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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HL2V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**
2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH FOSSTON**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/25/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 10/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/08/2015 (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
01/01/1988
(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
09/28/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245512

October 8, 2015

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

Dear Mr. Dish:

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

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

Effective September 22, 2015 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 8, 2015

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512025

Dear Mr. Dish:

On August 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 13, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 25, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 22, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 13, 2015, effective September 22, 2015 and therefore remedies outlined in our letter to you dated August 26, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245512	A. Building B. Wing	9/25/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/22/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/22/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/22/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/22/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	10/08/2015	33562	09/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/13/2015			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

October 8, 2015

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: Reinspection Results - Project Number S5512025

Dear Mr. Dish:

On September 25, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 13, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

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

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00461	A. Building B. Wing	9/25/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **09/22/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **09/22/2015**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	Correction Completed **09/22/2015**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **09/22/2015**	ID Prefix **20835** Reg. # **MN Rule 4658.0520 Subp. 2 A** LSC	Correction Completed **09/22/2015**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **09/22/2015**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4 A-I** LSC	Correction Completed **09/22/2015**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **09/22/2015**	ID Prefix **21675** Reg. # **MN Rule 4658.1410** LSC	Correction Completed **09/22/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	10/08/2015	33562	09/25/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/13/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HL2V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**

2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH FOSSTON**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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 **08/13/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Rebecca Haberle, HFE NEII — 09/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/28/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH
Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 26, 2015

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512025

Dear Mr. Dish:

On August 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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 a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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 September 22, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 22, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		9/22/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to include the use of wheelchair positioning devices and positioning needs for 1 of 1 resident (R33) who required the use of positioning devices. Findings include: R33's care plan dated 7/20/15, directed staff to assist R33 with transfers due to history of a stroke with left sided weakness. The care plan did not address any special wheelchair positioning needs. On 8/11/15, at 10:32 a.m. R33 was observed seated in a wheelchair in the south dining room. R33's wheelchair was observed equipped with a built up, left arm rest (lateral support). A full sized bed pillow was observed on top of the arm rest and tucked into the side of the chair next to R33. R33's left arm was observed positioned on top of the pillow. At the time of the observation, R33's left arm was observed to fall off the pillow and hang down the side of the chair. R33's arm was observed to hang until 11:02 a.m. at which time a physical therapy assistant (PTA) was observed to reposition R33's arm on top of the pillow / arm rest. On 8/12/15, at 11:57 a.m. R33 was observed seated in her wheelchair with a bed pillow under her left arm. R33's left arm was observed resting on her lap with the hand positioned over the end of her knees in a dependent position. R33's fingers and hand were observed to be a deep red/purple color. R33 was not observed to move	F 279	First Care Living Center policies require the development of, review, and revision of the resident¿s comprehensive plan of care with measurable objectives and timetables to meet a resident¿s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. A. Review and updates to Care Plan Comprehensive, Care Planning and Revision of Care Plan, Care Plan Audit policies completed 9-3-15. B. Review and updates to Repositioning Policy & Preventative and Alternative Device Policy completed 9-3-15. C. OT re-eval of left arm support and Care Plan update of R33 on 8-14-15, PT re-eval and Care Plan update of R33 on 8 -31-15. Plan to continue therapies 5x week and make ongoing changes as needed. D. RN MDS Coordinator completed a comprehensive assessment and care plan updates for resident R33 for left arm posey support cushion on her wheelchair on 8/30/15. E. All residents with positioning devices will have RN re-assessment and Care Plan review/updates by 9-22-15. Ongoing assessments and care plan implemented with new residents or change in status of current residents. F. Point of care charting in EHR system for task to be signed off by NARs. G. All staff attendees educated for compliance with following care plan for	

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F 279	Continued From page 2 her hand into a position in which her hand would not be a dependent and allow for blood flow. On 8/12/15, at 12:50 p.m. R33 was observed sleeping in her wheelchair in her room. PTA-A walked by R33's room and asked if R33 was alright. PTA-A stated R33's left hand frequently fell off of the arm rest or pillow. He stated R33's hand was not be strapped into the arm support device but rather resting on a pillow. PTA-A stated R33 did not have the ability to independently reposition her hand therefore staff would have to move her hand and reposition when needed. On 8/13/15, at 10:47 a.m. R33 was interviewed in her room. A 1/4 lap tray was observed sitting on the floor of her room. R33 stated staff had attempted to use the lap tray to hold her left arm/hand in place on the chair, but the tray cut into her ribs and was not comfortable. She stated staff had placed the blue arm rest cushion on her chair but that too was not enough to keep her arm in place on the wheelchair. R33 stated staff then started using the bed pillow to support her hand. She verified she was not able to move her left hand by herself and it had frequently fell off of the pillow support. The blue lateral support device was observed to cover the arm rest, however, the foam was observed sticking out of the lateral support next to the wheelchair armrest. On 8/13/15, at 10:55 a.m. NA-B stated R33's left arm frequently fell off of the positioning pillows. She stated staff had to reposition the arm several times a day as R33 was not able to reposition the arm back on the pillow independently. On 8/13/15, at 11:00 a.m. registered nurse (RN)-A stated the lateral supports on the	F 279	proper positioning devices at Licensed Staff meeting 9-2-15 and NAR staff meeting 9-3-15. H. Staff not attending provided education on Repositioning Policy & Preventative & Alternative Device policy, and Care Plan policy to be read/understood prior to their next scheduled shift and with all new employee orientation. I. RN Coordinators will audit by visual observation to ensure all residents are having their care plans followed for positioning device weekly until satisfactory x 4 weeks, then randomly thereafter and will document audit results. J. DON or her designee will audit documentation by nursing staff, MDS coding, and Care Plan for 3 residents weekly x 4 weeks until satisfactory, then randomly thereafter and will document results. K. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly. L. Completion date 9-22-15.	

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F 279	Continued From page 3 wheelchair were placed by occupational therapy to ensure proper body alignment while in the wheelchair. RN-A reviewed the care plan and verified the plan did not address what type of supports were needed in / on R33's wheelchair. On 8/13/15, at 12:20 p.m. the director of nurses verified R33's care plan did not address supportive devices to be used while in the wheelchair. On 8/13/15, at 2:55 p.m. contact with the occupational therapist was attempted without success. A policy related to care plan development was requested and none was provided.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		9/22/15

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include target behaviors for the use of antianxiety medication for 1 of 5 residents (R55) who received anti-anxiety medication. Findings include: R55's quarterly Minimum Data Set (MDS) dated 7/28/15, indicated R55 had moderate cognitive impairment and diagnoses that included anxiety, depressive disorder and hypertension. The MDS also identified R55 felt down, depressed or hopeless one day during the assessment period and felt tired or having had little energy nearly everyday. The MDS further identified R55 received antianxiety medication daily. R55's Psychotropic Medication Use Care Area Assessment (CAA) dated 4/30/15, indicated R55 had a diagnosis of anxiety and was on alprazolam (an antianxiety medication) to help with her feelings of anxiousness. R55's Care Plan dated 8/5/15, identified R55 received anti-anxiety medication for the treatment of anxiety and directed staff to monitor for drug use effectiveness and adverse consequences, monitor mood and response to medication and update family and doctor of any concerns. The Care Plan also indicated the pharmacy consultant would review R55's medications monthly. However, the Care Plan did not identify target behaviors related to R55's anxiety.	F 280	First Care Living Center policies require the residents/family/legal representative to participate in planning care and treatment or changes in care and treatment. Care plans are developed by interdisciplinary team within 7 days after the comprehensive assessment is done. Care plan reviewed and revised at least quarterly and with significant changes in plan of care. A. Review and update to Care Plan Preliminary policy, Care Planning & Revision of Care Plan policy completed 9-3-15. B. Review and updates to the Behavior Monitoring Policy completed 9-3-15. C. Care plan revision 8-20-15 completed for R55 to include identified target behaviors for the use of antianxiety medication per RN MDS Coordinator assessment. D. RN MDS Coordinator assessment and care plan updates for all residents on an antianxiety medication to include identified target behaviors. E. Primary care physician visit for R55 on 9-2-15 confirms therapeutic level of antianxiety medication regimen . F. Point of care charting in EHR system for task to be signed by NARs, to identify target behaviors of all residents on an antianxiety medication. G. Psychopharmacologic Medication Use	

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F 280	Continued From page 5 On 08/13/2015, at 1:39 p.m. registered nurse (RN)-A confirmed target behaviors were not identified or monitored for R55's anxiety and alprazolam use. On 08/13/2015, at 2:29 p.m. the director of nursing (DON) confirmed target behaviors were not identified or monitored for R55 and verified the care plan lacked target behaviors. No policy regarding care plan revision was provided.	F 280	in LTC inservice scheduled with Pharmacy consultant 9-28-15 to focus on target behavior charting. H. IDT team meetings monthly to review resident target behaviors. I. SSD or her designee will audit R55 documentation of target behaviors weekly x 4 weeks, and then audit monthly charting/target behaviors on all residents receiving antianxiety medication. J. All licensed staff attendees educated for compliance with identifying target behaviors and to document findings in EHR at licensed staff meeting 9-2-15. K. All NAR staff attendees educated for reporting indentified target behaviors to charge nurse & charting on task in EHR at NAR meeting 9-3-15. L. Staff not attending provided education on Behavior Monitoring Policy to be read/understood & education on charting on task in EHR prior to their next scheduled shift and with all new employee orientation. M. Compliance will be added to our QA program by DON and reported to QAPI meetings monthly. N. Completion date 9-22-15.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		9/22/15

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F 282	Continued From page 6 by: Based on observation, interview and document review, the facility failed to provide repositioning assistance as directed by the individualized care plan for 1 of 1 resident (R10) reviewed with an active pressure ulcer. Findings include: R10's care plan dated 6/24/15, indicated R10 was at risk for pressure ulcers related to decreased mobility. The plan also indicated R10 had a current pressure ulcer on her mid back, along the spine, and directed staff to keep a pressure reducing cushion on the seat and back of R10's wheelchair and to offload (relieve pressure) R10 every 1.5 hours while seated. On 8/12/15, from 12:50 p.m. to 3:37 p.m. R10 was continuously observed seated in a standard recliner in the front lobby area. The recliner was not observed to contain any type of pressure redistribution cushions. During the observation, R10 was not observed to be repositioned. -At 3:30 p.m. NA-E stated R10 was to receive assistance with repositioning every three hours. -At 3:37 p.m. nursing assistant (NA)-C and NA-D were observed to assist R10 to stand and transfer into a wheelchair. At this time, NA-C stated R10 had sat in the recliner since 12:30 p.m. a total of three hours and seven minutes. On 8/12/15, at 4:40 p.m. R10 was observed seated in the south dining room waiting for the evening meal. R10's wheelchair was observed equipped with a foam redistribution cushion on the seat and the back of the chair. R10 remained in the dining room until 5:26 p.m. at which time she was wheeled into the main lobby area. R10	F 282	First Care Living Center strives to provide services by qualified persons in accordance with each resident¿s written plan of care. A. Review and update to Care Plan Preliminary policy completed 9-3-15. B. Review and updates to Repositioning Policy and Monitoring, Turning, Repositioning and Toileting Policy completed 9-3-15. C. RN MDS Coordinator completed a comprehensive assessment, tissue tolerance, and care plan review/updates for R10 on 8-10-15. D. All residents at risk for pressure ulcers will have RN re-assessment, care plan review/ updates, and updates to NA care sheets/EHR profile for appropriate repositioning schedule by 9-22-15. E. All new residents have Preliminary Care Plan implemented within 24 hours of admission by RN MDS Coordinators or their designee. F. Review & Updates will be maintained by RN MDS coordinators quarterly, with each change of condition, or change in seating device. G. DON or her designee will audit appropriate repositioning schedules on 2 residents at risk for pressure ulcers weekly x 4 weeks until satisfactory then randomly. H. Licensed staff education provided on Repositioning Policy & repositioning schedules for all residents with risk for pressure ulcers 9-2-15. I. Education for NARs on Repositioning	

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F 282	Continued From page 7 remained in her wheelchair during the evening activities. -At 6:20 p.m. NA-F was observed to wheel R10 into the restroom. -At 7:12 p.m. NA-F stated R10 was to be repositioned every 2-3 hours She verified R10 had not been assisted since 4:30 p.m. a total of 1 hour and 50 minutes earlier. On 8/13/15, at 8:46 a.m. licensed practical nurse (LPN)-D was observed to compete wound care on R10's mid-spine following a bath. The old dressing had been removed during the bath. LPN-D measured the wound and reported the open area measured 1.4 cm x 0.4 cm. The wound bed was pink with a small amount of yellow slough. On 8/13/15, at 11:00 a.m. NA-B stated R10 was to be positioned every hour while seated in the wheelchair because of the sore on her back. On 8/13/15, at 12:00 p.m. registered nurse (RN)-A stated R10 was to be repositioned every 1.5 hours when seated in the wheelchair, as directed by the care plan. On 8/13/15, at 12:30 p.m. the director of nurses confirmed R10 was to be repositioned every 1.5 hours as directed by the care plan. A policy related to implementation of the care plan was requested and none was provided.	F 282	Policy & repositioning schedules for all residents with risk for pressure ulcers on NA care sheets and accessing the resident profile on the EHR system at NAR 9-3-15. J. Staff not attending provided education on the Repositioning Policy and repositioning schedules, for all residents with risk for pressure ulcers, to be read and understood prior to their next scheduled shift and with all new employee orientation. K. LPNs will put laminated ¿purple eggs¿ underneath a resident when in wheelchair or bed, then the NARs return the ¿purple egg¿ to the LPN when found & document results. Documentation on Purple Egg Monitoring Form will be reviewed by DON or her designee weekdays at AM report. This will reveal the length of time between repositioning of residents. Purple Egg audits done weekly on 10 residents who are at risk for pressure ulcers x 4 weeks until satisfactory, then randomly thereafter. Current staff are familiar with the ongoing purple egg practice and all new staff will be educated to the repositioning auditing practice in orientation. L. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly. M. Completion date 9-22-15.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		9/22/15

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F 309	Continued From page 8 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper wheelchair positioning for 1 of 1 resident (R33) in the sample reviewed for wheelchair positioning needs. Findings include: R33's admission Minimum Data Set (MDS) dated 7/6/15, indicated R33 had intact cognition, was diagnosed with diabetes mellitus and a history of a stroke with left sided weakness. The MDS also indicated R33 required extensive assistance of two staff for bed mobility, transfers and was unable to ambulate. R33's Activities of Daily Living Care Area Assessment (CAA) dated 7/14/15, indicated R33 was unable to be independent in mobility following her stroke. R33's care plan dated 7/20/15, directed staff to assist R33 with transfers. The care plan did not address any special wheelchair positioning needs. On 8/11/15, at 10:32 a.m. R33 was observed seated in a wheelchair in the south dining room. R33's wheelchair was observed equipped with a built up, left arm rest (lateral support). A full sized	F 309	First Care Living Center will ensure that each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. Review and updates to Preventative and Alternative Devices Policy completed 9-3-15. B. OT re-eval of left arm support and Care Plan update of R33 on 8-14-15, PT re-eval and Care Plan update of R33 on 8 -31-15. Plan to continue therapies 5x week and make ongoing changes as needed. C. RN MDS Coordinator completed a comprehensive assessment and care plan updates for resident R33 for left arm posey support cushion on her wheelchair on 8/30/15. D. All residents with positioning devices will have RN re-assessment and Care Plan review/updates by 9-22-15. E. Upon admit/readmit to facility, and with significant changes, residents will be assessed for use of preventative and alternative devices by therapy or Licensed staff. Education provided to direct care	

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F 309	Continued From page 9 bed pillow was observed on top of the arm rest and tucked into the side of the chair next to R33. R33's left arm was observed positioned on top of the pillow. At the time of the observation, R33's left arm was observed to fall off the pillow and hang down the side of the chair. R33's arm was observed to hang until 11:02 a.m. at which time a physical therapy assistant (PTA) was observed to reposition R33's arm on top of the pillow / arm rest. On 8/12/15, at 11:57 a.m. R33 was observed seated in her wheelchair with a bed pillow under her left arm. R33's left arm was observed resting on her lap with the hand positioned over the end of her knees in a dependent position. R33's fingers and hand were observed to be a deep red/purple color. R33 was not observed to move her hand into a position in which her hand would not be a dependent and allow for blood flow. On 8/12/15, at 12:50 p.m. R33 was observed sleeping in her wheelchair in her room. PTA-A walked by R33's room and asked if R33 was alright. PTA-A stated R33's left hand frequently fell off of the arm rest or pillow. He stated R33's hand was not be strapped into the arm support device but rather resting on a pillow. PTA-A stated R33 did not have the ability to independently reposition her hand therefore staff would have to move her hand and reposition when needed. On 8/13/15, at 10:47 a.m. R33 was interviewed in her room. A 1/4 lap tray was observed sitting on the floor of her room. R33 stated staff had attempted to use the lap tray to hold her left arm/hand in place on the chair, but the tray cut into her ribs and was not comfortable. She stated staff had placed the blue arm rest cushion on her	F 309	staff under the direction of licensed staff on how to use the positioning devices. F. Point of care charting in EHR system for task to be signed off by NARs. G. All staff attendees educated for compliance with following care plan for proper positioning devices for R33 and all other residents with positioning devices at Licensed Staff meeting 9-2-15 and NAR staff meeting 9-3-15. H. Staff not attending provided education on Preventative and Alternative Device Policy & Care Plan policy to be read/understood prior to their next scheduled shift and with all new employee orientation. I. RN Coordinators will audit by observation to ensure all residents are following care plan for positioning device weekly until satisfactory x 4 weeks, then randomly thereafter and will document audit results. J. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly. K. Completion date 9-22-15.	

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F 309	Continued From page 10	F 309		

chair but that too was not enough to keep her arm in place on the wheelchair. R33 stated staff then started using the bed pillow to support her hand. She verified she was not able to move her left hand by herself and it had frequently fell off of the pillow support. The blue lateral support device was observed to cover the arm rest, however, the foam was observed sticking out of the lateral support next to the wheelchair armrest.

On 8/13/15, at 10:55 a.m. NA-B stated R33's left arm frequently fell off of the positioning pillows. She stated staff had to reposition the arm several times a day as R33 was not able to independently reposition the arm back on the pillow.

Review of R33's clinical record indicated R33 was receiving occupational therapy five days a week for treatment related to the stroke.

R33's occupation therapy progress note dated 7/16/15, indicated R33's half tray on the wheelchair was changed out to a lateral arm support as she leaned heavily into the tray at times which may have been the contributing factor to R33's sore rib area on the left. The note continued to explain R33's arm did not remain on the lateral arm support and directed the arm to be strapped / secured into place on the support in which R33 had the ability to independently release the straps.

R33's clinical record lacked further documentation related to wheelchair positioning devices.

On 8/13/15, at 11:00 a.m. registered nurse (RN)-A stated R33's lateral arm support were placed on the wheelchair by occupational therapy.

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F 309	Continued From page 11 RN-A reviewed R33's clinical record and verified the record had not directed staff how to position R33's hand on the support device nor direct staff to use a bed pillow, lateral support or lap tray. She stated R33 did not have the ability to consistently reposition her hand and was dependent upon staff for positioning. RN-A verified R33's care plan did not direct staff how to position R33's hand or what supportive devices was to be used. On 8/13/15, at 12:20 p.m. the director of nurses verified R33's clinical record did not address support devices to be used while in the wheelchair. On 8/13/15, at 2:55 p.m. contact with the occupational therapist was attempted without success. Review of the Repositioning policy dated 8/2006, directed staff to ensure proper postural alignment while in the wheelchair. It did not direct the staff how to use positioning devices.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		9/22/15

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F 314	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning assistance as directed by the individualized care plan in order to prevent and / or promote the healing of pressure related ulcers for 1 of 1 resident (R10) who had an active pressure ulcer and required staff assistance for repositioning. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/15/15, indicated R10 was diagnosed with anxiety, orthopnea (difficulty breathing while lying), one stage two (partial thickness, the outer layer of skin and part of the underlying layer of skin is damaged or lost.) pressure ulcer and was at risk for the development of pressure ulcers. The MDS also indicated R10 required extensive assistance with bed mobility, transferring and activities of daily living. R10's Pressure Ulcer Care Area Assessment (CAA) dated 3/27/15, indicated R10 required extensive assistance with bed mobility, had a stage one pressure ulcer which was at risk of worsening and having increased pain. R10's care plan dated 6/24/15, indicated R10 was at risk for pressure ulcers related to decreased mobility. The plan also indicated R10 had an active pressure ulcer on her mid back along the spine and directed staff to keep a pressure reducing cushion in the seat and the back of the wheelchair and to offload (relieve pressure) R10 every 1.5 hours while seated. R10's Braden Assessment (skin risk assessment)	F 314	First Care Living Center will ensure that a resident who enters the facility without a pressure sore does not develop pressure sores unless the individual¿s clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. A. Review and update to Skin Assessment policy completed 9-2-15. B. Review and updates to Repositioning Policy completed 9-2-15. C. Review and updates to Preventative and Alternative Device policy completed 9 -3-15. D. RN MDS Coordinator completed a comprehensive assessment, tissue tolerance, and care plan review/updates for R10 on 8-10-15. E. All residents at risk for pressure ulcers will have RN re-assessment, current tissue tolerance, care plan review/updates, and updates to NA care sheets/EHR profile for appropriate repositioning schedule by 9-22-15. F. Review & Updates will be maintained on NA care sheets/ EHR profile by RN MDS coordinators quarterly, with each change of condition, or change in seating device. G. DON or her designee will audit appropriate repositioning schedule documentation of Purple Egg Monitoring forms on 10 residents at risk for pressure ulcers weekly x 4 weeks until satisfactory	

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F 314	Continued From page 13 dated 6/15/15, indicated R10 was at risk for the development of pressure ulcers. R10's quarterly Tissue Tolerance (pressure redistribution) assessment dated 6/12/15, indicated R10 was at risk for ulcers and directed staff to assist R10 with repositioning every 1.5 hours while seated and every 3 hours while in bed. Review of R10's progress notes revealed the following: - 3/21/15, R10 was admitted to the facility with two stage one (redness, skin may be painful, but it has no breaks or tears) pressure ulcer on her mid back along her spine. The wounds measure 5.0 cm x 6.0 cm centimeters (cm) and 4.0 cm x 2.6 cm. The staff placed a pressure reducing mattress on her bed and placed a Mepilex dressing on the wounds to prevent worsening. - 4/28/15, the wounds had opened. The center was cream colored measuring 0.7 cm x 0.6 cm. The skin surrounding the wound measured 0.9 cm x 0.8 cm and was red in color. - 6/5/15, the mid back wound had opened. The wound measured 1.7 cm in length and 6.0 cm in width. - 6/11/15, the red area in the mid spine measured 10.0 cm x 6.4 cm with a centralized open area which measured 1.9 x 1.2 cm with cream colored slough. - 6/12/15, R10 was placed on an every 1.5 hour repositioning schedule. The record indicated "primary area of concern is her back so this	F 314	then randomly. H. Licensed staff education provided on Skin Assessment Policy and Repositioning Policy & repositioning schedules for all residents with risk for pressure ulcers 9-2-15. I. Education for NARs on Repositioning Policy & repositioning schedules for all residents with risk for pressure ulcers on NA care sheets and accessing the resident profile on the EHR system at NAR 9-3-15. J. Staff not attending provided education on the Repositioning Policy and repositioning schedules, for all residents with risk for pressure ulcers, to be read and understood prior to their next scheduled shift and with all new employee orientation. K. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly. L. Completion date 9-22-15.	

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needs to be fully offloaded."

- 6/23/15, dressing to the back was changed. Wound measured 6.0 cm x 3.0 cm with light green and white non-odorous wound bed surrounded by a thin red border.

- 7/2/15, wound measured 3.4 cm x 2.9 cm and 0.1 cm depth. The wound was covered with a duoderm dressing.

- 7/9/15, the wound measured 3.4 cm by 2.2 cm with beefy red center and rolled outer edges that is pink scar tissue.

- 7/16/15, the wound measured 2.4 cm x 1.4 cm with pink scar tissue with rolled edges surrounding.

- 7/23/15, the wound measured 2.6 x 1.4 cm with a beefy red center with small specks of cream colored slough also mixed in.

- 7/23/15, a second note indicated R10 was seen by her primary physician which directed staff to avoid prolonged pressure on the back ulcer.

- 7/30/15, the wound measured 2.5 x 1.2 cm. The center continued to be beefy red with rolled edges.

- 8/6/15, the wound measured 2.0 cm x 3.0 cm without drainage. There was a second wound to the side of the main wound which measured 2.0 cm x 0.5 cm.

On 8/12/15, from 12:50 p.m. to 3:37 p.m. R10 was continuously observed seated in a standard recliner in the front lobby area. The recliner was

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not observed to contain any type of special pressure redistribution cushions. During this observation, R10 was not observed to reposition.
-At 3:30 p.m. NA-E stated R10 was to receive assistance with repositioning every three hours.
-At 3:37 p.m. nursing assistant (NA)-C and NA-D were observed to assist R10 to stand and transfer into a wheelchair. At this time, NA-C stated R10 had sat in the recliner since 12:30 p.m. for a total of three hours and 7 minutes without repositioning assistance.

On 8/12/15, at 4:40 p.m. R10 was observed seated in the south dining room waiting for the evening meal. R10's wheelchair was observed equipped with a foam redistribution cushion on the seat and the back of the chair. R10 remained in the dining room until 5:26 p.m. at which time she was wheeled into the main lobby area. R10 remained in her wheelchair during the evening activities.
-At 6:20 p.m. NA-F was observed to wheel R10 into the restroom.
-At 7:12 p.m. NA-F stated R10 was to be repositioned every 2-3 hours. NA-F verified R10 had not been repositioned since 4:30 p.m. a total of 1 hour and 50 minutes earlier.

On 8/13/15, at 8:46 a.m. licensed practical nurse (LPN)-D was observed to compete wound care on R10's mid-spine following a bath. The old dressing had been removed during the bath. LPN-D measured the wound and reported the open area measured 1.4 cm x .4 cm. The wound bed was pink with a small amount of yellow slough. The small open area along the main wound was healed. LPN-D stated the second wound was a skin reaction to tape. She

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F 314	Continued From page 16 explained the facility was now using a more gentle tape on R10's wound area. On 8/13/15, at 11:00 a.m. NA-B stated R10 was to be positioned every hour while seated in the wheelchair because of the sore on her back. On 8/13/15, at 12:00 p.m. registered nurse (RN)-A stated R10 was to be repositioned every 1.5 hours when seated in the wheelchair, as directed by her care plan. RN-A stated staff had been educated on how to ensure R10 was offloaded off of the back every 1.5 hours and should have provided that assistance. RN-A verified R10 routinely sat in a recliner in the lobby area however, the facility had not placed a pressure redistribution cushion in that chair. She verified R10 required additional interventions and was to be repositioned according to the care plan. On 8/13/15, at 12:30 p.m. the director of nurses confirmed R10 was to be repositioned every 1.5 hours as directed by the care plan. The Repositioning policy dated 8/2006, directed staff to reposition the resident according to the individual tissue tolerance assessment.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		9/22/15

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F 323	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure causal factors were identified and adequate interventions had been implemented in order to minimize the risk of falls / accidents and / or injury for 1 of 1 resident (R10) identified at risk for falls. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/15/15, indicated R10 had severe cognitive impairment, was at risk for falls and required extensive staff assistance with bed mobility, transferring and activities of daily living. The MDS also indicated R10 was diagnosed with anxiety, orthopnea (difficulty breathing when lying) and pain. In addition, the MDS indicated R10 had sustained two or more falls within the MDS reference period. R10's Falls Care Area Assessment (CAA) dated 4/2/15, indicated R10 required extensive assistance with activities of daily living and had poor balance. The assessment indicated she had the potential for continued falls and potential for injury. R10's Fall assessment dated 6/10/15, indicated R10 was at high risk for falls. R10's care plan dated 6/24/15, indicated R10 was	F 323	First Care Living Center will ensure resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. IDT team met 9-1-15 to review processes for LTC Fall Prevention Program and EHR event: Falls Scene Investigation Report. B. RN MDS Coordinator assessment and care plan updates for R10 for fall interventions and fall prevention devices completed on 8-30-15. C. All residents will have falls risk assessment by RN MDS Coordinator and care plan updates for fall interventions and fall prevention devices by 9-28-15. D. All LTC Staff will be provided education to ensure the Falls Scene Investigation Report is filled out completely and to ensure new interventions immediately/care plan updates with each resident fall at Licensed Staff Meeting 9-2-15 and NAR staff meeting on 9-3-15. E. Staff not attending provided education on the LTC Fall Prevention Program and completing the Falls Scene Investigation Report completely, implementing new interventions at the time of the fall & to update care plan, to be read and understood prior to their next scheduled shift and with all new employee orientation. F. RN MDS Coordinator will review and	

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F 323	Continued From page 18 risk for falling related to decreased mobility, history of falls and was to be on a fall prevention program. The plan directed staff to utilize anti-roll back wheelchair devices, a chair alarm, remind R10 to ask for assistance to ambulate and transfer, to keep R10's bed in the lowest position with brakes locked, to ensure R10 wore proper foot wear and to keep R10 in a highly visualized area when restless. Review of R10's Event Reports revealed the following: - 3/21/15, at 4:15 a.m. R10 was found on the floor in her room next to her night stand. No injuries sustained. The facility updated R10's toileting plan to include assisting R10 to the toilet every 4 hours at night. In addition R10's bed was to be placed in the lowest position. - 3/31/15, at 5:50 a.m. R10 was found on the floor in her room. No injuries were noted. The follow up report indicated R10 was very spontaneous and did not recognize danger to self. The bed was in the lowest position. The report directed staff to allow R10 to sleep in the common area at night. - 4/19/15, at 6:00 a.m. R10 was found on the floor in the hallway. R10 sustained a bruise to her right buttock. The facility made no changes to R10's fall interventions at that time. - 5/5/15, at 8:56 a.m. R10 was seated at the dining room table, stood up and attempted to independently walk and fell. No injuries. The falls team meeting note indicated R10 was working with restorative nursing on a walking program as	F 323	audit all falls using the Falls Scene Investigation Report to ensure it is complete and care plan updates prior to weekly falls meetings. G. Fall Prevention Team will meet weekly and will consist of DON, SSD, ADM, Therapy, Nursing staff. Team will assist to determine of root cause and suggest interventions to track and review fall trending information. IDT team will each week audit all Falls Scene Investigation reports for interventions/care plan updates. H. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly. I. Completion date 9-22-15.	

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R10 was not able to walk on her own. No other changes were made to R10's care plan following the fall.

- 6/6/15, at 2:40 a.m. R10 was found on the floor with her back against her bed. No injuries. The staff placed a body pillow next R10 while in bed. On 6/9/15, the director of nurses removed the body pillow to ensure R10 was not restrained. No other changes were made to R10's care plan following the fall.

- 6/20/15, at 7:30 p.m. R10 was found on the floor in the lobby area. R10's chair alarm was sounding. R10 had attempted to stand and sat down. No injuries. The Falls Team meeting note indicated "unidentified need not met," R10 stated she was "going to stand up." No other changes were made to R10's care plan following the fall.

- 6/25/15, at 8:20 p.m. R10 was found on the floor in the South wing public restroom. No injury noted. The record did not contain further documentation related to the fall.

- 7/21/15, 12:27 p.m. R10 was found on the floor next to her bed. The bed alarm was working. No injuries noted. No changes were made to R10's care plan following the fall.

-7/21/15, at 3:45 p.m. R10 was assisted out of the facility by a visitor. R10 wheeled her wheelchair off of the curb outside and fell. No injury noted. The Falls Team meeting notes indicated a wandergaurd was placed to alert staff of when R10 left the facility.

On 8/12/15, at 3:24 p.m. nursing assistant (NA)-C

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and NA-D were observed to extensively assist R10 from the recliner and into a wheelchair. R10 was observed to be able to stand and pivot transfer into the wheelchair with the NAs weight bearing assistance.
-At 3:27 p.m. R10 was assisted to the toilet. R10 was observed to hang onto the bathroom safety bars and transfer with extensive assistance of the two nursing assistants.
-At 4:38 p.m. R10 was observed seated at a table in the South dining room.

On 8/12/15, at 7:07 p.m. licensed practical nurse (LPN)-A stated when a resident fell, the nurse assessed the resident to make sure they were not injured, assisted the resident off of the floor and then attempted to figure out why the resident fell. LPN-A stated R10 often attempted to transfer herself from bed. She stated R10 had an alarm on her bed to alert the staff when she was trying to get up.

On 8/12/15, at 7:15 p.m. NA-F stated R10 had a history of falls. She stated staff tried to monitor her as much as possible.

On 8/12/15, at 7:15 p.m. NA-G stated R10 was to have a bed alarm on the bed and chair to alert staff she needed assistance.

On 8/13/15, at 6:58 a.m. R10 was observed asleep, in bed. R10's bed was equipped with a standard mattress with a gel overlay and a bed alarm.

On 8/13/15, at 7:10 a.m. NA-H and NA-I were observed to assist R10 from bed. R10 required extensive assistance. R10 was not observed to straighten her legs or participate with weight

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bearing during the transfer.

On 8/13/15, at 11:30 a.m. registered nurse (RN)-A stated the facility fall process was to make an immediate assessment for injuries following the fall and then review to look for the root cause of the fall by talking to the staff and determining interventions based on the root cause followed by updating the care plan.

On 8/13/15, at 12:35 p.m. the director of nurses (DON) stated following each fall, the facility performed an immediate assessment of the resident and reviewed the situation to determine if the fall could have been anticipated / prevented. The DON stated the 6/6/15, fall intervention of placement of a pillow was discontinued as the facility did not approve of the use of body pillows as an effective intervention, rather a restraint device. When the DON was asked what further interventions were implemented following the falls, the DON did not respond.

On 8/13/15, at 3:07 p.m. RN-A stated the facility completed a comprehensive fall assessment quarterly and with each significant change assessment. She stated at some point the staff had added the interventions of utilizing a bed alarm, however, it had not been added to the care plan. She verified the facility had not completed comprehensive assessment which included causal factors related to the falls and had not determined if further interventions were needed.

The undated Long Term Care Fall Prevention Program directed the fall prevention team to meet at least weekly and review the fall report to discuss the root cause of the fall. The team was also to review the intervention put into place to

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F 323	Continued From page 22 assure it is relative to the foot cause of the falls and any recommendation were to be forwarded to the RN falls champion for implementation.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure target behaviors were identified and monitored for 1 of 5 residents (R55) who received anti-anxiety medication	F 329	First Care Living Center will ensure that each resident¿s drug regimen must be free from unnecessary drugs. A. Review and updates to the Behavior	9/22/15

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	245512	A. BUILDING _____ B. WING _____	08/13/2015

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F 329	Continued From page 23 (alprazolam). Findings include: R55's quarterly Minimum Data Set (MDS) dated 7/28/15, indicated R55 had moderate cognitive impairment and diagnoses that included anxiety and depressive disorder. The MDS also identified R55 felt down, depressed or hopeless one day during the assessment period and felt tired or having had little energy nearly everyday. The MDS further identified R55 received antianxiety medication daily. R55's Psychotropic Medication Use Care Area Assessment (CAA) dated 4/30/15, indicated R55 had a diagnosis of anxiety and was on alprazolam (an antianxiety medication) to help with her feelings of anxiousness. The Physician Order Report dated 7/13/15-8/13/15, included orders for alprazolam 0.5 milligrams (mg) one tablet twice a day for anxiety and 1 mg, one tablet at bedtime to help sleep and relieve anxiety. The Medication Administration History dated 5/1/15, through 8/12/15, indicated R55 received alprazolam 0.5 mg one tablet twice a day and 1 mg tablet at bedtime daily. R55's Quarterly Psychotropic Drug Review dated 7/27/15, identified Anti-Anxiety Drugs with Dosage and Frequency to be: alprazolam 0.5 mg twice daily and 1 mg at bedtime for anxiety states. Under the section labeled Specific Behaviors or Moods Warranting Use of Medication, the drug review listed "meds [medications] used for	F 329	Monitoring Policy and Consultant Pharmacist Medication Regimen Review Policy completed 9-3-15. B. Care plan revision completed 8-20-15 for R55 to include identified target behaviors/symptoms of anxiety for the use of antianxiety medication per RN MDS Coordinator assessment. C. RN MDS Coordinator assessment and care plan updates for all residents on an antianxiety medication to include identified target behaviors/symptoms of anxiety. D. Primary care physician visit for R55 on 9-2-15 confirms therapeutic level of antianxiety medication regimen. E. Point of care charting in EHR system for task to be signed by NARs, to identify target behaviors/symptoms of anxiety of all residents on an antianxiety medication, updated by RN MDS Coordinators with each med change or change in resident condition. F. Consultant Pharmacy will review monthly all resident¿s medication orders to ensure they are free from unnecessary drugs & list target behaviors. G. Psychopharmacologic Medication Use in LTC inservice scheduled with Pharmacy consultant 9-28-15 to focus on target behavior charting and nonpharmacologic interventions. H. IDT team meetings monthly to review resident target behaviors/symptoms of anxiety. I. SSD or her designee will audit R55 target behaviors weekly x 4 weeks, and then audit monthly charting/target behaviors/symptoms of anxiety on all	

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F 329	Continued From page 24 depressive disorder and anxiety states. Does not have any prn orders for psychotropics (a chemical substance that changes brain function and results in alterations in perception, mood, or consciousness), only scheduled meds." The drug review did not identify specific target behaviors / symptoms related to R55's anxiety. R55's Care Plan dated 8/5/15, identified R55 received anti-anxiety medication for the treatment of anxiety and directed staff to monitor for drug use effectiveness and adverse consequences, monitor mood and response to medication and update family and doctor of any concerns. The Care Plan also indicated the pharmacy consultant would review R55's medications monthly. However, the Care Plan did not identify target behaviors / symptoms related to R55's anxiety. On 8/13/15, at 1:07 p.m. nursing assistant (NA)-A demonstrated on a computer workstation how behavior monitoring was done by the NAs for the facility. NA-A stated there was no behavior monitoring completed for R55. She indicated there was no prompt in the computer requiring monitoring by the NAs for R55 and stated the nurses might document something. On 08/13/2015, at 1:18 p.m. licensed practical nurse (LPN)-C indicated the nurses would document a reason for giving a prn [as needed] antianxiety medication. However, R55's antianxiety medication was given on a scheduled basis so no documentation was required. LPN-C stated she did not do any behavior monitoring for R55's anxiety but indicated R55 got agitated with a furrowed brow, wrung her hands, paced and got a worried look on her face when she was anxious.	F 329	residents receiving antianxiety medication. J. All licensed staff attendees educated for compliance with identifying target behaviors/symptoms of anxiety and to document findings in EHR at licensed staff meeting 9-2-15. K. All NAR staff attendees educated for reporting indentified target behaviors/symptoms of anxiety to charge nurse & charting on task in EHR at NAR meeting 9-3-15. L. Staff not attending provided education on Behavior Monitoring Policy to be read/understood & education on charting on task in EHR, indentifying symptoms of anxiety prior to their next scheduled shift and with all new employee orientation. M. Compliance will be added to our QA program by DON and reported to QAPI meetings monthly. N. Completion date 9-22-15.	

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F 329	Continued From page 25 On 08/13/2015, at 1:39 p.m. registered nurse (RN)-A confirmed target behaviors were not identified or monitored for R55's anxiety and alprazolam use. On 08/13/2015, at 2:29 p.m. the director of nursing (DON) confirmed target behaviors were not identified or monitored for R55 and verified the care plan lacked target behaviors for anxiety. The Behavior Monitoring policy dated 4/2015, indicated the purpose was to collect data related to targeted behaviors, analyze the data and develop interventions in the individualized care plan to meet the resident's needs. The policy also indicated residents who exhibited behaviors would have the behaviors documented on the POC [care plan], progress note and Matrix [computer system] profile. The policy further indicated residents on antianxiety and antipsychotic medications would be included.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		9/22/15

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F 441	Continued From page 26 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control procedures were followed for linen handling in order to prevent the spread of infection. This practice had the potential to affect all 40 residents who resided in the facility and had their linens washed by facility staff. In addition, the facility failed to perform adequate tracking, trending and analysis of resident infections which included symptoms, identified organism, treatment and resolution dates of resident infections. This had the potential to affect all 40 residents, visitors and staff in the facility.	F 441	First Care Living Center strives to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Personnel must handle, store. process and transport linens so as to prevent the spread of infections. A. Review & updates to First Care Living Center Laundry policies: Sorting Laundry, Bagging of Linen, Washing and Drying Nursing laundry, Sanitizing Laundry Barrels, Cleaning of Washers and Dryers 9-3-15.	

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F 441	Continued From page 27 Findings include: Linen Handling: During an interview on 8/13/15, at 7:20 a.m., trained medication aide (TMA)-A stated laundry for the nursing home facility was completed on the night shift. She stated, she picked up the laundry from a "yellow bin" and brought it to the laundry room to sort, wash, dry and fold. TMA-A stated, when she sorted laundry she wore gloves but did not wear a protective gown. TMA-A stated, she used laundry detergent provided by the facility and used bleach on the white clothes. During an interview on 8/13/15, at 7:54 a.m., the maintenance manager (MM) stated that personal linens that were soiled were placed in a bag designated for contaminated linens. He stated, "staff tear the bag open and wash the laundry." During an interview on 8/13/15, at 11:26 a.m., the director of nursing (DON) stated, the facilities personal laundry went into a white mesh bag and placed in the yellow bins. She stated the sorting of the personal laundry was done in the laundry room and staff should be wearing gloves and gowns while sorting dirty laundry. The DON further stated, if a resident had an infection such as c-diff (clostridium difficile colitis which is a bacteria that causes swelling and irritation of the large intestine or colon that can be passed from person to person) or MRSA (methicillin-resistant staphylococcus aureas which is a strain of bacteria that has become resistant to antibiotics), she would have to "check the policy" but disposable bags were available for use. She also stated the machines were cleaned every shift.	F 441	B. Review of Prairie Pines Assisted Living Standard Precautions for Infection policy & Essentia Health isolation quick reference guide, education provided to Assisted Living Laundry staff 9-3-15. C. Assisted Living Staff Laundry staff have been educated on the policies and the importance of wearing both gloves and gowns during the sorting of laundry 9-3-15. D. Assisted Living staff laundry have been educated on the policy updates to the use of yellow infectious linen bags, to be torn open and contaminated laundry put directly into the washers 9-3-15. E. Disposable gowns presently on a par level and are restocked by supply personnel. F. Audits of use of gowns/gloves will be done nightly by LPN nursing staff x one week and randomly thereafter. G. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly. H. Completion date 9-22-15 First Care Living Center strives to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection by established and maintained infection control program and prevent the spread of disease by tracking and trending illnesses. A. Review and updates to: Illness Report-Employee policy & Essentia Health Infection Prevention and Control Program Policy 9-3-15, B. Updated Report of Employee	

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F 441	Continued From page 28 A tour of the laundry facility on 8/13/15, at 12:33 p.m., revealed a room with two washers, two dryers, a sink, multiple cabinets and one counter approximately six feet in length for sorting and folding. An inspection of the laundry room and cabinets revealed no gowns were present for use when sorting laundry. Review of a policy labeled First Care Living Center: SORTING LAUNDRY, dated 6/8/15, instructed staff to sort linen according to color and temperature while wearing personal protective equipment: gown and gloves, to ensure the correct sorting of soiled linen. Infection tracking and trending: Review of Resident Illness Tracking Forms (RITF) for May 2015, June 2015, July 2015 and August 2015, direct staff to record all resident that have signs or symptoms of illness due to influenza like illness. The form had categories for date, resident name, s/s (sings/symptoms), VAC (vaccination) and age/sex of resident. The May 2015 RITF indicated nine residents had symptoms of infection. One resident had URI (upper respiratory infection) listed next to their name along with the antibiotic used to treat the infection. No symptoms were noted and no resolution date was indicated. Four residents had an indication of an infection of their skin or wound. No symptoms were noted, no resolution date was listed, nor was an organism identified. Four residents had antibiotics listed next to their names but no symptoms were noted, no indication for use of antibiotics and no resolution	F 441	Illness/call in report to reflect reportable infectious symptoms and follow up questionnaire 9-3-15. C. All staff educated on updated report of Employee Illness/call in report at staff meetings 9-2-15 and 9-3-15. D. Staff not attending with provided education on Employee Illness/call in report updates prior to their next scheduled shift and with new employee orientation. E. Implementation of Employee Infection tracking form for the purpose of trending communicable diseases 9-3-15. F. DON or her designee will review Employee Illness /call in reports daily for infectious symptoms. G. DON or her designee will document & summarize all employee infections weekly and report to monthly Infection Control Team meetings to trend all infections between employees and residents. H. Licensed nursing staff will complete EHR Infection Control¿Infection Report for each resident with new diagnoses/ antibiotic order. I. Updated Report of Resident Illness Report to facilitate tracking, trending, and analysis of resident infections which include symptoms, identified organism, treatment, and resolution of resident infections. J. DON or her designee will update & document on the Report of Resident Illness form weekdays at AM report. K. Audits of Employee and Resident infection tracking forms will be conducted on all residents who have had infections in the past month and documentation	

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F 441	Continued From page 29 dates were identified. The June 2015 RITF indicated seven residents had symptoms of infection. Four infections were noted to be URI's. One noted symptoms of coughing and fever, all four indicated use of an antibiotic, none listed a resolution date. Two resident were identified as receiving antibiotics, but no symptoms were noted, no resolution date and the source of the infection was not identified. One resident was noted to be receiving an antibiotic on two separate dates for infection of the skin, no organism was identified, no symptoms were listed and no resolution date was identified. The July 2015 RITF indicated eight residents were receiving antibiotics. Five residents had URI listed with no indication of symptoms and no resolution dates noted. One resident was noted to have a urinary tract infection (UTI), with no organism, symptoms or resolution date identified. Two residents had only the names of the antibiotic noted with no other information. The August RITF indicated three residents had symptoms of infection. One resident had URI noted with no symptoms and no resolution dated noted. Two residents were receiving antibiotics due to URI's with no resolution dates noted. A Separate tracking form titled First Care Living Center: Employee Illness Report and Nosocomial Rates indicated resident and employee illness were tracked by type of illness, but revealed no other tracking information. A document labeled, Meeting Agenda: Infection Prevention Committee, dated 7/02/15, indicated	F 441	presented to monthly Infection Control Team Meeting. L. Compliance will be added to our QA program by DON and reported to OAPI meetings quarterly & Essentia Infection Control meetings quarterly. M. Completion date 9-22-15.	

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F 441	Continued From page 30 review of the 2015, Surveillance report and Employee Illness report identified no noted correlation between staff and resident illness. No other tracking or trending was identified. During an interview on 8/13/15 at 11:33 a.m., the DON stated she tracked infections on a daily basis on the RITF and tracked staff and resident illness for comparison. She stated, "I track hallways to see if the infection is contained on specific hallways," but stated, "I do not track the organism." She stated she is currently tracking UTI's for a quality improvement project and that quarterly hand washing audits were done. The DON did not identify any tracking and trending of resident infections or analysis of the information gathered on the RITF.	F 441		

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	245512	A. BUILDING **01 - NURSING HOME** B. WING _____	**08/12/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY . A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Essentia Health Care-Fosston was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Essentia Health Care-Fosston is a one story building with a no basement. The building was constructed in 1972 & 1997, Type II(111) Construction. It is properly 2 hour fire separated from the attached hospital and assisted living. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 41 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is met.	K 000		

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

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

Electronically delivered
August 26, 2015

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5512025

Dear Mr. Dish:

The above facility was surveyed on August 10, 2015 through August 13, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

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

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

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	00461	A. BUILDING: _____ B. WING _____	08/13/2015

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ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00461	A. BUILDING: _____ B. WING _____	08/13/2015

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/10/15, 8/11/5, 8/12/15, and 8/13/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to include the use of wheelchair positioning devices and positioning needs for 1 of 1 resident (R33) who required the use of positioning devices. Findings include: R33's care plan dated 7/20/15, directed staff to assist R33 with transfers due to history of a stroke with left sided weakness. The care plan did not address any special wheelchair positioning needs. On 8/11/15, at 10:32 a.m. R33 was observed seated in a wheelchair in the south dining room. R33's wheelchair was observed equipped with a	2 560	Corrected	9/22/15

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2 560	Continued From page 3 built up, left arm rest (lateral support). A full sized bed pillow was observed on top of the arm rest and tucked into the side of the chair next to R33. R33's left arm was observed positioned on top of the pillow. At the time of the observation, R33's left arm was observed to fall off the pillow and hang down the side of the chair. R33's arm was observed to hang until 11:02 a.m. at which time a physical therapy assistant (PTA) was observed to reposition R33's arm on top of the pillow / arm rest. On 8/12/15, at 11:57 a.m. R33 was observed seated in her wheelchair with a bed pillow under her left arm. R33's left arm was observed resting on her lap with the hand positioned over the end of her knees in a dependent position. R33's fingers and hand were observed to be a deep red/purple color. R33 was not observed to move her hand into a position in which her hand would not be a dependent and allow for blood flow. On 8/12/15, at 12:50 p.m. R33 was observed sleeping in her wheelchair in her room. PTA-A walked by R33's room and asked if R33 was alright. PTA-A stated R33's left hand frequently fell off of the arm rest or pillow. He stated R33's hand was not be strapped into the arm support device but rather resting on a pillow. PTA-A stated R33 did not have the ability to independently reposition her hand therefore staff would have to move her hand and reposition when needed. On 8/13/15, at 10:47 a.m. R33 was interviewed in her room. A 1/4 lap tray was observed sitting on the floor of her room. R33 stated staff had attempted to use the lap tray to hold her left arm/hand in place on the chair, but the tray cut into her ribs and was not comfortable. She stated staff had placed the blue arm rest cushion on her	2 560		

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2 560	Continued From page 4 chair but that too was not enough to keep her arm in place on the wheelchair. R33 stated staff then started using the bed pillow to support her hand. She verified she was not able to move her left hand by herself and it had frequently fell off of the pillow support. The blue lateral support device was observed to cover the arm rest, however, the foam was observed sticking out of the lateral support next to the wheelchair armrest. On 8/13/15, at 10:55 a.m. NA-B stated R33's left arm frequently fell off of the positioning pillows. She stated staff had to reposition the arm several times a day as R33 was not able to reposition the arm back on the pillow independently. On 8/13/15, at 11:00 a.m. registered nurse (RN)-A stated the lateral supports on the wheelchair were placed by occupational therapy to ensure proper body alignment while in the wheelchair. RN-A reviewed the care plan and verified the plan did not address what type of supports were needed in / on R33's wheelchair. On 8/13/15, at 12:20 p.m. the director of nurses verified R33's care plan did not address supportive devices to be used while in the wheelchair. On 8/13/15, at 2:55 p.m. contact with the occupational therapist was attempted without success. A policy related to care plan development was requested and none was provided. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to the	2 560		

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2 560	Continued From page 5 development of care plans. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning assistance as directed by the individualized care plan for 1 of 1 resident (R10) reviewed with an active pressure ulcer. Findings include: R10's care plan dated 6/24/15, indicated R10 was at risk for pressure ulcers related to decreased mobility. The plan also indicated R10 had a current pressure ulcer on her mid back, along the spine, and directed staff to keep a pressure reducing cushion on the seat and back of R10's wheelchair and to offload (relieve pressure) R10 every 1.5 hours while seated.	2 565	Corrected	9/22/15

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2 565	Continued From page 6 On 8/12/15, from 12:50 p.m. to 3:37 p.m. R10 was continuously observed seated in a standard recliner in the front lobby area. The recliner was not observed to contain any type of pressure redistribution cushions. During the observation, R10 was not observed to be repositioned. -At 3:30 p.m. NA-E stated R10 was to receive assistance with repositioning every three hours. -At 3:37 p.m. nursing assistant (NA)-C and NA-D were observed to assist R10 to stand and transfer into a wheelchair. At this time, NA-C stated R10 had sat in the recliner since 12:30 p.m. a total of three hours and seven minutes. On 8/12/15, at 4:40 p.m. R10 was observed seated in the south dining room waiting for the evening meal. R10's wheelchair was observed equipped with a foam redistribution cushion on the seat and the back of the chair. R10 remained in the dining room until 5:26 p.m. at which time she was wheeled into the main lobby area. R10 remained in her wheelchair during the evening activities. -At 6:20 p.m. NA-F was observed to wheel R10 into the restroom. -At 7:12 p.m. NA-F stated R10 was to be repositioned every 2-3 hours She verified R10 had not been assisted since 4:30 p.m. a total of 1 hour and 50 minutes earlier. On 8/13/15, at 8:46 a.m. licensed practical nurse (LPN)-D was observed to compete wound care on R10's mid-spine following a bath. The old dressing had been removed during the bath. LPN-D measured the wound and reported the open area measured 1.4 cm x 0.4 cm. The wound bed was pink with a small amount of yellow slough. On 8/13/15, at 11:00 a.m. NA-B stated R10 was	2 565		

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2 565	Continued From page 7 to be positioned every hour while seated in the wheelchair because of the sore on her back. On 8/13/15, at 12:00 p.m. registered nurse (RN)-A stated R10 was to be repositioned every 1.5 hours when seated in the wheelchair, as directed by the care plan. On 8/13/15, at 12:30 p.m. the director of nurses confirmed R10 was to be repositioned every 1.5 hours as directed by the care plan. A policy related to implementation of the care plan was requested and none was provided. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to following care plans. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	2 570		9/22/15

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2 570	Continued From page 8 and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include target behaviors for the use of antianxiety medication for 1 of 5 residents (R55) who received anti-anxiety medication. Findings include: R55's quarterly Minimum Data Set (MDS) dated 7/28/15, indicated R55 had moderate cognitive impairment and diagnoses that included anxiety, depressive disorder and hypertension. The MDS also identified R55 felt down, depressed or hopeless one day during the assessment period and felt tired or having had little energy nearly everyday. The MDS further identified R55 received antianxiety medication daily. R55's Psychotropic Medication Use Care Area Assessment (CAA) dated 4/30/15, indicated R55 had a diagnosis of anxiety and was on alprazolam (an antianxiety medication) to help with her feelings of anxiousness. R55's Care Plan dated 8/5/15, identified R55 received anti-anxiety medication for the treatment of anxiety and directed staff to monitor for drug use effectiveness and adverse consequences, monitor mood and response to medication and update family and doctor of any concerns. The Care Plan also indicated the pharmacy consultant	2 570	Corrected	

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2 570	Continued From page 9 would review R55's medications monthly. However, the Care Plan did not identify target behaviors related to R55's anxiety. On 08/13/2015, at 1:39 p.m. registered nurse (RN)-A confirmed target behaviors were not identified or monitored for R55's anxiety and alprazolam use. On 08/13/2015, at 2:29 p.m. the director of nursing (DON) confirmed target behaviors were not identified or monitored for R55 and verified the care plan lacked target behaviors. No policy regarding care plan revision was provided. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to the revision of care plans. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830		9/22/15

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2 830	Continued From page 10 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure causal factors were identified and adequate interventions had been implemented in order to minimize the risk of falls / accidents and / or injury for 1 of 1 resident (R10) identified at risk for falls. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/15/15, indicated R10 had severe cognitive impairment, was at risk for falls and required extensive staff assistance with bed mobility, transferring and activities of daily living. The MDS also indicated R10 was diagnosed with anxiety, orthopnea (difficulty breathing when lying) and pain. In addition, the MDS indicated R10 had sustained two or more falls within the MDS reference period. R10's Falls Care Area Assessment (CAA) dated 4/2/15, indicated R10 required extensive assistance with activities of daily living and had poor balance. The assessment indicated she had the potential for continued falls and potential	2 830	Corrected	

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2 830	Continued From page 11 for injury. R10's Fall assessment dated 6/10/15, indicated R10 was at high risk for falls. R10's care plan dated 6/24/15, indicated R10 was risk for falling related to decreased mobility, history of falls and was to be on a fall prevention program. The plan directed staff to utilize anti-roll back wheelchair devices, a chair alarm, remind R10 to ask for assistance to ambulate and transfer, to keep R10's bed in the lowest position with brakes locked, to ensure R10 wore proper foot wear and to keep R10 in a highly visualized area when restless. Review of R10's Event Reports revealed the following: - 3/21/15, at 4:15 a.m. R10 was found on the floor in her room next to her night stand. No injuries sustained. The facility updated R10's toileting plan to include assisting R10 to the toilet every 4 hours at night. In addition R10's bed was to be placed in the lowest position. - 3/31/15, at 5:50 a.m. R10 was found on the floor in her room. No injuries were noted. The follow up report indicated R10 was very spontaneous and did not recognize danger to self. The bed was in the lowest position. The report directed staff to allow R10 to sleep in the common area at night. - 4/19/15, at 6:00 a.m. R10 was found on the floor in the hallway. R10 sustained a bruise to her right buttock. The facility made no changes to	2 830		

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2 830	Continued From page 12 R10's fall interventions at that time. - 5/5/15, at 8:56 a.m. R10 was seated at the dining room table, stood up and attempted to independently walk and fell. No injuries. The falls team meeting note indicated R10 was working with restorative nursing on a walking program as R10 was not able to walk on her own. No other changes were made to R10's care plan following the fall. - 6/6/15, at 2:40 a.m. R10 was found on the floor with her back against her bed. No injuries. The staff placed a body pillow next R10 while in bed. On 6/9/15, the director of nurses removed the body pillow to ensure R10 was not restrained. No other changes were made to R10's care plan following the fall. - 6/20/15, at 7:30 p.m. R10 was found on the floor in the lobby area. R10's chair alarm was sounding. R10 had attempted to stand and sat down. No injuries. The Falls Team meeting note indicated "unidentified need not met," R10 stated she was "going to stand up." No other changes were made to R10's care plan following the fall. - 6/25/15, at 8:20 p.m. R10 was found on the floor in the South wing public restroom. No injury noted. The record did not contain further documentation related to the fall. - 7/21/15, 12:27 p.m. R10 was found on the floor next to her bed. The bed alarm was working. No injuries noted. No changes were made to R10's care plan following the fall. -7/21/15, at 3:45 p.m. R10 was assisted out of the facility by a visitor. R10 wheeled her wheelchair	2 830		

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2 830	Continued From page 13 off of the curb outside and fell. No injury noted. The Falls Team meeting notes indicated a wandergaurd was placed to alert staff of when R10 left the facility. On 8/12/15, at 3:24 p.m. nursing assistant (NA)-C and NA-D were observed to extensively assist R10 from the recliner and into a wheelchair. R10 was observed to be able to stand and pivot transfer into the wheelchair with the NAs weight bearing assistance. -At 3:27 p.m. R10 was assisted to the toilet. R10 was observed to hang onto the bathroom safety bars and transfer with extensive assistance of the two nursing assistants. -At 4:38 p.m. R10 was observed seated at a table in the South dining room. On 8/12/15, at 7:07 p.m. licensed practical nurse (LPN)-A stated when a resident fell, the nurse assessed the resident to make sure they were not injured, assisted the resident off of the floor and then attempted to figure out why the resident fell. LPN-A stated R10 often attempted to transfer herself from bed. She stated R10 had an alarm on her bed to alert the staff when she was trying to get up. On 8/12/15, at 7:15 p.m. NA-F stated R10 had a history of falls. She stated staff tried to monitor her as much as possible. On 8/12/15, at 7:15 p.m. NA-G stated R10 was to have a bed alarm on the bed and chair to alert staff she needed assistance. On 8/13/15, at 6:58 a.m. R10 was observed asleep, in bed. R10's bed was equipped with a standard mattress with a gel overlay and a bed alarm.	2 830		

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2 830	Continued From page 14 On 8/13/15, at 7:10 a.m. NA-H and NA-I were observed to assist R10 from bed. R10 required extensive assistance. R10 was not observed to straighten her legs or participate with weight bearing during the transfer. On 8/13/15, at 11:30 a.m. registered nurse (RN)-A stated the facility fall process was to make an immediate assessment for injuries following the fall and then review to look for the root cause of the fall by talking to the staff and determining interventions based on the root cause followed by updating the care plan. On 8/13/15, at 12:35 p.m. the director of nurses (DON) stated following each fall, the facility performed an immediate assessment of the resident and reviewed the situation to determine if the fall could have been anticipated / prevented. The DON stated the 6/6/15, fall intervention of placement of a pillow was discontinued as the facility did not approve of the use of body pillows as an effective intervention, rather a restraint device. When the DON was asked what further interventions were implemented following the falls, the DON did not respond. On 8/13/15, at 3:07 p.m. RN-A stated the facility completed a comprehensive fall assessment quarterly and with each significant change assessment. She stated at some point the staff had added the interventions of utilizing a bed alarm, however, it had not been added to the care plan. She verified the facility had not completed comprehensive assessment which included causal factors related to the falls and had not determined if further interventions were needed. The undated Long Term Care Fall Prevention	2 830		

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2 830	Continued From page 15 Program directed the fall prevention team to meet at least weekly and review the fall report to discuss the root cause of the fall. The team was also to review the intervention put into place to assure it is relative to the foot cause of the falls and any recommendation were to be forwarded to the RN falls champion for implementation. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to resident falls. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper wheelchair positioning for 1 of 1 resident (R33) in the sample reviewed for wheelchair positioning	2 835	Corrected	9/22/15

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2 835	Continued From page 16 needs. Findings include: R33's admission Minimum Data Set (MDS) dated 7/6/15, indicated R33 had intact cognition, was diagnosed with diabetes mellitus and a history of a stroke with left sided weakness. The MDS also indicated R33 required extensive assistance of two staff for bed mobility, transfers and was unable to ambulate. R33's Activities of Daily Living Care Area Assessment (CAA) dated 7/14/15, indicated R33 was unable to be independent in mobility following her stroke. R33's care plan dated 7/20/15, directed staff to assist R33 with transfers. The care plan did not address any special wheelchair positioning needs. On 8/11/15, at 10:32 a.m. R33 was observed seated in a wheelchair in the south dining room. R33's wheelchair was observed equipped with a built up, left arm rest (lateral support). A full sized bed pillow was observed on top of the arm rest and tucked into the side of the chair next to R33. R33's left arm was observed positioned on top of the pillow. At the time of the observation, R33's left arm was observed to fall off the pillow and hang down the side of the chair. R33's arm was observed to hang until 11:02 a.m. at which time a physical therapy assistant (PTA) was observed to reposition R33's arm on top of the pillow / arm rest. On 8/12/15, at 11:57 a.m. R33 was observed seated in her wheelchair with a bed pillow under her left arm. R33's left arm was observed resting	2 835		

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2 835	Continued From page 17 on her lap with the hand positioned over the end of her knees in a dependent position. R33's fingers and hand were observed to be a deep red/purple color. R33 was not observed to move her hand into a position in which her hand would not be a dependent and allow for blood flow. On 8/12/15, at 12:50 p.m. R33 was observed sleeping in her wheelchair in her room. PTA-A walked by R33's room and asked if R33 was alright. PTA-A stated R33's left hand frequently fell off of the arm rest or pillow. He stated R33's hand was not be strapped into the arm support device but rather resting on a pillow. PTA-A stated R33 did not have the ability to independently reposition her hand therefore staff would have to move her hand and reposition when needed. On 8/13/15, at 10:47 a.m. R33 was interviewed in her room. A 1/4 lap tray was observed sitting on the floor of her room. R33 stated staff had attempted to use the lap tray to hold her left arm/hand in place on the chair, but the tray cut into her ribs and was not comfortable. She stated staff had placed the blue arm rest cushion on her chair but that too was not enough to keep her arm in place on the wheelchair. R33 stated staff then started using the bed pillow to support her hand. She verified she was not able to move her left hand by herself and it had frequently fell off of the pillow support. The blue lateral support device was observed to cover the arm rest, however, the foam was observed sticking out of the lateral support next to the wheelchair armrest. On 8/13/15, at 10:55 a.m. NA-B stated R33's left arm frequently fell off of the positioning pillows. She stated staff had to reposition the arm several times a day as R33 was not able to independently reposition the arm back on the pillow.	2 835		

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2 835	Continued From page 18 Review of R33's clinical record indicated R33 was receiving occupational therapy five days a week for treatment related to the stroke. R33's occupation therapy progress note dated 7/16/15, indicated R33's half tray on the wheelchair was changed out to a lateral arm support as she leaned heavily into the tray at times which may have been the contributing factor to R33's sore rib area on the left. The note continued to explain R33's arm did not remain on the lateral arm support and directed the arm to be strapped / secured into place on the support in which R33 had the ability to independently release the straps. R33's clinical record lacked further documentation related to wheelchair positioning devices. On 8/13/15, at 11:00 a.m. registered nurse (RN)-A stated R33's lateral arm support were placed on the wheelchair by occupational therapy. RN-A reviewed R33's clinical record and verified the record had not directed staff how to position R33's hand on the support device nor direct staff to use a bed pillow, lateral support or lap tray. She stated R33 did not have the ability to consistently reposition her hand and was dependent upon staff for positioning. RN-A verified R33's care plan did not direct staff how to position R33's hand or what supportive devices was to be used. On 8/13/15, at 12:20 p.m. the director of nurses verified R33's clinical record did not address support devices to be used while in the wheelchair.	2 835		

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2 835	Continued From page 19 On 8/13/15, at 2:55 p.m. contact with the occupational therapist was attempted without success. Review of the Repositioning policy dated 8/2006, directed staff to ensure proper postural alignment while in the wheelchair. It did not direct the staff how to use positioning devices. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to the proper wheelchair seating. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 835		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores	2 900		9/22/15

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2 900	Continued From page 20 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning assistance as directed by the individualized care plan in order to prevent and / or promote the healing of pressure related ulcers for 1 of 1 resident (R10) who had an active pressure ulcer and required staff assistance for repositioning. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/15/15, indicated R10 was diagnosed with anxiety, orthopnea (difficulty breathing while lying), one stage two (partial thickness, the outer layer of skin and part of the underlying layer of skin is damaged or lost.) pressure ulcer and was at risk for the development of pressure ulcers. The MDS also indicated R10 required extensive assistance with bed mobility, transferring and activities of daily living. R10's Pressure Ulcer Care Area Assessment (CAA) dated 3/27/15, indicated R10 required extensive assistance with bed mobility, had a stage one pressure ulcer which was at risk of worsening and having increased pain. R10's care plan dated 6/24/15, indicated R10 was at risk for pressure ulcers related to decreased mobility. The plan also indicated R10 had an active pressure ulcer on her mid back along the spine and directed staff to keep a pressure reducing cushion in the seat and the back of the	2 900	Corrected	

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2 900	Continued From page 21 wheelchair and to offload (relieve pressure) R10 every 1.5 hours while seated. R10's Braden Assessment (skin risk assessment) dated 6/15/15, indicated R10 was at risk for the development of pressure ulcers. R10's quarterly Tissue Tolerance (pressure redistribution) assessment dated 6/12/15, indicated R10 was at risk for ulcers and directed staff to assist R10 with repositioning every 1.5 hours while seated and every 3 hours while in bed. Review of R10's progress notes revealed the following: - 3/21/15, R10 was admitted to the facility with two stage one (redness, skin may be painful, but it has no breaks or tears) pressure ulcer on her mid back along her spine. The wounds measure 5.0 cm x 6.0 cm centimeters (cm) and 4.0 cm x 2.6 cm. The staff placed a pressure reducing mattress on her bed and placed a Mepilex dressing on the wounds to prevent worsening. - 4/28/15, the wounds had opened. The center was cream colored measuring 0.7 cm x 0.6 cm. The skin surrounding the wound measured 0.9 cm x 0.8 cm and was red in color. - 6/5/15, the mid back wound had opened. The wound measured 1.7 cm in length and 6.0 cm in width. - 6/11/15, the red area in the mid spine measured 10.0 cm x 6.4 cm with a centralized open area which measured 1.9 x 1.2 cm with cream colored slough.	2 900		

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2 900	Continued From page 22 - 6/12/15, R10 was placed on an every 1.5 hour repositioning schedule. The record indicated "primary area of concern is her back so this needs to be fully offloaded." - 6/23/15, dressing to the back was changed. Wound measured 6.0 cm x 3.0 cm with light green and white non-odorous wound bed surrounded by a thin red border. - 7/2/15, wound measured 3.4 cm x 2.9 cm and 0.1 cm depth. The wound was covered with a duoderm dressing. - 7/9/15, the wound measured 3.4 cm by 2.2 cm with beefy red center and rolled outer edges that is pink scar tissue. - 7/16/15, the wound measured 2.4 cm x 1.4 cm with pink scar tissue with rolled edges surrounding. - 7/23/15, the wound measured 2.6 x 1.4 cm with a beefy red center with small specks of cream colored slough also mixed in. - 7/23/15, a second note indicated R10 was seen by her primary physician which directed staff to avoid prolonged pressure on the back ulcer. - 7/30/15, the wound measured 2.5 x 1.2 cm. The center continued to be beefy red with rolled edges. - 8/6/15, the wound measured 2.0 cm x 3.0 cm without drainage. There was a second wound to the side of the main wound which measured 2.0 cm x 0.5 cm. On 8/12/15, from 12:50 p.m. to 3:37 p.m. R10	2 900		

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2 900	Continued From page 23 was continuously observed seated in a standard recliner in the front lobby area. The recliner was not observed to contain any type of special pressure redistribution cushions. During this observation, R10 was not observed to reposition. -At 3:30 p.m. NA-E stated R10 was to receive assistance with repositioning every three hours. -At 3:37 p.m. nursing assistant (NA)-C and NA-D were observed to assist R10 to stand and transfer into a wheelchair. At this time, NA-C stated R10 had sat in the recliner since 12:30 p.m. for a total of three hours and 7 minutes without repositioning assistance. On 8/12/15, at 4:40 p.m. R10 was observed seated in the south dining room waiting for the evening meal. R10's wheelchair was observed equipped with a foam redistribution cushion on the seat and the back of the chair. R10 remained in the dining room until 5:26 p.m. at which time she was wheeled into the main lobby area. R10 remained in her wheelchair during the evening activities. -At 6:20 p.m. NA-F was observed to wheel R10 into the restroom. -At 7:12 p.m. NA-F stated R10 was to be repositioned every 2-3 hours. NA-F verified R10 had not been repositioned since 4:30 p.m. a total of 1 hour and 50 minutes earlier. On 8/13/15, at 8:46 a.m. licensed practical nurse (LPN)-D was observed to compete wound care on R10's mid-spine following a bath. The old dressing had been removed during the bath. LPN-D measured the wound and reported the open area measured 1.4 cm x .4 cm. The wound bed was pink with a small amount of yellow slough. The small open area along the main wound was healed. LPN-D stated the second	2 900		

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2 900	Continued From page 24 wound was a skin reaction to tape. She explained the facility was now using a more gentle tape on R10's wound area. On 8/13/15, at 11:00 a.m. NA-B stated R10 was to be positioned every hour while seated in the wheelchair because of the sore on her back. On 8/13/15, at 12:00 p.m. registered nurse (RN)-A stated R10 was to be repositioned every 1.5 hours when seated in the wheelchair, as directed by her care plan. RN-A stated staff had been educated on how to ensure R10 was offloaded off of the back every 1.5 hours and should have provided that assistance. RN-A verified R10 routinely sat in a recliner in the lobby area however, the facility had not placed a pressure redistribution cushion in that chair. She verified R10 required additional interventions and was to be repositioned according to the care plan. On 8/13/15, at 12:30 p.m. the director of nurses confirmed R10 was to be repositioned every 1.5 hours as directed by the care plan. The Repositioning policy dated 8/2006, directed staff to reposition the resident according to the individual tissue tolerance assessment. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to the pressure ulcer care. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee.	2 900		

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2 900	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to perform adequate tracking,	21390	Corrected	9/22/15

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21390	Continued From page 26 trending and analysis of resident infections which included symptoms, identified organism, treatment and resolution dates of resident infections. This had the potential to affect all 40 residents, visitors and staff in the facility. Findings include: Review of Resident Illness Tracking Forms (RITF) for May 2015, June 2015, July 2015 and August 2015, direct staff to record all resident that have signs or symptoms of illness due to influenza like illness. The form had categories for date, resident name, s/s (sings/symptoms), VAC (vaccination) and age/sex of resident. The May 2015 RITF indicated nine residents had symptoms of infection. One resident had URI (upper respiratory infection) listed next to their name along with the antibiotic used to treat the infection. No symptoms were noted and no resolution date was indicated. Four residents had an indication of an infection of their skin or wound. No symptoms were noted, no resolution date was listed, nor was an organism identified. Four residents had antibiotics listed next to their names but no symptoms were noted, no indication for use of antibiotics and no resolution dates were identified. The June 2015 RITF indicated seven residents had symptoms of infection. Four infections were noted to be URI's. One noted symptoms of coughing and fever, all four indicated use of an antibiotic, none listed a resolution date. Two resident were identified as receiving antibiotics, but no symptoms were noted, no resolution date and the source of the infection was not identified. One resident was noted to be receiving an	21390		

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21390	Continued From page 27	21390		

antibiotic on two separate dates for infection of the skin, no organism was identified, no symptoms were listed and no resolution date was identified.

The July 2015 RITF indicated eight residents were receiving antibiotics. Five residents had URI listed with no indication of symptoms and no resolution dates noted. One resident was noted to have a urinary tract infection (UTI), with no organism, symptoms or resolution date identified. Two residents had only the names of the antibiotic noted with no other information.

The August RITF indicated three residents had symptoms of infection. One resident had URI noted with no symptoms and no resolution dated noted. Two residents were receiving antibiotics due to URI's with no resolution dates noted.

A Separate tracking form titled First Care Living Center: Employee Illness Report and Nosocomial Rates indicated resident and employee illness were tracked by type of illness, but revealed no other tracking information.

A document labeled, Meeting Agenda: Infection Prevention Committee, dated 7/02/15, indicated review of the 2015, Surveillance report and Employee Illness report identified no noted correlation between staff and resident illness. No other tracking or trending was identified.

During an interview on 8/13/15 at 11:33 a.m., the DON stated she tracked infections on a daily basis on the RITF and tracked staff and resident illness for comparison. She stated, "I track hallways to see if the infection is contained on specific hallways," but stated, "I do not track the organism." She stated she is currently tracking

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21390	Continued From page 28 UTI's for a quality improvement project and that quarterly hand washing audits were done. The DON did not identify any tracking and trending of resident infections or analysis of the information gathered on the RITF. SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to infection control surveillance. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the	21540		9/22/15

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21540	Continued From page 29 medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure target behaviors were identified and monitored for 1 of 5 residents (R55) who received anti-anxiety medication (alprazolam). Findings include: R55's quarterly Minimum Data Set (MDS) dated 7/28/15, indicated R55 had moderate cognitive impairment and diagnoses that included anxiety and depressive disorder. The MDS also identified R55 felt down, depressed or hopeless one day during the assessment period and felt tired or having had little energy nearly everyday. The MDS further identified R55 received antianxiety medication daily. R55's Psychotropic Medication Use Care Area Assessment (CAA) dated 4/30/15, indicated R55 had a diagnosis of anxiety and was on alprazolam (an antianxiety medication) to help with her feelings of anxiousness. The Physician Order Report dated	21540	Corrected	

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21540	Continued From page 30 7/13/15-8/13/15, included orders for alprazolam 0.5 milligrams (mg) one tablet twice a day for anxiety and 1 mg, one tablet at bedtime to help sleep and relieve anxiety. The Medication Administration History dated 5/1/15, through 8/12/15, indicated R55 received alprazolam 0.5 mg one tablet twice a day and 1 mg tablet at bedtime daily. R55's Quarterly Psychotropic Drug Review dated 7/27/15, identified Anti-Anxiety Drugs with Dosage and Frequency to be: alprazolam 0.5 mg twice daily and 1 mg at bedtime for anxiety states. Under the section labeled Specific Behaviors or Moods Warranting Use of Medication, the drug review listed "meds [medications] used for depressive disorder and anxiety states. Does not have any prn orders for psychotropics (a chemical substance that changes brain function and results in alterations in perception, mood, or consciousness), only scheduled meds." The drug review did not identify specific target behaviors / symptoms related to R55's anxiety. R55's Care Plan dated 8/5/15, identified R55 received anti-anxiety medication for the treatment of anxiety and directed staff to monitor for drug use effectiveness and adverse consequences, monitor mood and response to medication and update family and doctor of any concerns. The Care Plan also indicated the pharmacy consultant would review R55's medications monthly. However, the Care Plan did not identify target behaviors / symptoms related to R55's anxiety. On 8/13/15, at 1:07 p.m. nursing assistant (NA)-A demonstrated on a computer workstation how behavior monitoring was done by the NAs for the facility. NA-A stated there was no behavior	21540		

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21540	Continued From page 31 monitoring completed for R55. She indicated there was no prompt in the computer requiring monitoring by the NAs for R55 and stated the nurses might document something. On 08/13/2015, at 1:18 p.m. licensed practical nurse (LPN)-C indicated the nurses would document a reason for giving a prn [as needed] antianxiety medication. However, R55's antianxiety medication was given on a scheduled basis so no documentation was required. LPN-C stated she did not do any behavior monitoring for R55's anxiety but indicated R55 got agitated with a furrowed brow, wrung her hands, paced and got a worried look on her face when she was anxious. On 08/13/2015, at 1:39 p.m. registered nurse (RN)-A confirmed target behaviors were not identified or monitored for R55's anxiety and alprazolam use. On 08/13/2015, at 2:29 p.m. the director of nursing (DON) confirmed target behaviors were not identified or monitored for R55 and verified the care plan lacked target behaviors for anxiety. The Behavior Monitoring policy dated 4/2015, indicated the purpose was to collect data related to targeted behaviors, analyze the data and develop interventions in the individualized care plan to meet the resident's needs. The policy also indicated residents who exhibited behaviors would have the behaviors documented on the POC [care plan], progress note and Matrix [computer system] profile. The policy further indicated residents on antianxiety and antipsychotic medications would be included.	21540		

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21540	Continued From page 32 A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related medication monitoring. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21540		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure appropriate infection control procedures were followed for linen handling in order to prevent the spread of infection. This had the potential to affect all 40 residents who resided in the facility and had their linen washed by facility staff. Findings include:	21675	Corrected	9/22/15

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21675	Continued From page 33 Linen Handling: During an interview on 8/13/15, at 7:20 a.m., trained medication aide (TMA)-A stated laundry for the nursing home facility was completed on the night shift. She stated, she picked up the laundry from a "yellow bin" and brought it to the laundry room to sort, wash, dry and fold. TMA-A stated, when she sorted laundry she wore gloves but did not wear a protective gown. TMA-A stated, she used laundry detergent provided by the facility and used bleach on the white clothes. During an interview on 8/13/15, at 7:54 a.m., the maintenance manager (MM) stated that personal linens that were soiled were placed in a bag designated for contaminated linens. He stated, "staff tear the bag open and wash the laundry." During an interview on 8/13/15, at 11:26 a.m., the director of nursing (DON) stated, the facilities personal laundry went into a white mesh bag and placed in the yellow bins. She stated the sorting of the personal laundry was done in the laundry room and staff should be wearing gloves and gowns while sorting dirty laundry. The DON further stated, if a resident had an infection such as c-diff (clostridium difficile colitis which is a bacteria that causes swelling and irritation of the large intestine or colon that can be passed from person to person) or MRSA (methicillin-resistant staphylococcus aureas which is a strain of bacteria that has become resistant to antibiotics), she would have to "check the policy" but disposable bags were available for use. She also stated the machines were cleaned every shift. A tour of the laundry facility on 8/13/15, at 12:33 p.m., revealed a room with two washers, two dryers, a sink, multiple cabinets and one counter	21675		

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21675	Continued From page 34 approximately six feet in length for sorting and folding. An inspection of the laundry room and cabinets revealed no gowns were present for use when sorting laundry. Review of a policy labeled First Care Living Center: SORTING LAUNDRY, dated 6/8/15, instructed staff to sort linen according to color and temperature while wearing personal protective equipment: gown and gloves, to ensure the correct sorting of soiled linen. A SUGGESTED METHOD FOR CORRECTION: The director of environmental services could review and revise the policies and procedures related to linen handling. He/she or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21675		