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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HMLV11
Facility ID: 00429

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245349**

2. STATE VENDOR OR MEDICAID NO. (L2) **334740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STEWARTVILLE CARE CENTER**
(L4) **120 FOURTH STREET NORTHEAST**
(L5) **STEWARTVILLE, MN** (L6) **55976**

4. TYPE OF ACTION: 9 L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY 3/31/2016 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) 4/30/2016

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

12.Total Facility Beds 73 (L18)

13.Total Certified Beds 73 (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	73			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 04/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 04/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

24-5349

On March 31, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed to verify compliance with Federal certification regulations. This survey found most serious to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Post Certification Revisit (PCR) to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 14, 2016

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, Minnesota 55976

RE: Project Number S5349027

Dear Mr. Gustason:

On March 31, 2016, a a Minimum Data Set (MDS) 3.0/Staffing Focused survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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:

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 10, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the

latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

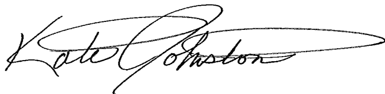
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING ______ B. WING ______	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Minimum Data Set (MDS) 3.0/Staffing Focused Survey was conducted. The following deficiencies were issued. The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff, if your ePoC for the respective deficiencies (if any) is acceptable.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		5/6/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/21/2016

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

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F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 4 residents (R3) who had falls, and for 1 of 2 residents (R2) who had an indwelling catheter. Findings include: Falls: R3's Progress Note dated 12/7/15, indicated: "Nurse heard clip alarm sounding and found resident on the ground with her head against the bed rail. Resident has a 2 cm [centimeter] by 2 cm hematoma on the crown of her head..." R3's MDS dated 12/22/15, was miscoded for falls with an injury. During review of a significant change MDS completed for R3 dated 12/22/15, the MDS had been coded as "Yes" in response to the question about whether the resident had experienced a fall since the prior assessment. However, although the resident had sustained an injury, a 2 cm x 2 cm hematoma to the crown of her head 12/7/15, the MDS had been coded "none" to indicate the resident had experienced no injury, and no injury (except major) skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain.	F 278	Regulation 483.20(g-j) Tag F278 Resident Assessment Stewartville Care Center staff routinely complete assessments that accurately reflect the residents status. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals; a registered nurse signs to verify that the assessment is complete; and each individual who completes a portion of the assessment certifies the accuracy of that portion of the assessment. The staff completing the assessment 1) are qualified to assess relevant care areas 2) are knowledgeable about the resident s status and needs 3) appropriately document the resident s medical, functional and psychosocial problems and 4) identify the resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. The policies and procedures for completing the minimum data set (MDS), including data gathering, were reviewed	

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

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F 278	Continued From page 2	F 278		

On 3/31/16, at 1:45 p.m. registered nurse (RN)-C, MDS coordinator, reviewed R3's Progress Notes and verified R3's MDS dated 12/22/15, had been coded inaccurately regarding falls.

The MDS 3.0 manual revised October 2015, defined a fall as an "Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person - this is still considered a fall."

Indwelling catheter:
R2's hospital Dismissal Summary dated 9/4/13, indicated R2 had chronic progressive multiple sclerosis and had an indwelling urinary suprapubic catheter which had to be changed every month.

A Physician's Order printed 3/30/15, indicated R2 had a urinary catheter and directed staff to change it every three weeks.

A Physician Progress Note Visit dated 12/8/15, indicated R2 had a diagnosis of neurogenic bladder and used a suprapubic catheter.

and found appropriate. The Director of Nursing counseled with the MDS Coordinator on March 15, 2016 regarding the coding of falls and injury in MDS Sections J1700, J1800 and J1900. The accurate coding of bowel and bladder appliances in MDS Section H0100 was also reviewed.

Resident number 3 The resident (receiving hospice services), died at the facility on April 15, 2016. The survey audit findings related to completion of the MDS Section J1900 have been reviewed as part of the facility s ongoing quality improvement program.

Resident number 2 -- A quarterly MDS assessment was completed with an Assessment Reference Date of March 15, 2016. The suprapubic catheter has been coded in MDS Section H0100A. The care plan was reviewed and found appropriate.

The Health Information Consultant will monitor compliance by auditing the MDS of all residents who have indwelling catheters and who have had falls within the past 30 days to assure accurate MDS coding. If noncompliance is noted additional auditing and staff education will be done. Compliance will be reviewed at the next quarterly Quality Assessment and Assurance Committee meeting.

Completion Date: May 6, 2016

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F 278	Continued From page 3 R2's quarterly MDS dated 12/15/15, reflected R2 had an active diagnoses of neurogenic bladder and multiple sclerosis however, did not identify R2's use of an indwelling catheter. On 3/30/16, at 1:00 p.m. RN-D stated R2 had utilized a suprapubic indwelling catheter as long as she had worked at the facility. RN-D indicated R2 received catheter care twice daily and showed the surveyor documentation in the treatment administration record to confirm. On 3/31/16, at 8:31 a.m. RN-B stated R2 had been admitted to the facility 9/4/13, and had the indwelling suprapubic catheter in place at admission. RN-B acknowledged she had miscoded the MDS and had not included R2's indwelling catheter use. RN-B further stated, "Was probably that day when we had a lot of them (MDS to complete)." On 3/31/16, at 1:53 p.m. the director of nursing stated he expected all resident MDS assessments to be coded accurately, "I'm sure it was an oversight, someone forgot to check something." According to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 dated last revised on October 2015, the intent of the items in the bladder section was to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. "Each resident who was incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications,	F 278		

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F 278	Continued From page 4 non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible." In addition the facility was follow the Steps for Assessment which included: "1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances."	F 278		
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.	F 329		5/6/16

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F 329	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct appropriate assessment and monitoring of psychoactive medications to determine efficacy of the medications used for 1 of 3 residents (R3) reviewed for unnecessary medications. Findings include: On 3/31/16, at 9:50 a.m. when reviewing R3's falls, registered nurse (RN)-E stated Seroquel (an antipsychotic medication) 6.25 milligrams (mg) had been initiated 11/4/15, and had been increased to 12.5 mg twice daily on 11/17/15, due to increased delusional behavior and paranoia. The Physician Order Reports dated 11/4/15 through 3/31/16, indicated R3 had utilized Seroquel, Celexa (antidepressant) and Lorazepam (antianxiety). R3 was observed on 3/31/16, at 10:55 a.m. seated in the wheelchair in the lobby across from the nursing station, asleep. At 10:59 a.m. the director of nursing (DON) approached R3 and adjusted R3's feet on the foot pedals prior to wheeling R3 to her room. At that time, the surveyor asked R3 how she was doing, and R3 stated she was "tired all the time." During the conversation R3 was observed to fall asleep. At 11:02 a.m. RN-A wheeled R3 out of her room and parked her wheelchair in front of the bird aviary. R3 remained in the same area until 11:34 a.m. appearing to be asleep, head leaning to the left and her left hand hanging on the outside of the wheelchair frame by the wheel. During the	F 329	483.25(l) Tag F329 Unnecessary Drugs Stewartville Care Center staff ensure that each resident s drug regime is free from unnecessary drugs. The resident s drug regime is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible. Stewartville Care Center staff ensures that 1) residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record and 2) residents who use psychotropic drugs receive gradual dose reductions to reduce the risk of adverse effects. The risks versus benefits of medications are routinely assessed by the consultant pharmacist and the attending physician/nurse practitioner. The interdisciplinary care team observes for medication effectiveness and side effects	

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F 329	Continued From page 6 observation, several staff were observed to walk past R3, but none offered to lay R3 down. At 11:35 a.m., when asked where the nurses documented antipsychotic medication side effect monitoring, RN-A stated the staff document medication side effects by exception. RN-A explained any side effects observed would be documented in the nurses' notes, or in the TAR (Treatment Administration Record). When asked about R3's behaviors, RN-A stated R3's behaviors had gotten much better since the Seroquel had been initiated. RN-A stated R3's previous behaviors had included being impulsive, falls, and verbal and physical behaviors. The Weights and Vitals Summary dated 11/1/15, through 3/31/16, noted no orthostatic blood pressures had been recorded for R3. RN-E verified the information. R3's Event reports from 11/1/15 through 3/31/16, revealed R3 had experienced seven incidents of falls with two major injuries, two with skin tears, laceration and hematoma and three without injury recorded on 11/2/15, 11/4/15, 11/7/15, 11/11/15, 11/16/15, 12/7/15, and 1/27/15. During further review it was revealed orthostatic blood pressures had not been conducted following any of the falls. R3's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/22/15, indicated R3 received an antipsychotic for paranoia, utilized an antidepressant, and was on Hospice. The CAA further indicated R3 had experienced no side effects from the medications however, indicated R3 was at risk for medication side effects, and was at risk for falls and injury. The CAA indicated medications were to be administered as ordered,	F 329	on an ongoing basis. At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licensed nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record reflects adequate indications for medication use, that the dose tapering attempts are in compliance with regulatory guidelines, and that the staff is observing for medication related adverse effects. The policies and procedures related to the administration of psychotropic medications were reviewed and revised to include monthly orthostatic blood pressures for residents receiving antipsychotic and antianxiety medications. During the April 4 and 5, 2016 mandatory staff meeting, the nursing staff were informed of the above policy changes and the need to be observant for medication side effects and consider the resident s medication regimen when completing the incident reports. On April 20, 2016, the Director of Nurses and the Nurse Supervisor reviewed the post-fall assessment procedures which were found to be appropriate. The Nurse Supervisor completes the electronic Post Fall Observation/Evaluation report which prompts an evaluation of the causal factors of the fall including medication changes/side effects as well as	

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F 329	Continued From page 7 and monitored for effectiveness and side effects. R3's psychotropic drug use care plan dated 1/4/16, indicated R3 had been increasingly agitated following a fall with pelvic fracture. The care plan indicated R3 was forgetful, argumentative, and at times had been known to hit staff, and that R3 had experienced fluctuating paranoia regarding stealing/vendetta's/stalking. The care plan included the initiation of Seroquel in November 2015, initiation of Celexa on 6/19/15, five falls in November 2015, one 12/2/15, and another 1/27/16. The care plan interventions directed staff to monitor use and effectiveness of psychotropic medications. On 3/31/16, at 11:30 a.m. nurse practitioner (NP) stated R3 had been very aggressive and agitated at the time the Seroquel was initiated. The NP indicated R3 had undergone many medication changes which were reflective of R3's status. The NP further acknowledged staff had discussed R3's medication use related to her R3's falls, but acknowledged there was not much documentation to verify those considerations. The NP stated she expected the facility to have systems in place to monitor for medication side effects. When asked about orthostatic blood pressure monitoring, the NP stated staff would have been unable to obtain the readings after R3's falls due to her agitation, however the NP acknowledged staff should have documented their attempts and the resident refusals. On 3/31/16, at 1:00 p.m. the DON stated he would have expected the staff nurses to have assessed R3's orthostatic blood pressures if they thought it was needed. The DON further acknowledged that although R3 had experienced	F 329	mental/ambulatory status, foot wear, adaptive equipment, pain, changes in condition, environment, etc. The plan of care is updated as necessary to reflect interventions to reduce the risks of falls/injuries. Resident number 2 who was receiving hospice services died at the facility on April 15, 2016. The survey audit findings regarding the administration and monitoring of psychotropic medications was reviewed as part of the facility s ongoing quality improvement program. To monitor compliance, the Nurse Supervisor will audit for orthostatic blood pressure readings when completing the quarterly psychotropic medication review. The Assistant Director of Nurses will review the Post-Fall Observation/Evaluation form for 30 days to ensure that medication changes/side-effects are included in the fall analysis when indicated. Compliance will be reviewed at the June quarterly Quality Assurance and Assessment Committee meeting and ongoing. Completion Date: May 6, 2016	

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F 329	Continued From page 8 many changes to her medications, the care team had not discussed all the medications in relation to the falls. The package insert for Seroquel indicated a number of potential side effects including but not limited to: somnolence, orthostatic hypotension, metabolic changes (including weight gain), and cognitive and motor impairment/changes. The package inserts for the Celexa and the Lorazepam also indicated sleepiness was a common side effect.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356		5/6/16

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F 356	Continued From page 9 for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift. This had the potential to affect visitors and all 57 residents residing in the facility. Findings include: Upon entrance to the facility on 3/30/16, at 8:10 a.m. the Daily Nurse Staffing Report was observed posted on a wall outside the social service office in the East Wing. The Daily Staffing Report was dated as 3/27/16, indicating a census of 57. At 8:31 a.m. on 3/30/16, the scheduler verified the Daily Staffing Report currently posted was for 3/27/16. When asked who was responsible for making sure the staff posting was posted for the current day, the scheduler stated she printed it and the charge nurse was supposed to post it at midnight. The scheduler went over to the nursing desk to locate the current posting information but was not able to locate it. At 8:36 a.m. the scheduler was overheard informing the nurse she was going downstairs to print another sheet for the day.	F 356	Regulation 483.30(e) Tag F356 Posted Nurse Staffing Information Stewartville Care Center routinely posts the following information on a daily basis in a prominent location in a clear and readable format: (i) Facility name. (ii) The current date. (iii) The number of registered nurses, licensed practical nurses, and certified nursing assistants directly responsible for resident care per shift. (iv) Resident census. The staff member responsible for providing the staffing data was instructed on the need for timely posting of information. The Administrator/designee will monitor compliance by random audits of the timeliness of the posted information. Completion Date: May 6, 2016	

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F 356	Continued From page 10 On 3/31/16, at 2:27 p.m. the administrator stated he would expect the Daily Staffing Report to be posted close to shift start. The facility's policy, Daily Staffing Report revised 3/2013, directed "2. The staff member responsible for posting the staffing information was reminded to update the posting with changes in census/staffing in a timely manner."	F 356		