6.0 cm with three stage II blisters within. The note indicated the physician and family member were notified and the intervention implemented to prevent future burns was to apply lids to R21's coffee cups, and the facility would look into decreasing the temperature of the readily available coffee. R21's incident report dated 3/9/18, at 1:49 p.m. indicated staff had reported R21 had a skin tear, however the area was assessed to be a burn with open areas which appeared to be non-intact blisters and treatment was applied. R21 was not aware of how he acquired the burn or what had happened. Immediate action taken was to put covers to coffee cups and questioning the need to	F 609	It is the policy and procedure of Heritage Living Center to ensure that all alleged violations including abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than two hours after the allegation is made, in the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the event that causes the allegation do not involve abuse and do not result in serious bodily harm, to the administrator of the facility , DON, Social Service and State Agency. 1. Corrective Action as it relates to the R21: a.) Care Plan was updated at time of the incident and staff educated on the need for the R21 to use a cup with a lid for his coffee. b.) Staff involved in the incident were educated on proper procedure. LPN involved did a great job having the area seen by the NP within a few hours and by immediately contacting the family. She was educated on the proper forms to fill out for the investigation and for the need to let Administrator, Social Service and at this time the DON designee of the incident. c.) Vulnerable Adult plan was reviewed with LPN and the procedure for reporting was reviewed with her. d.) The temperature of the coffee pot was turned down at time of incident. 2. Corrective Action as it relates to other residents:	

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F 609	Continued From page 6 decrease the temperature of coffee pots which are accessible to the resident. The report did not identify if the incident was witnessed. The report also did not reflect if temperatures of the coffee had been obtained to ensure safe temperature. The Incident/root cause analysis progress note dated 3/9/18, at 2:09 p.m. authored by registered nurse (RN)-B indicated R21's family and physician had been notified of the incident. The note also indicated R21 had received burns to left front anterior thigh from his coffee which were evaluated by the nurse practioner who determined R21 had second degree burns and prescribed treatment. Nursing was directed to intervene if they observed R21 helping himself to the coffee machine and provide assitance as R21 did not always ask for help. The dietary manager was aware and would be checking the coffee temperature settings. R21's medical record lacked evidence the administrator, social worker, or director of nursing/designee were immediately notified following the identification of the injury. The record also lacked evidence of a report having been made to the State agency. On 6/20/18, at 12:28 p.m. the director of nursing (DON) was asked about the aforementioned incident and she stated she had been on vacation when the incident had occurred, and to her knowledge R21 did not tell anybody about it when it happened. -At 12:33 p.m. the DON and RN-B stated R21 had the tendency to get his own coffee from the machines but they did not even know for sure if the burn was caused from the coffee or not. Both	F 609	a.) Vulnerable Adult policy and procedure updated and new copies placed on each wing. Other incidents and concerns will be brought to IDT to identify and monitor incidents not identified in POC. b.)Resident and family concerns will be reviewed M-F in ITD. Investigation and monitoring will by done by Social Worker to identify needed reporting of incident to proper agency. c.) Education provided on each wing on 06/25/18. On 07/17/18 Policy and Procedure education held for all staff. d.) Coffee pot will be turned off after staff use and staff will get coffee for residents as they request 3. Reoccurrence will be prevented by: a.) Dietary Manager will monitor coffee temperatures and turn off between staff usage. b.) QA results will be taken to QAPI meeting and team will decide if further action is needed. 4. Plan of Correction will be monitored by: Administrator, Dietary Manager, DON 5. Date of Correction: 08/01/18	

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F 609	Continued From page 7	F 609		

stated they were guessing it was a coffee related burn because they could not think of anything else that would have been hot enough to cause a burn. RN-B confirmed she had not reported the incident to the State agency. The DON stated upon her return to work, she had interviewed staff related to the injury, however, did not document the interviews.

-At 12:42 p.m. licensed practical nurse (LPN)-C stated the injury had first been reported to her by an NA who discovered the injury during the provision of a whirlpool bath. The NA described the injury as a skin tear. LPN-C stated she evaluated the area and determined it was consistent with a burn with non-intact blisters. LPN-C stated R21 did not have the injury the night before. LPN-C also stated R21 could not articulate how the injury had occurred and no one had witnessed the incident. LPN-C confirmed she had not interviewed staff as to the cause of the injury rather assumed it was caused from hot coffee due to R21's history of obtaining his own coffee and placing the filled cup along the side of his left leg while wheeling around in his wheelchair. LPN-C stated staff would put lids on the coffee cups, however, R21 would take them off. LPN-C stated she was not aware if temperatures of the coffee were ever obtained in order to ensure safe temperatures.

-At 1:30 p.m. the licensed social worker (LSW) stated LPN-C should have reported the injury to the charge nurse.

On 6/21/18, at 8:18 a.m. the LSW confirmed the injury should have been reported to the State agency and stated it was very much a mistake and an oversight that it was not.

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F 609	Continued From page 8 The facility Ecumen's Abuse Prevention Plan for Minnesota Skilled Nursing Facilities policy dated 11/2017, indicated injuries of unknown source may not need to be reported but must be investigated internally. An injury is considered any injury of unknown source and must be reported when both of the following conditions are present: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and 2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy also indicated incidents, including but not limited to an injury, fall, elopement, bruise or other injury of unknown origin, unusual happening, abuse, or any other maltreatment/mistreatment involving a resident are to be reported, documented, and investigated.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		8/1/18

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F 610	Continued From page 9 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 thoroughly investigate a thigh burn of unknown origin for 1 of 1 resident (R21) who had a thigh burn of unknown etiology which was not investigated. Findings include: R21's admission record dated 6/22/18, indicated R21's diagnoses included dementia with behavioral disturbances, visual loss of left eye, anxiety, and weakness. R21's quarterly Minimum Data Set (MDS) indicated R21 had moderate cognitive impairment, highly impaired vision, and required extensive staff assitance to perform activities of daily living with the exception of eating which R21 required set up help. R21's incident progress note dated 3/9/18, at 12:49 p.m. indicated staff reported R21 had a red open area on his left thigh. The area appeared to be a burn measuring 11 centimeters (cm) by 6.0 cm with three stage II blisters within. The note indicated the physician and family member were notified and the intervention implemented to prevent future burns was to apply lids to R21's coffee cups, and the facility would look into	F 610	It is the policy and procedure of Heritage Living Center to investigate, prevent, and correct alleged allegations of abuse, neglect, exploitation, or mistreatment and report the investigation to the proper State Agency. 1.Corrective Action as it relates to R21: a.) The LPN obtained immediate medical help and contacted the family. She did not feel it was reportable because she felt she knew what happened and that it was an accident. Policy and Procedure reviewed with her. The investigation forms were reviewed with her also. b.) R21 care plan was updated at the time of the incident. c.) Family brought in a cup with a lid to use for coffee. Charge nurse will monitor at each meal to ensure cup with lid is being used. d.) On day of accident Dietary Manager obtained temperature of coffee and contacted company and temperature was decreased. 2. Corrective Action as it relates to other residents: a.) Coffee pot will be turned off after it is used by staff. b.) Vulnerable Adult policy and procedure	

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F 610	Continued From page 10 decreasing the temperature of the readily available coffee. R21's incident report dated 3/9/18, at 1:49 p.m. indicated staff had reported R21 had a skin tear, however the area was assessed to be a burn with open areas which appeared to be non-intact blisters and treatment was applied. R21 was not aware of how he acquired the burn or what had happened. Immediate action taken was to put covers to coffee cups and questioning the need to decrease the temperature of coffee pots which are accessible to the resident. The report did not identify if the incident was witnessed. The report also did not reflect if temperatures of the coffee had been obtained to ensure safe temperature. The Incident/root cause analysis progress note dated 3/9/18, at 2:09 p.m. authored by registered nurse (RN)-B indicated R21's family and physician had been notified of the incident. The note also indicated R21 had received burns to left front anterior thigh from his coffee which were evaluated by the nurse practioner who determined R21 had second degree burns and prescribed treatment. Nursing was directed to intervene if they observed R21 helping himself to the coffee machine and provide assitance as R21 did not always ask for help. The dietary manager was aware and would be checking the coffee temperature settings. R21's medical record lacked evidence of a thorough investigation of the injury. On 6/20/18, at 12:28 p.m. the director of nursing (DON) was asked about the aforementioned incident and she stated she had been on vacation when the incident had occurred, and to her	F 610	reviewed with staff 06/23/18 and 07/17/18. c.) Coffee pot system to utilize air pots for resident areas ordered on 06/19/2018. d.) Education provided to staff 07/24/18 on the proper form and correct procedure to investigate and follow through on injuries of unknown origin. Education was also provided on the need to contact the Administrator, DON, Social Worker within two hours, and the need to have help with the investigation if they are unsure of what needs to be done to keep residents safe. 3. Reoccurrence will be prevented by: a.) Coffee pots in resident areas removed from service until air pots arrive. Will utilize pour over system that is set up in activities area by each service kitchen. These pots are not easily accessed by residents. b.) Staff will notify the Administrator, DON and Social Service of any injuries of unknown origin within two hours if there was actual harm. c.) Forms of any witnesses will be filled out immediately after the incident occurs. 4. Plan of Correction will be monitored by: Administrator, DON, Dietary Manager 5. Date of Correction: 08/01/18	

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F 610	Continued From page 11	F 610		

knowledge R21 did not tell anybody about it when it happened.

-At 12:33 p.m. the DON and RN-B stated R21 had the tendency to get his own coffee from the machines but they did not even know for sure if the burn was caused from the coffee or not. Both stated they were guessing it was a coffee related burn because they could not think of anything else that would have been hot enough to cause a burn. The DON stated upon her return to work, she had interviewed staff related to the injury, however, did not document the interviews.

-At 12:42 p.m. licensed practical nurse (LPN)-C stated the injury had first been reported to her by an NA who discovered the injury during the provision of a whirlpool bath. The NA described the injury as a skin tear. LPN-C stated she evaluated the area and determined it was consistent with a burn with non-intact blisters. LPN-C stated R21 did not have the injury the night before. LPN-C also stated R21 could not articulate how the injury had occurred and no one had witnessed the incident. LPN-C confirmed she had not interviewed staff as to the cause of the injury rather assumed it was caused from hot coffee due to R21's history of obtaining his own coffee and placing the filled cup along the side of his left leg while wheeling around in his wheelchair. LPN-C stated staff would put lids on the coffee cups, however, R21 would take them off. LPN-C stated she was not aware if temperatures of the coffee were ever obtained in order to ensure safe temperatures.

-At 1:30 p.m. the licensed social worker (LSW) stated LPN-C should have reported the injury to the charge nurse.

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F 610	Continued From page 12 On 6/21/18, at 8:18 a.m. the LSW confirmed the injury should have been reported and investigated stated it was very much a mistake and an oversight that it was not. The facility Ecumen's Abuse Prevention Plan for Minnesota Skilled Nursing Facilities policy dated 11/2017, indicated injuries of unknown source may not need to be reported but must be investigated internally. Incidents, including but not limited to an injury, fall, elopement, bruise or other injury of unknown origin, unusual happening, abuse, or any other maltreatment/mistreatment involving a resident are to be reported, documented, and investigated.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		8/1/18

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F 623	Continued From page 13 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623		

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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 623	Continued From page 14 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 623	It is the policy and procedure of Heritage	

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F 623	Continued From page 15 facility failed to notify the Long Term Care (LTC) Ombudsman of a facility initiated transfer for 1 of 1 resident (R61) reviewed for hospitalization. Findings include: R61's entry track record Minimum Data Set (MDS) dated 5/7/18, indicated R61 was admitted to the facility on 5/7/18. R61's Progress Note (PN) dated 5/9/18, at 5:53 a.m. indicated R61 was sent to the emergency room for an evaluation of a fever. A second PN at 1:42 p.m. indicated R61 was discharged to the hospital. Did not hold bed. On 6/21/18, at 1:43 p.m. the licensed social worker (LSW) confirmed R61 was admitted on 5/7/18, and discharged to the hospital on 5/9/18. On 6/22/18, at 9:06 a.m. the LSW indicated the facility had not had any facility initiated transfer/discharges which required notification to the Ombudsman since December. -At 1:26 p.m. the LSW stated she would not notify the ombudsman if the resident or the resident's guardian or family were involved in the decision to transfer to the hospital as she would not consider this a facility initiated transfer. Rather, the LSW stated she would only notify the Ombudsman if the facility alone made the decision to transfer. -At 4:02 p.m. the LSW confirmed the Ombudsman was not notified of R61's transfer to the hospital The Resident Transfer/Discharge Notice policy reviewed 6/22/18, indicated notice would be given to all transfers/discharges including hospital and	F 623	Living Center to notify the resident and/or their representative of the transfer or discharge and the reason for the move in writing. 1. Corrective Action as it pertains to R61: a) When R61 was sent to hospital a bed hold was sent with as resident was not sure if she was going to hold the bed. b.) R61's significant other called HLC and stated the physician was not sure how long R61 would need to be in the hospital so they opted not to hold the bed. c.) HLC failed to get the signed copy back and to send it to the Ombudsman. The information has been FAXED to Ombudsman on 07/13/18. On 07/13/18 letter was sent to R61 regarding the need for return written copy. 2. Corrective Action as it pertains to other residents: a.) Staff education provided on the importance of providing the notice in writing. b.) Policy and Procedure was updates and written in clearer directions on what needed to be done with each transfer or discharge. c.) All transfers, discharges, LOA, from 01/01/18 until 07/13/18 were sent to the Ombudsman. An easier to fill out and FAX form was started. On routine transfers, discharges, LOA's the information will be sent to Ombudsman monthly. If facility initiates a discharge due to non-payment etc. the Ombudsman will be notified immediately. d.) All admits will continue to receive information on transfers, discharge, LOA's in the admission packet.	

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F 623	Continued From page 16 emergency room.	F 623	3. Reoccurrence will be prevented by: a.) Weekly and PRN QA for 90 days. Results will be taken to QAPI meeting to determine if further action is required. 4. Plan of correction will be monitored by: Social Service, Business Office, Unit Mangers and DON. 5. Completion date: 08/01/18	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625		8/1/18

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F 625	Continued From page 17 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide notification to the resident and/or resident representative of the facility's bed hold policy at the time of an emergency transfer for 1 of 1 resident (R61) who was transferred to an acute care facility on an emergency basis. Findings include: R61's entry track record Minimum Data Set (MDS) dated 5/7/18, indicated R61 was admitted to the facility on 5/7/18. R61's Progress Note (PN) dated 5/9/18, at 5:53 a.m. indicated R61 was sent to the emergency room for evaluation of a fever. A second PN at 1:42 p.m. indicated R61 was discharged to the hospital. Did not hold bed. On 6/21/18, at 1:43 p.m. the licensed social worker (LSW) confirmed R61 was admitted on 5/7/18, and discharged to the hospital on 5/9/18. The LSW indicated the facility bed hold policy was reviewed with R61 upon her admission to the facility, however, upon transfer to the hospital, R61 had decided to discharge so she did not think a bed hold had been signed. On 6/22/18, at 4:02 p.m. the LSW confirmed the facility had not provided R61 or R61's representative notice of the facility bed hold policy at the time of the transfer to the hospital. The Notice of Bed-Hold policy dated 3/4/17, indicated staff would provide a bed hold notice to the resident or representative before transferring	F 625	It is the policy and procedure of Heritage Living Center to notify the resident and/or their representative of the transfer or discharge and the reason for the move in writing. 1. Corrective Action as it applies to R61: a.) When R61 was sent to the hospital a bed hold was sent with as resident was not sure if she was going to hold the bed. b.) R61's significant other called HLC and stated the physician was not sure how long R61 would need to be in the hospital so they opted not to hold the bed. He spoke to the DON who passed this information on to the Social Worker. c.) HLC failed to get the signed copy back and to send the information on to the Ombudsman. This information was FAXED to the Ombudsman 07/13/18. 3. Corrective Action as it relates to other residents: a.) Staff educating on the importance of receiving the signed copy of the bed hold back for our records. b.) Policy and Procedure was updated and written in clearer directions for staff to follow on transfers, discharges, LOA's. c.) Information from all transfers, discharges, and LOA's from 01/01/18 until 07/13/18 were sent to the Ombudsman. An easier form to fill out and FAX was started. On routine transfers, discharges, LOA's the information will be sent to the Ombudsman monthly. If the facility initiates a discharge due to non-payment etc. the Ombudsman will be notified	

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F 625	Continued From page 18 a resident to hospital or allowing a resident to go on therapeutic leave.	F 625	immediately. d.) All admits will continue to receive bed hold information on admission. 3. Reoccurrence will be prevented by: a.) Weekly and PRN QA for 90 days. Results will be taken to the QAPI meeting to see if any further action is needed. 4. Plan of Correction will be monitored by: Social Worker, Unit Managers, Business Office, DON. 5. Completion Date: 08/01/18.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a significant change in status Minimum Data Set assessment when two or more areas of change in a resident status were noted for 1 of 1 resident (R3) reviewed for activities of daily living (ADL) and had a MDS coded decline in abilities. Findings include:	F 637	It is the policy and procedure of Heritage Living Center within 14 days after the facility determines that there has been a significant change in the resident's physical or mental condition a comprehensive assessment shall be completed. 1. Correction for R3: a.) MDS Coordinator failed to pick up on	8/1/18

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R3's Admission Record provided on 6/22/18, indicated R3's diagnoses included anoxic brain damage, epilepsy, and muscle weakness.

R3's annual Minimum Data Set (MDS) dated 12/22/17, indicated R3 had severe cognitive impairment and required extensive assist of 2+ persons for bed mobility, transfers and toileting, extensive assist of one person for locomotion on/off unit, dressing, eating and personal hygiene. The MDS also indicated R3 had frequent incontinence of bowel.

R3's quarterly MDS dated 3/20/18, indicated R3 was totally dependent of 2+ staff for transfer, was totally dependent on one staff for locomotion on/off unit, required extensive assist of 2+ staff for transfers, dressing, personal hygiene, and extensive assist of one staff for eating. The MDS indicated R3 was always incontinent of bowel and diet was changed to mechanically altered diet.

Review of the above assessments revealed a decline in the functional status of activities of daily living related to transfers, locomotion on/off unit, dressing, bowel incontinence, personal hygiene, and diet change. However, R3's medical record lacked evidence regarding the identification of the decline as coded by the MDS and any status change notification or care conference notes.

The registered nurse assigned to complete R3's MDS's was not available for interview.

On 6/22/18, at 2:40 p.m. the director of nursing (DON) stated R3's MDS did not meet the criteria for a significant change rather she felt R3's MDS was coded incorrectly. The DON stated she

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the need for a significant change in status MDS. On 06/15/18 MDS Coordinator reviewed the chart and did complete a Comprehensive Assessment after Significant change decline.
b.) Education provided to MDS nurses on what triggers a change in status MDS.
c.) Resident continues to decline and hospice referral was obtained 07/09/18.
2. Correction as it applies to other residents:
a.) Guidelines in MDS manual will be followed to determine when there is a change in condition MDS assessment needed.
3. Reoccurrence will be prevented by:
a.) Discussing decline or improvement of resident's physical or mental condition Monday through Friday at IDT stand up. MDS will follow up when staff note a change.
b.) QA will be done on all MDSs completed in the next 90 days to ensure that change in status is not missed. Results will be taken to QAPI meeting to determine if any further action will be needed.
4. Plan of Correction will be monitored by: IDT, MDS Coordinators, Unit Managers, and DON.
5. Date of Correction: 08/01/18

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F 637	Continued From page 20 expected the staff who completed the MDSs to follow the CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3 Manual to determine/identify a significant change. The CMS's RAI Version 3.0 Manual pages 2-21 through 2-28 indicated 03. Significant Change in Status Assessment (SCSA). Assessment Management Requirements and Tips for Significant Change in Status Assessments: A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident current status to the most recent comprehensive assessment and any subsequent quarterly assessments, and the resident's condition is not expected to return to baseline within two weeks. Guidelines for Determining a Significant Change in Resident Status: The final decision what constitutes a significant change in status must be based upon the judgment of the IDT (interdisciplinary team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within two weeks. However, staff must note these transient changes in the resident status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. Some Guidelines to Assist in Deciding If a Change is Significant or Not: Decline in two or more of the following: Any decline in an ADL physical functioning area where	F 637		

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F 637	Continued From page 21 a resident is newly coded as extensive assistance, total dependence, or activity did not occur; Resident incontinence pattern changes or there was placement of an indwelling catheter.	F 637		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure physician parameters for the administration of pain medication were followed for 2 of 2 residents (R19, R13) who received pain medication outside of the prescribed parameters for use. In addition, the facility failed to monitor bruising for 1 of 1 resident (R5) observed with generalized upper extremity bruising and received anticoagulant therapy. Lastly, the facility failed to provide edema management for 2 of 2 residents (R5, R9) observed with edema which was not monitored; Findings include: R19's quarterly Minimum Data Set (MDS) dated 4/13/18, indicated R19 had moderate cognitive impairment and diagnoses which included weakness, pain in right shoulder, and pain in right upper arm. The MDS also indicated R19	F 684	It is the policy of Heritage Living Center to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 1. Corrective Action as it refers to R19: a.) Education was provided to staff about the need to follow physician guidelines for medication passes. b.) On 07/12/18 medications discussed with NP. Six medications were discontinued including the Tramadol and Tylenol 650 mg. Resident was started on Tylenol XS 500 mg two tablets tid for pain. Staff to ask her every time medication is given re: type and severity of pain symptoms. 1. Corrective Action for R13: a.) Resident was admitted to CHI hospital	8/1/18

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received as needed (PRN) pain medication for occasional pain.

R19's Order Summary Report signed 5/16/18, included the following orders:

--tramadol HCl 50 milligrams (mg) give 50 mg by mouth every 6 hours as needed for severe pain (8-10/10). The order start date was 12/3/17.
--acetaminophen give 650 mg every 4 hours as needed for pain/fever per standing house orders. Do not exceed 4 grams/24 hours. The order start date was 10/21/17.

R19's care plan provided 6/22/18, indicated R19 had a potential for pain/discomfort related to a history of knee pain, restless leg syndrome and had an impaired ability to report pain/discomfort related to Alzheimer's dementia and cognitive and communication impairment. The care plan directed staff to administer pain medications and/or interventions per orders or R19's suggestions. The care plan also directed staff to anticipate the need for pain relief and respond immediately to any complaint of pain or non-verbal indicators, monitor for probable cause of pain episodes, remove/limit causes where possible, monitor/record/report to nurse complaints of pain or requests for pain treatment, and to observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease range of motion, withdrawal or resistance to care.

R19's consultant pharmacist review dated 12/18/17, included a note to nursing which indicated Tramadol PRN order specified to use for pain >8. Per MAR [medication administration record] 12/2017, it was administered

F 684

07/09/18 for weakness, COPD and CHF. On hospital return her orders for Tylenol read: Tylenol 650 mg four times a day. The PRN order was not continued nor was the perimeters for giving the Tylenol. The resident would become upset if she rated her pain less than a 2 and the nurses tried to hold her Tylenol. Resident is alert and oriented and is able to make her own decisions.
1. Corrective Action as it relates to R5:
a.) On 07/18/18 bruising with anticoagulant therapy monitoring was put in place through PCC for nurse to check off on TAR when resident is on an anticoagulant. The nurse will do an incident report- injury of known/unknown cause for every bruise found and investigate origin of bruise and come up with interventions in our ITD meeting.
b.) Monitoring will be done every shift while resident is on anti-coagulant and policy and procedure will be followed for any noted bruising. (Skin assessment weekly until area is healed.)
c.)On 07/18/19 an order for monitoring when on a diuretic/dx of CHF was added to the TAR (through PCC) for daily charting for edema and monitoring of weights.
1. Corrective Action for R 9:
a.) Monitoring added to TAR (through PCC) on 07/18/18. This will be a monitor for edema, CHF, weights, and diuretic usage.
2. Correction as it relates to other residents:
a.) Staff education provided on the importance of following medication

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inappropriately on 12/10/2017, & 12/12/2017.

Review of R19's MARs dated 12/1/2017-12/31/2017, 2/1/18-2/28/18, 3/1/18-3/31/18, 5/1/18-5/31/18, and 6/1/18-6/30/18, revealed PRN tramadol administration for pain rated less than 8/10 a total of 9 times:

December 2017: 12/10/17 and 12/12/17 - for pain rated 7
February 2018: 2/3/18 and 2/20/18 - for pain rated 7
March 2018: 3/24/18 and 3/30/18 - for pain rated 6
May 2018: 5/1/18 - for pain rated 6, and 5/26/18 - for pain rated 7
June 2018: 6/17/18 - for pain rated 7

On 6/19/18, at 7:15 p.m. R19 was observed seated in a wheelchair in the dining room/common area at a music activity. R19 was attentive to the music. No non-verbal indicators of pain were observed.

On 6/20/18, at 8:37 a.m. R19 was observed seated on the edge of her bed, wearing pajamas. R19 was awake and alert with no non-verbal indicators of pain observed.

On 6/21/18, at 2:14 p.m. R19 was observed seated in a wheelchair, wheeling about in her room. No non-verbal indicators of pain were observed.

On 6/22/18, at 9:55 a.m. nursing assistant (NA)-E stated R19 did have some pain in her knees/lower extremities at times. NA-E stated R19 would sometimes go for a walk to relieve the

perimeters and the importance of reviewing with physician if it is the resident's choice not to follow the recommended perimeters. This education will be held more that once 07/18/18 through 07/24/18.
b.) Monitoring for anticoagulant therapy and for CHF/Diuretic use will be added to all residents on these type of medications by 07/26/18. Monitoring will be done every shift while resident remains on medication. The same procedure will be followed for all residents receiving these types of medication.
3. Reoccurrence will be prevented by:
a.)A weekly QA will be done for three months. Results will be taken to QAPI committee to see if further action is needed.
b.) Pharmacist will continue to do monthly reviews and will be asked to pay close attention to medication orders with perimeters.
c.) Medication review will be done for all residents who have medication orders with perimeters by 08/01/18.
4. Plan of Correction will be monitored by: Charge Nurses, Unit Managers, Pharmacist, DON.
5. Date of Correction: 08/01/18.

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pain as interventions such as hot/cold packs or pain relieving creams had not worked for her. NA-E indicated R19 received pain medication when needed so the staff would notify the nurse if R19 was having pain.

--At 10:30 a.m. licensed practical nurse (LPN)-A verified R19 was capable of rating her pain on a 1-10 scale. LPN-A could not identify what she would do if R19 rated her pain lower than 8. LPN-A stated she wouldn't turn away anyone who was having pain but did not know for sure what she would do. LPN-A confirmed R19 had a standing order for Tylenol and indicated it could also be given for pain.

--At 11:43 a.m. registered nurse (RN)-B stated she would expect the pain level, location of pain and the determination of the medication parameters be assessed prior to the administration of PRN pain medication. RN-B confirmed R19 was capable of rating her pain most of the time and if she could not, the nursing staff could have used an alternate pain scale to rate R19's pain. RN-B verified R19's order for tramadol was for pain rated 8-10/10 and indicated if R19 experienced pain that was not severe she would recommend using the standing order for Tylenol. RN-B stated she would have expected the physician's order be followed and the tramadol should not given for pain rated less than 8.

--At 2:54 p.m. the director of nursing (DON) stated she would expect resident medications be given per physician orders.
R13's significant change MDS dated 4/9/18, indicated R13 did not have cognitive impairment and had received scheduled and PRN pain

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medication.

R13's Admission Record provided on 6/22/18, indicated R13 had diagnoses which included chronic pain syndrome, low back pain, pain in right hip, unspecified osteoarthritis, pain in left shoulder, pain in right shoulder, and fibromyalgia.

R13's Order Summary Report provided on 6/22/18, included the following orders:

-acetaminophen 325 milligram (mg) give 2 tablets by mouth four times a day related to chronic pain syndrome. HOLD SCHEDULED DOSE if pain is 2 or less on 0/10 scale. The order start date was 4/25/18.
-acetaminophen 325mg give 2 tablets by mouth as needed (PRN) for pain only one time during noc (night) shift. PER RESIDENT REQUEST, if she falls asleep after asking for medication, DO NOT wake hr up. The order start date was 4/25/18.

R13's care plan provided 6/22/18, indicated R13 had chronic pain related to chronic pain syndrome (abdominal, back, bilateral shoulders), diabetic neuropathy, neuralgia, chronic osteoarthritis, fibromyalgia with daily and prn analgesic use. The care plan directed staff to:
-administer analgesia as per orders and give 1/2 hour before treatments or care as needed.
-anticipate R13's need for pain relief and respond immediately to any complaint of pain
-evaluate the effectiveness of pain interventions with medication doses
-identify and record previous pain history and management of that pain and impact on function
-monitor/record/report any signs/symptoms of non-verbal pain

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-notify physician if interventions are unsuccessful or if current complaint is a significant change from past.
-observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decease range of motion, withdrawal or resistance to care

R13's consultant pharmacy review dated 6/18/18, included a note to nursing which indicated Tylenol order had hold parameters for a pain level less than 2. However, it appeared Tylenol was being administered regardless of resident's pain level. Please make sure Tylenol is being held if resident's pain level is less than two.

Review of R13's MAR dated May (1-31) 2018, revealed:

-scheduled Tylenol (acetaminophen) was administered on 35 occasions when pain was rated 2 or less
-prn Tylenol (acetaminophen) was administered on one occasion when pain was rated 2 or less

Review of R13's MAR dated June (1-22) 2018, revealed:

-scheduled Tylenol (acetaminophen) was administered on 20 occasions when pain was rated 2 or less

On 6/20/18, at 8:29 a.m. R13 was observed in hallway telling NA-A "no walk today." R13 stated she was upset having to wait 45 minutes for pain medications.

On 6/22/18, at 1:24 p.m. trained medicaiton aide/NA-B was asked how to assess a resident

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who was asking for pain medication in which NA-B stated she asked the resident to rate their pain on a 1-10 scale (10 being worst pain), looked at their specific orders and when they had their last pain medication. NA-B confirmed R13 was capable of rating her pain and stated if R13 rated her pain at a 2 or less she would administer the medication anyway.

On 6/22/18, at 8:22 a.m. registered nurse (RN)-A stated he was unaware that Tylenol was being administered to R13 when pain was rated at 2 or less. RN-A confirmed, by looking at electronic MAR that this had occurred on several occasions in May and June 2018. RN-A stated he would expect the medication nurses to be following the physician orders regarding the parameters for administering medications. RN-A indicated he would expect staff to report to him any concerns regarding R13 rating pain low so he could communicate with R13's prescriber.

On 6/22/18, at 2:30 p.m. the DON stated the expectation would be for the medication nurse to follow the physician's order to hold the medicaiton if the pain rating was below 2.

The undated PRN Medication Clarification Policy and Procedure indicated it was the goal of the facility to safely use PRN medication to provide the most effective dose for each resident. The policy directed if a dose range was ordered by a physician, the nursing staff would stay within the range ordered by the physician. The policy also directed if a patient rated their pain low but was having non-verbal symptoms of pain, a call would be made to the physician to go outside the dose range ordered.
R5's Admission Record dated 6/22/18, indicated

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R5's diagnoses included diabetes type, anemia, chronic kidney disease stage 3, heart failure, atrial fibrillation, and long term use of anticoagulants (blood thinner medication).

R5's quarterly MDS dated 3/22/18, indicated R8 had moderate cognitive impairment, required extensive assist of two staff members for bed mobility, transfers, and toileting. The MDS also indicated R5 was on anticoagulant medication.

R5's physician orders dated 6/22/18, included:
-Aspirin 81 milligrams (MG) every morning
-Coumadin (blood thinner) 2.5 mg once a day every Sunday, Tuesday, Wednesday, Thursday, and Saturday related to Atrial fibrillation.
-Coumadin 5 mg once a day every Monday and Friday.

R5's care plan dated 6/22/18, indicated R5 was on anticoagulation therapy related to atrial flutter and the identified goal was for R5 to be free from discomfort or adverse reactions related to the anticoagulant use. The care plan directed staff to monitor for side effects and effectiveness every shift (12/20/17), and to monitor/document/report as needed adverse reactions of anticoagulant therapy which included bruising (12/20/17).

R5's Skin Assessments reviewed from 5/24/18, to 6/22/18, did not reflect identification nor monitoring of bruises.

R5's progress notes were reviewed from 5/24/18, to 6/22/18, which lacked evidence of monitoring for bruising or identification of the bruises on R5's arms.

On 6/18/18, at 8:51 a.m. R5 was observed in his

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room, seated in a recliner. R5's forearms were noted to have multiple bruises in various stages of healing which ranged from dime size to half dollar size. The right hand over and between the 3rd and 4th finger had fading bruises that were light bluish/purplish in color. R5 stated he was not sure how he was getting all of the bruises and that he had probably bumped into something. R5 stated he had bruises on his arms all of the time, sometimes worse than others.

6/19/18, at 4:09 p.m. R5 arms continued to show multiple bruises in various stages of healing.

On 6/20/18, at 10:00 a.m. LPN-C confirmed R5's multiple areas of bruising on his arm and stated R5 was on anticoagulant medication, had leukemia, anemia, and received periodic blood transfusions. LPN-C verified R5's bruises were not documented, monitored, and/or assessed/evaluated.

On 6/22/18, at 8:20 a.m. NA-M stated R5 frequently had bruises on his arms and he did not wear protective sleeves. NA-M stated staff were to report the bruises to the nurse.

On 6/22/18 at 10:45 a.m. RN-B stated staff should be monitoring R5 for signs and symptoms of bleeding related to him receiving blood thinning medication. RN-B stated the nursing assistants should have been alerting the nurses of bruises or if they noticed an increase in bruising. RN-B further stated the nurses should be looking for signs and symptoms of bleeding, monitoring and also documenting on bruises.

On 6/22/18, at 2:06 p.m. the DON stated the expectation was for nursing staff to monitor for

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side effects of anticoagulation therapy such as increased bleeding/bruises and identify/monitor/document bruises per facility policy.

Facility policy Skin Care/Pressure Ulcer Care dated 5/2011 indicated routine skin care was provided to promote healing and prevent complications. Skin problems are identified and treatments instituted promptly. Skin care was documented and included in the residents care plan. A registered nurse overseen each resident's skin care in accordance with the comprehensive assessment and care plan.

Facility policy related to the monitoring of side effects for anticoagulation therapy was requested and not received.

R5's Admission Record dated 6/22/18, included diagnoses of diabetes, venous insufficiency, localized edema, chronic kidney disease stage 3, heart failure, and atrial fibrillation.

R5's quarterly MDS dated 3/22/18, indicated R8 had moderate cognitive impairment, required extensive assist of two staff members for bed mobility, transfers, and toileting. The MDS also indicated R5 was on diuretic medication.

R5's Urinary Incontinence CAA dated 12/27/17, indicated R5 had a diagnosis of chronic renal disease stage 3, received two diuretic medications for 3+ edema and had a history of venous stasis ulcers.

R5's diuretic care plan related to venous stasis, lower extremity edema, and CHF dated 3/17/18, indicated R5 was to maintain weight within

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baseline. The care plan directed to elevate lower extremities as tolerated to assist in decreasing edema (1/4/18), and ted stockings on in the morning off at bedtime (1/4/18). R5's congestive heart failure care plan dated 3/17/18, directed staff to monitor/document/report as needed signs of CHF such as dependent edema of legs and feet, periorbital edema, weight gain unrelated to calorie intake (1/4/18). The care plan directed weight monitoring as ordered (1/4/18).

R5's physician order dated 6/22/18, included:

-Bumetanide 2.0 milligrams (mg) in the morning for edema (2/9/18)
-Elevate legs every shift for edema (12/18/17)
-weight daily call if there is a 4 lb (pound) weight gain one time a day for edema (1/5/18)
-Ted hose (compression stockings) on in the morning and off at night every day shift for edema, may use ace wraps until teds come (start date 1/3/18)

R5's medical record lacked evidence of documentation of edema for signs and symptoms of CHF as directed by the care plan.

R5's weights were reviewed from 5/1/18-5/31/18:

5/3/2018 2:35 p.m. 289.8 Lbs Mechanical Lift
5/4/2018 2:13 p.m. 293.8 Lbs Mechanical Lift
5/5/2018 1:44 p.m. 298.3 Lbs Wheelchair
5/21/2018 1:53 p.m. 278.8 Lbs Mechanical Lift
5/22/2018 2:10 p.m. 286.4 Lbs Wheelchair
R5's weights reflected a 4.0 lb. weight gain from 5/3 to 5/4, a 4.0 lb weight gain from 5/4/ to 5/5, and a 7.6 lb gain 5/21-5/22. The R5's record lacked evidence of physician notification and assessment of the weight gain.

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On 6/18/18, at 9:04 a.m. R5 was observed seated in the recliner with feet elevated. R5 was not wearing compression socks and both extremities were edematous from the feet to just below the knee. The right extremity was more edematous than the left. R5 stated he was supposed to have the socks on and he thought there was more swelling in his right leg today. R5 indicated the edema sometimes caused discomfort.

-At 4:09 p.m. R5 was observed seated in his wheelchair with yellow gripper socks on without compression socks on as ordered. Both extremities continued to have edema.

On 6/20/18, at 9:17 a.m. R5 was observed seated in his recliner with feet elevated and black black compression socks on. Both extremities remained edematous.
-at 10:00 a.m. LPN-C stated edema monitoring was not in place and/or documented on, however, R5's weights were monitored but was not sure who was assessing the weights related to fluid overload/edema.

On 6/22/18, at 8:20 a.m. R5 was observed seated in he recliner with feet elevated and yellow gripper socks on without compression socks. Both extremities remained edematous.

On 6/22/18, at 10:45 a.m. RN-C verified the physician order for notification of weight gain and stated it did not appear the physician was notified of the weight gain or if a re-weight was obtained. RN-C confirmed there was no documentation or assessments of R13's edema monitoring and should have been. RN-C stated the physician was at the facility weekly, however, R13's record did

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not reflect the monitoring by the physician on a weekly basis. In addition, RN-C verified R13's compression stockings should have been applied as directed.

On 6/22/18, at 2:06 p.m. the DON stated it was her expectation for nursing staff to manage and monitor edema per the care plan, physician's orders, and per facility policy.

R9's Admission Record dated 6/22/18, indicated R9's diagnoses included a history of congestive heart failure (CHF), cardiomegaly (enlarged heart), localized edema, hypokalemia, chronic obstructive pulmonary disease, shortness of breath, and tachycardia.

R9's quarterly MDS dated 3/12/18, indicated R9 had no cognitive impairment, had CHF, was independent with activities of daily living, had bilateral lower extremity functional range of motion impairment, and was on a diuretic medication.

R9's physician orders included an order for Lasix (diuretic medication) 40 milligrams (mg) every morning for CHF (start date 6/24/17) and Spironolactone (diuretic medication) 25 mg every morning for CHF (start date 6/24/17).

R9's care plan viewed on 6/18/18, directed staff to apply ace wraps to both legs in the morning and remove them at bedtime with a start date of 9/27/17. The care plan provided by the facility on 6/22/18, reflected a revision in which the directive to apply ace wraps was removed.

R9's care plan for diuretic therapy (Lasix and Spironolactone) related to edema and CHF

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indicated the diuretic care plan was not developed until 6/18/18, even though R9 had been prescribed diuretic medications since 6/24/17. The diuretic care plan directed staff of the following:

-Administer diuretic medications as ordered by the physician. Monitor for side effects and effectiveness every shift (start date 6/18/18)
-Many other medications may interact with antihypertensive to potentiate their effect. Monitor for interactions/adverse consequences (start date 6/18/18).
-Monitor/document/report as needed adverse reactions to diuretic therapy: dizziness, postural hypotension, fatigue, and an increased risk for falls (start date 6/18/18).
-Pertinent lab results to MD (medical doctor) (start date 6/18/18).

R9's nutrition care plan on 3/9/18, indicated R9 had the potential for a nutritional problem related to edema, and left 25% or more of food uneaten at most meals. R9's nutrition goal indicated R9 would maintain adequate nutritional status as evidenced by maintaining weight within 5% of 138 pounds (lbs). The care plan goal weight was revised on 6/19/18, that reflected R9 would maintain weight within 146.5 lbs.

R9's weight change note dated 6/15/18, indicated R9 triggered for significant weight gain for the past six months. Her weight range for the quarter had been 135.6 to 145 pounds which was highest weight for the quarter. Does receive two diuretic medications. However, R9's medical record lacked evidence of a comprehensive assessment of the significant weight gain. R9's care plan goal weight was increased from 5% of 138.0 lbs to

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146.5 lbs on 6/19/18.

R9's weight record reflected a steady increase in weight since 5/28/18;
5/28/18- 140 lbs.
5/20/18- 141.5 lbs.
6/1/18-142.6 lbs.
6/4/18-141 lbs.
6/6/18-142.1 lbs.
6/11/18-142.1 lbs.
6/15/18-145.0 lbs.
6/18/18-146 lbs.

R9's record lacked evidence of edema monitoring or symptoms of fluid overload/or dehydration related to the diuretic therapy and/or evidence of monitoring and evaluating the diuretic effectiveness.

On 6/18/18, at 9:00 a.m. R9 was observed seated in the recliner with feet elevated with white socks on. Both lower extremities were edematous.

On 6/19/18, at 2:20 p.m. bilateral lower extremity edema was noted. R9 had on ankle socks which left an indent where the top part of the sock had been. The indentation of the skin did not rebound after five second and before R9 let the sock go back in place. R9 stated her legs had started swelling up sometime last week. R9 further stated she was supposed to be wearing ace wraps which helped control the swelling but could not remember when the last time she had them on. R9 stated she had an unexpected and unintended weight gain over the last month or so and was trying to watch what she ate in order to lose the weight she had gained.

On 6/20/18, at 8:36 a.m. LPN-C observed R9's

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F 684	Continued From page 36 legs and stated her legs looked terrible, were very swollen and the doctor would be notified. LPN-C stated she would get the order for ace wraps restarted. R9 told LPN-C she wasn't sure when her legs became so puffy and that they had just blown up the other day. LPN-C stated there was no system in place to monitor, measure, or document edema. LPN-C stated R9 must have had developed the edema recently. LPN-C verified R9's weights were obtained every three days, however did not know if someone was evaluating the weights for fluid overload/dehydration or not. LPN-C stated R9's weights fluctuated between 3-4 lbs. and she drank a lot of the flavored water but was not on a fluid restriction. LPN-C stated she would notify R9's physician if there was a 4 lb. increase over the course of a day or even a week. LPN-C stated the nursing assistants were to report weight changes to the nurse. On 6/22/18, at 8:17 a.m. R9 was observed seated in the recliner with her feet in the dependent (down) position. R9's was wearing ankle socks and both legs continued to be edematous. On 6/22/18, at 10:16 a.m. when asked, RN-B was unaware R9 had significant edema and confirmed the ace-wraps had been discontinued a couple of months ago due to something about the wraps and the way R9's shoes fit when she had them on. RN-B stated R9 did not have parameters for physician notification pertaining to weight gain, and typically weight parameters were to notify the physician after a 3-5 lbs. weight increase within a week. RN-B indicated nursing and dietary were currently monitoring weights and verified there was no evaluation of the recent weight gain.	F 684		

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F 684	Continued From page 37 On 6/22/18, at 2:06 p.m. the DON stated the nursing staff were expected to follow facility policies and procedures related to edema monitoring and fluid management. Facility provided Edema Management Handout 2015, and Georgetown University Patient Handout Drugs Used to Treat Hypertension did not identify the facility's system on how they identified, monitored, assessed, documented and/or managed edema.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement prescribed repositioning/offloading, pressure ulcer treatment interventions and document resident refusals to reposition/offload for 1 of 1 resident (R5) who had active pressure related ulcer and specific physician orders for positioning/offloading, treatments and documentation in order to	F 686	It is the policy and procedure of HLC to provide necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. 1. Corrective Action: a.) Staff directly responsible for R5's	8/1/18

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promote healing.

Findings include:

R5's Admission Record printed on 6/22/18, indicated R5's diagnoses included a stage 3 (Full thickness tissue loss, subcutaneous fat may be visible, may include undermining and tunneling) sacral pressure ulcer dated 1/2/18, diabetes, chronic kidney disease, anemia, heart failure, urinary incontinence, and morbid obesity.

R5's admission Minimum Data Set (MDS) dated 12/25/17, indicated R5 was admitted to the facility with one stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) pressure ulcer and one unstageable (not stageable due to coverage of wound bed by slough and/or eschar) pressure ulcer which measured 3.0 centimeters (cm) x 2.5 cm with no depth.

R5's Pressure Ulcer Care Area Assessment (CAA) dated 12/27/17, indicated R5 had generalized weakness, did not like to lie down due to shortness of breath when lying flat, preferred to sleep in a recliner chair so staff assisted R5 with off loading (pressure relief) from side to side while in the chair. Staff had been encouraging R5 to lie in his bed for period of time so he could be positioned off the coccyx/buttocks. The CAA further indicated R5 was admitted with two pressure ulcers. The Pain CAA dated 12/27/17, indicated R5 utilized a RoHo (pressure redistribution) cushion in the wheelchair and recliner. R5 was offloaded frequently and encouraged to lie in bed for periods of time with the head of the bed elevated due to shortness of breath when lying flat.

F 686

care were educated on the need to follow the care plan.
b.) A turn and reposition sign off was initiated for R5 on 06/27/18. Will ask staff to use for two weeks and then will go back to POC documentation.
c.) LPN and CNA involved were educated on the need to respond in a timely manner when R5's dressing is not in place or he refuses to turn and reposition.
d.) Staff educated on the need to ask R5 to off load and not just assume he is going to refuse. RN Unit Manager will review risk vs benefit with the resident as needed at those times when he does refuse.
e.) Staff will continue to monitor R5 skin issues and review as needed with physician.
2. Corrective Action as it relates to other residents:
a.) Education given to all nursing staff on the importance of following the care plan, offering toileting and repositioning to each resident in accordance with their individual plan of care.
b.) Random QAs will be done weekly for three months on other residents needing to be turned and repositioned. These results will be taken to QAPI meeting to determine if further action is required.
3. Reoccurrence will be prevented by:
a.) Charge nurse will do every shift QA for three months to ensure plan of care is being followed.
b.) Results to be taken to QAPI meeting to determine if further action is needed.
4. Plan of Correction will be monitored by:

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F 686	Continued From page 39 R5's quarterly MDS dated 3/22/18, indicated R8 had moderate cognitive impairment, required extensive assist of two staff for bed mobility, transfers, and toileting. The MDS also indicated R5 was frequently incontinent of urine and occasionally incontinent of bowel. The MDS indicated R5 was at risk for pressure ulcers, had a current stage 2 pressure ulcer which started on 12/18/17, and had a stage 3 pressure ulcer which measured 3.0 cm x 1.0 cm x 0.5 cm. The MDS indicated R5 utilized a pressure reducing device in the chair and bed, was on a turning and repositioning program, and received pressure ulcer care. R5's care plan dated 3/17/18, indicated R5 had skin breakdown issues related to diminished circulation and directed the following: -requires one to two staff for extensive to total assist with bed mobility and offloading. -Air mattress on bed. Needs encouragement to lay in bed for side to side turning and repositioning. -able to bear weight for only short periods of time. One to two staff to transfer with mechanical standing lift when alert, use full body mechanical lift when weak/not alert. -Needs frequent reminders and encouragement to change position and off load. Prefers to sit in recliner chair but will lie in bed, positioned on side with pillow with the head of bed elevated at times but needs much encouragement to do so. -Off load every hour while in the recliner/wheelchair and as needed and turn and reposition every two hours as needed when lying in bed. Notify the nurse if help needed and if not completed. When awake offer toileting and use	F 686	CNAs, Charge Nurses, Unit Managers and DON. 5. Date of Correction: 07/19/8	

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standing lift to offload for one minute. Use Ruco cushion in recliner and wheelchair.
-Offload buttocks 1-2 hours three times a day with lying in bed.
-inspect skin every two hours with repositioning. Observe for redness, open areas, scratched, cuts bruising and report changes to the nurse.

-Actual skin impairment related to pressure ulcers coccyx, and pressure ulcers to right and left buttock, history of venous statis ulcers to lower extremities related to shearing, and moisture associated skin damage. The care plan directed the following:

-educate R5 of causative factors and measure to prevent skin injury
-R5 chooses to sleep in recliner verses bed and often declined repositioning and offloading. Risk/benefits discussed with R5 who declined to signed the waiver.
-Keep skin clean and dry.
-Medicate as ordered for ulcer related pain.
-monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms to infections, maceration etc. to physician.
-Provide repositioning and off loading per self care plan of care.
-Provide treatment as ordered for skin.

On 6/19/18, at 1:11 p.m. R5 stated he had a pressure ulcer but didn't think there was a dressing on the wound. R5 stated the wound was newer and did not have it before coming to the facility. When asked how often he was repositioned, R5 stated he spent a lot of time sitting in the chair and the nursing assistant (NA) would periodically get him out of the chair with the

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F 686	Continued From page 41 standing lift. R5 stated he was not aware of any frequency he was supposed to get out of the chair, but stated sometimes he laid down in the bed with the head elevated but because of his breathing, he was not able to tolerate it all the time. On 6/20/18, at 7:47 a.m. the director of nursing (DON) stated R5 was admitted with something on his coccyx that looked like it was going to open up and the doctors really did not know what it was. The DON stated when R5 was first admitted to the facility, he had multiple medical issues and would only sleep in his wheelchair. -at 9:17 a.m. R5 was observed in his room, seated in the recliner. NA-N entered R5's room with the standing lift and proceeded to transfer R5 from the recliner, into the bathroom, and positioned R5 over the toilet. NA-N removed R5's incontinent brief which was noted to be wet with urine and had a smear of stool with a small amount of drainage from the sacral/coccyx wound. There was no dressing in place over the wound, nor was the dressing observed in the incontinent brief. NA-N proceeded to lower R5 onto the toilet and left the room. -At 9:26 a.m. NA-N returned to the room and stated she had just reported to the nurse that R5 did not have a dressing in place over his sacral wound. NA-N confirmed R5 was to be repositioned every one hour when he was up in the chair and often refused to lay in bed, and to be repositioned. NA-N stated if R5 refused repositioning/offloading, staff were were to report it to the nurse. -At 9:35 a.m. NA-N confirmed she had provided morning cares to R5 and assisted him up between 6:30-7:00 a.m.. NA-A stated at that time,	F 686		

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F 686	Continued From page 42 R5 did not have a wound dressing in place and wasn't sure if the nurse was notified or not. -At 9:39 a.m. NA-N and licensed practical nurse (LPN)-C were observed to transfer R5 from the toilet and onto the bed in a side lying position. R5 was agreeable without encouragement from nursing staff. The sacral/coccyx wound noted to be clean with no slough or maceration around the wound periphery. LPN-C proceeded to provide R5's wound care per the physician's orders. R5 remained in the bed positioned on his left side with the head of the bed elevated. -At 11:37 a.m. LPN-C stated she had not been made aware R5's wound dressing was off until NA-N told her just prior to replacing the dressing. LPN-C stated R5 had a whirlpool last night and was not sure if the dressing was re-applied at that time or not. LPN-C verified the NAs were expected to alert the nurses if a wound dressings was off or in need of replacement. On 6/21/18, during a continuous observation from 8:27 a.m. until 11:04 a.m. the following was observed: -At 8:27 a.m. R5 was seated in the recliner with his feet elevated. -At 9:05 a.m. R5 remained seated in the recliner. An unidentified staff member delivered a water cup to R5's room and did not offer or encourage R5 to reposition/offload. -At 9:34 a.m. R5 remained seated in the recliner when nursing assistant (NA)-L entered R5's room and obtained R5's vital signs. NA-L did not offer or encourage R5 to to reposition/offload. -At 9:40 a.m. registered nurse (RN)-D entered the room and completed a pain assessment interview. RN-D did not offer or encourage R5 to reposition/offload. -At 10:21 a.m. R5 remained seated in the	F 686		

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recliner. At this time, NA-M stated she had assisted R5 to toilet at 6:20 a.m. and had no idea if R5 had been assisted to the bathroom or repositioned since then. NA-M stated R5 would notify the staff when he wanted to use the bathroom. NA-M stated she thought R5 was to be repositioned every hour but often declined and would often times decline to lay down in bed.
-At 10:56 a.m. NA-L stated she had last assisted R5 to the bathroom at 7:30 a.m. and was not aware of when the last time R5 was repositioned. NA-L referenced the Kardex (aide care guide) and verified R5's toileting was late and should have been done every two hours. NA-L stated the Kardex only identified every two hour repositioning therefore she was not aware of R5's physician order to reposition R5 every hour. NA-L stated she would assist R5 into the bathroom at this time. (three hours and 26 minutes without reposition assistance offered of provided to R5)
-At 11:43 a.m. LPN-C stated R5 should have been repositioned and/or offered to reposition every hour if he was seated in the recliner and if he refused, the NAs are to inform the nurse. LPN-C verified she had not been notified of any refusals of repositioning/offloading made by R5.

R5's Skin Assessment were reviewed and revealed the following:

-4/5/18, indicated right buttock pressure ulcer measured 0.5 cm circular and less than 0.1 cm in depth (stage 2). This same site comes and goes. The rectal pressure ulcer measured approximately 3.0 cm x 1.0 cm x 0.5 cm depth. No odor, scant drainage. Overall impression of the wounds was "unchanged."

-4/10/18, indicated pressure ulcer are above the

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F 686	Continued From page 44 rectum measured 3.0 cm x 1.5 cm x 0.75 cm with 25% yellow slough, peri-skin had blanchable redness. Right buttock has 0.5 cm circular area and less than 0.1 cm in depth stage 11 ulcer which comes and goes. Skin Issues and Analysis indicated R5 spent much of his day in the recliner and staff encouraged him much to lay in bed, offload/turn and reposition. treatments as ordered. Analysis also reflected no change in interventions. Overall impression of the ulcer was "worsening." -4/26/18: ulcer measured 3.5 cm x 1.0 cm x 0.70 cm with no slough and peri wound skin moist with blanchable dark redness. Staff report R5 does not want to lay down or offload and remind him of the risk and benefits. The Analysis indicated no change in interventions. Overall impression of the ulcer "unchanged." -5/3/18: both buttocks skin intact. Rectal pressure ulcer measured 3.7 cm x 1.0 cm x 0.7 cm with no slough and peri skin moist with blanchable redness. R5 spent most of day in the recliner, staff encourage him to lay in bed/offload/turn and reposition with not much success. Staff remind R5 of the risk and benefits. No change in interventions. Overall impression "unchanged." -5/10/18: Both buttocks skin intact. Rectal pressure ulcer measured 4.5 cm x 1.0 cm at the widest part and is approximately 0.3 cm at narrowest part with 0.70 cm depth. Overall impression "unchanged." -5/17/18: Buttocks remain intact. Rectal ulcer measured 4.5 c, x 1.2 cm x 0.50 cm depth with no slough, peri skin blanchable dark redness with Mepilex treatment as ordered. No changed to	F 686		

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interventions. Overall impression was "unchanged."

5/24/18: Buttocks remain intact with blanchable redness. Rectal ulcer measured 4.5 cm x 1.2 cm x 0.5 cm. Overall impression, "unchanged."

-5/31/18: Buttocks intact with blanchable redness. Rectal ulcer measured 4.0 cm x 2.0 cm x 0.7 cm with 80% slough and no odor, nearby skin is moist with blanchable dark redness. Overall impression of the ulcer "worsening." No change in interventions identified.

-6/1/18: Buttocks intact with blanchable redness. A right posterior upper thigh open area was noted which measured 6.0 cm x 1.0 cm x less than 0.1 cm in which the rounding nurse practitioner indicated the wound was related to skin shearing. Mepilex applied to area. The rectal ulcer measured 4.0 cm x 2.0 cm x 0.70 cm with noted minimal slough, wound red in color, peri skin blanchable dark redness. Received new orders to use Algicell twice per week and Mepilex. Overall impression of the ulcer "unchanged."

-6/7/18: Both buttocks intact with blanchable redness. The right thigh measured the same as the skin assessment dated 6/1/18. Rectal ulcer measured 3.7 cm x 2.0 cm x 0.8 cm. no slough, peri wound skin moist with blanchable redness. Orders changed back to Mepilex. Skin issues reflected the same as previous. Overall impression "unchanged."

-6/15/18: ulcer measured 3.8 cm x 2.0 cm x 0.8 cm with no slough. Orders changed back to Mepilex and Aquacel. R5 received a blood transfusion and continued to receive iron

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injections. Overall impression of the ulcer was "unchanged."
-6/15/18: Both buttocks intact with blanchable redness. The right posterior thigh ulcer measured 2.0 cm x 0.5 cm x less than 0.1 cm and treated with Mepilex and was noted to be improving. Rectal pressure ulcer measured approximately 3.8 cm x 2.0 cm at widest part of wound an approximately 0.2 cm at narrowest width x 0.8 cm depth at deepest depth of wound. No slough, wound bed red, no odor, no drainage. Nearby skin/peri wound is moist with blanchable dark redness. Orders changed back to Mepilex dressing and Aquacel.

The Skin Issue Notes section of each of the aforementioned assessment indicated R5 spent most of his day in the recliner, staff encouraged him much to lay in bed, offload/turn and reposition with not much success. Staff report R5 does not want to lay down or offload and remind R5 of the risk and benefits of not complying. Treatments provided as ordered. R5 was seen by the wound specialist as ordered/scheduled and as daughter approved. Rounding nurse practitioner overseeing wounds at facility. The Licensed Nurse Analysis section indicated R5 utilized an air mattress on bed, Roho in recliner and wheelchair, treatments as ordered, offload buttocks 1-2 hours three times a day with lying in his bed in addition to offloading every hour when in the wheelchair or recliner. Nursing gives much encouragement for offloading and for lying in bed.

R5's Progress Notes (PN) were reviewed from 4/1/18, to 6/22/18, which lacked evidence of ongoing documentation related to R5 refusing prescribed interventions for wound healing as directed by the physician order. Even though the

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weekly skin assessments reflected R5's refusals to repositiong/offloading, the PNs lacked documentation of the occurrences and declinations as they occurred. The PNs also lacked evidence that R5's daughter had been contacted with each occurrence, as directed, in order to offer additional encouragement to R5 to adhere to the interventions.

R5's physician orders dated 6/22/18, included the following orders:

-12/27/17: "PT to offload buttocks 1-2 hours three times a day with lying in his bed three times a day AFTER MEALS"
-12/28/17: Offload R5 every hour while in recliner/wheelchair and turn and reposition every two hours when lying in bed. Chart in progress notes declines in offloading/repositioning. During night use pillows on one side and change to other side every hour (alternate sides). When awake offer toileting and use standing lift to offload for one minute. When in bed turn side to side. Use Ruco cushion in both wheelchair and recliner for skin integrity.
-3/1/18: [power of attorney (POA)] wants to be called if R5 does not offload or declines whirlpools or cares. "She would like a call ANYTIME throughout the day, even during the NOCs [nightshift] every shift. Chart in progress note if POA needed to be updated.
-3/1/18: Need to review/risk benefit form/waiver with R5 each time R5 is non-adherent/declines to be offloaded, turned and repositioned, have brief changed when soiled or treatments, and document in a progress note.
-3/13/18: Lidocaine Gel 2% apply to coccyx wound topically as needed for pain with dressing change.

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F 686 Continued From page 48 F 686

-6/8/18: Aquacel-Ag Extra Hydrofiber Pad 2 (Silver-carboxymethylcellulose) placed into sacral wound every three days. Place Mepilex border over dressing every three days and as needed.

On 6/22/18, at 10:50 a.m. RN-B stated if R5 was seated in his recliner, he should be offloaded every hour by standing him up with the standing lift for at least one minute, and if R5 was in bed, he was supposed to be repositioned every two hours. RN-B further stated if R5 declined, the NAs were to report the refusals to the nurse and also review the risk/benefits of declining with R5. RN-B also stated R5's POA was supposed to notified of the refusals as well. RN-B stated the nurses were to then document the refusals/declines as directed by the physician's orders. RN-B stated they had been trying very hard to heal R5's wound by putting all of the interventions in place which included R5's individualized offloading/repositioning schedule. RN-B stated not implementing the interventions, could have accounted for the impaired healing rate of the ulcer. RN-B further indicated that offloading/repositioning and pressure relieving devices were very important interventions in order to assist in the healing of a pressure ulcer and to aid in preventing the worsening of the ulcer. RN-B verified R5's care plan and Kardex did not match and proceeded to revise R5's Kardex to reflect the care plan and physician orders.

-At 2:06 p.m. the DON stated it was the expectation of nursing staff to follow R5's care plan as well as facility policy and procedures.

The Facility Skin Care/Pressure Ulcer Care policy dated 5/2013, indicated routine skin care was provided to promote healing and prevent

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F 686	Continued From page 49 complications. Skin problems are identified and treatment was instituted promptly. -Expected Outcomes included: Residents with impaired skin integrity receive treatment according to standard protocol. Skin care was provided in accordance with physicians orders. -Procedures included: -staff provided skin care according to standard protocol, -skin care was documented and included in the resident's care plan, -staff received education on skin care and the standard protocol to assure accurate documentation and timely interventions for skin care problems. The General Wound and Skin Care Guidelines included: -turning/repositioning schedules to prevent skin breakdown and/or promote healing of skin ulcers. -educate residents on weight shifting in bed/chair and other interventions to prevent skin breakdown.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		8/1/18

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F 688	Continued From page 50 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative nursing services to maintain the lower extremity strength in order to maintain the ability to transfer with a standing mechanical lift for 1 of 1 resident (R3) reviewed for transferring. In addition, the facility failed to provide range of motion (ROM) restorative nursing services in order to maintain and/or prevent the further decline in ROM abilities for 2 of 2 residents (R51, R4) who had limitations in ROM and had not received ROM services according to their individualized assessed need. Findings include: R3's Admission Record provided on 6/22/18, indicated R3 had diagnoses which included anoxic brain damage, epilepsy, and muscle weakness. R3's annual Minimum Data Set (MDS) dated 12/22/17, indicated R3 had severe cognitive impairment, was nonambulatory, required extensive assist of 2+ staff for bed mobility, transfers and toileting, and extensive assist of one staff member for locomotion on/off unit, dressing, eating and personal hygiene. The MDS also indicated R3 had functional limitation in ROM of her upper extremity on one side and bilateral lower extremities impairment.	F 688	It is the policy of Heritage Living Center to ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's condition demonstrates that a reduction in range of motion is unavoidable; and a resident with limited range of motion and/or with limited mobility receives appropriate services, equipment and assistance to maintain or improve their ability. 1. Correction as it applies to R3, R51 and R4: a.) Restorative aides were taken off the Master schedule and will not be pulled for other duties. b.) Education provided to scheduler, Charge Nurses and Unit Managers that Restorative aides are not to be pulled. Staff that are off duty shall be called to see if they are interested in picking up the shift when there are call ins. c.) If there is no one that wants to pick up the shift floor staff will be mandated as per their union contracts. d.) Restorative aides will follow restorative programs and provide the care ordered. (R3 has been seen the 6th-16th of July per restorative aide). R4 did not have orders for Restorative nursing- will obtain a PT evaluation to obtain	

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F 688 Continued From page 51

R3's quarterly MDS dated 3/20/18, indicated R3 was totally dependent of 2+ staff for transfers, was totally dependent on one staff for locomotion on/off unit, required extensive assist of 2+ staff for dressing, personal hygiene, and extensive assist of one staff for eating.

R3's Urinary Incontinent Care Area Assessment (CAA) dated 1/3/18, indicated R3 utilized a PAL (mechanical standing lift) for transfers with assist of one staff or gait belt and two assist when toileting. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA was not triggered for further assessment.

R3's Physician Order's Summary Report signed 4/24/18, revealed an order dated 1/28/16, for restorative nursing program 3-6 times per week passive range of motion (PROM) to all extremities. Another order dated 6/7/16, directed restorative nursing program 3-6 times a week with added standing activities.

R3's care plan provided 6/22/18, indicated R3 had limited physical mobility related to anoxic brain injury, was unable to ambulate, and required extensive to total assistance of one to two staff for transfers. Staff may use the PAL lift with one to two staff when needed or the full body mechanical lift (Hoyer) with two staff when needed. Staff were directed to monitor/document and report any signs/symptoms of immobility such as contractures forming or worsening, thrombus formation, skin breakdown, and fall related injuries. The care plan also indicated R3 had activities of daily living self care performance limitations related to musculoskeletal impairment, limited mobility, disease process encephalopathy and diagnosis of rotator cuff strain. The care plan

F 688 (Provider's plan of correction)

recommendations for his program. R51 is receiving treatment approximately two times a week and is refusing at other times. Restorative aides are encouraged to continue to ask her if she wants treatment.
e.) A new RN was put in place to over see the program. If cares are not completed as ordered Restorative Aides giving him a list each day and why they were unable to complete treatment. There is also a back up RN who will be assisting to ensure all restorative cares are completed.
2. Corrective Action as it applies to other residents:
a.) DON went through each individual resident's restorative recommendations to make sure they were current. Folder for RN Restorative Supervisor and one for Restorative Aides that contains all the needed information was provided to both groups.
b.) Education provided to the scheduler, charge nurses and Unit Managers on the importance of not pulling the Restorative Aides. Aides were also told to say they were NOT to be pulled if it was suggested.
c.) An RN was put in charge to over see the program with a second RN as back up to ensure cares are provided as needed.
3. Reoccurrence will be prevented by:
a.) QA will be done weekly for 90 days and results will be taken to QAPI committee to ensure the POC is working.
b.) The RN's in charge of the Restorative Program are checking in with Restorative Aides on a daily basis on what cares were completed, who refused and why, and any concerns they may have about completing

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F 688	Continued From page 52 directed staff to provide RNP 3-6 times weekly to all extremities, and refer to R3's RNP plan of care. R3's Restorative Nursing Program Restorative Goal Setting and Plan dated 1/26/15, revealed R3 was to be provided the following lower extremity physical therapy (PT) recommendations: -PROM - All extremities 3-6 times per week -bilateral hip flexion/extension, hip abduction, internal rotation, external rotation, knee flexion/extension, ankle plantar flexion/dorsal flexion -all x10-15 repetitions -to prevent contractures On 6/20/18, at 8:00 a.m. R3 was observed in her room, seated in recliner. -At 9:53 a.m. R3 had been continuously observed to remain in her room, seated in the recliner. At this time, nursing assistant (NA)-A stated she was a restorative aid and confirmed the therapists had set up the residents' individualized restorative programs. NA-A stated which residents she provided restorative services each day depended on if she was pulled to work on the floor or not. NA-A stated the majority of time she was pulled from providing restorative services in order to work the floor therefore she was unable to provide the services. NA-A stated the residents' restorative programs took a backseat to the day to day resident care needs. NA-A stated there were two full time staff assigned to provide restorative nursing and it had been months since the other restorative aid had been able to work restorative regularly. NA-A stated the restorative nursing documentation was in the computer system and when the documentation indicated	F 688	each resident's plan of care. They are also completing weekly documentation if the program is not working and changes need to be made and monthly documentation if the program is working. This will continue on an on going basis. 4. Plan of Correction will be monitored by: Restorative Aides, RN's that were placed to over see the programs, and the DON. 5. Date of Correction: 09/01/18.	

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F 688	Continued From page 53	F 688		

"not applicable," it probably meant those were the days they were not able to complete the restorative programs, as directed. NA-A provided R3's Restorative Nursing program form dated 1/26/15, which outlined the details of R3's program. NA-A verified 1/26/15, was the correct date of the development and implementation of R3's current program and confirmed R3's program had not been revised since that time.
-At 11:03 a.m. R3 was continuously observed to remain in her room, seated in the recliner. At this time, NA-A and NA-D assisted R3 from the recliner to the wheelchair via a Hoyer lift. NA-A and NA-D stated the Hoyer lift was now utilized because R3 could no longer stand on her legs to assist with transfers like she used to. Neither NA could recall how long it had been since R3 was able to stand.

On 6/21/18, at 2:26 p.m. NA-O stated the restorative aids were pulled to work on the floor all the time therefore the residents' restorative programs were not getting done. NA-O stated it was a huge problem. NA-A stated she had noticed R3's joints were stiffer and she was more resistive to cares since she had not been getting her restorative services/exercises. NA-O stated R3 used to be able to use a PAL lift for transfers but for the past two months has required the use of a full body mechanical lift because the PAL was too dangerous as she felt R3 would slide right out of the PAL lift because she could no longer stand up to assist with the use of the PAL. NA-A stated R3's transfers out of the wheelchair and into bed were the worst so her transferring need was changed to direct the use of the Hoyer at all times. NA-O stated R3 was not able to stand anymore at all.

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F 688	Continued From page 54 R3's Documentation Survey Report v2 dated Jan-18 through Jun-18 identified the R3's Restorative (PT) program was to include AROM (active range of motion) 3-6 times/wk with a goal for R3 to be able to maintain ability to participate in standing transfers. Sit to stand at vertical bars min-mod assist standing 3-5 minutes complete x4-5 reps. The report revealed R3 received restorative services as follows: -January 2018: not applicable (NA) documented x29 days -February 2018: NA documented x 23 days. Four days were blank and R3 had participated once. -March 2018: NA was documented x23 days. Eight days were blank. -April 2018: NA was documented 27 times, three days were blank and R3 had participated once. -May 2018: NA was documented 17 times, 13 days were blank and R3 had participated once. -June 2018: NA was documented 13 times, 8 days were blank. R3's Documentation Survey Report v2 dated Jan-18 through Jun-18 also revealed R3 required increased total staff assistance for transferring and was currently transferred via a Hoyer lift. R3's most recent restorative nursing program progress note titled "RNP Charting" dated 5/24/17, indicated R3 was on PROM and AROM restorative programs. The goal was for R3 to be free of contractures and to be able to participate daily with standing transfers. Restorative nursing assistant's report indicated resident was tolerating program well and continued with no contractures at this time. Staff report resident does participate in standing transfers and with mechanical lift transfers. Resident will continue on current	F 688		

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programs/exercise/goals.

No other progress notes or recent physical therapy notes were provided by facility, as requested.

On 6/22/18, at 2:40 p.m. the director of nursing (DON) stated she was not aware the restorative nursing program was not being provided as directed and was unaware the restorative aids were being pulled to work on the floor instead of providing the service. The DON stated the RN who previously worked on R3's unit had informed her that all cares and services which included restorative programs had been provided on R3's unit. The DON stated she had not looked at the restorative documentation for completion of the program. When asked if a decline in function was to be expected for a resident if restorative nursing was not provided, the DON declined to answer.
R51's quarterly MDS dated 5/25/18, indicated R51 was cognitively intact and had diagnoses which included arthritis, muscle weakness, lymphedema, and pain in lower leg and left shoulder. The MDS also indicated R51 required extensive assistance of 1-2 staff for most activities of daily living and had functional limitation in ROM of her upper extremity with impairment on one side and of her lower extremities with impairment on both sides.

R51's Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA dated 12/1/17, indicated R51 had self care deficits with ADLs related to peripheral vascular disease with severe lymphedema of lower extremities, generalized osteoarthritis with associated pain, muscle weakness, impaired coordination, bilateral ankle/plantar flexion contractures (a

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F 688	Continued From page 56 condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and impaired ROM to right shoulder. The CAA indicated R51 received a restorative nursing program (RNP) 3-6 times per week for ROM. R51's Order Summary Report dated 6/5/18, included orders for RNP 3-6 times per week for exercises with a start date of 1/17/15, and RNP 3-6 times per week for lower extremity exercises with a start date of 2/19/14. R51's care plan provided 6/21/18, indicated R51 had limited physical mobility related to weakness, lymphedema, bilateral ankle/plantar flexion contractures, history of pain and discomfort in legs and required extensive assistance with transfers and bed mobility. The care plan goal was R51 would remain free of complications related to immobility, including contractures, thrombus formation, skin breakdown, and fall related injury. The care plan directed R51 required RNP 3 to 6 times a week and referred to RNP care plan. On 6/20/18, at 8:12 a.m. R51 stated she received therapy when she was first admitted to the facility however, now receives exercises with the NAs. R51 stated the NAs provided the exercises as often as they could but sometimes they did not have the time to do it as they had quite a few people to assist. R51 stated she could do pretty much all of the exercises by herself except the exercises for her feet. --At 8:22 a.m. NA-F and NA-D stated the restorative aides were responsible for completing the residents' restorative nursing programs, however, the restorative aides were also pulled to	F 688		

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work the floor if help was needed to complete resident cares therefore the programs were not provided.

--At 9:53 a.m. NA-A confirmed she was a restorative aid and verified the therapists had set up the residents' individual restorative programs. NA-A stated the residents she worked with each day depended on if she was pulled to work on the floor or not. NA-A stated she was frequently pulled from restorative services to work the floor and the majority of the time she worked on the floor instead of providing restorative nursing. NA-A stated she was not able to get all the rehab services done due to the care needs on the floor and indicated the restorative programs took a backseat to the day to day cares. NA-A stated there were supposed to be two staff assigned to provide restorative nursing full time, however, it had been months since the other restorative aid had been able to work restorative regularly. NA-A stated the restorative nursing documentation was in the computer system and stated the documentation which indicated "not applicable" probably meant those were the days they were not able to provide the restorative services.

On 6/21/18, at 9:25 a.m. NA-A provided R51's restorative nursing program.

The current Restorative Nursing Program Restorative Goal Setting and Plan dated 11/20/17, indicated the following occupational therapy (OT) recommendations:

1. Complete table slider 2# x 20 in (2) motions - straight forward and circles for ROM needed for self care and prevention of contractures 3-6 times/week

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F 688	Continued From page 58 2. Complete wand exercises x 10 reps shoulder flexion, protraction/retraction, abduction x 20 reps for ROM needed for self cares 3 to 6 times/week 3. Complete 6-pack hand exercises for hand ROM needed for self care 3 to 6 times per week The current Restorative Nursing Program Restorative Goal Setting and Plan dated 4/14/15, indicated the following physical therapy (PT) recommendations: --seated lower extremity exercises, seated hamstring stretching 20 seconds 3 times bilaterally to prevent further contractures 3 to 6 times/week. The Documentation Survey Report v2 dated Jan-18 through Jun-18 revealed the following: Restorative (PT): Active ROM 3-6 times/wk: Goal: Resident will be free of further contractures to ankles and knees by next review date. Approach: Seated lower extremity exercises-seated hamstring stretching 20 sec. 3 x bilaterally. Restorative Nursing Program (OT) ROM 3-6 times/week (5/13/14) Goal: Resident will be able to maintain to participate in self cares by washing hands/face and place arms in shirt after set up on a daily basis through next review date. Approach: Resident to complete RTB [resistance therapy band] x 20 BUE [bilateral upper extremities] (10/22/14) Approach: PROM to ankles/feet/knees with passive stretch at end range and ROM to knees/ankles 3-6 times/weeks (10/14/14)	F 688		

F 688 Continued From page 59 F 688

--January 2018: participated x 2, not available x 1, not applicable (NA) x 28
--February 2018: participated x 2, not available x 2, NA x 24
--March 2018: participated x 6, not available x 3, blank x 1, NA x 21
--April 2018: participated x 1, not available x 2, NA x 27
--May 2018: participated x 0, resident refused x 1, blank x 1, NA x 29
--June 2018: participated x 3, not available x 1, blank x 1, NA x 14

On 6/21/18, at 11:07 a.m. NA-A was observed to assist R51 with her restorative nursing program. NA-A first assisted R51 to complete ROM exercises with her fingers, wrists and arms and then complete table slides. R51 stated she did some exercises on her own for her upper extremities and had completed some that morning. R51 then completed exercises using a wand approximately 3 feet long including bar raises and abduction/adduction exercises with side to side movement of her arms holding the wand in front of her. R51 tolerated the upper extremity exercises well with only cueing provide by NA-A. NA-A removed R51's lap blanket and assisted with lower extremity exercises which included knee raises, PROM of R51's feet and heel cord stretches. R51's feet and ankles were observed to be swollen and noted to be contracted inward with the toes pointing downward. R51 was observed to only have slight movement in both feet/ankles with PROM exercises. R51 and NA-A stated they thought R51's feet hadn't gotten any worse. NA-A then provided cues for R51 to complete lower extremity abduction exercises. R51 tolerated the exercise program well without any complaints of

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pain.

On 6/22/18, at 10:55 a.m. RN-A confirmed the restorative aides had been pulled to work the medication cart or provide resident cares on the floor, at times. R51's restorative nursing participation was reviewed with RN-A who confirmed the report as listed above and verified R51 had not received ROM services as directed by the therapists' recommendations.

--At 3:01 p.m. the DON stated she expected restorative services to be provided as directed.

R4's Admission Record dated 6/22/18, indicated R4's diagnoses included hemiplegia following a stroke, end stage renal disease, diabetes, low back pain, and osteoarthritis.

R4's annual MDS dated 3/23/18, indicated R4 had intact cognition, required extensive to total staff assist with activities of daily living, and had one sided functional limitation in ROM.

R4's care plan provided 6/20/18, indicated a goal to maintain current level of ROM by daily ROM exercises, as tolerated. The care plan also indicated R4 was unable to ambulate, had arthritis of the knees and right shoulder and left hemiparesis due to a stroke. The plan directed staff to provide daily ROM, both active and passive, as tolerated. Provide gentle ROM as tolerated with daily care. In addition, occupational therapy and physical therapy consult may be indicated. Staff were to monitor/document/report to the physician as needed for any signs or symptoms of complications related to arthritis such as joint pain, joint stiffness, usually worse on wakening, swelling, decline in mobility, decline in

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self care ability, contracture formation/joint shape changes, crepitus (creaking or clicking with joint movement), pain after exercise or weight bearing. Staff to encourage to practice good general health practices for adequate exercise.

R4's care conference notes dated 4/5/18, indicated R4 participated in a RNP/ROM to prevent contractures. Restorative nurses aide provided PROM to the left lower extremity and AROM to right lower extremities, as resident allowed. R4 indicated she wished to have this program continued.

Reviewed Hubbard County Heritage Living Center for monitoring documentation survey report v2 revealed the following Restorative Intervention/Task to be completed:

Intervention/Task: Restorative ROM:
Frequency 3-6x/wk (PT) .
Goal: R4 will be free from contractures through review date.
Approach: PROM Left lower extremity all motions x 15 reps, AROM right lower extremity x 15 reps

Approach:
1. Left upper extremity all planes, all joints 7x/week
2. Complete on right only 30 reps, 3# BB ex in curls, PNF, supination/pronation chest press, wrist extension/flexion shoulder flexion 3-6x/week
3. Complete GTB ex in shoulder extension, pronation, retraction, shoulder flexion, abduction, curls, 3-6x/wk

The January 2018: report revealed 22 blank days, 6 "NA" and 3 "No", resident refused
February 2018: 19 blank days, 5 "NA" and, 4 "No"

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F 688	Continued From page 62 March 2018: 18 blank days, 11 "NA" and, 2 "No" April 2018: 15 blank days, 14 "NA", and 1 "No" May 2018: 8 blank days, 10 "NA", and 1 "No" and 2 resident refused - "RR" June 1 - June 21, 2018: 18 blank days, 10 "NA", 3 "No". A second line revealed 20 "X" and one "No" On 6/18/18, at 12:45 p.m. R4 stated he had not received ROM services and would like to. On 6/22/18, 10:30 a.m. NA-Q stated stated the restorative aids provided ROM services. On 6/22/18, at 2:49 p.m. RN-B stated no ROM was offered to the residents today due to a staff call in and another staff member was pulled to the work the floor. The Restorative Services Goal and Objectives policy indicated rehabilitative goals and objectives were developed for each resident and were outlined in his/her plan of care relative to therapy services.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)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 689	It is the policy of Heritage Living Center to	8/1/18

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F 689	Continued From page 63 review, the facility failed to provide adequate supervision and implement interventions for 1 of 1 resident (R21) who independently accessed the facility's automatic coffee dispensers. In addition, the facility failed to ensure a smoking apron was utilized as directed for 1 of 1 resident (R4) reviewed for smoking. Findings include: R21's Admission Record dated 6/22/18, indicated R21's diagnoses included dementia with behavioral disturbance, visual loss of the left eye, anxiety disorder, and weakness. R21's quarterly Minimum Data Set (MDS), indicated R21 had moderate cognitive impairment, highly impaired vision, and required extensive assistance from staff to perform activities of daily living with the exception of eating which was set-up help. R21's incident progress note dated 3/9/18, at 12:49 p.m. indicated staff reported R21 had a red open area on his left thigh. The area appeared to be a burn measuring 11 centimeters (cm) by 6.0 cm with three stage II blisters within. The note indicated the physician and family member were notified and the intervention implemented to prevent future burns was to apply lids to R21's coffee cups, and the facility would look into decreasing the temperature of the readily available coffee. R21's incident report dated 3/9/18, at 1:49 p.m. indicated staff had reported R21 had a skin tear, however the area was assessed to be a burn with open areas which appeared to be non-intact blisters and treatment was applied. R21 was not	F 689	ensure that the resident environment remain as free of accident hazards as is possible; and to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. 1. Corrective action as it relates to R21: a.) Staff education provided on the need to use his cup with the lid for any hot liquids. His care plan was reviewed with staff on 06/18/2018. b.) Family will bring in another cup so one is available when the other is being cleaned. c.) Coffee pots were shut off between staff usage on 06/19/18 and were completely taken out of service 07/13/18. On 06/19/18 air pots were ordered to utilize in resident areas. Staff will utilize pour over system that is set up in activities area by each service kitchen. These pots are not easily accessed by residents. d.) Staff will monitor at each meal to ensure that his cup with a lid is being used. This will be on going as long as he needs the lid for safety. 1. Corrective Action as it relates to R4: a.) Smoking assessment was reviewed 06/26/18. Resident has refused the smoking apron for almost a year. He also goes up town by himself and smokes when he is gone. Care plan reviewed and updated. b.) Risk vs benefit education shared with resident. He states that he does not want to wear the smoking apron. He states that it is too heavy and is harder to smoke with the use of it then it is without it. He does not need it at this time. Risk vs benefit form was signed and reviewed per IDT on	

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F 689	Continued From page 64 aware of how he acquired the burn or what had happened. Immediate action taken was to put covers to coffee cups and questioning the need to decrease the temperature of coffee pots which are accessible to the resident. The report did not identify if the incident was witnessed. The report also did not reflect if temperatures of the coffee had been obtained to ensure safe temperature. The Incident/root cause analysis progress note dated 3/9/18, at 2:09 p.m. authored by registered nurse (RN)-B indicated R21's family and physician had been notified of the incident. The note also indicated R21 had received burns to left front anterior thigh from his coffee which were evaluated by the nurse practioner who determined R21 had second degree burns and prescribed treatment. Nursing was directed to intervene if they observed R21 helping himself to the coffee machine and provide assitance as R21 did not always ask for help. The dietary manager was aware and would be checking the coffee temperature settings. R21's care plan revised on 3/9/18, indicated R21 had recurring dermatitis and chronic scabs to the right lower extremity from having suffered burns on 3/9/18, from coffee. The plan directed staff to encourage R21 to use the coffee mug which family provided and had a screw type lid and to assist with filling it and fastening the lid. If nursing observed R21 attempting to get his own coffee, R21 would accept staff assitance as R21 did not always ask for help. On 6/18/18, at approximately 8:45 a.m. the second floor kitchenette areas were observed to have coffee dispensers on the counters which were accessible to all residents, visitors, and	F 689	06/26/18. Left on care plan to encourage smoking apron if there is a change in resident condition. c.) IDT will review Quarterly and/or with a change of status to determine if resident is still able to safely smoke without a smoking apron. 2. Corrective Action as it relates to other residents: a.) Hot coffee taken away as a hazard risk for all residents. b.) Smoking assessments will continue to be done for all residents who want to smoke while they are residing in the facility. c.) Staff education provided on the importance of following the care plan and notifying Unit Manager when something on the care plan is out dated. Discussion also held with Unit Managers to have nursing assistants that are coming to care conference read the care plan closer to catch any errors in the cares they are actually providing. 3. Reoccurrence will be prevented by: a.) QA will be done with each meal and PRN for 90 days to make sure lid is being used for R21 when hot coffee is being consumed. QA results will be taken to QAPI team to determine if further action is required. b.) BIMS and resident R4's ability to make own decisions and not wear his smoking apron will be done quarterly on an ongoing basis and will continue as long as he is a resident at HLC. 4. Plan of Correction will be monitored by: CNAs, Charge Nurses, Unit Managers, IDT, and DON.	

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F 689	Continued From page 65 staff. On 6/20/18, at 11:45 a.m. R21 was observed seated in his wheelchair at the dining room table. R21 had a maroon coffee cup that was ¾ full of coffee. The coffee cup was a facility cup and did not have a lid on it. -At 11:52 a.m. dietary assistant (DA)-B walked up to R21 and explained what the food was on his plate asked R21 if he wanted something else. DA-B did not identify the coffee cup did not have a lid on it and that it was not the mug family had provided. -At 12:26 p.m. trained medication assistant (TMA)-B stated R21 was supposed to have a covered cup all the time because he had a tendency to spill. -At 12:28 p.m. the director of nursing (DON) confirmed R21 had been getting his own coffee out of the machines, however, he was not doing that anymore. The DON stated she had been on vacation when the burn incident occurred, and R21 had not informed staff of the incident/burn. -At 12:29 p.m. nursing assistant (NA)-J stated R21 used to get himself coffee out of the dispensers and was getting it all over the place, but now he usually asked for help. NA-J stated R21 had not informed staff when he had obtained the burn. -At 12:33 p.m. the DON and registered nurse (RN)-B confirmed R21 had the tendency to get his own coffee from the machines and they were not aware of what the temperature of the coffee was at the time when the burn was identified. Both stated they were guessing the burn was	F 689	Date of Correction: 07/21/19.	

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F 689	Continued From page 66 coffee related because they could not think of anything else that would have been hot enough to cause a burn. The DON stated after she had returned from vacation, she had interviewed staff regarding R21's burn, however, did not document the interviews. The DON stated the staff had not found the wound/burn the day it had occurred. RN-B stated R21 was only to use the mug with the screw type lid when he wheeled around the facility, and not during meals. -At 12:42 p.m. licensed practical nurse (LPN)-C stated the injury had first been reported to her by an NA who discovered the injury during the provision of a whirlpool bath. The NA described the injury as a skin tear. LPN-C stated she evaluated the area and determined it was consistent with a burn with non-intact blisters. LPN-C stated R21 did not have the injury the night before. LPN-C also stated R21 could not articulate how the injury had occurred and no one had witnessed the incident. LPN-C confirmed she had not interviewed staff as to the cause of the injury rather assumed it was caused from hot coffee due to R21's history of obtaining his own coffee and placing the filled cup along the side of his left leg while wheeling around in his wheelchair. LPN-C stated staff would put lids on the coffee cups, however, R21 would take them off. LPN-C stated she was not aware if temperatures of the coffee were ever obtained in order to ensure safe temperatures. -At 12:51 p.m. NA-E stated prior to R21 obtaining the burn, there had been more than one incident of R21 spilling coffee on himself. NA-A stated once he had witnessed R21 spilling coffee on himself while sated at the dining room table. NA-E responded by removing R21 from the	F 689		

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dining room, reporting to a nurse, and immediately applying ice to the area. R21 stated this incident had not resulted in a burn. Although NA-E could not recall the date this occurred, he confirmed it had happened prior to the unwitnessed incident which had resulted on a R21's thigh burn on 3/9/18. NA-E stated he had reported the burn to LPN-C which was identified during the provision of a bath in which LPN-C came into the shower room to evaluate and treat the wound. NA-E stated staff had been putting lids on R21's coffee cup prior to 3/9/18, because R21 had a tendency to spill his coffee.

-At 1:45 p.m. the certified dietary manager (CDM) indicated prior to the R21's burn, she had contacted Farmer Brother's when she identified the coffee dispensed from the machines were 180 degrees, however, did not know the exact date she had contacted them. The CDM stated the technician came the the facility on 3/7/18, two days prior to the burn incident and adjusted the temperature down to the lowest temperature setting of 160 degrees. The CDM indicated there was no documentation of temperatures having been checked or recorded after R21 had obtained the burn. The CDM stated at this time, she verfied with the distributor the lowest temperature setting on the machines was at 160 degrees and then checked the temperatures of all four of the coffee dispensers which were accessible to the residents and determined the temperatures ranged from 160-165 degrees. The CDM stated 160-165 degree coffee could cause burns so she turned off all the coffee dispensing machines indefinitely until a system was in place to identify residents who were at risk for burns.

A signed statement from the CDM dated 6/21/18,

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indicated: spoke with Farmer's Brother's representative who called the technician regarding lowering the coffee temperatures. Temp of hot well in machines on 3/7/18, was set at the lowest setting per their standards.

On 6/21/18, at 12:10 pm. Family member (F)-1 stated was aware of R21's burn and stated the facility was not aware of how coffee was spilled or when it had even occurred. F-1 stated the family had purchased a special coffee mug where the lid screwed on to prevent R21 from spilling the hot coffee. F-1 stated R21 was supposed to be using that mug at all times even during meals because he had a tendency to spill liquids on himself and they wanted to prevent more burns. F-1 also stated R21 would always take off the plastic lids from the facility coffee cups and throw them away hence the reason for the screw on lid. F-1 stated the use of the mug at all times should have been in his care plan. F-1 also stated during visits, R21's mug was missing from his room.

On 6/22/18, at 8:11 a.m. R21 was observed at the table, seated in the wheelchair, with his head down and eyes closed while holding onto a covered maroon coffee cup handle with his right hand. The coffee cup was a facility cup with a white plastic lid. R8's mug with the screw on top was not observed in R21's room.

On 6/22/18, at 2:06 p.m. the DON stated it was her expectation for the staff to follow the care plan as directed.

A policy related burns/accidents was requested but not received.
R4's Admission Record dated 6/22/18, indicated R4's diagnoses included hemiplegia following a

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stroke, end stage renal disease, diabetes, low back pain, and osteoarthritis.

R4's annual MDS dated 3/23/18, indicated R4 had intact cognition, required extensive to total staff assist with activities of daily living, and had one sided functional limitation in ROM and used tobacco products.

R4's Activity of Daily Living CAA dated 3/29/18, indicated R4 required extensive to total staff with assistance due to a stroke with left sided hemiparesis.

R4's care plan revised on 3/18/18, indicated R4 liked to smoke and had declined nicotine addiction.
The plan indicated R45 could take himself in/out of the designated smoking areas, he kept his lighter and cigarettes safely in his room, and a smoking assessment would be completed quarterly. The plan directed staff to assist R4 with applying and removing a smoking apron.

On 6/19/18, at 7:50 p.m. and on 6/21/18, at 7:59 a.m. R4 was observed outside, seated in the motorized wheelchair, smoking cigarettes without difficulty. However, R4 did not have the smoking apron as directed by the care plan.

On 6/22/18, at 10:20 a.m NA-Q confirmed R4 was to wear a smoking apron when smoking. NA-Q located a white smoking apron in R4's lounge chair and stated R4 had refused to wear the apron and would go outside to smoke without informing staff.

On 6/22/18, at 2:52 p.m. RN-B confirmed R4's care plan directed the use of the smoking apron,

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F 689	Continued From page 70 however, stated R4 would be offered and would refuse to wear it. The facility Smoking And Smoking Assessment Policy And Procedure For Heritage Living Center indicated a smoking assessment would be completed on admission and quarterly to ensure a resident was capable of smoking safely. The resident care plan would reflect the smoking status of the resident and any staff assistance needed with this function.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		8/1/18

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F 690	Continued From page 71 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting and incontinence assistance for 3 of 3 residents (R55, R5, R3) who were dependent on staff for assistance with toileting and incontinence cares. Findings include: R55's annual Minimum Data Set (MDS) dated 5/28/18, indicated R55 was cognitively intact and had diagnoses which included hemiplegia/hemiparesis (paralysis of one side of the body), morbid obesity and history of urinary tract infections. The MDS indicated R55 required extensive assist of two staff for bed mobility, dressing, toilet use and personal hygiene. The MDS further indicated R55 was always incontinent of urine and was not on a toileting program. R55's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 6/6/18, indicated R55 was continent of bowel but always incontinent of urine most likely related to her CVA [stroke] with left hemiparesis. She reported urgency since childhood. R55 wore a brief and staff provided extensive assist with	F 690	Heritage Living Center policy and procedure is to ensure that residents who are continent of bowel and bladder on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. 1. Corrective Action For R55,R5 and R3: a.) The staff involved were educated/given counseling forms on the importance of following the plan of care for each individual resident. The staff were all long term staff who have been educated on the importance of keeping residents at their highest level of functioning. They were also educated on the need to reposition and keep the resident comfortable. b.) Daily shift checks will be done by RN/Charge nurse to ensure that residents are receiving the care as outlined in their care plan. Resident R55 is able to voice if she is taken to toilet. In addition RN Unit Manager will ask her about her toileting needs three times weekly for three months to ensure that she is being assisted as needed.	

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toileting and incontinence cares. R55 was toileted with the standing lift and denied signs and symptoms of urinary tract infection. Staff reported they attempt to toilet R55 every two hours and have had success with keeping her dry but R55 had refused and chose to just void in her brief. She would even refuse incontinence care and chose to stay in her wet brief. R55's daughter had come to the facility at times and talked with R55 so she would allow staff to toilet and change her brief.

R55's care plan provided 6/22/18, identified an alteration in elimination related to chronic urinary incontinence and history of frequent loose stools brought on by stress. The care plan directed staff to ask 30 minutes before each meal if R55 needed to use the bathroom. The care plan also indicated R55's toileting plan included toileting every two hours during awake hours.

On 6/20/18, at 8:08 a.m. R55 was observed in her room, seated in a wheelchair while nursing assistant (NA)-F brushed her hair followed by assisting R55 to a dining room table. R55 remained at the table eating her breakfast independently.
--At 8:47 a.m. R55 pushed herself back from the table.
--At 8:49 a.m. NA-D wheeled R55 to her room and asked if she would like to stay up for awhile. NA-F joined NA-D. R55 indicated she would like to stay up. NA-D and NA-F left the room and shut the door behind them per R55's request.
--At 8:54 a.m. NA-B briefly entered R55's room and then left the room.
--At 9:17 a.m. laundry staff knocked on R55's door and delivered clean clothes.
--At 9:49 a.m. R55 turned on her call light.

Provider's Plan of Correction (F 690):

c.) The resident assessments were reviewed by 07/20/18 and they remain accurate.
2. Corrective Action as it relates to other residents:
a.) Residents needing assistance will have weekly checks to ensure their care plan is being followed.
3. Reoccurrence will be prevented by:
a.) QAs weekly for three months and results will be taken to QAPI committee to see if further action is needed.
4.) Plan of Correction will be monitored by; Unit Managers and DON.
Date of Correction: 08/01/18

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--At 9:51 a.m. NA-D entered the room, turned off the call light and immediately left the room.
--At 10:05 a.m. NA-F and NA-D entered R55's room and utilizing a mechanical lift, assisted R55 to bed. NA-F and NA-D removed the lift sling from under R55. NA-F asked R55 her position preference and then positioned R55 slightly to her left side and placed a pillow behind her back with a pillow between her knees. NA-D and NA-F placed R55's bedside table within her reach, tidied the room and left the room without offering R55 toileting or checking her for incontinence. NA-F indicated R55 was supposed to be repositioned and toileted every two hours, however regularly refused. NA-F confirmed they had not offered toileting or checked R55 for incontinence and stated R55 often only allowed this before lunch.

R55 remained in her bed and was not offered toileting or checked for incontinence until requested by the surveyor.

--At 11:34 a.m. NA-D indicated R55 would only let staff change her twice per shift at the most and stated it depended on her mood. NA-D confirmed they were still supposed to offer toileting/incontinence cares even if R55 refused.
--At 11:37 a.m. NA-F and NA-D entered R55's room and asked if it was ok if they checked her incontinence brief. R55 agreed. NA-D closed the window shade and raised the bed. NA-F and NA-D donned gloves and cued R55 to roll side to side while they lowered her shorts and brief. NA-F indicated R55's brief was moderately wet. NA-D provided perineal cares. R55's buttocks were observed to have two small areas approximately 1.0 centimeter (cm) x 1.0 cm in diameter on each buttock which were

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F 690	Continued From page 74 reddish/purple in color. The skin was not observed to be open. NA-D and NA-F proceeded to cue R55 to roll side to side while they applied a clean brief and raised her shorts. On 6/22/18, at 10:46 a.m. registered nurse (RN)-A confirmed R55 was on a toileting schedule while awake and had a history of issues with impaired skin integrity to her buttocks. RN-A stated it would be his expectation for staff to offer toileting and check for incontinence as directed by the care plan. --At 2:52 p.m. the director of nursing (DON) stated she expected staff to follow the facility policies and procedures related to providing toileting assistance. R5's Admission Record dated 6/22/18, indicated R5's diagnoses included diabetes, chronic kidney disease stage 3, heart failure, pressure ulcer to sacral region stage 3, benign prostatic hyperplasia (BPH) without urinary tract symptoms, and urinary incontinence. R5's quarterly MDS dated 3/22/18, indicated R8 had moderate cognitive impairment, required extensive assist of two staff members for bed mobility, transfers, and toileting. The MDS also indicated R5 was frequently incontinent of urine, occasionally incontinent of bowel, was on diuretic medication. R5's Urinary Incontinence CAA dated 12/27/17, indicated R5 had chronic kidney disease, used diuretic medication, and had BPH. The CAA indicated R5 had urinary frequency to the point of not having the indication to urinate, and staff used the standing lift to assist him.	F 690		

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R5's activities of daily living care plan for toileting dated 3/17/18, indicated R5 required extensive assistance of 1-2 staff for toileting with the standing lift, wore a bariatric brief and staff assisted with changing and providing incontinent care with each incontinent episode.
R5's functional urinary incontinence/dribbling care plan dated 3/17/18, indicated R5 had urinary incontinence related to chronic kidney disease, BPH, diuretic use, and immobility. The care plan indicated R5 reported inability to feel the need to void, however, put on the call light and asked to go to the bathroom but was usually wet as well. The care plan indicated R5 was on a prompted voiding program and directed staff to assist to the bathroom at 9:00 a.m. and at 11:00 a.m. in addition to every two hours and/or as requested.

On 6/21/18, continuous observations started at 8:27 a.m. and the following was observed: -At 8:27 a.m. R5 was seated in his recliner with his feet elevated.
-At 9:05 a.m. an unidentified staff member delivered a water cup to R5's room and did not offer and/or prompt R5 to use the restroom.
-At 9:34 a.m. NA-L entered R5's room and obtained R5's vital signs. NA-L did not offer or prompt R5 to use the restroom.
-At 9:40 a.m. RN-D entered the room and completed a pain assessment interview. RN-D did not offer or prompt R5 to use the restroom.
-At 10:21 a.m. NA-M stated she had last toileted R5 at 6:20 a.m. and did not have any idea if R5 had been to the restroom since then. NA-M indicated R5 called when he wanted to go to the restroom and someday's he was just incontinent. NA-M stated R5 always had urgency, and was always wet in the morning.
-At 10:56 a.m. NA-L stated she had last toileted

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R5 at 7:30 a.m.
-At 11:05 a.m. NA-L referenced the Kardex (aide care guide) and verified R5's toileting was late and should have been done every two hours. NA-L stated she would take him to the restroom now.
-At 11:43 a.m. Licensed practical nurse (LPN)-C stated R5 should have been prompted or offered to use the restroom, and NA's should have followed the care plan.

On 6/22/18, at 10:50 a.m. RN-B stated the NAs should have offered R5 toileting assistance at least three times during the day in addition to when R5 asked to use the bathroom.

On 6/22/18, at 2:06 p.m. the DON stated the expectation was for the nursing staff to provide toileting assistance as directed by the individual resident care plans.
R3's Admission Record provided on 6/22/18, indicated R3's diagnoses included anoxic brain damage, epilepsy, and muscle weakness.

R3's quarterly Minimum Data Set (MDS) dated 3/20/18, indicated R3 required extensive assist of two staff for toileting.

R3's Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 12/22/17, did not trigger R3 as having any self care deficits to include toileting.

R3's care plan provided on 6/22/18, indicated R3 had functional bladder incontinence related to physical limitations, disease process, dementia, impaired mobility and inability to communicate needs consistently and had a history of an over

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F 690	Continued From page 77 active bladder. The plan directed staff R3 wore disposable briefs, to check/change every two hours and as needed or requested, change clothing as needed, The plan also indicated R3 was on a daytime toileting plan from 7:00 a.m. until 9:00 p.m. in which staff were directed to offer R3 the bed pan every two hours and to only check and change incontinent brief during the night time hours. On 6/20/18 R3 was continually observed to remain in her room, seated in a recliner from 8:00 a.m. until 11:03 a.m (3 hours & 3 minutes) without assitance to toilet from staff offered or provided. -At 11:03 a.m. NA-A and NA-D assisted R3 from the recliner to the wheelchair using a hoyer lift. When asked when the last time R3 had been provided toileting or incontinence cares, both NAs stated R3 had been last checked and changed when cares were completed sometime before breakfast but could not recall time. The NAs proceeded to return R3 to bed in order to provide incontinence cares. R3's brief was removed and was noted to be saturated with urine. The NA's confirmed R3 was suppose to be checked and changed every two hours minimally, as directed by the care plan. On 6/22/18, at 2:40 p.m. the DON stated she expected staff to follow the care plan regarding toileting and incontinence cares. A policy was requested but not received.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		8/1/18

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F 695	Continued From page 78 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oxygen therapy equipment was changed and/or disinfected as directed for 5 of 6 residents (R36, R13, R38, R40, R9) observed to not have oxygen equipment cleaned and/or replaced as directed. In addition, the facility failed to develop individualized goals for oxygen therapy for 1 of 6 residents (R9) reviewed for respiratory care. Findings include: R36's Diagnosis Report dated 5/3/18, indicated R38 had diagnoses which included pneumonia, chronic respiratory failure with hypoxia (diminished availability of oxygen to the body tissue), hypoxemia (an abnormally low level of oxygen in the blood), and shortness of breath. R36's 14 day Minimum Data Set (MDS) dated 5/12/18, indicated R36 had no cognitive impairment, required limited assistance of one for most activities of daily living, and received oxygen therapy. R36's Order Summary Report dated 5/3/18, included an order to use oxygen 0-4 liters via nasal cannula to keep SaO2 (oxygen saturation) above 90% every shift for congestive heart failure. Orders also included DuoNeb solution 1	F 695	It is the policy and procedure of HLC to provide respiratory care consistent with professional standards of practice, the person-centered care plan, the residents' goals and preferences. Corrective Action: a. On 06/22/18 R36, R13,R38, R40 and R9 respiratory supplies were all replaced and dated. The concentrators and equipment were cleaned as per HLC policy and procedure. b. Cleaning and policy and procedure for respiratory equipment was shared with nursing staff on 06/22/18. HLC follows Northwest Respiratory policy and procedures for cleaning and changing of the equipment. c. Treatment sheets were changed so Charge Nurse staff are aware of need to follow policy and procedure. 2. Corrective Action as it pertains to other residents: a. On 06/23/18 all residents receiving respiratory therapy were reviewed and equipment changed and cleaned. b. On 06/23/18 treatment sheets were updated for all resident's receiving respiratory therapy. 3. Reoccurrence will be prevented by: a.) Health Unit Coordinator will do weekly	

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F 695	Continued From page 79 vial inhale orally (via nebulizer) four times daily and every four hours as needed for lung congestion and bronchiospasms (tightening of the muscles that line the airways in lungs). There were no orders to indicate the changing of tubing or masks with the oxygen or nebulizer treatments. R36's care plan provided on 6/22/18, indicated R36 had oxygen therapy related to shortness of breath with exertion and recent pneumonia. Care plan interventions included to provide oxygen at 0-2 liters per nasal prongs to keep oxygen saturation greater than 90% and monitor oxygen saturation as ordered and as needed. Staff were directed to monitor/document breathing patterns and abnormalities. R36's care plan did not include the use of nebulizer machine (drug delivery device used to administer medication in the form of a mist inhaled into the lungs). On 6/19/18, at 7:14 p.m. R36 was observed in his room, seated in recliner, receiving oxygen via nasal cannula and a concentrator. The tubing attached to the concentrator was not labeled or dated. R36 had a portable oxygen tank on his wheelchair and the tubing attached to the tank was dated 1/15/17. On 6/21/18, at 9:37 a.m. R36 was observed in his room, seated in the recliner with the nebulizer machine running. The tubing attached to the nebulizer machine was not labeled or dated. R36's Treatment Administration Record (TAR) dated 5/1/18 - 5/31/18, and 6/1/18 to 6/30/18, included the following orders: -oxygen 0-4 liters via nasal cannula every shift for congestive heart failure -change oxygen tubing and clean filters on	F 695	QA checks on equipment to ensure policy and procedure is being followed. b.) Charge nurse will be educated if tubing and equipment has not been changed. 4. Plan of Correction will be monitored by: HUC, Charge Nurse, Unit Managers, and DON 5. Date of Correction: 07/19/8	

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concentrator every Sunday
The TAR did not address the cleaning of concentrator or nebulizer tubing. Documentation indicated the tubing was changed and the filters were cleaned weekly, on Sundays.

On 6/22/18, at 8:24 a.m. registered nurse RN-A verified R36's oxygen and nebulizer tubing were not labeled or dated with the exception of the oxygen tubing for the portable tank on the wheelchair which was dated 1/15/17. RN-A stated the tubing should have been changed weekly and he would change the tubing immediately.

R13's Admission Record provided 6/22/18, indicated R13 had diagnoses which included heart failure, chronic obstructive pulmonary disease (COPD) and history of pneumonia.

R13's significant change MDS dated 4/9/18, indicated R13 had no cognitive impairment, required extensive assistance with most activities of daily living and received oxygen therapy.

R13's Order Summary Report provided 6/22/18, included the following orders:
- change oxygen tubing weekly
- clean oxygen filter with warm water weekly
- oxygen at 1.5 - 2.0 liters per nasal cannula

R13's care plan provided on 6/22/18, indicated R13 had an altered respiratory function related to asthma, COPD, pulmonary fibrosis, restrictive lung disease, and recurrent pneumonia. Care plan interventions included oxygen therapy at 1.5 - 2.0 liters and nebulizer treatments (although no orders were indicated for nebulizer treatments).

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On 6/19/18, at 6:43 p.m. oxygen tubing attached to R13's concentrator and bubbler canister were observed to be dated 6/11/18.

On 6/20/18, at 12:54 p.m. the oxygen tubing attached to portable tank on R13's wheelchair was dated 6/11/18.

R13's TAR dated 5/1/18 - 5/31/18, and 6/1/18 - 6/30/18, included the following orders:
-oxygen at 1.5-2 liters every shift for shortness of breath
-change oxygen tubing weekly every Sunday for oxygen use
-clean filter with warm water weekly every Sunday for oxygen use
-wipe down oxygen concentrator weekly every Sunday
Documentation indicated these items were completed weekly, on Sundays.

On 6/22/18, at 8:26 a.m. RN-A verified the tubing to both the concentrator and portable oxygen tank and bubbler were dated 6/11/18, and the filter in the concentrator had a moderate amount of white colored dust adhered to it. RN-A stated the tubing should be changed weekly and the filter cleaned weekly. RN-A confirmed it had been documented on the TAR as being completed 6/17/18, however the date on the tubing indicates it had not been changed as required.
R38's Diagnosis Report provided 6/22/18, indicated R38 had diagnoses which included asthma, hypoxemia, and shortness of breath.

R38's quarterly MDS dated 5/16/18, indicated R38 had moderate cognitive impairment, required extensive assist of one for most activities of daily living, and received oxygen therapy while a

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resident.

R38's Order Summary Report signed 5/12/18, included an order to use oxygen 0-2 liters for shortness of breath and to keep sats [oxygen saturation] >90% related to hypoxia.

R38's care plan provided 6/22/18, indicated R38 had altered respiratory status and complaints of shortness of breath related to a restrictive airway. Care plan interventions included provide oxygen at 0-2 liters per nasal cannula to keep oxygen saturation greater than 90% and monitor oxygen saturation every shift and as needed.

On 6/18/18, at 9:12 a.m. R38 was observed in her room, seated in a wheelchair, receiving oxygen via nasal cannula and a concentrator. The tubing attached to the concentrator was labeled with white tape and dated 4/30/18, the bubbler attached to the concentrator was dated 4/30/18.

On 6/20/18, at 8:06 a.m. and 6/21/18, at 2:23 p.m. R38's oxygen tubing and bubbler remained dated 4/30/18.

R38's TAR dated 5/1/18-5/31/18, and 6/1/18 to 6/30/18, included the following orders:

-change tubing for oxygen and clean filters on concentrators every Sunday for oxygen use. May D/C [discontinue] when concentrator no longer used.
-may use oxygen 0-2 liters for shortness of breath and to keep sats [oxygen saturation] >90% for hypoxia.
Documentation indicated the tubing had been changed weekly on Sunday except for 5/27/18,

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F 695	Continued From page 83 which was blank. On 6/22/18, at 8:35 a.m. RN-A verified R38's oxygen tubing and bubbler were dated 4/30/18. RN-A also indicated the filter on the back of the oxygen concentrator was dirty and in need of cleaning. RN-A stated the tubing and bubbler should have been changed weekly and the filter should have also been cleaned weekly. RN-A verified the documentation in the TAR indicated the tubing and bubbler had been changed, however, indicated it had not been done. RN-A indicated he would change the tubing and bubbler immediately. R40's Admission Record provided 6/22/18, indicated R40 had diagnoses which included acute and chronic respiratory failure with hypercapnia (excessive carbon dioxide in the bloodstream), centrilobular emphysema, pulmonary hypertension, hypoxemia, and a history of pulmonary embolism (a blood clot in the lung). R40's admission MDS dated 5/4/18, indicated R40 had moderate cognitive impairment, required extensive assistance with most activities of daily living and received oxygen therapy while a resident. R40's Order Summary Report signed 6/5/18, included an order for oxygen via nasal cannula 0-4 liters every shift for shortness of breath. R40's care plan provided 6/22/18, indicated R40 had altered respiratory status and difficulty breathing, asthma, and shortness of breath related to acute and chronic respiratory failure with hypercapnia, hypoxemia, and pulmonary	F 695		

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hypertension. Care plan interventions included oxygen via nasal prongs at 1-4 liters as needed. The care plan directed staff to encourage R40 to wear oxygen when short of breath or when oximeter dropped below 92%.

On 6/18/18, at 1:35 p.m. the oxygen tubing attached to R40's concentrator was noted to be dated 6/11/18.

On 6/19/18, at 7:06 p.m. the oxygen tubing attached to R40's concentrator continued to be dated 6/11/18. The Oxygen tubing attached to a portable oxygen tank was also noted to be dated 6/11/18.

On 6/20/18, at 8:23 a.m. the oxygen tubing attached to R40's concentrator and portable oxygen tank continued to be dated 6/11/18.

On 6/21/18, at 2:20 p.m. R40's oxygen tubing to the concentrator and portable oxygen tank remained dated 6/11/18.

On 6/22/18, at 8:50 a.m. licensed practical nurse (LPN)-B indicated the nurse or trained medication aid (TMA) who was assigned to work the medication cart was responsible to change the residents' oxygen tubing. LPN-B stated this used to be done weekly by the night shift staff, however, had recently been moved to the day shift staff and was completed on Sunday mornings. LPN-B indicated this included changing the tubing, wiping down concentrators, cleaning filters and wiping down the nebulizers. LPN-B stated when this was completed it was signed off on the TAR and the tubing was to be labeled with the date it had been changed.

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R40's TAR dated 5/1/18-5/31/18, and 6/1/18, to 6/30/18, included the following orders:

-oxygen via nasal cannula 0-4 liters every shift for shortness of breath
-change nebulizer tubing weekly every Sunday for nebulizer usage.
-change oxygen tubing weekly every Sunday for oxygen usage
-clean filter with warm water weekly every Sunday for oxygen usage.
-wipe down oxygen concentrator weekly every Sunday for oxygen usage.
Documentation indicated these items had been completed weekly, on Sunday.

On 6/22/18, at 8:59 a.m. RN-C confirmed R40's concentrator tubing and the tubing attached to the portable oxygen tank were dated 6/11/18, and indicated they should have been changed. RN-C confirmed it had been documented as completed, however, stated with the date on the tubing she assumed it had not been changed as required.

--At 9:49 a.m. the DON verified it was the facility policy to change oxygen tubing and bubblers and to clean the concentrator filters weekly and stated the staff should have done so.

R9's Admission Record dated 6/22/18, included diagnoses of history of congestive heart failure (CHF), localized edema, chronic obstructive pulmonary disease (COPD), and shortness of breath.

R9's quarterly MDS dated 3/12/18, indicated R9 had no cognitive impairment, identified diagnoses of CHF and COPD, and used oxygen therapy.

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On 6/18/18, at 9:00 a.m. and on 6/19/18, at 2:20 p.m. R9's oxygen tubing and oxygen humidifier bubbler were noted to be dated 6/4. R9 stated she only used the oxygen at night.

R9's physician orders on 6/22/18, did not include the humidification of the oxygen. The orders included:

-Oxygen at 1.5 liters/minute via nasal cannula (nc) as needed (PRN) and at bedtime for CHF and COPD (start date 8/1/2017). The order did not reflect a parameter of when to administer as needed oxygen and did not reflect a goal or parameter for blood oxygen saturations.
-Change oxygen tubing weekly on Sundays, clean filter weekly with warm water, and wipe down oxygen concentrator.

R9's oxygen therapy care plan last viewed on 6/19/18, indicated R9 used oxygen therapy related to CHF. The identified goal of therapy was R9 would have no signs or symptoms of poor oxygen absorption through the review date. The care plan directed the following:

-Setting for oxygen delivery was 1.5 liters continuous with humidification dated 3/14/18.
-Monitor for signs and symptoms of respiratory distress, which included pulse oximetry (blood oxygen saturations) dated 6/26/17.
The care plan printed and provided by the facility on 6/22/18, reflected a revision of the care plan on 6/20/18, after the inconsistency between physician order and the care plan was identified during the survey process. The 6/20/18, revision reflected current physician orders and no longer directed the use humidification. The care plan also did not address goals for oxygen therapy or

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PRN administration parameters.

R9's June 2018, TAR reflected the order to change the tubing weekly on Sundays. The TAR indicated on 6/3 the tubing was changed, on 6/10, the box reflected "9" and did not reflect the chart codes indicated that were numbered 1-6. The TAR on 6/17, indicated the tubing was not changed because R9 was out of the facility with medications.

Review of R9's electronic oxygen saturations and progress notes were reviewed from 5/25/18 to 6/18/18. The recordings captured were during daytime hours while R9 was not using oxygen and does not reflect monitoring when the oxygen was on during the night.

6/12/2018, at 2:11 p.m. 92.0 % Room Air
6/9/2018, at 12:50 p.m. 91.0 % Room Air
6/6/2018, at 12:06 p.m. 91.0 % Room Air
6/3/2018, at 1:51 p.m. 94.0 % Room
5/31/2018, at 12:09 p.m. 92.0 % Room Air
5/28/2018, at 8:55 a.m. 93.0 % Room Air
5/25/2018, at 11:05 a.m. 92.0 % Room Air

On 6/20/18, at 8:09 a.m. R9's oxygen tubing and bubbler were dated 6/4. The green oxygen tubing had areas of condensation inside the tubing.

-At 8:36 a.m. LPN-C stated the oxygen tubing either said 5/4 or 6/4. LPN-C stated the oxygen tubing should be replaced weekly on Sundays and if there was condensation, the tubing and bubblers should be replaced. LPN-C removed the tubing and threw it away.

On 6/22/18, at 8:17 a.m. R9 was observed in her room, seated in the recliner. No oxygen tubing

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was present, and the bubbler reflected a date of 6/4. R9 was asked about her oxygen tubing and responded she had not used oxygen last night.

On 6/22/18, at 10:16 a.m. RN-B stated oxygen tubing and bubblers were supposed to be changed weekly and when condensation was identified in the tubing. RN-B stated R9's oxygen order changed at the last care conference. The previous order used to be for continuous oxygen which was changed to night time use only. RN-B stated the old order had a goal identified for oxygen saturations, however, it was not reflected on the new order. RN-B stated oxygen saturations were usually kept above 90%. RN-B verified R9's documented oxygen blood saturations was obtained during the daytime hours and not during the night time hours when R9 was using oxygen.

On 6/22/18, at 2:06 p.m. the DON stated the expectation was for nursing to follow facility policies and procedures for respiratory care.

On 6/22/18, at 2:30 p.m. the DON stated she expected staff to follow the policies and procedures related to the required changing of oxygen/nebulizer tubing, masks, and the cleaning of filters and concentrators.

The facility's Oxygen Tanks and Concentrators Use Policy and Procedures dated May 2018, directed staff to change tubing and mask/cannula weekly.

The customer handbook from Northwest Respiratory Services provided on 6/22/18, recommended to reduce the risk of infections it was very important to keep the equipment clean

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F 695	Continued From page 89 by: -replacing cannula/mask weekly -cleaning the humidifier bottle between fills or once per week -rinse nebulizer equipment after each use - allow to air dry -daily soak nebulizer equipment in warm soapy water -store nebulizer in a clean/dry plastic bag -disinfect nebulizer twice per week with vinegar/water solution -replace nebulizer every two weeks Facility policy Oxygen Concentrator Use dated 5/2018, directed staff to chart resident's reaction, comments of oxygen use. Facility policy Oxygen Usage dated 5/2018, included, oxygen would be administered under a physician's order unless of an emergency nature where immediate application is necessary, as per standing orders. The policies did not address care plan, goals for oxygen use, or frequency of assessment.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		8/1/18

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F 725	Continued From page 90 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement restorative nursing programs according to residents' assessed need and as directed by the care plan. This practice had the potential to affect 37 residents who were assessed to require restorative nursing services Findings include: See F688: the facility failed to provide restorative nursing services in order to maintain and/or prevent further decline in ROM abilities for 3 of 3 residents (R3, R51, R4) who had limitations in ROM and had not received ROM services according to their individualized assessed need. On 6/20/18, at 8:12 a.m. R51, an alert and oriented resident, stated she received therapy when she was first admitted to the facility	F 725	It is the goal of Heritage Living Center to provide sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services o assure resident safety and attain or maintain each residents highest well being. 1. Corrective Action as it relates to R3, R4, R51: a.) See corrective Action Under 688. b.) Programs have been reviewed and put back in place. Staff have been educated on the importance of not pulling the Restorative Aides. c.) Two RN's have been put in place to oversee the program. (One as the Primary and one as the back up.) d.) Please also see POC for tag #0688. 2. Corrective Action as it relates to other residents: a.) Once a week Restorative Aides will	

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however, now only received exercises with the nursing assistants (NA). R51 stated the NAs provided the exercises as often as they could but they sometimes did not have the time to do it as they had quite a few people to assist. R51 stated she could do pretty much all of the exercises by herself except the exercises for her feet.

Staff Concerns:

On 6/21/18, at 8:52 a.m. NA-D and NA-G stated staffing was terrible and the restorative aids frequently were pulled from providing the services therefore the restorative programs had not been provided.

--At 10:13 a.m. trained medication aide (TMA)-A and NA-H stated staffing had been bad for a couple of months. NA-H stated restorative nursing services had not been provided for months and stated she could tell because becomes some of the residents' [joints] appeared more stiff. TMA-A stated when restorative programs were not provided on a regular basis, the residents would get out of the habit of doing them [exercises etc] and would no longer want to complete the programs, such as ambulation.

--At 10:21 a.m. NA-I stated staffing was better now that summer was here, however felt the bigger issue was with the staffing of restorative nursing. NA-I stated the restorative aides had been frequently pulled to work on the floor. NA-I indicated the residents' were more agile when they received their programs.

--At 10:26 a.m. NA-J stated restorative nursing had not been getting done. NA-J indicated the restorative aides had been pulled to work on the

F 725

meet with the RNs over seeing the program to bring forth any concerns and to review how each resident is doing.
b.) RNs will complete the tasks if Restorative Aides are unable to.
c.) Plan on posting a computer based program to see if there is staff that would be interested in filling in when Restorative Aides are gone. This would not be until October of 2018 before this can be completed.
3. Reoccurrence will be prevented by: QA will be done daily for 90 days and results taken to QAPI meeting to see if any further action is needed.
4. Plan of Correction will be monitored by; Restorative Aides, RNs, Therapy Department, DON
5. Date of Completion: 09/01/18.

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floor and stated she had noticed the residents' seemed to be having more pain and seemed to be stiffer [joints] when their restorative programs were not provided.

--At 10:50 a.m. NA-K stated the restorative aids had been pulled to the floor "all the time" therefore the residents' restorative programs had not been getting done.

On 6/22/18, at 10:55 a.m. registered nurse (RN)-A confirmed at times, the restorative aides had been pulled to work the medication cart of the floor.

--At 10:07 a.m. licensed practical nurse (LPN)-A confirmed the restorative aids had been pulled to work other duties and verified restorative nursing had not been getting done due to the staffing needs on the floor.

--At 10:19 a.m. LPN-B confirmed the restorative aids had been pulled to work the floor so restorative services had not been provided.

The Facility Assessment reviewed 1/22/18, indicated the facility's overall resident population consisted of diseases of the circulatory system, musculoskeletal system, and endocrine, nutritional and metabolic diseases. The assessment also indicated the facility embraced a person-centered culture in which care and services were provided based on the resident population and included restorative nursing. Personnel identified in the facility assessment included two restorative aides.

On 6/22/18, at 3:03 p.m. the director of nursing (DON) stated the staffing plan for restorative

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F 725	Continued From page 93 nursing was to have two full time restorative aides to provide services to the residents. The staffing schedules from 4/15/18, to 6/21/18, were reviewed with the DON who verified the following restorative aid staff shortages: -Week of 4/15/18: 5 shifts -Week of 4/23/18: 8 shifts -Week of 4/29/18: 7 shifts -Week of 5/6/18: 7 shifts -Week of 5/13/18: 7 shifts -Week of 5/20/18: 5 shifts -Week of 5/27/18: 7 shifts -Week of 6/3/18: 5 shift -Week of 6/10/18: 3 shifts -Week of 6/17/18: 5 shifts The DON stated they had a staff member out on leave and she was unaware one of the restorative aides had been pulled to cover for this position. The DON confirmed if the restorative aides were pulled from their duties or if they needed time off, no one else was assigned to provide the restorative nursing programs. The DON stated the staffing for restorative nursing needed to be addressed. A policy related to sufficient staffing was requested, however none was provided.	F 725		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		8/1/18

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F 791	Continued From page 94 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents	F 791	Heritage Living Center provides dental services for all residents needing dental	

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Continued From page 95

received dental services as needed for 1 of 1 resident (R13) reviewed who had ongoing uncomfortable, loose fitting partials without further dental services provided or arranged.

Findings include:

R13's significant change Minimum Data Set (MDS) dated 4/9/18, indicated R13 had no cognitive impairment and did not identify any dental issues including loosely fitting partial dentures.

R13's care plan provided on 6/22/18, indicated R13 had upper and lower partials and her dentist recommended staff to assist with brushing flossing of own teeth and cleaning of the partials but R13 refused the assistance at times. The plan also directed staff to remind R39 to complete oral/denture care and to remove partials before she went to bed. R39 was able to brush her own teeth after supplies had been set up. Exam per the dentist per resident request.

On 6/19/18, at 6:43 p.m. R13 stated she had went to a dentist in Fargo and had her four lower front teeth pulled. R13 stated her lower plate did not fit properly and had been told it could not be readjusted. R13 stated she felt so embarrassed without her front lower teeth. R39 also stated she had seen a dentist a couple months ago and was told there was nothing they could do for her.

On 6/21/18, at 2:33 p.m. R13 stated staff had been aware of her concerns with her lower partial and as far as she knew, no appointments had been made with the dentist to adjust them.

R13's Progress Note (PN) dated 12/7/17,

F 791

service.
1.) Corrective Action for R13:
R13 was seen 14 times in 2017 by dentist. She also refused 5 appointments that staff made for her in 2017. She was seen 1/22/18 and 2/12/18. In Nov. of 2017 she was given a lower partial. She has had problems with the partial and the dentist has told her since she has jaw line and gum problems this is the best they can get it to fit. She went back to dentist 06/28/18 and dentist once again attempted to adjust her lower partial. She came back from the dentist and pulled it out of her mouth and has refused to wear it since. A follow up appointment was scheduled for 07/18/18. She refused to go to appointment. When asked if she wanted to go and see if someone could fix it better for her she stated "there is nothing they can do because of my gums and jaw." Will continue to ask her on a quarterly basis if she wants to go either back to that dentist or out of town to another dentist that will take MA (for a second opinion.) She is alert and oriented. Staff will respect her wishes and do what she decides to do.
b.) MDH made the suggestion we ask the physician to write an order to pull her two front teeth she has left. Physician feels that is the dentists call. Dentist feels she would not have anything to hold the partial in if that happened. If resident decides she wants them pulled we will set up another appointment for her.
2.) Corrective Action as it relates to other residents:
a.)HLC will continue to monitor dental

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	245405	A. BUILDING ______ B. WING ______	06/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

(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 791	Continued From page 96	F 791		

indicated R13 had a dental appointment yesterday in which the sore areas of partial were adjusted, and the clamps were tightened. R39 was to monitor for symptoms.

-A PN dated 12/8/17, indicated R39 reported pain to her jaw, especially with eating, "is unchanged." What has changed is when she eats or drinks the lower partial moves upward. R39 was using "the guppy" which was not helping. R39 was not waiting after putting on before eating or drinking. Discussed with R39 trying to allow it time to set up before drinking and eating so see if that helps. R39 agreed to try to see if made a difference and would let the writer know the following Tuesday, if it made a difference.

-A PN dated 1/4/18, indicated R39 complained of a sore mouth and not being able to eat due to the soreness. Writer looked at R39's mouth which appeared slight red on her tongue. The nurse practitioner was notified.

-A PN dated 4/18/18, (Care Conference Summary/Dietary) indicated intake poor at 36%. R39 has new dentures, however, does not wear them as they are too loose. Weight stable for six months.

On 6/22/18, at 8:26 a.m. registered nurse (RN)-A confirmed he was aware of R39's poor appetite at times and stated R13 had not verbalized that her partials were ill fitting so choose not to wear them.

On 6/22/18, at 2:30 p.m. director of nursing (DON) stated R13 has been offered dental appointments but could not not recall specific dates of the appointments. The DON stated she

needs and assist with appointments as indicated.
b.) Unit Manager will ask about need or want to see dentist on admission and with each quarterly care conference review.
c.) All residents charts will be reviewed by 08/01/18 to ensure that dental needs have been met. If the information is not available in the chart resident and/or family will be notified to see if dental services are needed/wanted/
3.) Reoccurrence will be prevented by: QA monthly for three months. Results will be taken to QAPI committee to see if further action is needed.
4. Plan of correction will be monitored by: Unit Mangers, Social Service, DON
5. Date of Correction: 08/01/18.

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F 791	Continued From page 97 was not aware of any new concerns with R13's partial. The facility provided documentation from Community Dental Clinic which indicated that R13 was seen on 12/6/17, 1/22/18, and 2/12/18, for lower partial adjustments, however, no further evidence was provided to indicate if dental appointments had been offered since 2/12/18, in an attempt to resolve R39's ongoing dental concerns. The undated Routine and Emergency Dental Services policy provided on 6/22/18, indicated Heritage Living Center would provide routine dental services to meet the needs of each resident. Routine dental services included dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, and orthodontic procedures. Heritage Living Center would assist the resident in making appointments and arranging transportation to and from the dental service location. The undated Pathway Health Dental Policy and Procedure provided on 6/22/18, indicated it was the policy of the facility to provide ongoing assessment and care of the resident with dentures. Staff were directed to report to the nurse if a resident dentures were broken or chipped or there was a problem with fitting. The nurse would refer the resident to dental services within three days. For extenuating circumstances or a delay, the interdisciplinary team would assess and care plan interventions to be implemented for the resident to eat and drink adequately while awaiting dental services.	F 791		

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F 880	Continued From page 98	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		8/1/18

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F 880	Continued From page 99 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure lancets used for blood glucose monitoring were disposed of properly for 1 of 1 resident (R13) observed with contaminated lancets disposed of in the resident garbage can. The facility also failed to ensure staff used personal protective equipment (PPE) properly during cleaning of resident care equipment and environmental cleaning for 1 of 1	F 880	Heritage Living Center has an established and has maintained an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 1. Corrective Action for R13: a.) TMA was provided education and	

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F 880	Continued From page 100 resident (R163) identified with Clostridium difficile (C. diff)(bacterium that causes diarrhea and more serious intestinal conditions such as colitis) infection. This had the potential to affect all 59 residents who resided in the facility as well as staff and visitors. Findings include: On 6/19/18, at 6:41 p.m. during the environmental tour of R13's room, three used lancets (a pricking needle device used to obtain drops of blood for testing) were visible in R13's garbage can. On 6/20/18, at 11:23 a.m nursing assistant/trained medication aide (NA)-B was observed to perform R13's blood glucose check. When completed, NA-B placed the used lancet device in the sharps container on the medication cart. NA-B verified there were three used lancet devices visible in in R13's garbage can and stated the lancets were to be disposed of in the sharps container after use. On 06/21/18, at 8:43 a.m. licensed practical nurse (LPN)-A stated she always disposed of used lancets in the sharps container. Policy and Procedure for blood glucose testing was requested but not provided by facility. Arkay glucometer competency checklist (undated) was provided by the facility on 6/22/18, but did not identify the proper disposal method of used lancet devices. According to the Centers for Disease Control and Prevention (CDC) website for Injection Safety	F 880	policy and procedure for proper disposal of lancets. b.) Policy and Procedure was FAXED to MDH after it was written they had not received it. 1. Corrective Action as it relates to R163: a.)CNA involved in the incident was educated and reminded of the correct procedure for residents with C-diff. b.) Housekeeper was given the educational hand outs from previous educational meeting that was given regarding C-diff and the proper procedure for cleaning room. 2. Corrective Action as it relates to others: a.) Policy and Procedure reviewed with all nursing staff on Glucometer procedures. b.) Policy and Procedure for C-diff reviewed with nursing staff and housekeeping. There is no resident on isolation at present time. When a resident is placed on precautions education will be provided and procedure for PPE monitored daily until compliance is met with all staff working that unit. c.) As isolation is needed for other residents education will need to be provided again for all staff. 3. Reoccurrence will be prevented by: a.) Nursing staff will be tested annually on their ability to safely do glucometer checks. b.) Daily checks will be done on each shift for three months to ensure that no lancets are placed in waste baskets. c.) QA will be done daily on each shift for any isolation/infection control procedures required for 90 days. Results will be	

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F 880	Continued From page 101 recommended the disposal of used lancets at the point of use in an approved sharps container. R163's Admission Record provided 6/22/18, indicated R163 had diagnoses which included enterocolitis due to Clostridium difficile (C-Diff: contagious bacterium that could cause symptoms ranging from diarrhea to life threatening inflammation of the colon). R163's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 6/19/18, indicated R163 required extensive assist of 1-2 staff with toileting and incontinence care. R163 had C-diff with related diarrhea and was incontinent of bowel twice during the assessment period. R163's Baseline Care Plan dated 6/7/18, identified R163 had loose stools related to a chronic C-diff infection. The care plan directed staff to follow the C-diff protocol. On 6/18/18, at 12:25 p.m. NA-H stated R163 was on isolation precautions due to his C-diff infection. NA-H stated the staff assisted R163 with perineal cares and ensured everything was bagged and contained in order to prevent the spread of infection. NA-H indicated R163 used to have severe diarrhea but it was more controlled at this time. On 6/20/18, at 8:25 a.m. R163 was not observed in his room, however, a commode was observed positioned at the bedside and a small cart containing PPE was located in the shared area of the two bedroom resident suite. NA-H entered the room wearing gloves but no other PPE. NA-H brought the soiled commode basin from the bedside commode to the bathroom and emptied	F 880	brought to QAPI meeting to see if any further action is required. 4. Plan of Correction will be monitored by; Unit Managers, DON 5. Date of Correction: 0/8/01/18	

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F 880	Continued From page 102 the contents into the toilet. NA-H proceeded to lower the spray arm attached to the toilet and rinsed the commode basin out and dumped it into the toilet. NA-H returned the basin to the bedside commode, removed and discarded her gloves and applied hand sanitizer. NA-H stated the cart in the shared space was placed there due to R163's C-diff infection and verified staff were to wear a gown, gloves and mask when doing any of R163's cares. NA-H stated other than rinsing the commode out in the toilet, the staff did not have to do any else specifically for infection control purposes because R163 used the commode. --At 9:42 a.m. NA-H stated she had forgotten to explain additional cleaning requirements for R163's commode. NA-H stated the staff had a special spray that was to be sprayed onto the commode after emptying it which was locked up and stored in the soiled utility room. NA-H stated she had sprayed the commode after emptying it earlier. --At 1:19 p.m. NA-H retrieved a bottle of Clorox Healthcare Fuzion cleaner disinfectant from the soiled utility room and indicated she had used it to clean R163's commode. NA-H stated the procedure was to spray the commode and toilet with the cleaner and leave to air dry as the cleaner required a two minute contact time for effectiveness. The label of the cleaner indicated it killed C-diff. On 6/21/18, at 8:43 a.m. housekeeping assistant (HA)-A indicated R163's room was cleaned as normal and she was only required to do something different if R163 was in the room, at which time, she needed to wear PPE. HA-A indicated she used the Clorox Healthcare Fuzion cleaner in his room for the toilet, sink and shower and stated the spray was special for his room.	F 880		

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F 880	Continued From page 103 However, HA-A indicated R163's floor was washed with the usual cleaner and surfaces other than the toilet, shower, and sink were cleaned with regular cleaner used for all resident rooms. HA-A stated she wore gloves when cleaning in the room but did not wear any other PPE unless R163 was in the room. On 6/22/18, at 2:36 p.m. registered nurse (RN)-C all staff were to wear a mask, gown and gloves any time they walked into R163's room. RN-C verified isolation precautions for residents with C-diff infection included a private room if available, or a dedicated commode if not. A special cleaner was to be used for cleaning environmental surfaces and any items used to clean the room were to be bagged in a red bag and brought to laundry. RN-C verified gloves, gown and mask should have been worn when cleaning the commode and confirmed housekeeping should have worn a gown, glove and a mask when cleaning R163's room. --At 2:56 p.m. the director of nursing (DON) confirmed she would expect staff to wear, at minimum, gloves and gown when cleaning R163's commode or room. The undated C-diff protocol directed gloves were to be used when entering a resident's room for environmental contact and gowns were to be used if likely resident or environmental soiling.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		8/1/18

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F 921	Continued From page 104 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 drink dispenser drip trays were cleaned and sanitized in 1 of 2 kitchenettes on the second floor and potentially used for 31 of 31 residents who resided on the 2nd floor of the facility. Findings include On 6/19/18, the two kitchenettes on the facility's second floor were both equipped with one coffee and one juice dispenser. The 211-220 hallway kitchenette coffee dispenser drip tray was full of coffee and had a sour odor. The juice dispensers' drip tray had stagnant pinkish fluid with flakes of grayish floating debris with a whitish/gray congealed flaking substance on the bottom. The 200-210 hallway kitchenette's coffee dispenser drip tray had a thin layer of congealed brownish/black film which covered the bottom of the tray. The juice dispenser drip tray had pinkish stagnant fluid with an area of whitish/gray film. On 6/22/18, at 8:22 a.m. the coffee and juice dispensers in both the kitchenettes continued to have the same appearance with no evidence they had been cleaned after 6/19/18, when first observed. -At 8:23 a.m. dietary aide (DA)-C visualized the drip trays and stated the drip trays could stand to be cleaned as they had not been cleaned for awhile. -At 9:36 a.m. the certified dietary manager (CDM) observed and verified the condition of the drip trays and stated the trays needed to be cleaned	F 921	It is the goal of Heritage Living Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. Corrective Action as it relates to all residents, staff and the public: a.) Coffee machines were put out of service 07/13/18. Air pots were ordered 06/19/18 to utilize for resident areas. HLC will utilize pour over system that is set up in activities area by each service kitchen. Coffee pots will not be used even by staff. b.) Juice machines will be removed from resident service areas and staff will provide pitchers of juice in resident refrigerators. C.) Juice machines will be used by dietary staff. They will be cleaned each shift and drip tray will be sent through dishwasher. Farmer Bothers representative checks the juice machine weekly for cleanliness. Dietary Manager and/or cook will check daily to make sure cleaning is complete. 2. Reoccurrence will be prevented by: a.) Education provided to all involved staff. b.) Dietary Manager will monitor new system daily for 90 days. Results will be brought to QAPI meeting to ensure that no further action is needed. 3. Plan of Correction will be monitored by: Dietary Supervisor, Dietary Staff and Administrator. 4. Date of Completion: 08/01/18.	

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F 921	Continued From page 105 as they appeared as though they had not been cleaned as scheduled. The CDM indicated the drip trays were supposed to be washed daily and cleaned after meals, as needed. The undated Facility Checklist For Closing Kitchens directed staff to: Juice Coffee Counter- remove all drains and run through dish machine. The undated facility policy and procedure titled Bag-In Box juice cleaning and Sanitization Protocol Counter Dispensing Systems drip trays should be cleaned daily in warm soapy water followed by flushing with hot water.	F 921		

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

F5405028

PRINTED: 07/20/2018
FORM APPROVED
OMB NO. 0938-0391

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	245405	A. BUILDING 04 - WEST WING B. WING ______	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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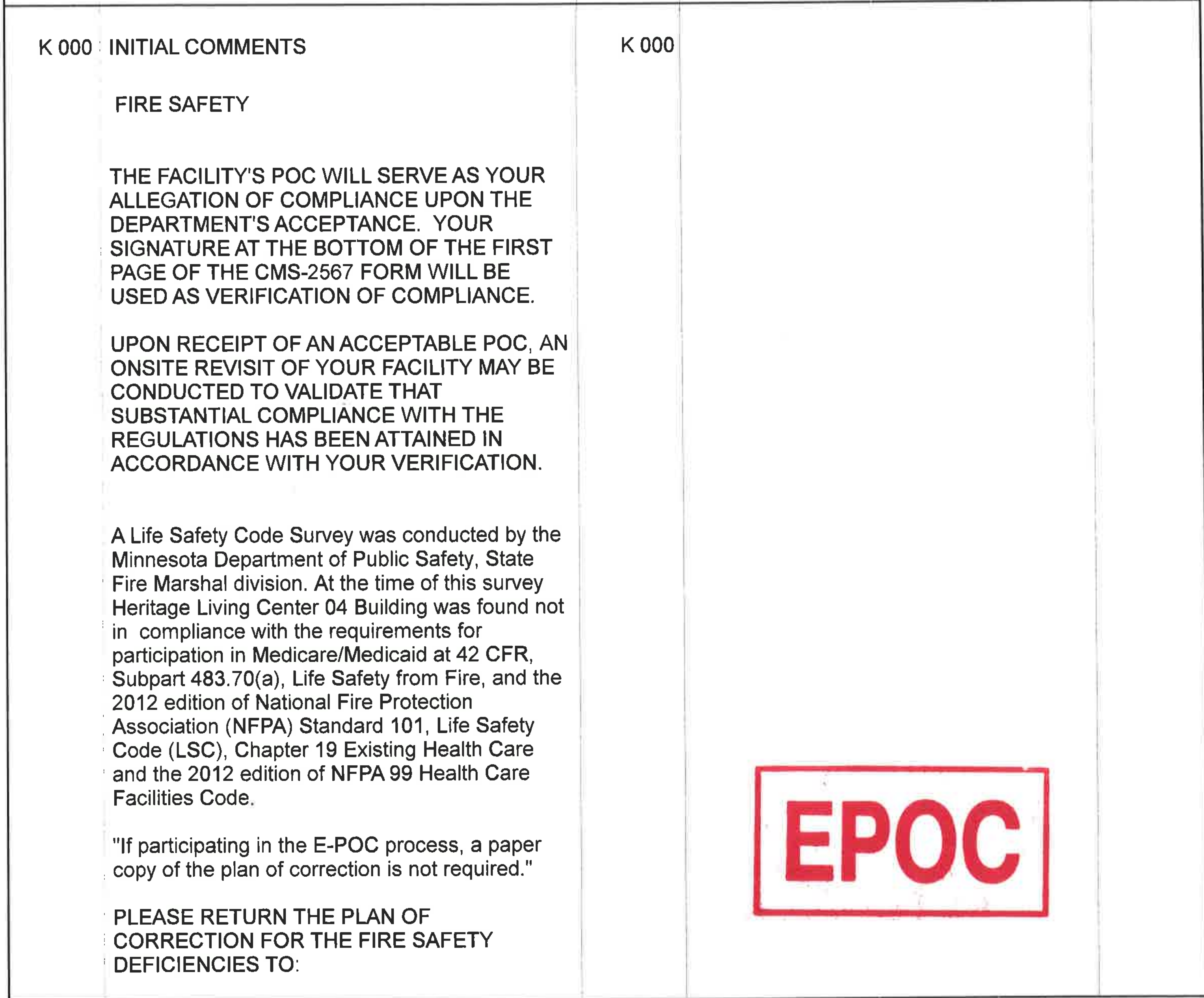

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K 000	INITIAL COMMENTS	K 000		

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 REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal division. At the time of this survey Heritage Living Center 04 Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Health Care Facilities Code.

"If participating in the E-POC process, a paper copy of the plan of correction is not required."

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 07/19/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING **04 - WEST WING** B. WING	**06/20/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	**619 WEST SIXTH STREET** **PARK RAPIDS, MN 56470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Heritage Living Center is a two story building with a partial basement with a construction type of II (111). In 2016/2017 the original building and all additions, except for the 1994 bldg was razed and replaced with new construction. The 1994 addition and basement was left to undergo a complete remodel. The facility has 2 fire barriers separating the Physical Therapy, kitchen, laundry and maintenance areas. The resident wings have 2 smoke barriers separating the north and west wings on each floor. The facility is fully sprinkled per NFPA 13 and has a monitored fire alarm system per NFPA 13. There are smoke detectors in the corridors,	K 000		

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K 000	Continued From page 2 spaces open to the corridors and in the resident rooms. The facility has a capacity of 64 beds and had a census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	K 131	It is the policy of Heritage Living Center to	8/1/18

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K 131	Continued From page 3 facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affect and an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 observations revealed the following. 1. Observations revealed a door in the 2 hour fire barrier along the kitchen wall, was not on a mag hold open and was blocked in the open position by a refrigerator. 2. Observations revealed the cross corridor doors in the 2 hour fire barrier across from the elevator on the first floor had 60 minute doors instead of 90 minute and three softball size holes not properly fire stopped in the wall above the ceiling at the cross corridor doors. 3. Observations revealed a 1 inch x 4 inch penetration not properly fire stopped in the 2 hour fire barrier above the ceiling in front of the PT area. This deficient condition was confirmed by the Maintenance Supervisor.	K 131	maintain the proper two hour fire resistive ratings for occupancies as described in the Life Safety Code. 1. Correct action: a.) Refrigerator was relocated within kitchen area. Magnet will be installed to hold the door open. b.) The 60 minute door will be changed to a 90 minute door. The three softball size holes were fire stopped. c.) The 1 inch X 4 inch penetration was fire stopped in the two hour barrier above the ceiling in front of the PT area. 2. The actual or proposed completion date: 08/01/2018 3. Plan of Correction will be monitored by: Head of Environmental Service and Administrator.	
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure	K 311		8/1/18

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K 311	Continued From page 4 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide fire resistance to 1stair enclosures as described in the 2012 edition of the Life Safety Code, NFPA 101, section 19.3.1.1. This deficient practice could allow for smoke or flame to migrate to another floor affecting an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 observations revealed in the stair shaft leading to the basement from the first floor, a 3 inch diameter hole in the wall. This deficient condition was confirmed by the Maintenance Supervisor	K 311	It is the policy of Heritage Living Center to provide enclosure of vertical openings. 1. Corrective Action: a.) The 3 inch hole in the wall of stair shift leading into basement will be patched by the Mason Contractor. 2. Actual or proposed date of Completion: 08/01/18 3. Plan of correction will be monitored by: Head of Environmental Services and Administrator	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.	K 321		8/1/18

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K 321	Continued From page 5 When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous room and one combustible storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm	K 321	It is the policy of Heritage Living Center to have hazardous areas protected by a fire barrier. 1. Corrective Action: a.)Separation of large storage room and electrical room will be obtained by installation of cement block and patch material. Mason Contractor will be fixing this. b.) The wood shop in the basement shall be separated by sealing the door jamb between the corridor and wood shop by contractor.	

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K 321	Continued From page 6 on 06/19/2018 observations revealed the following. 1. Observations revealed the large storage room in the basement was not separated from the electrical room which consisted of openings in the wall between the two spaces, the door jamb not sealed from the corridor openings in the corridor walls from abated pipes. 2. Observations revealed the wood shop in the basement was not sealed from the corridor. Openings in the corridor walls from abated pipes. This deficient condition was confirmed by the Maintenance Supervisor	K 321	2. Actual or proposed date of Completion: 08/01/18 3. Plan of Correction will be monitored by: Head of Environmental Services and Administrator.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced	K 341		8/1/18

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K 341	Continued From page 7 by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 16 of the 64 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 observations revealed the following. 1. Observations revealed a smoke detector in the laundry cart room across from the laundry was within 36 inches of an HVAC diffuser. 2. Observations revealed a smoke detector in the clean utility room on the second floor not secured to the ceiling, it is hanging from its wires. This deficient condition was confirmed by the Maintenance Supervisor.	K 341	It is the policy of Heritage Living Center to have a fire alarm system and components approved for the purpose to provide effective warning of fire in any part of the building. 1. Corrective Action: a.)The smoke detector in the laundry cart room across from the laundry was moved to a greater distance than the 36 inches from the HVAC diffuser. b.) Smoke detector in the clean utility room on the second floor will be properly secured to the ceiling. 2. Actual or proposed date of completion: 08/01/18 3. Plan will be monitored by: Head of Environmental Services and Administrator.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		8/1/18

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K 345	Continued From page 8 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to verify the DACT signal as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.3 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, table 14.3.1. This deficient condition could delay alarm notification to emergency personnel in case of a failure and affect all 64 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 documentation review revealed there was no record of the transmission of the fire alarm signal the day following the night shift drill. This deficient condition was confirmed by the Maintenance Supervisor.	K 345	It is the policy and procedure of Heritage Living Center to have the fire alarm system tested and maintained in accordance with an approved program and with records of system acceptance, maintenance and testing readily available. 1. Corrective Action: a.) Records will be maintained of the transmission of the fire alarm signal the day following all fire drills. b.) Education was provided by the Administrator 0n 07/19/18 to staff involved. 2. Actual or proposed date of completion: 08/01/18 3. Plan of correction will be monitored by: Head of Environmental Services and Administrator.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _______________	K 353		8/1/18

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K 353	Continued From page 9 b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1, 5.2.5 The standard for testing and maintenance of sprinkler systems & NFPA 13. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all 64 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 the following was revealed. 1. Documentation review revealed there was no record of the annual sprinkler system inspection for 2017. 2. Documentation review there was no record of the 2nd quarter flow test in 2018. 3. Observations revealed the sprinkler head box did not contain 2 of each type of head used in the facility. This deficient condition was confirmed by the Maintenance Supervisor.	K 353	It is the policy and procedure of Heritage Living Center to inspect, test and maintain the automatic sprinkler and standpipe systems. 1. Corrective Action: a.) During construction the 2017 record for the annual sprinkler inspection was missed. A 2018 inspection will be done and a record kept. Environmental Service will conduct an annual sprinkler system inspection. b.) A flow test will be completed now and then quarterly and results recorded. c.) The sprinkler head box will be updated with 2 of each type of head used in the facility by the Sprinkler System Contractor. 2. Actual or proposed date of completion: 08/01/18 3. Plan will be monitored by: Head of Environmental Services and Administrator.	
K 362	Corridors - Construction of Walls	K 362		8/1/18

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K 362 SS=D	Continued From page 10 CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating ______________ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the fire resistance of corridor walls in accordance with the Life Safety Code (NFPA 101) 2012 edition section 19.3.6.2.2. This deficient practice could allow for the spread of smoke and fire making the corridor untenable for exiting, affecting an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 observations revealed the corridor in the basement is not constructed to resist the	K 362	It is the policy of Heritage Living Center to ensure corridors are separated from use areas by walls constructed with at least 1/2 -hour fire resistance rating. 1. Corrective Action: a.) Building project mason will patch all noted holes along the corridor in the basement to resist the passage of smoke. 2. Actual or proposed date of completion: 08/01/18 3. Plan of correction will be monitored by: Head of Environmental Services and Administrator.	

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K 362	Continued From page 11 passage of smoke. Several holes in the wall along its length from abated pipes. This deficient condition was confirmed by the Maintenance Supervisor.	K 362		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain two of four smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 32 of the 64 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 observations revealed the following.	K 372	It is the policy of Heritage Living to construct smoke barriers as per NFPA standards. 1. Corrective Action: a.) The smoke barriers on the first floor in the North and West wings were the wire bundles were located above the cross corridor doors have had the holes filed with rockwool insulation to create the proper fire stopping. b.) The smoke barrier on the second floor west wing was also filled with rockwool insulation to create the proper fire stopping.	8/1/18

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K 372	Continued From page 12 1. Observations revealed the smoke barriers on the first floor in the North & West wings have a wire bundle penetrating the wall above the cross corridor doors not properly fire stopped. 2. Observations revealed the smoke barrier on the 2nd floor west wing, a wire bundle above the cross corridor doors not properly fire stopped. This deficient condition was confirmed by the Maintenance Supervisor.	K 372	2. Actual or proposed date of Completion: 08/01/18 3. Plan of correction will be monitored by: Head of Environmental Services and Administrator.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 64 residents and an undetermined amount of staff and visitors.	K 711	It is the policy and procedure of Heritage Living Center to have a written plan for the protection of all the residents and for their evacuation in the event of an emergency. 1. Corrective Action: a.) The fire safety plan will be updated to address the preparation of floors and	8/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING 04 - WEST WING B. WING ______	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

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K 711	Continued From page 13 Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 documentation review revealed the fire safety plan did not address the preparation of floors and building for evacuation. This deficient condition was confirmed by the Maintenance Supervisor.	K 711	building for evacuation, per our new building. 2. Actual or proposed date of completion: 08/01/18 3. Plan of correction will be monitored by: Safety Committee, Head of Environmental Services and Administrator.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 64 residents and an undetermined amount of staff and visitors. Findings include:	K 712	It is the policy and procedure of Heritage Living Center to hold fire drills at expected and unexpected times under varying conditions, at least quarterly on each shift. 1. Corrective Action: a.) Fire drills will be scheduled as per the Life Safety Code and proper documentation will be completed. b.) Fire drill held 07/18/18 with 39+ staff responding to drill. 2. Actual or proposed date of completion:	8/1/18

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	245405	A. BUILDING **04 - WEST WING** B. WING	**06/20/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 712	Continued From page 14 On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 documentation review revealed there was no record of a fire drill on the 2nd shift of the first quarter in 2018. This deficient condition was confirmed by the Maintenance Supervisor.	K 712	08/01/18 3. Plan of Correction will be monitored by: Safety Committee, Head of Environmental Services and Administrator.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to conduct inspections of all fire rated doors and required by NFPA 101 (12) Life Safety Code, section 7.2.1.15.2 & 7.2.1.15.4. This deficient practice could allow for the spread of fire if the doors were not maintained in accordance with its rating. This could affect all 64 residents and an undetermined amount of staff and visitors.	K 761	It is the policy and procedure of Heritage Living Center to inspect and test fire doors annually in accordance with NFPA 80. 1. Corrective Action: a.) The fire doors will be tested within the next two weeks and then annually. Record of inspections will be kept by the Head of Environmental Services. 2. Actual or proposed date of completion: 08/01/2018	8/1/18

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	245405	A. BUILDING **04 - WEST WING** B. WING ______	**06/20/2018**

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K 761	Continued From page 15 Findings include: On the facility tour between 8:00 am to 1:00 pm on 06/19/2018 documentation review revealed there was no record of inspections for the fire rated doors in the last 12 months. This deficient condition was confirmed by the Maintenance Supervisor.	K 761	3. Plan of Correction will be monitored by: Head of Environmental Services and Administrator.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect all residents, as well as an undetermined number of staff, and visitors. Findings include: On the facility tour, between 8:00 am to 1:00 pm on 06/19/2018 , during record review the facility	K 901	It is the policy and procedure of Heritage Living Center to comply with the NFPA 99 code to complete and keep current a facility Risk Assessment procedure performed by qualified personnel. 1. Corrective Action: a.) Risk assessment document will be updated to include new construction per Administrator. b.) The facility will provide a complete and current facility Risk Assessment in accordance with NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1.	8/1/18

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

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	245405	A. BUILDING **04 - WEST WING** B. WING ______	**06/20/2018**

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K 901	Continued From page 16 was not able to provide a risk assessment document based on NFPA 99. This deficient condition was confirmed by the Maintenance Supervisor.	K 901	2. Actual or proposed date of completion: 08/01/18 3. Plan of care will be monitored by: Safety Committee, Head of Environmental Services, and Administrator.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 64 of 64 residents as well as an undetermined number	K 914	It is the policy and procedure of Heritage Living Center to inspect receptacles in the resident care areas on an annual basis. 1. Corrective Action: a.) Receptacles not listed as hospital-grade will be tested at intervals	8/1/18

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K 914	Continued From page 17 of staff, and visitors to the facility. Findings include: On the facility tour between 8:30 am to 1:00 pm on 06/19/2018 documentation review revealed there was no record of receptacle inspections in the resident care areas in the last 12 months. This deficient condition was confirmed by the Maintenance Supervisor.	K 914	not exceeding 12 months. Records will be kept by Environmental Service Director. 2. Actual or proposed completion date: 08/01/18 3. Plan of correction will be monitored by: Head of Environmental Services and Administrator.	