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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HUFX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245528**
2.STATE VENDOR OR MEDICAID NO.
(L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUNDERSEN HARMONY CARE CENTER**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

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 **04/06/2015** (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 **43** (L18)

13.Total Certified Beds **43** (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
	43			
(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 :
Gary Nederhoff, Unit Supervisor 04/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/242015 (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
04/01/1988
(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
03/31/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered CMS Certification Number (CCN): 245528

April 24, 2015

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, Minnesota 55939

Dear Mr. Samuelson:

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 March 31, 2015 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds located in rooms .

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 6, 2015

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, Minnesota 55939

RE: Project Number S5528025

Dear Mr. Samuelson:

On March 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 20, 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 April 6, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 2, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 31, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 20, 2015, effective March 31, 2015 and therefore remedies outlined in our letter to you dated March 10, 2015, will not be imposed.

However, as we notified you in our letter of March 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from NO DATA.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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
245528	A. Building B. Wing	4/6/2015

Name of Facility	Street Address, City, State, Zip Code
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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 **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/31/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/31/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/31/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/31/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/31/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/31/2015**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/31/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/31/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/31/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/31/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/31/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/31/2015**
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	GPN/kfd	04/06/2015	25822	04/06/2015
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
2/20/2015			

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
245528	A. Building B. Wing **01 - MAIN BUILDING**	4/2/2015

Name of Facility	Street Address, City, State, Zip Code
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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	Correction Completed **03/31/2015**	ID Prefix	Correction Completed **03/31/2015**	ID Prefix	Correction Completed **03/31/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0050		LSC K0062		LSC K0144	
ID Prefix	Correction Completed **03/31/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0147		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	04/06/2015	25822	04/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/17/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HUFX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245528**
2.STATE VENDOR OR MEDICAID NO.
(L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUNDERSEN HARMONY CARE CENTER**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

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 **02/20/2015** (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 **43** (L18)

13.Total Certified Beds **43** (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
	43			
(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 :
Josephine Hassinger, HFE NE II 03/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/27/2015 (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
04/01/1988
(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
March 10, 2015

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, Minnesota 55939

RE: Project Number S5528025

Dear Mr. Samuelson:

On February 20, 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;

<u>Potential Consequences</u> - 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 April 1, 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 April 1, 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 May 20, 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 August 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(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 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview review the facility failed to ensure equipment used for hygiene assessed needs were kept in a state of good repair and clean for 4 of 4 resident (R28, R42, R53, R55) who used a portable commode and also failed to maintain wheelchair upholstery in a state of good repair for 1 of 3 residents (R24) who utilized a wheelchairs for movement. Findings include: An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and housekeeping director (HD)-A. Soiled commodes: R28 located in room 120 had a portable	F 253	" Commodes have been ordered for replacement " Wheel chair cleaned and arms replaced- maintenance by March 31, 2015 " Staff will receive reminder from administrator to report problems with wheelchairs to maintenance via the maintenance request book by March 31, 2015 " DAC supervisor will be report needed repair or infection control problems related to commodes and wheelchairs to the maintenance via the maintenance request book.	3/31/15

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

Electronically Signed | 03/18/2015

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	245528	A. BUILDING _____ B. WING _____	02/20/2015

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F 253	Continued From page 1 commode set over the toilet. The portable commode was observed to have cracked plastic arm rests and a severely stained bucket to be soiled with debris and rust on metal. It was learned that R42 in room 121 used this same portable commode. R58 located in room 135 and R55 located in room 137 used the same portable commode which was observed to have a chipped plastic seat and rusty areas on the legs. Also in bathroom of R58 and R55 the grab bars were worn and rust was noted on the metal. During an interview on 2/19/15 at 1:30 p.m. the HD-A stated she felt these were not cleanable surfaces. Wheelchair upholstery torn and soiled: R24 located in in room 130B on 2/17/15 at 11:40 a.m. had a wheel chair that was observed to be soiled with debris, and the arms of wheel chair had vinyl missing exposing the foam underneath. During an interview on 2/19/15 at 1:30 p.m. the maintenance director stated staff have a procedure to notify him of wheelchair issues and is unaware of this wheelchair needing to be fixed.	F 253	" Environmental services department will do random audits for cleanliness and repair problems, no less than bi-weekly for three months. If continued problems are noted a monthly random audit for the remainder of the year will be initiated. " A facility Safety Inspection that is done every other month will now include inspection of commodes and wheel chairs.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		3/31/15

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F 280	Continued From page 2 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise and update the care plan for 4 of 7 residents (R15, R32, R37, and R43) reviewed who had facility urinary tract infection (UTI). Findings include: R15 experienced recurrent UTIs but lacked revision of an individualized plan of care to provide directions to the staff regarding UTI management and interventions to minimize the risk of recurrent UTIs. R15 was admitted to the facility on 1/15/13 and the admission record listed diagnoses that included neurogenic bladder, urinary tract infection, urine retention, urinary frequency. The quarterly Minimum Data Set (MDS) dated 1/7/15 indicated R15 had impaired cognitive/memory, required extensive assistance with activities of daily living, had an indwelling catheter, had a neurogenic bladder and had no UTIs past 30 days. However of the clinical record indicated R15 had experienced three UTIs between August 2014 and December 2014 that were identified as facility acquired.	F 280	" R15- POC will be updated with interventions to prevent UTI by March 20, 2015 " R32- POC will be updated with interventions to prevent UTI by March 20, 2015 " R37- resident has expired, no individual action will be taken " R43- POC will be updated with directions to minimize the risk of recurrent UTI by March 20, 2015 Nurse Managers will update plan of care (POC) " Director of Nursing will meet with Medical Director to clarify orders for urinalysis and culture of specimens and use of prophylactic antibiotics to eliminate inappropriate use of antibiotic medications by March 31, 2015 " A required meeting will be held for all nursing staff (RN, LPN and CNAs). In this meeting the following will be presented by the Director of Nursing and Nurse Managers: o Nursing staff will be re-educated on methods of prevention for UTI including	

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F 280	Continued From page 3 The care plan dated 12/15/14 was reviewed. The care plan noted R15 required total assistance for toileting and hygiene. The care plan identified an indwelling Foley catheter and interventions to identify UTIs, but did not include interventions to minimize the risk of UTIs. R32 experienced recurrent UTIs but lacked revision of an individualized plan of care to provide directions to the staff regarding UTI identification and management and interventions to minimize the risk of recurrent UTIs. R32 was admitted to the facility in 2013 and the resident admission record listed diagnoses as dysuria (painful urination) urethral discharge, urinary tract infection, urinary catheterization, diarrhea, neurogenic bladder, stage II chronic kidney disease. The quarterly MDS dated 11/19/14 was reviewed. R32 had a BIMS (brief interview of mental status) was 9 or moderate impairment, required extensive assistance for activities of daily living (ADLs), was frequently incontinent, had a neurogenic bladder, and had experienced a UTI during the previous 30 days. Review of the clinical record indicated R32 had experienced four UTIs between July 2014 and November 2014 that were identified as facility acquired. The care plan dated 1/14/15 identified interventions that included use mechanical lift to transfer R32 to toilet. The care plan listed a medical diagnosis that include renal insufficiency, but did not list interventions to help minimize the risk of recurrent UTIs. R37 experienced recurrent UTIs but lacked revision of an individualized plan of care to provide directions to the staff regarding UTI identification and management and interventions to minimize the risk of recurrent UTIs.	F 280	proper peri-care, catheter care, increasing fluids and food/fluids that naturally inhibit infection o Nursing staff will be re-educated on signs and symptoms of UTI including temperature, odor, dysuria, flank pain and confusion/behavioral changes in some persons o Nursing staff will be re-educated regarding appropriate nursing interventions to take if residents exhibit any signs of UTI and advised of updated orders for UTI management o RN/LPN staff will be re-educated in the use of temporary care plans for any resident diagnosed with a UTI o This meeting will be held by March 26, 2015 " A Quality Assessment Performance Improvement project will be initiated by the Director of Nursing to further identify any underlying systematic problems related to assessment and control of urinary tract infections and plan for a resolution. This will be part of an Infection Control Program overhaul. The project will be initiated by March 31,2015	

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F 280	Continued From page 4 R37 was admitted on 6/6/14 and had diagnoses listed on the admission record as diabetes, stage III chronic kidney disease, malaise and fatigue, urinary infection. The significant change MDS dated 10/24/14 indicated memory impairment, required extensive assistance, was frequently incontinent of urine, and experienced no UTI is previous 30 days. Review of the clinical record reviewed R37 had experienced three UTIs between June and December 2014 that were identified as facility acquired. The care plan dated 11/3/14 was reviewed. The care plan identified R37 was incontinent of bladder. The care plan directed R37 needed assist with toileting dated 8/1/14 but was not revised to include identification and interventions to prevent UTIs. R43 experienced recurrent UTIs but lacked revision of an individualized plan of care to provide directions to the staff regarding UTI identification and management and to interventions to minimize the risk of recurrent UTIs. R43 was admitted 5/1/14. The physician orders dated 1/19/15 through 2/19/14 listed diagnoses that included chronic diarrhea, urinary tract infection, dysuria (pain with urination) The quarterly MDS dated 11/5/14 was reviewed. The MDS indicated R43 had no cognitive impairment, was independent with all activities of daily living, was always continent, and had not experienced a UTI during the previous 30 days. Review of the clinical record revealed R43 had experienced an UTI in December 2014 that was identified as facility acquired. Care plan dated 1/13/15 noted R43 was continent of bladder and independent with toileting but did not direct staff related to UTI risk or	F 280		

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F 280	Continued From page 5 management. The care plan did have a problem related to a diagnosis of diarrhea, but the interventions did not include minimizing the risk of UTIs. During an interview on 2/19/15 at 2:36 p.m. registered nurse (RN)-C stated she did have a temporary care plan that could be used for residents that had UTIs, but she had not been using it. At 5:10 p.m. on 2/19/15 registered nurse (RN)-C stated the care plans provided were the most current for R15, R32, R37, and R43.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 3 of 26 residents (R23, R21, R56) to meet each resident identified need and services. Findings included: R23 failure to provide nail care and follow registered dietician's recommendations. On 2/18/15, at 12:27 p.m. R23 was observed to have very long finger nails with light brown debris underneath nails and at least one of ten nails showed broken jagged sharp edges. R23's quarterly Minimum Data Set (MDS) dated 1/23/15 included the diagnoses of diabetes mellitus, psychotic disorder, and stage four kidney disease and open-angle glaucoma. The	F 282	" (R23) Director of Nursing and Dietary, Nurse Managers met with Dietician to review and revise methods of documentation of food/fluids within the facility March 13, 2015 o Guidelines will be devised for the appropriate practice of documentation by March 31, 2015 o Director of nursing and Dietary manager will provide education to all nursing and dietary through writing and face to face instruction of the improved plan for documentation by March 31, 2015 o Dietary manager will pull a weekly documentation report for 6 weeks to monitor for compliance following staff	3/31/15

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F 282	Continued From page 6 assessment indicated no cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 15. The MDS also indicated R23 required extensive assist from staff to perform activities of daily living (ADLs) of dressing and hygiene. R23's care plan provided by the facility on 2/19/15 related to grooming and hygiene read, "Assist ...as needed for dressing, personal hygiene, transfers and toileting. Encourage independence as able-but needs supervision and checks for thoroughness. " Care plan indicated bath days were on Tuesday and Thursday. R23's care plan did not address how nail care was provided, how often, or by who nail care should be provided by. During an interview on 2/18/15, at 5:54 p.m. registered nurse (RN)-B stated diabetic nail care was performed by a nurse on bath days. During an interview on 2/19/15, at 10:38 a.m., director of nursing (DON) explained if nail care was not specifically care planned the expectation was the person that gave the bath would check finger nails. DON also stated nail care should be care planned. R23 ' s care plan provided by the facility on 2/19/15 related to nutrition indicated R23 ' s ideal fluid intake was between 1800-2000 cubic centimeters (cc ' s) and directed staff to record meal and fluid intake at all meals. R23's fluid intake record from 1/19/15 through 2/19/15 was reviewed. The record revealed twelve meal fluid intakes had not been recorded. During an interview on 2/19/15, at 10:38 a.m., DON confirmed missing fluid intake entries and explained strict intake monitoring was performed only if the registered dietician had made that recommendation. During an interview on 2/19/15, at 1:29 p.m., certified dietary manager (CDM) stated R23's	F 282	instruction. A random audit of documentation will be done over the next year, no less than once each month, followed by re-education of staff as needed starting the week following staff education, April 6, 2015. " (R23, R24, R56) Bathing protocol will be written and all staff providing baths will be educated in the protocol including the proper care of nails and care of facial hair by March 31, 2015 o All newly hired CNA staff will receive orientation to the bathing protocol and will spend time with a trained CNA to practice these skills o The protocol will include a method of reporting to nurses when a resident requires nursing action for nail care (i.e. Diabetics) o Random audits will be performed at least once per month throughout the next year to see that bathing protocol is being followed--nails clean and trimmed and facial hair shaved as appropriate to the individual. The Director of Nursing will perform or assign the audits to another nurse. Re-education will be performed for any noted problems. " (R21) A plan for monitoring the use of any psychoactive medication has already been initiated within the facility consisting of a committee of Nurse Managers, Director of Nursing and Consulting Pharmacist with consultation by the Medical Director. Monitoring of target behaviors (moods) was outlined at the meeting with our consulting pharmacist in January and initiated February 19, 2015 in preparation for our meeting March 6,	

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F 282	Continued From page 7 fluid intake had been recommended because R23 was on diuretics and had a urinary catheter. R24 on 2/17/15, at 10:15 a.m. and on 2/18/15, at 12:46 p.m. and at 6:39 p.m. R24 was observed to have long facial hair on her upper lip. R24 ' s quarterly MDS dated 11/26/14 included diagnoses of dementia and anxiety disorder. The assessment indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6. The MDS also indicated R24 required extensive assist of one staff member to perform activities of daily living (ADL's) of dressing and hygiene. R24's care plan provided by the facility on 2/19/15 read, "ADL: dressing, sponge bath, grooming: requires set up and moderate-max assist/check for thoroughness twice a day AM and PM. Assist [R24] with personal hygiene. [R24] would like to be offered assist with shaving chin hair weekly on bath day. Family has been notified that they need to bring in an electric razor." The care plan indicated bath day was Wednesday. During an interview on 2/18/15, at 5:44 p.m. RN-B confirmed R24 did have bath and R24 ' s facial hair should have been removed. During an interview on 2/18/15, at 6:39 p.m., R24 stated she had not been aware of the facial hair, did not wish for it to be there, and wanted it removed. During an interview on 2/18/15, at 6:40 p.m., nursing assistant (NA)-A confirmed R24 had facial hair. A policy on shaving female resident ' s facial hair was requested and was not provided by the facility. On 2/18/15, at 7:50 p.m. the DON stated the facility did not have a policy related to female facial hair. RESTORATIVE NURSING: R21's care plan dated 6/27/12 identified a	F 282	2015. Data on moods/target behaviors will be collected on-going or as sample collections for each individual utilizing any of these types of medications within the facility. This data will be collected within our Electronic Health Record. o The resident (R21) is slated for review at our April 8, 2015 meeting. o (R21) POC will be updated to reflect target behavior/mood monitoring by March 20, 2015 o The Consulting Pharmacist will continue to meet with designated members of the nursing staff to review each resident□s medication regime monthly and this team will make on-going recommendations related to the continued use, a request for change in orders or additional information from the medical provider.	

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problem of at risk for losing strength in legs. Approaches dated 2/10/15, included: ambulate with R21 to and from all meals with 4 wheel walker, lower extremity seated exercises-marches, kicks, knee bends, toe taps 15 times each once a day; lower extremity standing exercises- marches, squats, sidekicks, heel raises 15 times each once a day. Care plan approaches dated 8/1/14, included: invite to falls and balance program led by activity staff once a morning and goal was R21 to attend three times a week; restorator or recumbent bike 10-15 minutes; restorative program will be reviewed quarterly and as needed.

R21's care plan dated 5/31/12 identified a problem of at risk for falling related to poor eye sight and variable balance. Approaches dated 8/1/14, included: administer medication, use walker with ambulation, encourage participating in falls and balancing program, keep items within reach, and keep room free of clutter.

Physical therapy daily treatment notes revealed R21 received 12 physical therapy visits for exercises and ambulation between 1/5/15 and 1/30/15.

Document review of physical therapy progress and discharge summary dated 1/30/15, revealed analysis of functional outcome read, "Made significant progress towards" physical therapy goals. "Will continue to address ongoing deficits with a functional maintenance program directed by facility staff. "

Document review of Physical Therapy Restorative Program dated 1/30/15, revealed the following exercise program for R21:

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F 282	Continued From page 9 Lower extremity seated exercises: marches with 2 pounds (#) 15 times, kicks with 2# 15 times, knee bends with blue band 15 times, toe taps 30 times, ball squeezes 30 times; Lower extremity standing exercises: marches active range of motion 15 times, squats active range of motion 15 times, sidekicks active range of motion 15 times, heel raises active range of motion 15 times; Ambulation: Please ambulate with R21 to/from all meals with 4 wheel walker and contact guard assistance and follow with wheelchair due to dizziness. R21 is to have contact guard assistance with all ambulation in hallway. Please have R21 perform all exercises 5-7 days per week as tolerates and is willing to participate. Please contact physical therapy department with any questions or concerns. Document review of restorative nursing flow sheet dated 2/1/15 to 2/19/15, revealed the following: Falls and balance, invite once a morning, will attend three times a week, R21 attended 1 session out of 19 days; Restorator or recumbent bike 10-15 minutes a day, Sunday through Saturday, goal to pedal 15 minutes, R21 refused two sessions and attended 1 session out of 19 days; Falls and balance once a day Monday through Friday, R21 attended one session out of 19 days. The restorative nursing flow sheet did not identify any of the physical therapy recommended exercises dated 1/30/15. During interview on 2/19/15, at 10:25 a.m., RN-B verified the physical therapy recommendations for restorative nursing were not part of the restorative nursing flow sheet. RN-B verified, although the	F 282		

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care plan directed restorative nursing exercises, none were provided. RN-B stated the falls and balance program was on the flow sheet two times but was actually the same program offered by activity staff whenever they can do it. RN-B verified R21 received the falls and balance program and the bike exercise one session out of 19 days. She verified R21 had not received restorative therapy exercises as recommended by physical therapy on 1/30/15.

During interview on 2/19/15, at 12:50 p.m., director of nursing stated the facility had been short staffed and they have rescheduled restorative aides to work on the floor. Director of nursing verified the facility had no plan in place to provide restorative therapy exercises when restorative aides were rescheduled to work the floor.

UNNECESSARY MEDICATIONS:
R21 ' s care plan dated 3/5/14 identified a problem of psychotropic medication use due to received lorazepam for diagnosis of anxiety. Approaches identified included monitor mood and response to medications.

R21 was identified on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, moods score of 15 including moods of little interest, feeling depressed, trouble sleeping, tired, poor appetite, feel bad about self, no behaviors, and received antianxiety medication.

Document review of care area assessment (CAA) for mood dated 1/20/15, stated R21 " endorses some mood indicators but voices a desire not to

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change anything at this time as she feels mood is improving, " and " Mood is addressed in care plan d/t (due to) mood issues. " CAA for psychotropic medication dated 1/20/15, stated, " Psychotropic med (medication) use triggered d/t (due to) ativan (lorazepam) use for longstanding anxiety problems. " CAA identified R21 started on antidepressant medication. CAA identified psychotropic medication use was addressed in the care plan due to antianxiety and antidepressant use.

Document review of physician orders report dated 1/19/15 to 2/19/15, revealed orders for lorazepam 0.5 milligrams daily for anxiety disorder, with a start date of 6/13/14; lorazepam 1 milligram two times a day for anxiety disorder, with a start date of 6/13/14; and lorazepam 0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14. The same physician order report had physician orders for Zoloft 50 milligrams once an evening for anxiety, with a start date of 1/16/15.

Document review of facility medication administration record dated 1/1/15 to 1/30/15, revealed R21 received lorazepam and Zoloft as ordered.

During interview on 2/19/15, at 10:45 a.m., RN-B verified the facility did not identify or monitor target moods or response to medications. RN-B stated the facility knew the medication was effective by just talking with the nurses. RN-B stated the facility quarterly mood and behavior charting on the MDS assessment was the facility monitoring of moods and behaviors.

During interview on 2/19/15, at 4:15 p.m., director

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of nursing stated the facility had no medication related policies.

FACIAL HAIR:
R56 was identified by the facility as dependent on one staff for activities of daily living, according to document review of facility progress notes dated 2/7/15, 2/12/15, and 2/17/15.

R56 was admitted to the facility on 2/4/15, according to review of R56's medical record face sheet.

During observations on 2/17/15, at 3:19 p.m., 2/18/15, at 6:00 p.m., and 2/18/15, at 7:40 p.m., R56 was observed with long chin hairs.

Document review of R56's interim plan of care, not dated, directed staff to check for chin hairs, hair and nail care by staff, oral care assist as needed.

Document review of facility resident profile with start date of 2/9/15, directed staff to assist R56 with grooming and hygiene as needed.

During interview on 2/18/15, at 7:40 p.m., RN-A verified R56 has long chin hairs. RN-A stated female resident's facial hair was shaved on the day shift. RN-A verified R56 did not shave own facial hair.

During interview on 2/18/15, at 7:45 p.m., nursing assistant (NA)-A stated female residents ' facial hair was shaved in the mornings.

During interview on 2/18/15, at 7:50 p.m., director of nursing stated she expected female facial hair was shaved on bath day and offered as needed.

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F 282	Continued From page 13 She stated the facility did not have a policy for shaving facial hair.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services for 1 of 1 resident (R21) to help maintain or improve ability to ambulate. Findings include: R21 was identified by the facility on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, transfers, walk in room and walk in corridor self-performance was supervision; transfer support was one person physical assist, walk in room support was set up help only, and walk in corridor support was no set up help or physical help from staff; no falls since last assessment, balance during transitions and walking was unsteady but able to stabilize without human assistance, no impairment in functional limitation in range of motion of upper and lower extremity, and received physical therapy with start date of 1/5/15. Document review of falls care area assessment dated 1/20/15, revealed falls triggered due to recent falls without injury and some balance	F 311	" (R21) Care plan will be updated by nurse manager to show interventions to be taken should the resident refuse her recommended restorative program by March 20, 2015 " Nurse Manager will further evaluate R21□s acceptance and participation in her program by March 31, 2015 and plan to continue, change or discontinue the program based on the resident□s choice and response to the program. Additional review will occur at the resident□s next quarterly care conference or sooner should a significant change occur. " All nursing staff will be educated by Director of Nursing and Nurse Managers in the rationale for Restorative Care and expectations for other staff on duty to provide Restorative services if a Restorative Aid is not scheduled by March 31, 2015 o Persons working with the Restorative Nursing program will meet and initiate a Quality Assessment Performance Improvement project for the program to include better definition of the program	3/31/15

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F 311	Continued From page 14 problems. R21 was hard of hearing, had poor vision, walks with assist of staff, used wheelchair. Document review of physician orders dated 1/19-2/19/15, revealed the following orders: may ambulate independently in room and halls with 4 wheel walker, and falls and balance program once a day Monday through Friday. During observations on 2/17/15, at 2:00 p.m., R21 sat in room recliner with feet up. At that time, R21 transferred by self to wheelchair and wheeled out of the room to church service. R21's care plan dated 6/27/12 identified a problem of at risk for losing strength in legs. Approaches dated 2/10/15, included: ambulate with R21 to and from all meals with 4 wheel walker, lower extremity seated exercises-marches, kicks, knee bends, toe taps 15 times each once a day; lower extremity standing exercises- marches, squats, sidekicks, heel raises 15 times each once a day. Approaches dated 8/1/14, included: invite to falls and balance program led by activity staff once a morning and goal was R21 to attend three times a week; restorator or recumbent bike 10-15 minutes; restorative program will be reviewed quarterly and as needed. R21's care plan dated 5/31/12 identified a problem of at risk for falling related to poor eye sight and variable balance. Approaches dated 8/1/14, included: administer medication, use walker with ambulation, encourage participating in falls and balancing program, keep items within reach, and keep room free of clutter. Document review of past three months of falls	F 311	itself, a plan for back-up and identification of persons responsible for review and evaluation of the program, including resident response, on a weekly to biweekly basis. The first meeting will be held by March 31, 2015	

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revealed no falls in 12/2014, and no falls in 1/2015.
The following two falls occurred in 2/2015:
Document review of the event report dated 2/14/15, revealed R21 stated had fall in bathroom and got up on her own, c/o back pain, and call lite was within reach. The report identified R21 was seen by a provider on 2/13/15 for respiratory symptoms and cough. Interventions were to ask R21 to use call light or wait for assist. Investigation identified R21 had been more unsteady on feet and was to have assistance to walk in hallways.

Document review of event report dated 2/18/15, revealed R 21 was on floor in front of roommates chair, trying to move her bedside table. R21 stated was just weak, denied pain, lung sounds clear. R212 had a cough, was seen on 2/13/15 for cough, was seen after fall on 2/18/15 for cough and weakness and started on antibiotic. R21 was reeducated to use the call light. R21 was alert and oriented and made own decisions.

Document review of physical therapy plan of care dated 1/5/15, identified start of care date of 1/5/15, reason for referral: R21 presents with a decline in ambulation and transfers due to recent onset of the flu. R21 started noticing a decline approximately 2 weeks ago which has since resulted in the patient now requiring significantly more assistance for the completion of transfers and ambulation. Therapy necessity: R21 requires skilled physical therapy at this time for strengthening, balance training, gait and transfer in order to regain prior level of function. Physical therapy to discharge with patient at maximum potential with long term plan in place. Short term goal: ambulates 40 feet with 4 wheeled walker on

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even surfaces requiring contact guard assistance. Goal: will ambulate 100 feet safely with 4 wheeled walker on even surfaces with supervision in order to regain prior functional level. Long term goal: will be able to safely ambulate with use of her 4 wheeled walker throughout the facility with modified independence in order to return to her prior level of function. Plan of care was signed by physician for 1/5/15 to 2/1/15, for 3 times a week for 4 weeks.

Document review of physical therapy daily treatment notes revealed the following:
1/16/15, revealed R21 was proud of her ambulation today and reports she can tell she is getting stronger.
1/23/15, R21 ambulated 320 feet with 4 wheeled walker and contact guard assistance. R21 demonstrated improved ambulation distance and independence with mobility.
1/30/15, R21 requested to discharge from physical therapy due to legs hurt after therapy. R21 agreed to restorative therapy and ambulating with staff. Ambulation and restorative program completed.

R21 received 12 physical therapy visits for exercises and ambulation between 1/5/15 and 1/30/15.

Document review of physical therapy progress and discharge summary dated 1/30/15, revealed analysis of functional outcome included R21 made significant progress towards physical therapy goals. R21 will continue to address ongoing deficits with a functional maintenance program directed by facility staff.

Document review of Physical Therapy Restorative

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F 311	Continued From page 17 Program dated 1/30/15, revealed the following exercises: Lower extremity seated exercises: marches with 2# 15 times, kicks with 2# 15 times, knee bends with blue band 15 times, toe taps 30 times, ball squeezes 30 times; lower extremity standing exercises: marches active range of motion 15 times, squats active range of motion 15 times, sidekicks active range of motion 15 times, heel raises active range of motion 15 times; Ambulation: Please ambulate with R21 to/from all meals with 4 wheel walker and contact guard assistance and follow with wheelchair due to dizziness. R21 is to have contact guard assistance with all ambulation in hallway. Please have R21 perform all exercises 5-7 days per week as tolerates and is willing to participate. Please contact physical therapy department with any questions or concerns. Document review of restorative nursing flow sheet dated 2/1/15 to 2/19/15, revealed the following: Falls and balance, invite once a morning, will attend three times a week, R21 attended 1 session out of 19 days; Restorator or recumbent bike 10-15 minutes a day, Sunday through Saturday, goal to pedal 15 minutes, R21 refused two sessions and attended 1 session out of 19 days; Falls and balance once a day Monday through Friday, R21 attended one session out of 19 days. During interview on 2/19/15, at 10:25 a.m., registered nurse (RN)-B verified the physical therapy recommendations for restorative nursing were not part of the restorative nursing flow sheet. RN-B verified although the care plan directed restorative nursing exercises, none were	F 311		

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provided. RN-B stated the falls and balance program was on the flow sheet two times but was actually the same program offered by activity staff whenever they can do it. RN-B verified R21 received the falls and balance program and the bike exercise one session out of 19 days. She verified R21 had not received restorative therapy exercises as recommended by physical therapy on 1/30/15. RN-B verified the recommendations had not been added to the restorative flow sheet. RN-B stated the facility had two restorative aides who assisted with restorative exercises.

During interview on 2/19/15, at 10:56 a.m., nursing assistant (NA)-C (NA-C) stated she provided lower extremity exercise bike for 10 minutes whenever R21 would go to the exercise room. NA-C verified not aware of the physical therapy recommended restorative program exercises. NA-C stated restorative aides frequently have to work on the floor and the restorative exercises do not get done.

During interview on 2/19/15, at 12:35 p.m., PTA-C stated had completed the monthly physical therapy evaluation at that time. She stated the evaluation included a review of nurse ' s notes and talked with nursing assistants. PTA-C verified the evaluation did not include exercises or ambulation. PTA-C stated R21 needed more help to get dressed which was progressively worse with most recent illness, increased dizziness and unsteadiness, refused to use call light, and was self- transferring despite education to use call light. PTA-C stated, based on the evaluation, R21 had declined since discharge from therapy on 1/30/15. Surveyor requested PTA-C attempt to ambulate R 21 that day.

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F 311	Continued From page 19 During interview on 2/19/15, at 12:50 p.m., director of nursing stated the facility had been short staffed and they have rescheduled restorative aides to work on the floor. Director of nursing verified the facility had no plan in place to provide restorative therapy exercises when restorative aides were rescheduled to work the floor. During interview on 2/19/15, at 3:10 p.m., RN-B stated R21 had declined due to influenza in 12/2015 and worsening eye sight. RN-B stated R21 requested to discharge from physical therapy 1/30/15, because she did not like therapy and did not want to continue. RN-B verified R21 had declined as she no longer walked to meals.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services for 3 of 3 residents (R24, R23 and R56) who were dependent of staff to meet their activities of daily living (ADL). Findings included: R24 on 2/17/15, at 10:15 a.m. and on 2/18/15, at 12:46 p.m. and at 6:39 p.m. was observed to have long facial hair on her upper lip.	F 312	" (R23, R24, R56) Bathing protocol will be written and all staff providing baths will be educated in the protocol including the proper care of nails and care of facial hair by Director of Nursing by March 31, 2015 o All newly hired CNA staff will receive orientation to the bathing protocol and will spend time with a trained CNA to practice these skills o The protocol will include a method of	3/31/15

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F 312	Continued From page 20 R24's quarterly MDS dated 11/26/14 included diagnoses of dementia and anxiety disorder. The assessment indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6. The MDS also indicated R24 required extensive assist of one staff member to perform ADLs including hygiene. R24's care plan provided by the facility on 2/19/15 read, "ADL: dressing, sponge bath, grooming: requires set up and moderate-max assist/check for thoroughness twice a day AM and PM. Assist R24 with personal hygiene. R24 would like to be offered assist with shaving chin hair weekly on bath day. Family has been notified that they need to bring in an electric razor." The care plan indicated bath day was Wednesday. During an interview on 2/18/15, at 5:44 p.m. registered nurse (RN)-B confirmed R24 did have bath and R24's facial hair should have been removed. During an interview on 2/18/15, at 6:39 p.m., R24 stated she had not been aware of the facial hair, did not wish for it to be there, and wanted it removed. During an interview on 2/18/15, at 6:40 p.m., nursing assistant (NA)-A confirmed R24 had facial hair. A policy on shaving female resident's facial hair was requested and was not provided by the facility. On 2/18/15, at 7:50 p.m. the DON stated the facility did not have a policy related to female facial hair. R23 on 2/18/15, at 12:27 p.m. was observed to have very long finger nails with light brown debris underneath nails and at least one of ten nails showed broken jagged sharp edges. R23's quarterly MDS dated 1/23/15 included the diagnoses of peripheral arterial disease, diabetes mellitus, and open-angle glaucoma. The	F 312	reporting to nurses when a resident requires nursing action for nail care (i.e. Diabetics) o Random audits will be performed at least once per month throughout the next year to see that bathing protocol is being followed--nails clean and trimmed and facial hair shaved as appropriate to the individual. The Director of Nursing will perform or assign the audits to another nurse. Re-education will be performed for any noted problems.	

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assessment indicated no cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 15. The MDS also indicated R23 required extensive assist from staff to perform ADLs including hygiene.
R23's care plan provided by the facility on 2/19/15 related to grooming and hygiene read, "Assist ...as needed for dressing, personal hygiene, transfers and toileting. Encourage independence as able-but needs supervision and checks for thoroughness. " Care plan indicated bath days were on Tuesday and Thursday. R23's care plan did not address how nail care was provided, how often, or by who nail care should be provided by.
During an interview on 2/18/15, at 5:54 p.m. RN-B stated diabetic nail care was performed by a nurse on bath days.
During an interview on 2/19/15, at 10:38 a.m., director of nursing (DON) explained if nail care was not specifically care planned the expectation was the person that gave the bath would check finger nails. DON also stated nail care should be care planned.
R56 was identified by the facility as dependent on one staff for activities of daily living, according to document review of facility progress notes dated 2/7/15, 2/12/15, and 2/17/15.

R56 was admitted to the facility on 2/4/15, according to review of R56's medical record face sheet.

During observations on 2/17/15, at 3:19 p.m., 2/18/15, at 6:00 p.m., and 2/18/15, at 7:40 p.m., R56 was observed with long chin hairs.

Document review of R56 ' s interim plan of care, not dated, directed staff to check for chin hairs, hair and nail care by staff, oral care assist as

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F 312	Continued From page 22 needed. Document review of facility resident profile with start date of 2/9/15, directed staff to assist R56 with grooming and hygiene as needed. During interview on 2/18/15, at 7:40 p.m., RN-A verified R56 long chin hairs. RN-A stated female resident's facial hair was shaved on the day shift. RN-A verified R56 did not shave own facial hair. During interview on 2/18/15, at 7:45 p.m., NA-A stated female residents ' facial hair was shaved in the mornings. During interview on 2/18/15, at 7:50 p.m., director of nursing stated she expected female facial hair was shaved on bath day and offered as needed. She stated the facility did not have a policy for shaving facial hair.	F 312		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 315	" R51-POC-resident has been	3/31/15

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F 315	Continued From page 23 failed to assess urinary tract infections (UTIs), then develop interventions to prevent further UTIs from developing for 7 of 7 residents (R51, R37, R43, R16, R15, R32, R23) identified with having or history of having a UTI, Also failed to reassess a resident following a decline in urinary continence for 1 of 3 residents (R33) reviewed for urinary incontinence. Findings include: UTIs: R51 experienced recurrent UTIs and lacked consistent identification of symptoms of an infection, lacked an assessment of UTI risk, and lacked a care plan for the management of the UTIs. R51 was admitted to the facility 10/31/14 and had diagnoses that included urinary tract infection, urinary frequency. The 60-day Minimum Data Set (MDS) dated 12/26/14 indicated R51 was cognitively intact. required extensive assistance with activities of daily living (ADLs), was occasionally incontinent of bladder and had experienced a UTI during the previous 30 days. The observation report/evaluation dated 11/07/14 was reviewed. The observation report noted resident was always incontinent of urine, required extensive assistance with toileting, had mixed (urge and stress) incontinence, but did not assess/evaluate the residents risk to develop UTIs. The care plan dated 1/7/15 had a problem or urinary incontinence and a history of UTI. The interventions included: administer antibiotics, encourage fluid, encourage emptying of bladder, provide incontinence. The care plan did not	F 315	discharged, no individual action will be taken " R37- POC-resident has expired, no individual action will be taken " R43- POC will be updated with directions to minimize the risk of recurrent UTI and the management of UTIs by March 20, 2015 " R16- POC-resident has expired, no individual action will be taken " R15- POC will be updated with interventions to prevent UTI by March 20, 2015 " R32- POC will be updated with interventions to prevent UTI by March 20, 2015 " R23-POC will be updated with interventions to prevent UTI by March 20, 2015 o R23, prophylactic use of antibiotics has been discontinued. Nurse Mangers will be responsible to update all POC " Director of Nursing will meet with Medical Director to clarify orders for urinalysis and culture of specimens and use of prophylactic antibiotics to eliminate inappropriate use of antibiotic medications by March 31, 2015 " A required meeting will be held for all nursing staff (RN, LPN and CNAs). In this meeting the following will be presented by Director of Nursing: o Nursing staff will be re-educated on methods of prevention for UTI including proper peri-care, catheter care, increasing fluids and food/fluids that naturally inhibit infection o Nursing staff will be re-educated on	

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F 315	Continued From page 24 assist staff to identify the resident ' s symptoms of UTIs. Registered nurse (RN)-C was interviewed on 2/19/15 at 2:36 p.m. RN-C stated only one culture was done even though R23 had three UTIs and 3 were treated with antibiotics. The UTIs were treated based on the dip stick result, but not a culture. R37 experienced recurrent UTIs (3 UTIs in 6 months) but lacked an assessment of the risk to develop UTIs, lacked identification of symptoms prior to treatment, and lacked revision of care plan to include management and prevention of UTIs. R37 was admitted on 6/6/14 and had diagnoses listed on the admission record as diabetes, stage III chronic kidney disease, malaise and fatigue, urinary infection. The significant change MDS dated 10/24/14 indicated memory impairment, required extensive assistance, was frequently incontinent of urine, and experienced no UTI is previous 30 days. R37's observation report/ evaluation dated 10/20/14 for bowel and bladder significant change, identified R37 as frequently incontinent, requiring extensive assistance with toileting use, experiencing mixed (urge and stress) incontinence, but did not assess R37's risk factors to develop UTIs. The care plan dated 11/3/14 was reviewed. The care plan identified C37 as being admitted to hospice. The care plan identified R37 as at time incontinent of bladder. The care plan directed R37 needed assist with toileting dated 8/1/14 but was not revised to include identification and management of UTIs. R43 experienced a UTI but lacked, identification of urinary symptoms, lacked an assessment to	F 315	signs and symptoms of UTI including temperature, odor, dysuria, flank pain and confusion/behavioral changes in some persons o Nursing staff will be re-educated regarding appropriate nursing interventions to take if residents exhibit any signs of UTI and advised of updated orders for UTI management o RN/LPN staff will be re-educated in the use of temporary care plans for any resident diagnosed with a UTI o This meeting will be held by March 26, 2015 " A Quality Assessment Performance Improvement project will be initiated by Director of Nursing to further identify any underlying systematic problems related to assessment and control of urinary tract infections and plan for a resolution. The project will be initiated by March 31, 2015 " R33-an elimination assessment was performed on February 20, 2015 and a referral to occupational therapy was initiated. Resident is currently participating in the therapy. " Further assessment of a change in condition is a standard process when completing the RAI process. Completing the elimination assessment is part of our standard practice, and should drive the continued process of further data collection and care planning as needed. In this case a step was missed. Resources and protocol for accurate completion of this process are already available within the facility; therefore, Nurse Managers and Director of Nursing will meet to review the process in order to evaluate and	

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F 315	Continued From page 25 determine risk to develop recurrent UTIs, and failed to have a revision of the care plan to include UTI management. R43 was admitted 5/1/14 according to the face sheet. The physician orders dated 1/19/15 through 2/19/14 listed diagnoses that included chronic diarrhea, urinary tract infection, dysuria (pain with urination). The MDS dated 11/5/14 was reviewed. The MDS indicated R43 had no cognitive impairment, was independent with all activities of daily living, was always continent, and had not experienced a UTI during the previous 30 days. Care plan dated 1/13/15 noted R43 was continent of bladder and independent with toileting but did not direct staff related to UTI risk or management. The care plan did have a problem related to a diagnosis of diarrhea, but the interventions did not include minimizing the risk of UTIs. R16 lacked consist identification of symptoms of urinary tract infection prior to initiation of treatment and lacked a UTI risk assessment with recurrent UTIs (5 UTIs in 8 months) and use of prophylactic antibiotic. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care. The infection control reports listed R16 as having urinary tract infections on 3/11/14, 4/11/14, 7/31/14 and 10/24/14. The February 2014 log noted R16 started prophylactic antibiotics 6/18/13 for UTIs. Event reports included: 1) 8/14/14 for UTI. Symptoms of frequency, behaviors, and flank pain were listed. 2) 10/22/14 for UTI R16 ' s care plan dated 12/12/14 indicated R16	F 315	revise the process if needed or to be reminded/re-educated of the steps required to complete the process accurately by March 31, 2015	

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required assistance with toileting (E-Z stand for transfer, and assist with personal hygiene), had restorative nursing for urinary incontinence exercise, The care plan had a problem dated 11/7/13 which read, " At risk for urinary tract infection related to past history of UTI." The interventions noted to administer prophylactic antibiotics, educate staff on proper hygiene, encourage fluids, encourage bladder emptying and provide peri-care.
The quarterly MDS dated 12/10/14 noted R16 had a BIMS score of 8 or moderate cognitive impairment, had no UTI past 30 days, required extensive assistance with all ADLs, had not received an antibiotic during the previous 7 days.
The facility Observation Report/bladder/bowel observation dated 6/21/14 was provided. The observation indicated a significant change of condition, urinary incontinence, the resident required extensive assistance to toilet, resident had mixed form of incontinence, but did not evaluate/assess R16 ' s risk to develop UTIs or reversible factors to minimize the risk for developing UTIs or use of prophylactic antibiotics.
The physician orders dated 11/19/14 to 2/19/15 indicated R16 was to receive Bactrim DS twice a day with a day of 4/11/13 and discontinue date of 1/17/15. R16 had a physician ' s order for ceftriaxone twice a day with a start date of 3/18/13 and a discontinue date of 1/17/15. On 11/20/14 the physician order Cephalexin daily and stop until Cipro complete. 12/30/13 the physician noted Cipro daily, hold Bactrim while on Cipro then resume.
During an interview on 2/19/15 at 2:36 p.m. with RN-C/infection control director state R16 was on a prophylactic antibiotic off and hoping it would stop the UTIs. RN-C stated she did not know the cause of the infections but would identify that if

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R16 started to self-transfer she would have an infection. R16 was on hospice at this time and had since died.

R15 experienced recurrent UTIs (3 in 3 months) but lacked an assessment of UTI risk and revision of care plan to minimize the risk of recurrent UTIs.
R15 was admitted to the facility on 1/15/13 and the admission record listed diagnoses that included neurogenic bladder, urinary tract infection, urine retention, urinary frequency.
Event report dated 8/4/14 identified a UTI. The culture was completed, but no organisms identified and symptoms related to behaviors, lethargy, and urine changes were listed. Event report dated 11/9/14 indicated a UTI, that was cultured and the organisms were list, and symptoms of lethargy, decreased intake, blood in urine and cloudy urine were noted. Event report dated 12/4/14 indicated R15 had a UTI that was cultured and the organism was listed and symptoms of low grade temp, decreased appetite, and malaise were listed.
The quarterly MDS dated 1/7/15 indicated R15 had impaired cognitive/memory, required extensive assistants with activities of daily living, had an indwelling catheter, had a neurogenic bladder and had no UTIs past 30 days.
The observation report/evaluation for indwelling catheter and frequently incontinent of bowel dated 12/29/14 was reviewed. The report indicated the resident had an indwelling catheter and was incontinent of bowel daily. The report did not assess the resident ' s risk of developing urinary tract infections

The care plan dated 12/15/14 was reviewed. R15 had been admitted to hospice. The care plan

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noted C15 required total assistance for toileting and hygiene. The care plan identified an indwelling Foley catheter and interventions to identify UTIs, but did not include interventions to minimize the risk of UTIs.

R32 experienced 4 UTIs in 5 months but lacked identification of symptoms of a UTI, lacked an assessment of UTI risk with recurrent UTIs, and revision of care plan.
R32 was admitted to the facility in 2013 and the resident admission record listed diagnoses as dysuria (painful urination) urethral discharge, urinary tract infection, urinary catheterization, diarrhea, neurogenic bladder, stage II chronic kidney disease.
The quarterly MDS dated 11/19/14 was reviewed. R32 had a BIMS (brief interview of mental status) was 9 or moderate impairment, required extensive assistance for ADLs, frequently incontinent, had a neurogenic bladder, and had experienced a UTI during the previous 30 days.
Event report dated 7/11/14 for UTI identified urine cultured, but no organisms, and did not list signs and symptoms of an infection. Event report dated 8/15/14 for UTI indicated a culture was done, but did not list organisms and listed no signs and symptoms of an infection. The infection control report listed a UTI for R21 on 10/24/14 with Escherichia coli (commonly abbreviated E. coli) as the organism. No symptoms were listed. The infection control log listed a UTI for R32 on 11/26/14 with E-coli as the organism and no symptoms were listed.
The observation report/evaluation dated 8/21/14 for quarterly bowel and bladder indicated R32 was occasionally incontinent of bladder during the past assessment period but currently frequently incontinent, was incontinent of bowel, required

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extensive assistance with toileting, experienced mixed (urge and stress) incontinence, but did not include an assessment of R32's risk to develop UTIs.
The care plan dated 1/14/15 identified interventions of need to use mechanical lift to transfer R32 to toilet. The care plan listed a medical diagnosis that include renal insufficiency, but did not list interventions to help minimize the risk of developing recurrent UTIs.
R23 received prophylactic antibiotics but lacked an assessment for risk of UTIs and lacked a clinical rationale for the continued use of the prophylactic antibiotic use.
R23 was admitted to the facility in 6/14/14 as found on the resident admission record which also listed diagnoses as chronic stage IV kidney disease, urinary tract infection, diabetes, neurogenic bladder.
The quarterly MDS dated 1/23/15 indicated no cognitive impairment, no UTIs past 30 days, a neurogenic bladder, and an ostomy (Suprapubic catheter into bladder).
Review of the clinical records indicated R23 had experienced a UTI in April and in May of 2014, but had not experienced a UTI in the past 6 months.
Physician orders dated 1/19/15 through 2/15/15 was reviewed. The physician ordered trimethoprim an antibiotic on 8/22/13 for neurogenic bladder. The infection control log identified the trimethoprim as a prophylactic antibiotic for UTIs. Review of the urology notes for June 18, 2014 through July 23, 2014, noted R23 had a suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics.
The observation report/evaluation for significant

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change bowel and bladder dated 5/6/14 indicated the use of an indwelling catheter, required extensive assist for toileting, but lacked identification of use of prophylactic antibiotics and risk for developing UTIs.
The care plan dated 1/26/15 was reviewed. The care plan listed a problem of urinary incontinence and supra pubic catheter. The interventions listed the use of prophylactic antibiotic, intervention to change indwelling catheter monthly, and to report signs of UTI.
During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility.
R33's admission record noted R33 had been admitted on 7/12/2013 with diagnoses that included but were not limited to congestive heart failure, acute and chronic respiratory failure and stage III chronic kidney disease.

R33's quarterly Minimum Data Set (MDS) dated 11/26/14 indicated R33 was occasionally incontinent (this was a decline for R33) of urine, was not on a toileting program and required extensive assistance to toilet. However, the previous admission MDS dated 8/26/14, included R33 was always continent of urine, was not on a toileting program and required extensive assistance to toilet.

R33's medical record review revealed the facility failed to complete a comprehensive bladder assessment for R33 when the quarterly MDS dated 11/26/14 showed a decline in bladder incontinence.

R33's care plan problem for toileting dated 6/27/14 indicated that R33 was generally

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F 315	Continued From page 31 continent of bowel/bladder, and directed staff to contact the provider to review possible causes of incontinence if she experienced any incontinence. The care plan goal was for R33 to remain continent of bladder and bowel. However it did not include specific interventions to promote normal bladder function or further loss of bladder control. On 2/19/15 at 12:48 p.m. registered nurse (RN)-B verified R33 displayed a decline in incontinence according to most recent MDS assessment. RN-B stated R33 let staff know when she needed to go to the bathroom and was not on a toileting program. RN-B verified the facility did not fully assess R33's toileting plan to prevent further decline in incontinence, to restore optimal bladder function or to maintain optimal bladder function. On 2/19/15 at 2:58 p.m. the director of nursing (DON) stated when the quarterly MDS assessment identified a decline with bladder incontinence for R33, the nurse should have completed an assessment to determine the reason for the change in incontinence and the care plan should have been revised to reflect the change in incontinence and toileting needs. The DON verified a comprehensive bladder assessment should have been completed for R33 to help restore and maintain optimal bladder function and prevent further decline in bladder incontinence. A bladder assessment policy was requested, but not provided by the facility.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		3/31/15

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F 318	Continued From page 32 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R21) received range of motion (ROM) exercises and ambulation as recommended by physical therapy. Findings include: R21 was identified by the facility on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, transfers, walk in room and walk in corridor self-performance was supervision; transfer support was one person physical assist, walk in room support was set up help only, and walk in corridor support was no set up help or physical help from staff; no falls since last assessment, balance during transitions and walking was unsteady but able to stabilize without human assistance, no impairment in functional limitation in range of motion of upper and lower extremity, and received physical therapy with start date of 1/5/15. Document review of falls care area assessment dated 1/20/15, revealed falls triggered due to recent falls without injury and some balance problems. R21 was hard of hearing, had poor	F 318	" (R21) Care plan will be updated by Nurse Manager to show interventions to be taken should the resident refuse her recommended restorative program by March 20, 2015 o Nurse Manager will further evaluate R21□s acceptance and participation in her program by April 3, 2015 and plan to continue, change or discontinue the program based on the resident□s choice and response to the program. " Persons working with the Restorative Nursing program will meet and initiate a Quality Assessment Performance Improvement project for the program to include better definition of the program itself, a plan for back-up and identification of persons responsible for review and evaluation of the program, including resident response, on a weekly to biweekly basis. The first meeting will be held by March 31, 2015	

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F 318	Continued From page 33 vision, walks with assist of staff, used wheelchair. Document review of physician orders dated 1/19-2/19/15, revealed the following orders: may ambulate independently in room and halls with 4 wheel walker, and falls and balance program once a day Monday through Friday. During observations on 2/17/15, at 2:00 p.m., R21 sat in room recliner with feet up. At that time, R21 transferred by self to wheelchair and wheeled out of the room to church service. R21's care plan dated 6/27/12 identified a problem of at risk for losing strength in legs. Approaches dated 2/10/15, included: ambulate with R21 to and from all meals with 4 wheel walker, lower extremity seated exercises-marches, kicks, knee bends, toe taps 15 times each once a day; lower extremity standing exercises- marches, squats, sidekicks, heel raises 15 times each once a day. Approaches dated 8/1/14, included: invite to falls and balance program led by activity staff once a morning and goal was R21 to attend three times a week; restorator or recumbent bike 10-15 minutes; restorative program will be reviewed quarterly and as needed. R21's care plan dated 5/31/12 identified a problem of at risk for falling related to poor eye sight and variable balance. Approaches dated 8/1/14, included: administer medication, use walker with ambulation, encourage participating in falls and balancing program, keep items within reach, and keep room free of clutter. Document review of past three months of falls	F 318		

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revealed no falls in 12/2014, and no falls in 1/2015. The following two falls occurred in 2/2015:
Document review of the event report dated 2/14/15, revealed R21 stated had fall in bathroom and got up on her own, c/o back pain, and call lite was within reach. The report identified R21 was seen by a provider on 2/13/15 for respiratory symptoms and cough. Interventions were to ask R21 to use call light or wait for assist. Investigation identified R21 had been more unsteady on feet and was to have assistance to walk in hallways.

Document review of event report dated 2/18/15, revealed R 21 was on floor in front of roommate ' s chair, trying to move her bedside table. R21 stated was just weak, denied pain, lung sounds clear. R212 had a cough, was seen on 2/13/15 for cough, was seen after fall on 2/18/15 for cough and weakness and started on antibiotic. R21 was reeducated to use the call light. R21 was alert and oriented and made own decisions.

Document review of physical therapy plan of care dated 1/5/15, identified start of care date of 1/5/15, reason for referral: R21 presents with a decline in ambulation and transfers due to recent onset of the flu. R21 started noticing a decline approximately 2 weeks ago which has since resulted in the patient now requiring significantly more assistance for the completion of transfers and ambulation. Therapy necessity: R21 requires skilled physical therapy at this time for strengthening, balance training, gait and transfer in order to regain prior level of function. Physical therapy to discharge with patient at max potential with long term plan in place. Short term goal: ambulates 40 feet with 4 wheeled walkers on

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GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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even surfaces requiring contact guard assistance. Goal: will ambulate 100 feet safely with 4 wheeled walker on even surfaces with supervision in order to regain prior functional level. Long term goal: will be able to safely ambulate with use of her 4 wheeled walker throughout the facility with modified independence in order to return to her prior level of function. Plan of care was signed by physician for 1/5/15 to 2/1/15, for 3 times a week for 4 weeks.

Document review of physical therapy daily treatment notes revealed the following:
1/16/15, R21 was proud of her ambulation today and reports she can tell she is getting stronger.
1/23/15, R21 ambulated 320 feet with 4 wheeled walker and contact guard assistance. R21 demonstrated improved ambulation distance and independence with mobility.
1/30/15, R21 requested to discharge from physical therapy due to legs hurt after therapy. R21 agreed to restorative therapy and ambulating with staff. Ambulation and restorative program completed.

R21 received 12 physical therapy visits for exercises and ambulation between 1/5/15 and 1/30/15.

Document review of physical therapy progress and discharge summary dated 1/30/15, revealed analysis of functional outcome included R21 made significant progress towards physical therapy goals. R21 will continue to address ongoing deficits with a functional maintenance program directed by facility staff.

Document review of Physical Therapy Restorative Program dated 1/30/15, revealed the following

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exercise program for R21:
Lower extremity seated exercises: marches with 2# 15 times, kicks with 2# 15 times, knee bends with blue band 15 times, toe taps 30 times, ball squeezes 30 times;
Lower extremity standing exercises: marches active range of motion 15 times, squats active range of motion 15 times, sidekicks active range of motion 15 times, heel raises active range of motion 15 times; Ambulation: Please ambulate with R21 to/from all meals with 4 wheel walker and contact guard assistance and follow with wheelchair due to dizziness. R21 is to have contact guard assistance with all ambulation in hallway. Please have R21 perform all exercises 5-7 days per week as tolerates and is willing to participate. Please contact physical therapy department with any questions or concerns.

Document review of restorative nursing flow sheet dated 2/1/15 to 2/19/15, revealed the following:
Falls and balance, invite once a morning, will attend three times a week, R21 attended 1 session out of 19 days;
Restorator or recumbent bike 10-15 minutes a day, Sunday through Saturday, goal to pedal 15 minutes, R21 refused two sessions and attended 1 session out of 19 days;
Falls and balance once a day Monday through Friday, R21 attended one session out of 19 days.

The restorative nursing flow sheet did not identify any of the physical therapy recommended exercises dated 1/30/15.

During interview on 2/19/15, at 10:25 a.m., registered nurse (RN)-B verified the physical therapy recommendations for restorative nursing

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were not part of the restorative nursing flow sheet. RN-B verified, although the care plan directed restorative nursing exercises, none were provided. RN-B stated the falls and balance program was on the flow sheet two times but was actually the same program offered by activity staff whenever they can. RN-B verified R21 received the falls and balance program and the bike exercise one session out of 19 possible sessions. She verified R21 had not received restorative therapy exercises as recommended by physical therapy on 1/30/15. RN-B verified the recommendations had not been added to the restorative flow sheet. RN-B stated the facility had two restorative aides who assisted with restorative exercises.

During interview on 2/19/15, at 10:54 a.m., physical therapy assistant (PTA)-C stated she was responsible to complete monthly physical therapy evaluations on residents. PTA-C stated had not completed an evaluation for R 21 this month and would complete that day.

During interview on 2/19/15, at 10:56 a.m., nursing assistant (NA)-C verified she was responsible to provide facility restorative nursing exercises. NA-C stated she provided lower extremity exercise bike for 10 minutes whenever R21 would go to the exercise room. NA-C verified not aware of the physical therapy recommended restorative program exercises. NA-C stated restorative aides frequently have to work on the floor and the restorative exercises do not get done.

During interview on 2/19/15, at 12:35 p.m., PTA-C stated had completed the monthly physical therapy evaluation at that time. She stated the

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F 318	Continued From page 38 evaluation included a review of nurse ' s notes and talked with nursing assistants. PTA-C verified the evaluation did not include exercises or ambulation. PTA-C stated R21 needed more help to get dressed which was progressively worse with most recent illness, increased dizziness and unsteadiness, refused to use call light, and was self- transferring despite education to use call light. PTA-C stated, based on the evaluation, R21 had declined since discharge from therapy on 1/30/15. Surveyor requested PTA-C attempt to ambulate R 21 that day. During interview on 2/19/15, at 12:50 p.m., director of nursing stated the facility had been short staffed and they have rescheduled restorative aides to work on the floor. Director of nursing verified the facility had no plan in place to provide restorative therapy exercises when restorative aides were rescheduled to work the floor. During interview on 2/19/15, at 3:10 p.m., RN-B stated R21 had declined due to influenza in 12/2015 and worsening eye sight. RN-B stated R21 requested to discharge from physical therapy 1/30/15, because she did not like therapy and did not want to continue. RN-B verified R21 had declined as she no longer walked to meals.	F 318		
F 329 SS=E	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	F 329		3/31/15

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F 329	Continued From page 39 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 obtain clinical rationale for continued use of prophylactic medication administered for urinary tract infection (UTI) for 2 of 2 residents (R23, R16) who currently received for prophylactic antibiotic therapy and the facility failed to ensure that psychoactive medications were monitored for effectiveness and/or identified clear parameters as to when antianxiety medication is to be used for 2 of 5 residents (R24, R21) reviewed for unnecessary medications. Findings include: Lack of physician justification for ongoing use of an antibiotic prophylactic therapy to prevent	F 329	" Prophylactic medications are currently not in use within the facility; (R23) s order was discontinued and (R16) has expired. No further individual actions are needed at this time. " Director of Nursing will meet with Medical Director to clarify use of prophylactic antibiotics in order to prevent their inappropriate use within the facility in the future by March 31, 2015 " Regular meetings with our Consulting Pharmacist already occur on a monthly basis within the facility. Should any orders be received in the future for prophylactic antibiotics the Consulting Pharmacist will make monthly notes to ask medical providers for on-going assessment and	

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F 329	Continued From page 40 urinary tract infections: R23 received a prophylactic antibiotic but lacked a clinical rationale for the continued use of the medication. R23 was admitted to the facility in 6/14/14 and the resident admission record listed diagnoses as chronic stage IV kidney disease, urinary tract infection, diabetes, neurogenic bladder, The quarterly Minimum Data Set (MDS) dated 1/23/15 indicated no cognitive impairment, no UTIs past 30 days, a neurogenic bladder, and an ostomy (suprapubic catheter). The observation report/evaluation for significant change bowel and bladder dated 5/6/14 indicated the use of an indwelling catheter, required extensive assist for toileting, but lacked identification of use of prophylactic antibiotics. The care plan dated 1/26/15 was reviewed. The care plan listed a problem of urinary incontinence and supra pubic catheter. The interventions listed the use of prophylactic antibiotic. Review of the clinical records indicated R23 had experienced a UTI in April 2014 and in May of 2014, but had not experienced a UTI in the past 6 months. Physician orders dated 1/19/15 through 2/15/15 was reviewed. The physician ordered trimethoprim an antibiotic on 8/22/13 for neurogenic bladder and has continued to receive this antibiotic. However, a physician ' s justification for the ongoing use of a prophylactic antibiotic was requested and none was provided. Registered nurse (RN) -C who was designated as the infection control director was asking to provide physician documentation related to the continued use of the prophylactic antibiotic. Review of the three urology notes for June 18, 2014 through July 23, 2014, revealed R23 had a	F 329	documentation of the medical necessity of such medications. The Pharmacist will be advised of this immediately and our next meeting will be held April 9, 2015. " Nurse Managers will clarify the parameters for (R24) and (R21)s anti-anxiety medications by March 31, 2015 " A plan for monitoring the use of any psychoactive medication has already been initiated within the facility. The Consulting Pharmacist will continue to meet with designated members of the nursing staff to review each resident s medication regime monthly. The pharmacist and nursing team will monitor for orders that do not include clear parameters for administration beyond the medical diagnosis and will request medical providers assist with identification of parameter to be included in these orders. The next meeting will be held April 9, 2015. o Nursing staff will receive education about the risk of prophylactic antibiotics and the necessity of clarity in documentation in the use of any medication, especially psychoactive medications. This training will occur by March 26, 2015 presented by the Director of Nursing and further training on psychotropic medications and their effect on geriatric residents will be provided to RN and LPN staff within the 2015 year. In addition to the monitoring activities, policies will reviewed, updated and clarified over the next six month to correlate with the plan being developed between the Consulting Pharmacist and	

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F 329	Continued From page 41 suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics. During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic to prevent UTIs. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care. The quarterly MDS dated 12/10/14 noted R16 had a BIMS score of 8 or moderate cognitive impairment, had no UTI past 30 days, required extensive assistance with all activities of daily living (ADL/s), had not received an antibiotic during the previous 7 days. The facility Observation Report/bowel/bladder observation dated 6/21/14 was reviewed and did not identify the use of prophylactic antibiotics. The plan of care dated 12/12/14 indicated R16 listed a problem of "At risk for urinary tract infection related to past history of UTI " and had an intervention to administer prophylactic antibiotics. The Infection Control Reports and Infection Event Reports for March 2014 through November 2014 revealed that R16 had 5 UTIs during this period. During these 5 UTIs R16 received an antibiotic a few times and not for all UTIs. The physician orders dated 11/19/14 to 2/19/15 were reviewed for R16. The physician orders indicated R16 received Bactrim DS (antibiotic) twice a day starting 4/11/13 and had a discontinue date of 1/17/15. R16 had a physician's order for ceftriaxone twice a day with a start date of 3/18/13 and a discontinue date of	F 329	the nursing team. Policies related to these medications will be submitted to the medical director for approval no later than September 30, 2015.	

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F 329	Continued From page 42 1/17/15. On 11/20/14 the physician order Cephalexin daily and stop until Cipro complete. 12/30/13 the physician noted Cipro daily, hold Bactrim while on Cipro then resume. The infection reports were reviewed for January 2014 through January 2015. The log identified prophylactic antibiotics for R16 on January 2014 as Bactrim DS with an order date of 6/18/13 The Log indicated the antibiotic had been discontinued in March 2014, The October 2014 infection control log identified R16 as receiving a prophylactic antibiotic of cephalexin starting 10/27/14. The January 2015 log noted R16 expired on 1/16/15. During the time period identified as receiving the prophylactic antibiotics R16 did have UTIs. During an interview on 2/19/15 at 2:36 p.m. with RN-C stated R16 was on a prophylactic antibiotic off and on hoping it would stop the UTIs. RN-C stated she did not know the cause of the infections but would identify that if R16 started to self-transfer she would have an infection. R16 was on hospice at this time and had since died. No further information or physician justification for the use of the prophylactic antibiotic was received when requested. Lack of identifying and evaluate symptoms of anxiety and depression to ensure effectiveness and appropriateness of prescribed anti-depressant and anti-anxiolytic medications prescribed: R24 had last been admitted to the facility on 5/28/13 according to her Resident Admission Record. R24's quarterly MDS dated 11/26/14 included diagnoses of dementia, anxiety disorder, and depressive disorder. The assessment indicated severe cognitive impairment with a Brief Interview	F 329		

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F 329	Continued From page 43 of Mental Status (BIMS) score of 6. The MDS also indicated a PHQ9 (monitors mood) score of 7 indicating minimal depression symptoms, and the revealed no behaviors had been present at the time of assessment. R24's medication orders identified on physician visit dated 2/16/15 included: Buspar 7.5 milligram (mg) (anti-anxiety medication) daily, Paxil (anti-depressant medication) 40 mg daily, Lorazepam 0.5 mg three times a day as needed for anxiety and Lorazepam 1 mg three times a day. R24's care plan indicated R24 had a diagnosis of anxiety and depression. The care plan identified interventions to assist with alleviating associated symptoms however, the care plan failed to identify the anxiety and depression target symptoms in order to administer as needed Lorazepam. There was not a clear direction on when to administer medication or use individualized non-pharmacological interventions. R24's medication administration record (MAR) for February 2015 indicated as needed Lorazepam was administered for varied behavioral issues that included: "Abdominal pain, cold symptoms with uneasiness, wanting to go home, complain of something in throat, anxiety [undefined], weepy" and repetitive use of call light. During an interview on 2/19/15, at 2:24 p.m. licensed practical nurse (LPN)-B verified there were not any specific parameters for the use of Lorazepam. During an interview on 2/19/15, at 2:36 p.m. registered nurse (RN)-B stated Lorazepam was administered after behavioral interventions were tried. Ongoing symptom monitoring and evaluations for depression was not found in the medical record nor were there evaluations of anxiety symptoms.	F 329		

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F 329	Continued From page 44 Nurse's progress notes and assessments were reviewed since 11/26/14 to 2/19/15; notes did not reflect symptoms of depression or anxiety had not been quantified and individualized target behaviors and/or symptoms to specifically monitor were not identified and individualized interventions (including both pharmacological and non-pharmacological) were not evaluated for effectiveness. During an interview on 2/18/15, at 5:30 p.m. RN-B stated target (resident specific symptoms and signs to indicate need of antidepressant) behavior monitoring was not done for anti-depressant medications only for anti-psychotic medications unless there is a concern then the resident would be monitored for short time period. RN-B verified no quarterly evaluation of medication effectiveness, and evaluation of behaviors and interventions had not been completed. During an interview on 2/19/15, at 2:36 p.m., consulting pharmacist indicated he may have missed issuing a recommendation for medication laboratory monitoring for R24. In relation to as needed Lorazepam parameters; consulting pharmacist indicated target symptoms and frequency of symptoms had not been identified yet as evidenced on the February 2015 MAR, and pharmacist said the as needed Lorazepam was initially started on 6/17/14. Lacked evidence of identification and monitoring of target behaviors and target symptoms for the use of antianxiety and antidepressant and lacked analysis of data to determine if the medications and interventions were effective: R21 had diagnosis of anxiety and depression according to facility admission record dated 12/25/10.	F 329		

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F 329	Continued From page 45 R21 was identified on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, moods score of 15 including moods of little interest, feeling depressed, trouble sleeping, tired, poor appetite, feel bad about self, no behaviors, and received antianxiety medication. Document review of care area assessment (CAA) for mood dated 1/20/15, stated R21"endorses some mood indicators but voices a desire not to change anything at this time as she feels mood is improving. Mood is addressed in care plan d/t (due to) mood issues." CAA for psychotropic medication dated 1/20/15, read, "Psychotropic med (medication) use triggered d/t (due to) ativan use for longstanding anxiety problems." CAA identified R21 started on antidepressant medication. CAA identified psychotropic medication use was addressed in the care plan due to antianxiety and antidepressant use. Document review of physician orders report dated 1/19/15 to 2/19/15, revealed orders for lorazepam 0.5 milligrams daily for anxiety disorder, with a start date of 6/13/14; lorazepam 1 milligram two times a day for anxiety disorder, with a start date of 6/13/14; and lorazepam 0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14. The same physician order report had physician orders for Zoloft 50 milligrams once an evening for anxiety, with a start date of 1/16/15. Document review of facility medication administration record dated 1/1/15 to 1/30/15, revealed R21 received lorazepam (Ativan) and Zoloft as ordered.	F 329		

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F 329	Continued From page 46 During observations on 2/17/15, at 10:30 a.m. and 2/18/15, at 12:55 p.m., R21 sat in a recliner in room. No moods or behaviors were noted at that time. R21's care plan dated 3/5/14 identified a problem of psychotropic medication use due to received lorazepam for diagnosis of anxiety. Approaches identified included monitor mood and response to medications. Care plan dated 1/10/12, identified a problem of mood/behavior, has a longstanding history of chronic anxiety and insomnia. Approaches included Ativan as scheduled and as needed, observe for side effects and worsening anxiety, report to social worker, case manager, and charge nurse changes in mood or behavior. During interview on 2/19/15, at 10:45 a.m., RN-B verified the facility did not identify or monitor target moods or response to medications. RN-B stated the facility knew the medication was effective by "Talking with the nurses." RN-B stated the facility quarterly mood and behavior charting on the MDS assessment was the facility monitoring of moods and behaviors. RN-B stated the facility did not document an analysis or summary note of effectiveness of the medication. RN-B stated she reviewed moods and behaviors by "Talking with nurses" and the summary was "Done in my head." However, it was not reproducible to evaluate content for accuracy. During interview on 2/19/15, at 4:15 p.m., director of nursing stated the facility had no medication related policies. Lack of clear parameters to use of antianxiety medication use:	F 329		

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F 329	Continued From page 47	F 329		

R21 had diagnosis of anxiety and depression according to facility admission record dated 12/25/10.

R21 was identified on the significant change MDS, an assessment dated 1/7/15, to have cognition intact, moods score of 15 including moods of little interest, feeling depressed, trouble sleeping, tired, poor appetite, feel bad about self, no behaviors, and received antianxiety medication.

Document review of care area assessment (CAA) for mood dated 1/20/15, stated R21 "endorses some mood indicators but voices a desire not to change anything at this time as she feels mood is improving. Mood is addressed in care plan d/t [due to] mood issues." CAA for psychotropic medication dated 1/20/15, read, "Psychotropic med [medication] use triggered d/t ativan use for long standing anxiety problems." CAA identified R21 started on antidepressant medication. CAA identified psychotropic medication use was addressed in the care plan due to antianxiety and antidepressant use.

Document review of physician orders report dated 1/19/15 to 2/19/15, revealed orders for lorazepam 0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14.

Document review of facility as needed medication administration history revealed R21 received the following as needed lorazepam: 12/1/14 to -12/31/14-10 times; 1/1/15 - 1/31/15-3 times; 2/1/15 -2/18/15-1 time. The medication record identified as needed lorazepam was administered for sleep, nerves, agitation, anxiety, distressed, and resident request.

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F 329	Continued From page 48 During observations on 2/17/15, at 10:30 a.m. and 2/18/15, at 12:55 p.m., R21 sat in a recliner in room. No moods or behaviors were noted at that time. R21's care plan dated 3/5/14 identified a problem of psychotropic medication use due to received lorazepam for diagnosis of anxiety. Approaches identified included monitor mood and response to medications. Care plan dated 1/10/12, identified a problem of mood/behavior, has a longstanding history of chronic anxiety and insomnia. Approaches included Ativan (lorazepam) as scheduled and as needed, observe for side effects and worsening anxiety, report to social worker, case manager, and charge nurse changes in mood or behavior. During interview on 2/19/15, at 2:30 p.m., RN-B stated staff administered as needed lorazepam for anxiety, after attempting non-pharmacological interventions, or administered lorazepam when R21 requested as needed lorazepam. RN-B verified the facility lacked specific identification of symptoms of anxiety in order to administer as needed lorazepam. During interview on 2/19/15, at 4:15 p.m., director of nursing stated the facility had no medication related policies.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		3/31/15

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F 428	Continued From page 49 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility failed to ensure the consultant pharmacist identified and reported medication irregularities for 2 of 7 residents (R24 and R21) reviewed for unnecessary medications. Findings included: R24 had last been admitted to the facility on 5/28/13 according to facility's "Resident Admission Record." R24's quarterly Minimum Data Set (MDS) dated 11/26/14 which included diagnoses of dementia, anxiety disorder, heart failure, hypertension, and hyperlipidemia. The assessment indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6. R24's medication orders identified on physician visit dated 2/16/15 included: Lisinopril (lipid lower medication) 10 milligrams (mg) daily, Lorazepam 0.5 mg three times a day as needed for anxiety and 1 mg scheduled three times a day, Zaroxolyn (diuretic) 2.5 mg daily, Lopressor (anti-hypertensive medication) 50 mg daily, and Torsemide (diuretic medication) 10 mg daily. Record review of medication lab monitoring revealed no labs had been completed during the last year to ensure safe ongoing use of prescribed medications and/or continued need of prescribed medications. During an interview on 2/19/15, director of	F 428	" Nurse Managers will clarify the parameters for (R24) and (R21)s anti-anxiety medications by March 31, 2015 " A plan for monitoring the use of any psychoactive medication has already been initiated within the facility. The Consulting Pharmacist will continue to meet with designated members of the nursing staff to review each resident s medication regime monthly. The pharmacist and nursing team will monitor for orders that do not include clear parameters for administration beyond the medical diagnosis and will request medical providers assist with identification of parameter to be included in these orders. The next meeting will be held April 9, 2015. o In addition to the monitoring activities, policies will reviewed, updated and clarified over the next six month to correlate with the plan being developed between the Consulting Pharmacist and the nursing team. Policies related to these medications will be submitted to the medical director for approval no later than September 30, 2015. " Nursing staff will receive education	

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F 428	Continued From page 50 nursing (DON) confirmed no medication laboratory monitoring had been completed during the last year. R24 ' s care plan indicated R24 had a diagnosis of anxiety and depression. The care plan identified interventions to assist with alleviating associated symptoms however, the care plan failed to identify the anxiety and depression target symptoms in order to administer as needed Lorazepam. No clear direction on when to administer medication or use individualized non-pharmacological interventions. R24 ' s medication administration record (MAR) for February 2015 indicated as needed Lorazepam was administered for varied behavioral issues that included: "Abdominal pain, cold symptoms with uneasiness, wanting to go home, complain of something in throat, anxiety [undefined], weepy" and repetitive use of call light. According to the February 2015 MAR, as needed Lorazepam was initially started on 6/17/14 During an interview on 2/19/15, at 2:24 p.m. licensed practical nurse (LPN)-B verified there were not any specific parameters for the use of Lorazepam. During an interview on 2/19/15, at 2:36 p.m. registered nurse (RN)-B stated Lorazepam was administered after behavioral interventions were tried. During an interview on 2/19/15, at 2:36 p.m., consulting pharmacist indicated he may have missed issuing a recommendation for medication laboratory monitoring for R24. In relation to as needed Lorazepam parameters; consulting pharmacist indicated facility had not identified specific resident behaviors/mood. Lack of parameters for use of Ativan:	F 428	about the necessity of clarity in documentation in the use of any medication, especially psychoactive medications. This training will occur by March 26, 2015 and further training on psychotropic medications and their effect on geriatric residents will be provided to RN and LPN staff within the 2015 year.	

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F 428	Continued From page 51 R21 had diagnosis of anxiety and depression according to facility admission record dated 12/25/10. R21 was identified on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, moods score of 15 including moods of little interest, feeling depressed, trouble sleeping, tired, poor appetite, feel bad about self, no behaviors, and received antianxiety medication. Document review of physician orders report dated 1/19/15 to 2/19/15, revealed orders for lorazepam 0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14. Document review of facility as needed medication administration history revealed R21 received the following as needed lorazepam: 12/1/14 to -12/31/14-10 times; 1/1/15 - 1/31/15-3 times; 2/1/15 -2/18/15-1 time. The medication record identified as needed lorazepam was administered for sleep, nerves, agitation, anxiety, distressed, and resident request. The facility lacked identification of specific parameters to administer as needed lorazepam. During telephone interview on 2/19/15, at 3:20 p.m., facility consultant pharmacist stated he expected very specific parameters identified for when to use as needed lorazepam.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		3/31/15

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F 431	Continued From page 52 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a bottle of Aplisol (tuberculin testing solution) was discarded 30 days after being opened. This has the potential to effect new resident admissions and new employees	F 431	" Facility already practices a protocol of checking medication storage for expired medications on a weekly basis; furthermore, the Consulting Pharmacologist also checks for expired	

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F 431	Continued From page 53 hired. Findings included: On 2/19/15, at 11:50 a.m. during a medication storage tour with registered nurse (RN)-B revealed an opened bottle of Aplisol (tuberculin testing solution) with an open date of 11/1/14 in the medication storage room refrigerator. RN-B verified the date on the bottle and stated the vial should have been discarded 30 days after open date (December 1, 2014). The Apisol package insert read, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. Failure to store and handle Aplisol as recommended may result in loss of potency and inaccurate test results."	F 431	medications monthly and representatives from our providing pharmacy do the same. Regardless of the triple check method already in place, this vial of medication escaped notice because it was buried under other medication containers. To prevent a future occurrence, the facility will locate and order brightly colored "do not use after (date)" labels that can be attached to opened containers for better visualization by March 31, 2015. " All persons responsible for medication administration will be instructed in the use of these labels and reminded of the importance of discarding expired medications in a meeting by March 26, 2015 by Director of Nursing. " Consulting Pharmacist and nursing team will continue their monthly and weekly checks, monitoring for any future problems on-going.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		3/31/15

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F 441	Continued From page 54 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 record review the facility failed to maintain an infection control program that analyzed infection patterns and trends, to identifying recurrent urinary tract infections and monitoring of symptoms to prevent the spread of infection. This practice could affect all residents in the home. Findings include: Lack of analyzing infections to determine appropriate and timely interventions to prevent the spread of infection/s: The infection control data analysis: May 2014 through January 2015 infection control logs were	F 441	" The Infection Control Nurse and Director of Nursing will initiate a plan for performance improvement which will include updating our methods of documentation to include the analysis of patterns and trends of infections or suspected infections. The initiation of this plan will occur by March 30, 2015. o The leadership team in the facility which includes all Department Heads and Nurse Managers were educated about the program objectives and initiation of this plan by February 28, 2015. o The Safety Committee was educated	

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F 441	Continued From page 55 reviewed. The log had a place to list resident name, onset date, site of infection, diagnosis, culture and x-ray dates and results, antibiotic used, date resolved, and if this was a nosocomial infection. Review of the logs revealed the cultures were not consistently completed to determine the cause of the urinary tract infection/s (UTI) prior to antibiotic use and taking X-rays were not consistently completed to determine pneumonia prior to treatment. The logs did not indicate resident location in the facility or any timely nursing/facility interventions to assist the resident to manage the infection or to minimize the spread of the infection. The logs did not indicate an analysis or trend had been completed. No further documentation regarding the analysis of the data was provided when requested. The facility policy Infection-Clinical Protocol dated 10/20/14 was reviewed. The policy directed: A log of facility infections being treated will be kept and reported at quarterly Quality Improvement meetings. This log will include the type of infections and the treatment provided. The log will be reviewed for any patterns within the facility. Registered nurse (RN)-C, who was appointed as the infection control director was interviewed on 2/19/15 at 2:30 p.m. RN-C stated she kept the infection control logs and would keep track of employee illness as well as resident illness. She indicated she would keep a working log of infections during the month and then recopy at the end of the month. RN-C said she did not do a written report or analyze the data or trend. She would discuss the infections at the morning meetings. She would look at the cultures and areas of the nursing home that infections occur, but would just keep the information in her head. RN-C stated she would take the information of	F 441	in the program objectives and initiation of this plan on March 11, 2015. The Safety committee participated in a review of the infection control logs for trends or patterns and the Infection Control nurse provided a summary report of the Committee findings. o The QA&A team will be educated and participate in further review of the logs for any missed patterns or trends at the next meeting April 9, 2015. o All staff will be informed of the change in process by March 30, 2015.	

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numbers to the Quality Improvement meeting and discuss what she "had in her head." Which was not reproducible.
Recurrent Infections: The infection control logs for July 2014 through December 2014 were reviewed. In July 2014 the log identified three (3) urinary tract infections (UTI) treated with antibiotics, but organisms cultured were not consistently identified on the log. In August 2014 the log listed six (6) UTI treated with antibiotics, but no organisms. In October 2014 three (3) UTIs were identified. In November 2014, four (4) UTIs, and in December 2014, five (5) UTIs were identified.
The infection control logs for 2014 were reviewed. R16, although on prophylactic antibiotic had four (4) recurrent UTIs from March through October 2014. R23 although on prophylactic antibiotics had two (2) recurrent UTIs in April and May. R 15 had two (2) UTIs identified in November and December 2014. R51 had three (3) UTIs identified during December 2014 and January 2015. R37 had three (3) UTIs identified during January through December 2014 R32 had two (2) UTIs identified during August through October 2014.
The Infections-Clinical Protocol dated 10/20/14 noted that changes in the resident's mental or physical status that could indicate a possible infections were to be documented and the charge nurse was to perform an additional assessment prior to notifying the physician. The Protocol directed the symptoms would include fever, changes in urine appearance, complaints of dysuria (frequency) or behavioral changes. If a urinary tract infection was suspected a urinalysis was advisable. The Protocol stated staff would provide supportive measures to assist the resident in managing the infection. The Protocol

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did not direct staff related to recurrent infections or need for re-assessments to determine potential reversible causes.
RN-C was interviewed on 2/19/15 at 2.30 p.m. RN-C stated she had not developed any infection control policies. She stated that she was aware that some residents had recurrent UTIs. RN-C stated she would like nursing to document signs and symptoms of infection, but that did not always happen. Nursing staff would contact the clinic, but not always document the symptoms. RN-C stated that she and RN-B were responsible to complete the infection event reports. She stated that she was aware that some residents had recurrent UTIs. RN-C state she would look back at the logs to see if any recurrent UTIs.
Lack of infection management for influenza season and pneumonia: Review of the infection control log for December 2014 and January 2015 indicated one resident R18 had been diagnosed with influenza. One other resident was identified in December has having COPD exacerbation, and one with pneumonia. No other residents with respiratory infections or symptoms of possible respiratory infections whether treated with antibiotics or not were identified. No analysis or trends had been documented to determine if the facility had any other respiratory illness or influenza among the residents or staff.
The Infections-Clinical Protocol dated 10/20/14 directed staff to document the symptoms that include fever, changes in urine appearance, or behavioral changes. If pneumonia was suspected then a pulse oximetry may be completed as well as possibly a chest x-ray. The Protocol directed if influenza was suspected, then test as ordered by the physician,
On 2/19/15 at 11:00 a.m. the director of nursing (DON) verified the facility had had influenza, but

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F 441	Continued From page 58 that the physicians had decided not to do a full house prophylactic treatment of other residents. The DON stated that to her knowledge no line listing of residents with respiratory symptoms during this time period had been kept.	F 441		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a clean, comfortable and homelike environment for several resident rooms. Findings include: An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and the housekeeping director (HD-A. Rooms 107, 135, 124, 128, 129, 131, 137, were observed to have a buildup of black substance and several windows had moisture noted. During the tour the maintenance director stated this was dirt on the insulation and MD-A stated Room 107 had a humidifier which caused water on windows. It was also noted the outside temperature was around 0 degrees Fahrenheit. The administrator was interviewed on 2/19/15 at 4:00 p.m. He stated that he was aware of the moisture on windows as they are getting old and need replacing. The dining room/solarium had missing mop boards (had not been replaced after painting walls recently) and damaged plaster. The south	F 465	Dirt accumulation (black substance) on the window calk has been removed with lacquer thinner in rooms 107,135,124,128,129,131 and 137. All windows are dry of moisture. Maintenance will develop a schedule to remove all dirt accumulation on the inside of windows using the same method of cleaning as described above. Person responsible: Maintenance Director This administrator and maintenance director cannot find the missing mop board and damaged plaster in the Solarium and the missing plaster on the Solarium south wall. The ceiling in the dining room will be cleaned with a vacuum to remove accumulated black substance (dust near the vents). The surveyor quoted the administrator as saying paint the ceiling. There is no intention to paint the ceiling. Bids are being sought to install a drop	3/31/15

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F 465	Continued From page 59 wall had missing plaster and paint. Written information provided by MD-A on 2/19/15 indicated the dining room/solarium had been recently repainted. The ceiling in the dining room had black substances over the majority of the surface and around the vents. MD-A was interviewed on 2/19/15 at 1:30 p.m. and stated he had plans to replace and lower the ceiling in the solarium, but that nothing had been finalized and no bids have been obtained. The administrator was interviewed on 2/19/15 at 4:00 p.m. and stated he had plans to replace the lighting in the dining room, and repaint the ceiling. Bathroom floors in rooms 105, 107, 120, 121, 124, 136, had black debris behind toilet or floor with debris. During an interview on 2/19/15 at 1:30 p.m. MD-A stated the toilets in the bathrooms had been replaced, and that the black areas was probably from the old toilets. He added they had not gotten the spots up. There was a strong smell of urine in bathroom of room 135. Observed hanging over the bathroom door two catheter bags each in a pillow case. The resident had been discharged to the hospital two day previously. During an interview on 2/19/15 at 1:30 p.m. the housekeeping director stated the catheter bags were washed per procedure and stored in the pillow cases. She stated they should have been thrown away when the resident left the building.	F 465	ceiling with integrated light fixtures in the drop ceiling. Person responsible: Maintenance director and Administrator Bathroom floors in rooms 105,107,120,121,124,135 and 136 are scheduled to be cleaned and old putty removed after replacing all stools in resident toilets with higher stools that accommodate handicapped persons. The project is in process and was not complete when surveyed. A schedule of the toilet floor cleaning will be completed by the housekeeping supervisor. Person responsible: Housekeeping supervisor/maintenance director There is no resident in room 135 who had need of a catheter bag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, GUNDERSEN HARMONY CARE CENTER was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/2015

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

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH** **HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The GUNDERSEN HARMONY CARE CENTER is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1964, addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 38 beds at the time of the survey.	K 000		

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2	K 000		
K 050 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 35 residents. Findings include: On facility tour between 11:00 AM and 2:30 PM on 02/17/2015, the review of the fire drills reports for February 2014 to January 2015. The following fire drills were missed: 1. 2014/2015 - 1st quarter - Night shift	K 050	Maintenance Director has established a yearly calendar with all fire drills planned for the 4th quarter 2015 and the year 2016. The plan assures a drill every shift each quarter Person Responsible: Maintenance Director	3/31/15

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/17/2015**

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GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

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K 050	Continued From page 3 2. 2014 - 3rd quarter - Day shift 3. 2014 - 4th quarter - Evening/Night shifts This deficient practice was confirmed by the Director of Maintenance (SL) at the time of discovery.	K 050		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7, and 1998 NFPA 25, section 2-4.1.1 (c). This deficient practice could affect all 5 out of 35 residents. Findings include: On facility tour between 11:00 AM and 2:30 PM on 02/17/2015, observation revealed that the dry fire sprinkler heads in the walk-in cooler and the freezer have clear fluid in them. This deficient practice was confirmed by the Director of Maintenance (SL) at the time of discovery.	K 062	Solid sprinkler heads and a requisition for installation have been ordered to replace the dry fire sprinkler heads in the walk-in cooler and freezer with a solder sprinkler head that is not affected by temperature. Person Responsible: Maintenance Director	3/31/15
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		3/31/15

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/17/2015**

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K 144	Continued From page 4 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1 and 6.4.2. The deficient practice could affect all 35 residents. Findings include: On facility tour between 11:00 AM and 2:30 PM on 02/17/2015, documentation review revealed the following: 1. Review of the emergency generator weekly inspection log sheets from February 17, 2014 to February 13, 2015, indicated that there was no documentation from 7/14/14 to 11/6/14 that the weekly inspection were completed and documented. 2. Review of the emergency generator monthly run test log sheets from February 19, 2014 to January 30, 2015, indicated that there was no documentation from 7/17/14 to 1/30/15 that the monthly run tests were completed and documented.	K 144	The Maintenance Director will record the weekly inspection of the emergency generator in a log and keep the log current. The monthly generator run test log sheets will be kept current with documentation of the event by the Maintenance Director. The monthly run test will test and be documented one of the following: a. Loading maintains the minimum exhaust temperatures as recommended by the manufacturer. b. The generator under load of 30 percent or more of the nameplate rating for the specific generator or c. Two (2) hour load bank test (first 30 minutes □ 25%, next 30 minutes □ 50%, and last 1 hour □ 75%). Person Responsible: Maintenance Director	

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K 144	Continued From page 5 3. The review of the monthly run test indicated that the generator did not meet one of the following: a. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or b. under load of 30 percent or more of the nameplate rating of generator or c. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) These deficient practices were confirmed by the Director of Maintenance (SL) at the time of discovery.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70 and 2007 MSFC. The deficient practice could affect 15 out of 35 residents. Findings include: On facility tour between 11:00 AM and 2:30 PM on 02/17/2015, observation revealed, that the following was found: 1. The following locations have circuit breaker	K 147	The laundry storage and boiler room circuit breaker panels have been cleared of storage that blocked access to the panels. The maintenance office will be hard wired by an electrician to meet code. The power strip plugged in to another power strip has been removed. The Maintenance Director will monitor the building to prevent clutter in front of electrical panels and use of power strips. Person Responsible: Maintenance Director	3/31/15

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K 147	Continued From page 6 panels that are blocked: a. Laundry room storage b. Boiler room 2. Maintenance office has the following: a. Extension cord running through wall in white PVC piping b. Power strip plugged into extension cord 3. Solarium area - two power strips plugged into each other These deficient practices were confirmed by the Director of Maintenance (SL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
March 10, 2015

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, Minnesota 55939

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5528025

Dear Mr. Samuelson:

The above facility was surveyed on February 17, 2015 through February 20, 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, Compliance Monitoring 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 Gary Nederhoff at (507) 206-2731.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00125	A. BUILDING: _____ B. WING _____	02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 February 17, 18, 19, and 20 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. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 follow the plan of care for 3 of 26 residents (R23, R21, R56) to meet each resident identified need and services. Findings included: R23 failure to provide nail care and follow registered dietician's recommendations. On 2/18/15, at 12:27 p.m. R23 was observed to have very long finger nails with light brown debris underneath nails and at least one of ten nails showed broken jagged sharp edges. R23's quarterly Minimum Data Set (MDS) dated 1/23/15 included the diagnoses of diabetes mellitus, psychotic disorder, and stage four kidney disease and open-angle glaucoma. The assessment indicated no cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 15. The MDS also indicated R23 required extensive assist from staff to perform activities of daily living (ADLs) of dressing and hygiene.	2 565	corrected	3/31/15

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2 565	Continued From page 3 R23's care plan provided by the facility on 2/19/15 related to grooming and hygiene read, "Assist ...as needed for dressing, personal hygiene, transfers and toileting. Encourage independence as able-but needs supervision and checks for thoroughness. " Care plan indicated bath days were on Tuesday and Thursday. R23's care plan did not address how nail care was provided, how often, or by who nail care should be provided by. During an interview on 2/18/15, at 5:54 p.m. registered nurse (RN)-B stated diabetic nail care was performed by a nurse on bath days. During an interview on 2/19/15, at 10:38 a.m., director of nursing (DON) explained if nail care was not specifically care planned the expectation was the person that gave the bath would check finger nails. DON also stated nail care should be care planned. R23 ' s care plan provided by the facility on 2/19/15 related to nutrition indicated R23 ' s ideal fluid intake was between 1800-2000 cubic centimeters (cc ' s) and directed staff to record meal and fluid intake at all meals. R23's fluid intake record from 1/19/15 through 2/19/15 was reviewed. The record revealed twelve meal fluid intakes had not been recorded. During an interview on 2/19/15, at 10:38 a.m., DON confirmed missing fluid intake entries and explained strict intake monitoring was performed only if the registered dietician had made that recommendation. During an interview on 2/19/15, at 1:29 p.m., certified dietary manager (CDM) stated R23's fluid intake had been recommended because R23 was on diuretics and had a urinary catheter. R24 on 2/17/15, at 10:15 a.m. and on 2/18/15, at 12:46 p.m. and at 6:39 p.m. R24 was observed to have long facial hair on her upper lip. R24 ' s quarterly MDS dated 11/26/14 included diagnoses of dementia and anxiety disorder. The	2 565		

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2 565	Continued From page 4 assessment indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6. The MDS also indicated R24 required extensive assist of one staff member to perform activities of daily living (ADL's) of dressing and hygiene. R24's care plan provided by the facility on 2/19/15 read, "ADL: dressing, sponge bath, grooming: requires set up and moderate-max assist/check for thoroughness twice a day AM and PM. Assist [R24] with personal hygiene. [R24] would like to be offered assist with shaving chin hair weekly on bath day. Family has been notified that they need to bring in an electric razor." The care plan indicated bath day was Wednesday. During an interview on 2/18/15, at 5:44 p.m. RN-B confirmed R24 did have bath and R24 ' s facial hair should have been removed. During an interview on 2/18/15, at 6:39 p.m., R24 stated she had not been aware of the facial hair, did not wish for it to be there, and wanted it removed. During an interview on 2/18/15, at 6:40 p.m., nursing assistant (NA)-A confirmed R24 had facial hair. A policy on shaving female resident ' s facial hair was requested and was not provided by the facility. On 2/18/15, at 7:50 p.m. the DON stated the facility did not have a policy related to female facial hair. RESTORATIVE NURSING: R21's care plan dated 6/27/12 identified a problem of at risk for losing strength in legs. Approaches dated 2/10/15, included: ambulate with R21 to and from all meals with 4 wheel walker, lower extremity seated exercises-marches, kicks, knee bends, toe taps 15 times each once a day; lower extremity standing exercises- marches, squats, sidekicks,	2 565		

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2 565	Continued From page 5 heel raises 15 times each once a day. Care plan approaches dated 8/1/14, included: invite to falls and balance program led by activity staff once a morning and goal was R21 to attend three times a week; restorator or recumbent bike 10-15 minutes; restorative program will be reviewed quarterly and as needed. R21's care plan dated 5/31/12 identified a problem of at risk for falling related to poor eye sight and variable balance. Approaches dated 8/1/14, included: administer medication, use walker with ambulation, encourage participating in falls and balancing program, keep items within reach, and keep room free of clutter. Physical therapy daily treatment notes revealed R21 received 12 physical therapy visits for exercises and ambulation between 1/5/15 and 1/30/15. Document review of physical therapy progress and discharge summary dated 1/30/15, revealed analysis of functional outcome read, "Made significant progress towards" physical therapy goals. "Will continue to address ongoing deficits with a functional maintenance program directed by facility staff. " Document review of Physical Therapy Restorative Program dated 1/30/15, revealed the following exercise program for R21: Lower extremity seated exercises: marches with 2 pounds (#) 15 times, kicks with 2# 15 times, knee bends with blue band 15 times, toe taps 30 times, ball squeezes 30 times; Lower extremity standing exercises: marches active range of motion 15 times, squats active range of motion 15 times, sidekicks active range of motion 15 times, heel raises active range of	2 565		

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2 565	Continued From page 6 motion 15 times; Ambulation: Please ambulate with R21 to/from all meals with 4 wheel walker and contact guard assistance and follow with wheelchair due to dizziness. R21 is to have contact guard assistance with all ambulation in hallway. Please have R21 perform all exercises 5-7 days per week as tolerates and is willing to participate. Please contact physical therapy department with any questions or concerns. Document review of restorative nursing flow sheet dated 2/1/15 to 2/19/15, revealed the following: Falls and balance, invite once a morning, will attend three times a week, R21 attended 1 session out of 19 days; Restorator or recumbent bike 10-15 minutes a day, Sunday through Saturday, goal to pedal 15 minutes, R21 refused two sessions and attended 1 session out of 19 days; Falls and balance once a day Monday through Friday, R21 attended one session out of 19 days. The restorative nursing flow sheet did not identify any of the physical therapy recommended exercises dated 1/30/15. During interview on 2/19/15, at 10:25 a.m., RN-B verified the physical therapy recommendations for restorative nursing were not part of the restorative nursing flow sheet. RN-B verified, although the care plan directed restorative nursing exercises, none were provided. RN-B stated the falls and balance program was on the flow sheet two times but was actually the same program offered by activity staff whenever they can do it. RN-B verified R21 received the falls and balance program and the bike exercise one session out of 19 days. She verified R21 had not received restorative therapy exercises as recommended	2 565		

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2 565	Continued From page 7 by physical therapy on 1/30/15. During interview on 2/19/15, at 12:50 p.m., director of nursing stated the facility had been short staffed and they have rescheduled restorative aides to work on the floor. Director of nursing verified the facility had no plan in place to provide restorative therapy exercises when restorative aides were rescheduled to work the floor. UNNECESSARY MEDICATIONS: R21 ' s care plan dated 3/5/14 identified a problem of psychotropic medication use due to received lorazepam for diagnosis of anxiety. Approaches identified included monitor mood and response to medications. R21 was identified on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, moods score of 15 including moods of little interest, feeling depressed, trouble sleeping, tired, poor appetite, feel bad about self, no behaviors, and received antianxiety medication. Document review of care area assessment (CAA) for mood dated 1/20/15, stated R21 " endorses some mood indicators but voices a desire not to change anything at this time as she feels mood is improving, " and " Mood is addressed in care plan d/t (due to) mood issues. " CAA for psychotropic medication dated 1/20/15, stated, " Psychotropic med (medication) use triggered d/t (due to) ativan (lorazepam) use for longstanding anxiety problems. " CAA identified R21 started on antidepressant medication. CAA identified psychotropic medication use was addressed in the care plan due to antianxiety and	2 565		

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2 565	Continued From page 8 antidepressant use. Document review of physician orders report dated 1/19/15 to 2/19/15, revealed orders for lorazepam 0.5 milligrams daily for anxiety disorder, with a start date of 6/13/14; lorazepam 1 milligram two times a day for anxiety disorder, with a start date of 6/13/14; and lorazepam 0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14. The same physician order report had physician orders for Zoloft 50 milligrams once an evening for anxiety, with a start date of 1/16/15. Document review of facility medication administration record dated 1/1/15 to 1/30/15, revealed R21 received lorazepam and Zoloft as ordered. During interview on 2/19/15, at 10:45 a.m., RN-B verified the facility did not identify or monitor target moods or response to medications. RN-B stated the facility knew the medication was effective by just talking with the nurses. RN-B stated the facility quarterly mood and behavior charting on the MDS assessment was the facility monitoring of moods and behaviors. During interview on 2/19/15, at 4:15 p.m., director of nursing stated the facility had no medication related policies. FACIAL HAIR: R56 was identified by the facility as dependent on one staff for activities of daily living, according to document review of facility progress notes dated 2/7/15, 2/12/15, and 2/17/15. R56 was admitted to the facility on 2/4/15, according to review of R56's medical record face	2 565		

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2 565	Continued From page 9 sheet. During observations on 2/17/15, at 3:19 p.m., 2/18/15, at 6:00 p.m., and 2/18/15, at 7:40 p.m., R56 was observed with long chin hairs. Document review of R56's interim plan of care, not dated, directed staff to check for chin hairs, hair and nail care by staff, oral care assist as needed. Document review of facility resident profile with start date of 2/9/15, directed staff to assist R56 with grooming and hygiene as needed. During interview on 2/18/15, at 7:40 p.m., RN-A verified R56 has long chin hairs. RN-A stated female resident's facial hair was shaved on the day shift. RN-A verified R56 did not shave own facial hair. During interview on 2/18/15, at 7:45 p.m., nursing assistant (NA)-A stated female residents ' facial hair was shaved in the mornings. During interview on 2/18/15, at 7:50 p.m., director of nursing stated she expected female facial hair was shaved on bath day and offered as needed. She stated the facility did not have a policy for shaving facial hair. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 570	Continued From page 10	2 570		
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, 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 interview and document review, the facility failed to revise and update the care plan for 4 of 7 residents (R15, R32, R37, and R43) reviewed who had facility urinary tract infection (UTI). Findings include: R15 experienced recurrent UTIs but lacked revision of an individualized plan of care to provide directions to the staff regarding UTI management and interventions to minimize the risk of recurrent UTIs. R15 was admitted to the facility on 1/15/13 and the admission record listed diagnoses that included neurogenic bladder, urinary tract infection, urine retention, urinary frequency. The quarterly Minimum Data Set (MDS) dated 1/7/15 indicated R15 had impaired cognitive/memory, required extensive assistance	2 570	Corrected	3/31/15

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2 570	Continued From page 11 with activities of daily living, had an indwelling catheter, had a neurogenic bladder and had no UTIs past 30 days. However of the clinical record indicated R15 had experienced three UTIs between August 2014 and December 2014 that were identified as facility acquired. The care plan dated 12/15/14 was reviewed. The care plan noted R15 required total assistance for toileting and hygiene. The care plan identified an indwelling Foley catheter and interventions to identify UTIs, but did not include interventions to minimize the risk of UTIs. R32 experienced recurrent UTIs but lacked revision of an individualized plan of care to provide directions to the staff regarding UTI identification and management and interventions to minimize the risk of recurrent UTIs. R32 was admitted to the facility in 2013 and the resident admission record listed diagnoses as dysuria (painful urination) urethral discharge, urinary tract infection, urinary catheterization, diarrhea, neurogenic bladder, stage II chronic kidney disease. The quarterly MDS dated 11/19/14 was reviewed. R32 had a BIMS (brief interview of mental status) was 9 or moderate impairment, required extensive assistance for activities of daily living (ADLs), was frequently incontinent, had a neurogenic bladder, and had experienced a UTI during the previous 30 days. Review of the clinical record indicated R32 had experienced four UTIs between July 2014 and November 2014 that were identified as facility acquired. The care plan dated 1/14/15 identified interventions that included use mechanical lift to transfer R32 to toilet. The care plan listed a medical diagnosis that include renal insufficiency, but did not list interventions to help minimize the risk of recurrent UTIs.	2 570		

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2 570	Continued From page 12 R37 experienced recurrent UTIs but lacked revision of an individualized plan of care to provide directions to the staff regarding UTI identification and management and interventions to minimize the risk of recurrent UTIs. R37 was admitted on 6/6/14 and had diagnoses listed on the admission record as diabetes, stage III chronic kidney disease, malaise and fatigue, urinary infection. The significant change MDS dated 10/24/14 indicated memory impairment, required extensive assistance, was frequently incontinent of urine, and experienced no UTI is previous 30 days. Review of the clinical record reviewed R37 had experienced three UTIs between June and December 2014 that were identified as facility acquired. The care plan dated 11/3/14 was reviewed. The care plan identified R37 was incontinent of bladder. The care plan directed R37 needed assist with toileting dated 8/1/14 but was not revised to include identification and interventions to prevent UTIs. R43 experienced recurrent UTIs but lacked revision of an individualized plan of care to provide directions to the staff regarding UTI identification and management and to interventions to minimize the risk of recurrent UTIs. R43 was admitted 5/1/14. The physician orders dated 1/19/15 through 2/19/14 listed diagnoses that included chronic diarrhea, urinary tract infection, dysuria (pain with urination) The quarterly MDS dated 11/5/14 was reviewed. The MDS indicated R43 had no cognitive impairment, was independent with all activities of daily living, was always continent, and had not experienced a UTI during the previous 30 days. Review of the clinical record revealed R43 had experienced an UTI in December 2014 that was	2 570		

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2 570	Continued From page 13 identified as facility acquired. Care plan dated 1/13/15 noted R43 was continent of bladder and independent with toileting but did not direct staff related to UTI risk or management. The care plan did have a problem related to a diagnosis of diarrhea, but the interventions did not include minimizing the risk of UTIs. During an interview on 2/19/15 at 2:36 p.m. registered nurse (RN)-C stated she did have a temporary care plan that could be used for residents that had UTIs, but she had not been using it. At 5:10 p.m. on 2/19/15 registered nurse (RN)-C stated the care plans provided were the most current for R15, R32, R37, and R43. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to the need to evaluate and update care plans and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.	2 895		3/31/15

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2 895	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R21) received range of motion (ROM) exercises and ambulation as recommended by physical therapy. Findings include: R21 was identified by the facility on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, transfers, walk in room and walk in corridor self-performance was supervision; transfer support was one person physical assist, walk in room support was set up help only, and walk in corridor support was no set up help or physical help from staff; no falls since last assessment, balance during transitions and walking was unsteady but able to stabilize without human assistance, no impairment in functional limitation in range of motion of upper and lower extremity, and received physical therapy with start date of 1/5/15. Document review of falls care area assessment dated 1/20/15, revealed falls triggered due to recent falls without injury and some balance problems. R21 was hard of hearing, had poor vision, walks with assist of staff, used wheelchair. Document review of physician orders dated 1/19-2/19/15, revealed the following orders: may ambulate independently in room and halls with 4 wheel walker, and falls and balance program once a day Monday through Friday.	2 895	Corrected	

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2 895	Continued From page 15 During observations on 2/17/15, at 2:00 p.m., R21 sat in room recliner with feet up. At that time, R21 transferred by self to wheelchair and wheeled out of the room to church service. R21's care plan dated 6/27/12 identified a problem of at risk for losing strength in legs. Approaches dated 2/10/15, included: ambulate with R21 to and from all meals with 4 wheel walker, lower extremity seated exercises-marches, kicks, knee bends, toe taps 15 times each once a day; lower extremity standing exercises- marches, squats, sidekicks, heel raises 15 times each once a day. Approaches dated 8/1/14, included: invite to falls and balance program led by activity staff once a morning and goal was R21 to attend three times a week; restorator or recumbent bike 10-15 minutes; restorative program will be reviewed quarterly and as needed. R21's care plan dated 5/31/12 identified a problem of at risk for falling related to poor eye sight and variable balance. Approaches dated 8/1/14, included: administer medication, use walker with ambulation, encourage participating in falls and balancing program, keep items within reach, and keep room free of clutter. Document review of past three months of falls revealed no falls in 12/2014, and no falls in 1/2015. The following two falls occurred in 2/2015: Document review of the event report dated 2/14/15, revealed R21 stated had fall in bathroom and got up on her own, c/o back pain, and call lite was within reach. The report identified R21 was seen by a provider on 2/13/15 for respiratory symptoms and cough. Interventions were to ask	2 895		

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2 895	Continued From page 16 R21 to use call light or wait for assist. Investigation identified R21 had been more unsteady on feet and was to have assistance to walk in hallways. Document review of event report dated 2/18/15, revealed R 21 was on floor in front of roommate ' s chair, trying to move her bedside table. R21 stated was just weak, denied pain, lung sounds clear. R212 had a cough, was seen on 2/13/15 for cough, was seen after fall on 2/18/15 for cough and weakness and started on antibiotic. R21 was reeducated to use the call light. R21 was alert and oriented and made own decisions. Document review of physical therapy plan of care dated 1/5/15, identified start of care date of 1/5/15, reason for referral: R21 presents with a decline in ambulation and transfers due to recent onset of the flu. R21 started noticing a decline approximately 2 weeks ago which has since resulted in the patient now requiring significantly more assistance for the completion of transfers and ambulation. Therapy necessity: R21 requires skilled physical therapy at this time for strengthening, balance training, gait and transfer in order to regain prior level of function. Physical therapy to discharge with patient at max potential with long term plan in place. Short term goal: ambulates 40 feet with 4 wheeled walkers on even surfaces requiring contact guard assistance. Goal: will ambulate 100 feet safely with 4 wheeled walker on even surfaces with supervision in order to regain prior functional level. Long term goal: will be able to safely ambulate with use of her 4 wheeled walker throughout the facility with modified independence in order to return to her prior level of function. Plan of care was signed by physician for 1/5/15 to 2/1/15, for 3 times a week for 4 weeks.	2 895		

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2 895	Continued From page 17 Document review of physical therapy daily treatment notes revealed the following: 1/16/15, R21 was proud of her ambulation today and reports she can tell she is getting stronger. 1/23/15, R21 ambulated 320 feet with 4 wheeled walker and contact guard assistance. R21 demonstrated improved ambulation distance and independence with mobility. 1/30/15, R21 requested to discharge from physical therapy due to legs hurt after therapy. R21 agreed to restorative therapy and ambulating with staff. Ambulation and restorative program completed. R21 received 12 physical therapy visits for exercises and ambulation between 1/5/15 and 1/30/15. Document review of physical therapy progress and discharge summary dated 1/30/15, revealed analysis of functional outcome included R21 made significant progress towards physical therapy goals. R21 will continue to address ongoing deficits with a functional maintenance program directed by facility staff. Document review of Physical Therapy Restorative Program dated 1/30/15, revealed the following exercise program for R21: Lower extremity seated exercises: marches with 2# 15 times, kicks with 2# 15 times, knee bends with blue band 15 times, toe taps 30 times, ball squeezes 30 times; Lower extremity standing exercises: marches active range of motion 15 times, squats active range of motion 15 times, sidekicks active range of motion 15 times, heel raises active range of motion 15 times; Ambulation: Please ambulate with R21 to/from all meals with 4 wheel walker	2 895		

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2 895	Continued From page 18 and contact guard assistance and follow with wheelchair due to dizziness. R21 is to have contact guard assistance with all ambulation in hallway. Please have R21 perform all exercises 5-7 days per week as tolerates and is willing to participate. Please contact physical therapy department with any questions or concerns. Document review of restorative nursing flow sheet dated 2/1/15 to 2/19/15, revealed the following: Falls and balance, invite once a morning, will attend three times a week, R21 attended 1 session out of 19 days; Restorator or recumbent bike 10-15 minutes a day, Sunday through Saturday, goal to pedal 15 minutes, R21 refused two sessions and attended 1 session out of 19 days; Falls and balance once a day Monday through Friday, R21 attended one session out of 19 days. The restorative nursing flow sheet did not identify any of the physical therapy recommended exercises dated 1/30/15. During interview on 2/19/15, at 10:25 a.m., registered nurse (RN)-B verified the physical therapy recommendations for restorative nursing were not part of the restorative nursing flow sheet. RN-B verified, although the care plan directed restorative nursing exercises, none were provided. RN-B stated the falls and balance program was on the flow sheet two times but was actually the same program offered by activity staff whenever they can. RN-B verified R21 received the falls and balance program and the bike exercise one session out of 19 possible sessions. She verified R21 had not received restorative therapy exercises as recommended by physical therapy on 1/30/15. RN-B verified the	2 895		

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2 895	Continued From page 19 recommendations had not been added to the restorative flow sheet. RN-B stated the facility had two restorative aides who assisted with restorative exercises. During interview on 2/19/15, at 10:54 a.m., physical therapy assistant (PTA)-C stated she was responsible to complete monthly physical therapy evaluations on residents. PTA-C stated had not completed an evaluation for R 21 this month and would complete that day. During interview on 2/19/15, at 10:56 a.m., nursing assistant (NA)-C verified she was responsible to provide facility restorative nursing exercises. NA-C stated she provided lower extremity exercise bike for 10 minutes whenever R21 would go to the exercise room. NA-C verified not aware of the physical therapy recommended restorative program exercises. NA-C stated restorative aides frequently have to work on the floor and the restorative exercises do not get done. During interview on 2/19/15, at 12:35 p.m., PTA-C stated had completed the monthly physical therapy evaluation at that time. She stated the evaluation included a review of nurse ' s notes and talked with nursing assistants. PTA-C verified the evaluation did not include exercises or ambulation. PTA-C stated R21 needed more help to get dressed which was progressively worse with most recent illness, increased dizziness and unsteadiness, refused to use call light, and was self- transferring despite education to use call light. PTA-C stated, based on the evaluation, R21 had declined since discharge from therapy on 1/30/15. Surveyor requested PTA-C attempt to ambulate R 21 that day.	2 895		

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2 895	Continued From page 20 During interview on 2/19/15, at 12:50 p.m., director of nursing stated the facility had been short staffed and they have rescheduled restorative aides to work on the floor. Director of nursing verified the facility had no plan in place to provide restorative therapy exercises when restorative aides were rescheduled to work the floor. During interview on 2/19/15, at 3:10 p.m., RN-B stated R21 had declined due to influenza in 12/2015 and worsening eye sight. RN-B stated R21 requested to discharge from physical therapy 1/30/15, because she did not like therapy and did not want to continue. RN-B verified R21 had declined as she no longer walked to meals. SUGGESTED METHOD FOR CORRECTION: The DON, director of therapy or designee(s) could review and revise as necessary the policies and procedures regarding implementing and maintaining proper range of motion care. The DON, director of therapy or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident ' s plan of care. The DON, director of therapy or designee(s) could monitor to assure residents receive proper range of motion treatment. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the	2 910		3/31/15

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2 910	Continued From page 21 comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to assess urinary tract infections (UTIs), then develop interventions to prevent further UTIs from developing for 7 of 7 residents (R51, R37, R43, R16, R15, R32, R23) identified with having or history of having a UTI, Also failed to reassess a resident following a decline in urinary continence for 1 of 3 residents (R33) reviewed for urinary incontinence. Findings include: UTIs: R51 experienced recurrent UTIs and lacked consistent identification of symptoms of an infection, lacked an assessment of UTI risk, and lacked a care plan for the management of the UTIs. R51 was admitted to the facility 10/31/14 and had diagnoses that included urinary tract infection, urinary frequency. The 60-day Minimum Data Set (MDS) dated 12/26/14 indicated R51 was cognitively intact.	2 910	Corrected	

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2 910	Continued From page 22 required extensive assistance with activities of daily living (ADLs), was occasionally incontinent of bladder and had experienced a UTI during the previous 30 days. The observation report/evaluation dated 11/07/14 was reviewed. The observation report noted resident was always incontinent of urine, required extensive assistance with toileting, had mixed (urge and stress) incontinence, but did not assess/evaluate the residents risk to develop UTIs. The care plan dated 1/7/15 had a problem or urinary incontinence and a history of UTI. The interventions included: administer antibiotics, encourage fluid, encourage emptying of bladder, provide incontinence. The care plan did not assist staff to identify the resident ' s symptoms of UTIs. Registered nurse (RN)-C was interviewed on 2/19/15 at 2:36 p.m. RN-C stated only one culture was done even though R23 had three UTIs and 3 were treated with antibiotics. The UTIs were treated based on the dip stick result, but not a culture. R37 experienced recurrent UTIs (3 UTIs in 6 months) but lacked an assessment of the risk to develop UTIs, lacked identification of symptoms prior to treatment, and lacked revision of care plan to include management and prevention of UTIs. R37 was admitted on 6/6/14 and had diagnoses listed on the admission record as diabetes, stage III chronic kidney disease, malaise and fatigue, urinary infection. The significant change MDS dated 10/24/14 indicated memory impairment, required extensive assistance, was frequently incontinent of urine, and experienced no UTI is previous 30 days. R37's observation report/ evaluation dated	2 910		

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2 910	Continued From page 23 10/20/14 for bowel and bladder significant change, identified R37 as frequently incontinent, requiring extensive assistance with toileting use, experiencing mixed (urge and stress) incontinence, but did not assess R37's risk factors to develop UTIs. The care plan dated 11/3/14 was reviewed. The care plan identified C37 as being admitted to hospice. The care plan identified R37 as at time incontinent of bladder. The care plan directed R37 needed assist with toileting dated 8/1/14 but was not revised to include identification and management of UTIs. R43 experienced a UTI but lacked, identification of urinary symptoms, lacked an assessment to determine risk to develop recurrent UTIs, and failed to have a revision of the care plan to include UTI management. R43 was admitted 5/1/14 according to the face sheet. The physician orders dated 1/19/15 through 2/19/14 listed diagnoses that included chronic diarrhea, urinary tract infection, dysuria (pain with urination). The MDS dated 11/5/14 was reviewed. The MDS indicated R43 had no cognitive impairment, was independent with all activities of daily living, was always continent, and had not experienced a UTI during the previous 30 days. Care plan dated 1/13/15 noted R43 was continent of bladder and independent with toileting but did not direct staff related to UTI risk or management. The care plan did have a problem related to a diagnosis of diarrhea, but the interventions did not include minimizing the risk of UTIs. R16 lacked consist identification of symptoms of urinary tract infection prior to initiation of treatment and lacked a UTI risk assessment with recurrent UTIs (5 UTIs in 8 months) and use of	2 910		

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2 910	Continued From page 24 prophylactic antibiotic. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care. The infection control reports listed R16 as having urinary tract infections on 3/11/14, 4/11/14, 7/31/14 and 10/24/14. The February 2014 log noted R16 started prophylactic antibiotics 6/18/13 for UTIs. Event reports included: 1) 8/14/14 for UTI. Symptoms of frequency, behaviors, and flank pain were listed. 2) 10/22/14 for UTI R16 ' s care plan dated 12/12/14 indicated R16 required assistance with toileting (E-Z stand for transfer, and assist with personal hygiene), had restorative nursing for urinary incontinence exercise, The care plan had a problem dated 11/7/13 which read, " At risk for urinary tract infection related to past history of UTI." The interventions noted to administer prophylactic antibiotics, educate staff on proper hygiene, encourage fluids, encourage bladder emptying and provide peri-care. The quarterly MDS dated 12/10/14 noted R16 had a BIMS score of 8 or moderate cognitive impairment, had no UTI past 30 days, required extensive assistance with all ADLs, had not received an antibiotic during the previous 7 days. The facility Observation Report/bladder/bowel observation dated 6/21/14 was provided. The observation indicated a significant change of condition, urinary incontinence, the resident required extensive assistance to toilet, resident had mixed form of incontinence, but did not evaluate/assess R16 ' s risk to develop UTIs or reversible factors to minimize the risk for developing UTIs or use of prophylactic antibiotics. The physician orders dated 11/19/14 to 2/19/15 indicated R16 was to receive Bactrim DS twice a	2 910		

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2 910	Continued From page 25 day with a day of 4/11/13 and discontinue date of 1/17/15. R16 had a physician ' s order for ceftriaxone twice a day with a start date of 3/18/13 and a discontinue date of 1/17/15. On 11/20/14 the physician order Cephalexin daily and stop until Cipro complete. 12/30/13 the physician noted Cipro daily, hold Bactrim while on Cipro then resume. During an interview on 2/19/15 at 2:36 p.m. with RN-C/infection control director state R16 was on a prophylactic antibiotic off and hoping it would stop the UTIs. RN-C stated she did not know the cause of the infections but would identify that if R16 started to self-transfer she would have an infection. R16 was on hospice at this time and had since died. R15 experienced recurrent UTIs (3 in 3 months) but lacked an assessment of UTI risk and revision of care plan to minimize the risk of recurrent UTIs. R15 was admitted to the facility on 1/15/13 and the admission record listed diagnoses that included neurogenic bladder, urinary tract infection, urine retention, urinary frequency. Event report dated 8/4/14 identified a UTI. The culture was completed, but no organisms identified and symptoms related to behaviors, lethargy, and urine changes were listed. Event report dated 11/9/14 indicated a UTI, that was cultured and the organisms were list, and symptoms of lethargy, decreased intake, blood in urine and cloudy urine were noted. Event report dated 12/4/14 indicated R15 had a UTI that was cultured and the organism was listed and symptoms of low grade temp, decreased appetite, and malaise were listed. The quarterly MDS dated 1/7/15 indicated R15 had impaired cognitive/memory, required extensive assistants with activities of daily living,	2 910		

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2 910	Continued From page 26 had an indwelling catheter, had a neurogenic bladder and had no UTIs past 30 days. The observation report/evaluation for indwelling catheter and frequently incontinent of bowel dated 12/29/14 was reviewed. The report indicated the resident had an indwelling catheter and was incontinent of bowel daily. The report did not assess the resident ' s risk of developing urinary tract infections The care plan dated 12/15/14 was reviewed. R15 had been admitted to hospice. The care plan noted C15 required total assistance for toileting and hygiene. The care plan identified an indwelling Foley catheter and interventions to identify UTIs, but did not include interventions to minimize the risk of UTIs. R32 experienced 4 UTIs in 5 months but lacked identification of symptoms of a UTI, lacked an assessment of UTI risk with recurrent UTIs, and revision of care plan. R32 was admitted to the facility in 2013 and the resident admission record listed diagnoses as dysuria (painful urination) urethral discharge, urinary tract infection, urinary catheterization, diarrhea, neurogenic bladder, stage II chronic kidney disease. The quarterly MDS dated 11/19/14 was reviewed. R32 had a BIMS (brief interview of mental status) was 9 or moderate impairment, required extensive assistance for ADLs, frequently incontinent, had a neurogenic bladder, and had experienced a UTI during the previous 30 days. Event report dated 7/11/14 for UTI identified urine cultured, but no organisms, and did not list signs and symptoms of an infection. Event report dated 8/15/14 for UTI indicated a culture was done, but did not list organisms and listed no signs and symptoms of an infection. The infection control	2 910		

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2 910	Continued From page 27 report listed a UTI for R21 on 10/24/14 with Escherichia coli (commonly abbreviated E. coli) as the organism. No symptoms were listed. The infection control log listed a UTI for R32 on 11/26/14 with E-coli as the organism and no symptoms were listed. The observation report/evaluation dated 8/21/14 for quarterly bowel and bladder indicated R32 was occasionally incontinent of bladder during the past assessment period but currently frequently incontinent, was incontinent of bowel, required extensive assistance with toileting, experienced mixed (urge and stress) incontinence, but did not include an assessment of R32's risk to develop UTIs. The care plan dated 1/14/15 identified interventions of need to use mechanical lift to transfer R32 to toilet. The care plan listed a medical diagnosis that include renal insufficiency, but did not list interventions to help minimize the risk of developing recurrent UTIs. R23 received prophylactic antibiotics but lacked an assessment for risk of UTIs and lacked a clinical rationale for the continued use of the prophylactic antibiotic use. R23 was admitted to the facility in 6/14/14 as found on the resident admission record which also listed diagnoses as chronic stage IV kidney disease, urinary tract infection, diabetes, neurogenic bladder. The quarterly MDS dated 1/23/15 indicated no cognitive impairment, no UTIs past 30 days, a neurogenic bladder, and an ostomy (Suprapubic catheter into bladder). Review of the clinical records indicated R23 had experienced a UTI in April and in May of 2014, but had not experienced a UTI in the past 6 months. Physician orders dated 1/19/15 through 2/15/15 was reviewed. The physician ordered	2 910		

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2 910	Continued From page 28 trimethoprim an antibiotic on 8/22/13 for neurogenic bladder. The infection control log identified the trimethoprim as a prophylactic antibiotic for UTIs. Review of the urology notes for June 18, 2014 through July 23, 2014, noted R23 had a suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics. The observation report/evaluation for significant change bowel and bladder dated 5/6/14 indicated the use of an indwelling catheter, required extensive assist for toileting, but lacked identification of use of prophylactic antibiotics and risk for developing UTIs. The care plan dated 1/26/15 was reviewed. The care plan listed a problem of urinary incontinence and supra pubic catheter. The interventions listed the use of prophylactic antibiotic, intervention to change indwelling catheter monthly, and to report signs of UTI. During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility. R33's admission record noted R33 had been admitted on 7/12/2013 with diagnoses that included but were not limited to congestive heart failure, acute and chronic respiratory failure and stage III chronic kidney disease. R33's quarterly Minimum Data Set (MDS) dated 11/26/14 indicated R33 was occasionally incontinent (this was a decline for R33) of urine, was not on a toileting program and required extensive assistance to toilet. However, the previous admission MDS dated 8/26/14, included R33 was always continent of urine, was not on a toileting program and required extensive	2 910		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 29 assistance to toilet. R33's medical record review revealed the facility failed to complete a comprehensive bladder assessment for R33 when the quarterly MDS dated 11/26/14 showed a decline in bladder incontinence. R33's care plan problem for toileting dated 6/27/14 indicated that R33 was generally continent of bowel/bladder, and directed staff to contact the provider to review possible causes of incontinence if she experienced any incontinence. The care plan goal was for R33 to remain continent of bladder and bowel. However it did not include specific interventions to promote normal bladder function or further loss of bladder control. On 2/19/15 at 12:48 p.m. registered nurse (RN)-B verified R33 displayed a decline in incontinence according to most recent MDS assessment. RN-B stated R33 let staff know when she needed to go to the bathroom and was not on a toileting program. RN-B verified the facility did not fully assess R33's toileting plan to prevent further decline in incontinence, to restore optimal bladder function or to maintain optimal bladder function. On 2/19/15 at 2:58 p.m. the director of nursing (DON) stated when the quarterly MDS assessment identified a decline with bladder incontinence for R33, the nurse should have completed an assessment to determine the reason for the change in incontinence and the care plan should have been revised to reflect the change in incontinence and toileting needs. The DON verified a comprehensive bladder assessment should have been completed for R33 to help restore and maintain optimal bladder	2 910		

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	00125	A. BUILDING: _____ B. WING _____	02/20/2015

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2 910	Continued From page 30 function and prevent further decline in bladder incontinence. A bladder assessment policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director or nursing could review/revise bowel and bladder assessment policies and procedures, review identification of signs and symptoms of urinary tract infections prior to the initiation of treatment, and educate staff on recurrent UTI's and revising the plan of care to minimize the risk of UTI's. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		3/31/15

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2 915	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services for 1 of 1 resident (R21) to help maintain or improve ability to ambulate. Findings include: R21 was identified by the facility on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, transfers, walk in room and walk in corridor self-performance was supervision; transfer support was one person physical assist, walk in room support was set up help only, and walk in corridor support was no set up help or physical help from staff; no falls since last assessment, balance during transitions and walking was unsteady but able to stabilize without human assistance, no impairment in functional limitation in range of motion of upper and lower extremity, and received physical therapy with start date of 1/5/15. Document review of falls care area assessment dated 1/20/15, revealed falls triggered due to recent falls without injury and some balance problems. R21 was hard of hearing, had poor vision, walks with assist of staff, used wheelchair. Document review of physician orders dated 1/19-2/19/15, revealed the following orders: may ambulate independently in room and halls with 4 wheel walker, and falls and balance program once a day Monday through Friday. During observations on 2/17/15, at 2:00 p.m.,	2 915	Corrected	

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2 915	Continued From page 32 R21 sat in room recliner with feet up. At that time, R21 transferred by self to wheelchair and wheeled out of the room to church service. R21's care plan dated 6/27/12 identified a problem of at risk for losing strength in legs. Approaches dated 2/10/15, included: ambulate with R21 to and from all meals with 4 wheel walker, lower extremity seated exercises-marches, kicks, knee bends, toe taps 15 times each once a day; lower extremity standing exercises- marches, squats, sidekicks, heel raises 15 times each once a day. Approaches dated 8/1/14, included: invite to falls and balance program led by activity staff once a morning and goal was R21 to attend three times a week; restorator or recumbent bike 10-15 minutes; restorative program will be reviewed quarterly and as needed. R21's care plan dated 5/31/12 identified a problem of at risk for falling related to poor eye sight and variable balance. Approaches dated 8/1/14, included: administer medication, use walker with ambulation, encourage participating in falls and balancing program, keep items within reach, and keep room free of clutter. Document review of past three months of falls revealed no falls in 12/2014, and no falls in 1/2015. The following two falls occurred in 2/2015: Document review of the event report dated 2/14/15, revealed R21 stated had fall in bathroom and got up on her own, c/o back pain, and call lite was within reach. The report identified R21 was seen by a provider on 2/13/15 for respiratory symptoms and cough. Interventions were to ask R21 to use call light or wait for assist. Investigation identified R21 had been more	2 915		

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2 915	Continued From page 33 unsteady on feet and was to have assistance to walk in hallways. Document review of event report dated 2/18/15, revealed R 21 was on floor in front of roommates chair, trying to move her bedside table. R21 stated was just weak, denied pain, lung sounds clear. R212 had a cough, was seen on 2/13/15 for cough, was seen after fall on 2/18/15 for cough and weakness and started on antibiotic. R21 was reeducated to use the call light. R21 was alert and oriented and made own decisions. Document review of physical therapy plan of care dated 1/5/15, identified start of care date of 1/5/15, reason for referral: R21 presents with a decline in ambulation and transfers due to recent onset of the flu. R21 started noticing a decline approximately 2 weeks ago which has since resulted in the patient now requiring significantly more assistance for the completion of transfers and ambulation. Therapy necessity: R21 requires skilled physical therapy at this time for strengthening, balance training, gait and transfer in order to regain prior level of function. Physical therapy to discharge with patient at maximum potential with long term plan in place. Short term goal: ambulates 40 feet with 4 wheeled walker on even surfaces requiring contact guard assistance. Goal: will ambulate 100 feet safely with 4 wheeled walker on even surfaces with supervision in order to regain prior functional level. Long term goal: will be able to safely ambulate with use of her 4 wheeled walker throughout the facility with modified independence in order to return to her prior level of function. Plan of care was signed by physician for 1/5/15 to 2/1/15, for 3 times a week for 4 weeks. Document review of physical therapy daily	2 915		

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2 915	Continued From page 34 treatment notes revealed the following: 1/16/15, revealed R21 was proud of her ambulation today and reports she can tell she is getting stronger. 1/23/15, R21 ambulated 320 feet with 4 wheeled walker and contact guard assistance. R21 demonstrated improved ambulation distance and independence with mobility. 1/30/15, R21 requested to discharge from physical therapy due to legs hurt after therapy. R21 agreed to restorative therapy and ambulating with staff. Ambulation and restorative program completed. R21 received 12 physical therapy visits for exercises and ambulation between 1/5/15 and 1/30/15. Document review of physical therapy progress and discharge summary dated 1/30/15, revealed analysis of functional outcome included R21 made significant progress towards physical therapy goals. R21 will continue to address ongoing deficits with a functional maintenance program directed by facility staff. Document review of Physical Therapy Restorative Program dated 1/30/15, revealed the following exercises: Lower extremity seated exercises: marches with 2# 15 times, kicks with 2# 15 times, knee bends with blue band 15 times, toe taps 30 times, ball squeezes 30 times; lower extremity standing exercises: marches active range of motion 15 times, squats active range of motion 15 times, sidekicks active range of motion 15 times, heel raises active range of motion 15 times; Ambulation: Please ambulate with R21 to/from all meals with 4 wheel walker and contact guard assistance and follow with	2 915		

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2 915	Continued From page 35 wheelchair due to dizziness. R21 is to have contact guard assistance with all ambulation in hallway. Please have R21 perform all exercises 5-7 days per week as tolerates and is willing to participate. Please contact physical therapy department with any questions or concerns. Document review of restorative nursing flow sheet dated 2/1/15 to 2/19/15, revealed the following: Falls and balance, invite once a morning, will attend three times a week, R21 attended 1 session out of 19 days; Restorator or recumbent bike 10-15 minutes a day, Sunday through Saturday, goal to pedal 15 minutes, R21 refused two sessions and attended 1 session out of 19 days; Falls and balance once a day Monday through Friday, R21 attended one session out of 19 days. During interview on 2/19/15, at 10:25 a.m., registered nurse (RN)-B verified the physical therapy recommendations for restorative nursing were not part of the restorative nursing flow sheet. RN-B verified although the care plan directed restorative nursing exercises, none were provided. RN-B stated the falls and balance program was on the flow sheet two times but was actually the same program offered by activity staff whenever they can do it. RN-B verified R21 received the falls and balance program and the bike exercise one session out of 19 days. She verified R21 had not received restorative therapy exercises as recommended by physical therapy on 1/30/15. RN-B verified the recommendations had not been added to the restorative flow sheet. RN-B stated the facility had two restorative aides who assisted with restorative exercises. During interview on 2/19/15, at 10:56 a.m.,	2 915		

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2 915	Continued From page 36 nursing assistant (NA)-C (NA-C) stated she provided lower extremity exercise bike for 10 minutes whenever R21 would go to the exercise room. NA-C verified not aware of the physical therapy recommended restorative program exercises. NA-C stated restorative aides frequently have to work on the floor and the restorative exercises do not get done. During interview on 2/19/15, at 12:35 p.m., PTA-C stated had completed the monthly physical therapy evaluation at that time. She stated the evaluation included a review of nurse ' s notes and talked with nursing assistants. PTA-C verified the evaluation did not include exercises or ambulation. PTA-C stated R21 needed more help to get dressed which was progressively worse with most recent illness, increased dizziness and unsteadiness, refused to use call light, and was self- transferring despite education to use call light. PTA-C stated, based on the evaluation, R21 had declined since discharge from therapy on 1/30/15. Surveyor requested PTA-C attempt to ambulate R 21 that day. During interview on 2/19/15, at 12:50 p.m., director of nursing stated the facility had been short staffed and they have rescheduled restorative aides to work on the floor. Director of nursing verified the facility had no plan in place to provide restorative therapy exercises when restorative aides were rescheduled to work the floor. During interview on 2/19/15, at 3:10 p.m., RN-B stated R21 had declined due to influenza in 12/2015 and worsening eye sight. RN-B stated R21 requested to discharge from physical therapy 1/30/15, because she did not like therapy and did not want to continue. RN-B verified R21 had	2 915		

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2 915	Continued From page 37 declined as she no longer walked to meals. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with restorative rehabilitative services. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services for 3 of 3 residents (R24, R23 and R56) who were dependent of staff to meet their activities of daily living (ADL). Findings included: R24 on 2/17/15, at 10:15 a.m. and on 2/18/15, at 12:46 p.m. and at 6:39 p.m. was observed to have long facial hair on her upper lip.	2 920	Corrected	3/31/15

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2 920	Continued From page 38 R24's quarterly MDS dated 11/26/14 included diagnoses of dementia and anxiety disorder. The assessment indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6. The MDS also indicated R24 required extensive assist of one staff member to perform ADLs including hygiene. R24's care plan provided by the facility on 2/19/15 read, "ADL: dressing, sponge bath, grooming: requires set up and moderate-max assist/check for thoroughness twice a day AM and PM. Assist R24 with personal hygiene. R24 would like to be offered assist with shaving chin hair weekly on bath day. Family has been notified that they need to bring in an electric razor." The care plan indicated bath day was Wednesday. During an interview on 2/18/15, at 5:44 p.m. registered nurse (RN)-B confirmed R24 did have bath and R24's facial hair should have been removed. During an interview on 2/18/15, at 6:39 p.m., R24 stated she had not been aware of the facial hair, did not wish for it to be there, and wanted it removed. During an interview on 2/18/15, at 6:40 p.m., nursing assistant (NA)-A confirmed R24 had facial hair. A policy on shaving female resident's facial hair was requested and was not provided by the facility. On 2/18/15, at 7:50 p.m. the DON stated the facility did not have a policy related to female facial hair. R23 on 2/18/15, at 12:27 p.m. was observed to have very long finger nails with light brown debris underneath nails and at least one of ten nails showed broken jagged sharp edges. R23's quarterly MDS dated 1/23/15 included the diagnoses of peripheral arterial disease, diabetes mellitus, and open-angle glaucoma. The assessment indicated no cognitive impairment	2 920		

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2 920	Continued From page 39 with a Brief Interview of Mental Status (BIMS) score of 15. The MDS also indicated R23 required extensive assist from staff to perform ADLs including hygiene. R23's care plan provided by the facility on 2/19/15 related to grooming and hygiene read, "Assist ...as needed for dressing, personal hygiene, transfers and toileting. Encourage independence as able-but needs supervision and checks for thoroughness. " Care plan indicated bath days were on Tuesday and Thursday. R23's care plan did not address how nail care was provided, how often, or by who nail care should be provided by. During an interview on 2/18/15, at 5:54 p.m. RN-B stated diabetic nail care was performed by a nurse on bath days. During an interview on 2/19/15, at 10:38 a.m., director of nursing (DON) explained if nail care was not specifically care planned the expectation was the person that gave the bath would check finger nails. DON also stated nail care should be care planned. R56 was identified by the facility as dependent on one staff for activities of daily living, according to document review of facility progress notes dated 2/7/15, 2/12/15, and 2/17/15. R56 was admitted to the facility on 2/4/15, according to review of R56's medical record face sheet. During observations on 2/17/15, at 3:19 p.m., 2/18/15, at 6:00 p.m., and 2/18/15, at 7:40 p.m., R56 was observed with long chin hairs. Document review of R56 ' s interim plan of care, not dated, directed staff to check for chin hairs, hair and nail care by staff, oral care assist as needed.	2 920		

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2 920	Continued From page 40 Document review of facility resident profile with start date of 2/9/15, directed staff to assist R56 with grooming and hygiene as needed. During interview on 2/18/15, at 7:40 p.m., RN-A verified R56 long chin hairs. RN-A stated female resident's facial hair was shaved on the day shift. RN-A verified R56 did not shave own facial hair. During interview on 2/18/15, at 7:45 p.m., NA-A stated female residents' facial hair was shaved in the mornings. During interview on 2/18/15, at 7:50 p.m., director of nursing stated she expected female facial hair was shaved on bath day and offered as needed. She stated the facility did not have a policy for shaving facial hair. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents receive assistance with activities of daily living as determined necessary by their individualized plan of care. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection	21375		3/31/15

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21375	Continued From page 41 control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain an infection control program that analyzed infection patterns and trends, to identifying recurrent urinary tract infections and monitoring of symptoms to prevent the spread of infection. This practice could affect all residents in the home. Findings include: Lack of analyzing infections to determine appropriate and timely interventions to prevent the spread of infection/s: The infection control data analysis: May 2014 through January 2015 infection control logs were reviewed. The log had a place to list resident name, onset date, site of infection, diagnosis, culture and x-ray dates and results, antibiotic used, date resolved, and if this was a nosocomial infection. Review of the logs revealed the cultures were not consistently completed to determine the cause of the urinary tract infection/s (UTI) prior to antibiotic use and taking X-rays were not consistently completed to determine pneumonia prior to treatment. The logs did not indicate resident location in the facility or any timely nursing/facility interventions to assist the resident to manage the infection or to minimize the spread of the infection. The logs did not indicate an analysis or trend had been completed. No further documentation regarding the analysis of the data was provided when requested. The facility policy Infection-Clinical Protocol dated 10/20/14 was reviewed. The policy directed: A	21375	Corrected	

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21375	Continued From page 42	21375		

log of facility infections being treated will be kept and reported at quarterly Quality Improvement meetings. This log will include the type of infections and the treatment provided. The log will be reviewed for any patterns within the facility.
Registered nurse (RN)-C, who was appointed as the infection control director was interviewed on 2/19/15 at 2:30 p.m. RN-C stated she kept the infection control logs and would keep track of employee illness as well as resident illness. She indicated she would keep a working log of infections during the month and then recopy at the end of the month. RN-C said she did not do a written report or analyze the data or trend. She would discuss the infections at the morning meetings. She would look at the cultures and areas of the nursing home that infections occur, but would just keep the information in her head. RN-C stated she would take the information of numbers to the Quality Improvement meeting and discuss what she "had in her head." Which was not reproducible.
Recurrent Infections: The infection control logs for July 2014 through December 2014 were reviewed. In July 2014 the log identified three (3) urinary tract infections (UTI) treated with antibiotics, but organisms cultured were not consistently identified on the log. In August 2014 the log listed six (6) UTI treated with antibiotics, but no organisms. In October 2014 three (3) UTIs were identified. In November 2014, four (4) UTIs, and in December 2014, five (5) UTIs were identified.
The infection control logs for 2014 were reviewed. R16, although on prophylactic antibiotic had four (4) recurrent UTIs from March through October 2014. R23 although on prophylactic antibiotics had two (2) recurrent UTIs in April and May. R 15 had two (2) UTIs identified in November and December 2014. R51 had three (3) UTIs

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identified during December 2014 and January 2015. R37 had three (3) UTIs identified during January through December 2014 R32 had two (2) UTIs identified during August through October 2014.
The Infections-Clinical Protocol dated 10/20/14 noted that changes in the resident's mental or physical status that could indicate a possible infections were to be documented and the charge nurse was to perform an additional assessment prior to notifying the physician. The Protocol directed the symptoms would include fever, changes in urine appearance, complaints of dysuria (frequency) or behavioral changes. If a urinary tract infection was suspected a urinalysis was advisable. The Protocol stated staff would provide supportive measures to assist the resident in managing the infection. The Protocol did not direct staff related to recurrent infections or need for re-assessments to determine potential reversible causes.
RN-C was interviewed on 2/19/15 at 2.30 p.m. RN-C stated she had not developed any infection control policies. She stated that she was aware that some residents had recurrent UTIs. RN-C stated she would like nursing to document signs and symptoms of infection, but that did not always happen. Nursing staff would contact the clinic, but not always document the symptoms. RN-C stated that she and RN-B were responsible to complete the infection event reports. She stated that she was aware that some residents had recurrent UTIs. RN-C state she would look back at the logs to see if any recurrent UTIs.
Lack of infection management for influenza season and pneumonia: Review of the infection control log for December 2014 and January 2015 indicated one resident R18 had been diagnosed with influenza. One other resident was identified in December has having COPD exacerbation,

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21375	Continued From page 44 and one with pneumonia. No other residents with respiratory infections or symptoms of possible respiratory infections whether treated with antibiotics or not were identified. No analysis or trends had been documented to determine if the facility had any other respiratory illness or influenza among the residents or staff. The Infections-Clinical Protocol dated 10/20/14 directed staff to document the symptoms that include fever, changes in urine appearance, or behavioral changes. If pneumonia was suspected then a pulse oximetry may be completed as well as possibly a chest x-ray. The Protocol directed if influenza was suspected, then test as ordered by the physician, On 2/19/15 at 11:00 a.m. the director of nursing (DON) verified the facility had had influenza, but that the physicians had decided not to do a full house prophylactic treatment of other residents. The DON stated that to her knowledge no line listing of residents with respiratory symptoms during this time period had been kept. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service employees responsible for infection control program to include tracking, evaluating, interventions to prevent the spread of infection. Also the administrator or designee could develop policies to ensure a clean environment and resident equipment were maintained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy.	21530		3/31/15

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21530	Continued From page 45 This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist'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 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 assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: The facility failed to ensure the consultant	21530	Corrected	

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21530	Continued From page 46 pharmacist identified and reported medication irregularities for 2 of 7 residents (R24 and R21) reviewed for unnecessary medications. Findings included: R24 had last been admitted to the facility on 5/28/13 according to facility's "Resident Admission Record. " R24's quarterly Minimum Data Set (MDS) dated 11/26/14 which included diagnoses of dementia, anxiety disorder, heart failure, hypertension, and hyperlipidemia. The assessment indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6. R24's medication orders identified on physician visit dated 2/16/15 included: Lisinopril (lipid lower medication) 10 milligrams (mg) daily, Lorazepam 0.5 mg three times a day as needed for anxiety and 1 mg scheduled three times a day, Zaroxolyn (diuretic) 2.5 mg daily, Lopressor (anti-hypertensive medication) 50 mg daily, and Torsemide (diuretic medication) 10 mg daily. Record review of medication lab monitoring revealed no labs had been completed during the last year to ensure safe ongoing use of prescribed medications and/or continued need of prescribed medications. During an interview on 2/19/15, director of nursing (DON) confirmed no medication laboratory monitoring had been completed during the last year. R24's care plan indicated R24 had a diagnosis of anxiety and depression. The care plan identified interventions to assist with alleviating associated symptoms however, the care plan failed to identify the anxiety and depression target symptoms in order to administer as needed Lorazepam. No clear direction on when to administer medication or use individualized non-pharmacological interventions.	21530		

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21530	Continued From page 47 R24's medication administration record (MAR) for February 2015 indicated as needed Lorazepam was administered for varied behavioral issues that included: "Abdominal pain, cold symptoms with uneasiness, wanting to go home, complain of something in throat, anxiety [undefined], weepy" and repetitive use of call light. According to the February 2015 MAR, as needed Lorazepam was initially started on 6/17/14 During an interview on 2/19/15, at 2:24 p.m. licensed practical nurse (LPN)-B verified there were not any specific parameters for the use of Lorazepam. During an interview on 2/19/15, at 2:36 p.m. registered nurse (RN)-B stated Lorazepam was administered after behavioral interventions were tried. During an interview on 2/19/15, at 2:36 p.m., consulting pharmacist indicated he may have missed issuing a recommendation for medication laboratory monitoring for R24. In relation to as needed Lorazepam parameters; consulting pharmacist indicated facility had not identified specific resident behaviors/mood. Lack of parameters for use of Ativan: R21 had diagnosis of anxiety and depression according to facility admission record dated 12/25/10. R21 was identified on the significant change Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, moods score of 15 including moods of little interest, feeling depressed, trouble sleeping, tired, poor appetite, feel bad about self, no behaviors, and received antianxiety medication. Document review of physician orders report dated 1/19/15 to 2/19/15, revealed orders for lorazepam	21530		

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21530	Continued From page 48 0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14. Document review of facility as needed medication administration history revealed R21 received the following as needed lorazepam: 12/1/14 to -12/31/14-10 times; 1/1/15 - 1/31/15-3 times; 2/1/15 -2/18/15-1 time. The medication record identified as needed lorazepam was administered for sleep, nerves, agitation, anxiety, distressed, and resident request. The facility lacked identification of specific parameters to administer as needed lorazepam. During telephone interview on 2/19/15, at 3:20 p.m., facility consultant pharmacist stated he expected very specific parameters identified for when to use as needed lorazepam. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage related to identifying and reporting irregularities. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:	21535		3/31/15

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21535	Continued From page 49 A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to obtain clinical rationale for continued use of prophylactic medication administered for urinary tract infection (UTI) for 2 of 2 residents (R23, R16) who currently received for prophylactic antibiotic therapy and the facility failed to ensure that psychoactive medications were monitored for effectiveness and/or identified clear parameters as to when antianxiety medication is to be used for 2 of 5 residents (R24, R21) reviewed for unnecessary medications. Findings include: Lack of physician justification for ongoing use of	21535	Corrected	

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21535	Continued From page 50 an antibiotic prophylactic therapy to prevent urinary tract infections: R23 received a prophylactic antibiotic but lacked a clinical rationale for the continued use of the medication. R23 was admitted to the facility in 6/14/14 and the resident admission record listed diagnoses as chronic stage IV kidney disease, urinary tract infection, diabetes, neurogenic bladder, The quarterly Minimum Data Set (MDS) dated 1/23/15 indicated no cognitive impairment, no UTIs past 30 days, a neurogenic bladder, and an ostomy (suprapubic catheter). The observation report/evaluation for significant change bowel and bladder dated 5/6/14 indicated the use of an indwelling catheter, required extensive assist for toileting, but lacked identification of use of prophylactic antibiotics. The care plan dated 1/26/15 was reviewed. The care plan listed a problem of urinary incontinence and supra pubic catheter. The interventions listed the use of prophylactic antibiotic. Review of the clinical records indicated R23 had experienced a UTI in April 2014 and in May of 2014, but had not experienced a UTI in the past 6 months. Physician orders dated 1/19/15 through 2/15/15 was reviewed. The physician ordered trimethoprim an antibiotic on 8/22/13 for neurogenic bladder and has continued to receive this antibiotic. However, a physician ' s justification for the ongoing use of a prophylactic antibiotic was requested and none was provided. Registered nurse (RN) -C who was designated as the infection control director was asking to provide physician documentation related to the continued use of the prophylactic antibiotic. Review of the three urology notes for June 18, 2014 through July 23, 2014, revealed R23 had a	21535		

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suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics.
During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility.
R16 lacked clinical rationale for use of a prophylactic antibiotic to prevent UTIs.
R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care.
The quarterly MDS dated 12/10/14 noted R16 had a BIMS score of 8 or moderate cognitive impairment, had no UTI past 30 days, required extensive assistance with all activities of daily living (ADL/s), had not received an antibiotic during the previous 7 days. The facility Observation Report/bowel/bladder observation dated 6/21/14 was reviewed and did not identify the use of prophylactic antibiotics.
The plan of care dated 12/12/14 indicated R16 listed a problem of "At risk for urinary tract infection related to past history of UTI " and had an intervention to administer prophylactic antibiotics.
The Infection Control Reports and Infection Event Reports for March 2014 through November 2014 revealed that R16 had 5 UTIs during this period. During these 5 UTIs R16 received an antibiotic a few times and not for all UTIs.
The physician orders dated 11/19/14 to 2/19/15 were reviewed for R16. The physician orders indicated R16 received Bactrim DS (antibiotic) twice a day starting 4/11/13 and had a discontinue date of 1/17/15. R16 had a physician's order for ceftriaxone twice a day with a start date of 3/18/13 and a discontinue date of 1/17/15. On 11/20/14 the physician order

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Cephalexin daily and stop until Cipro complete. 12/30/13 the physician noted Cipro daily, hold Bactrim while on Cipro then resume.
The infection reports were reviewed for January 2014 through January 2015. The log identified prophylactic antibiotics for R16 on January 2014 as Bactrim DS with an order date of 6/18/13 The Log indicated the antibiotic had been discontinued in March 2014, The October 2014 infection control log identified R16 as receiving a prophylactic antibiotic of cephalexin starting 10/27/14. The January 2015 log noted R16 expired on 1/16/15. During the time period identified as receiving the prophylactic antibiotics R16 did have UTIs.
During an interview on 2/19/15 at 2:36 p.m. with RN-C stated R16 was on a prophylactic antibiotic off and on hoping it would stop the UTIs. RN-C stated she did not know the cause of the infections but would identify that if R16 started to self-transfer she would have an infection. R16 was on hospice at this time and had since died. No further information or physician justification for the use of the prophylactic antibiotic was received when requested.

Lack of identifying and evaluate symptoms of anxiety and depression to ensure effectiveness and appropriateness of prescribed anti-depressant and anti-anxiolytic medications prescribed:
R24 had last been admitted to the facility on 5/28/13 according to her Resident Admission Record.

R24's quarterly MDS dated 11/26/14 included diagnoses of dementia, anxiety disorder, and depressive disorder. The assessment indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6. The MDS

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21535	Continued From page 53 also indicated a PHQ9 (monitors mood) score of 7 indicating minimal depression symptoms, and the revealed no behaviors had been present at the time of assessment. R24's medication orders identified on physician visit dated 2/16/15 included: Buspar 7.5 milligram (mg) (anti-anxiety medication) daily, Paxil (anti-depressant medication) 40 mg daily, Lorazepam 0.5 mg three times a day as needed for anxiety and Lorazepam 1 mg three times a day. R24's care plan indicated R24 had a diagnosis of anxiety and depression. The care plan identified interventions to assist with alleviating associated symptoms however, the care plan failed to identify the anxiety and depression target symptoms in order to administer as needed Lorazepam. There was not a clear direction on when to administer medication or use individualized non-pharmacological interventions. R24's medication administration record (MAR) for February 2015 indicated as needed Lorazepam was administered for varied behavioral issues that included: "Abdominal pain, cold symptoms with uneasiness, wanting to go home, complain of something in throat, anxiety [undefined], weepy" and repetitive use of call light. During an interview on 2/19/15, at 2:24 p.m. licensed practical nurse (LPN)-B verified there were not any specific parameters for the use of Lorazepam. During an interview on 2/19/15, at 2:36 p.m. registered nurse (RN)-B stated Lorazepam was administered after behavioral interventions were tried. Ongoing symptom monitoring and evaluations for depression was not found in the medical record nor were there evaluations of anxiety symptoms. Nurse's progress notes and assessments were reviewed since 11/26/14 to 2/19/15; notes did not	21535		

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reflect symptoms of depression or anxiety had not been quantified and individualized target behaviors and/or symptoms to specifically monitor were not identified and individualized interventions (including both pharmacological and non-pharmacological) were not evaluated for effectiveness.
During an interview on 2/18/15, at 5:30 p.m. RN-B stated target (resident specific symptoms and signs to indicate need of antidepressant) behavior monitoring was not done for anti-depressant medications only for anti-psychotic medications unless there is a concern then the resident would be monitored for short time period. RN-B verified no quarterly evaluation of medication effectiveness, and evaluation of behaviors and interventions had not been completed.
During an interview on 2/19/15, at 2:36 p.m., consulting pharmacist indicated he may have missed issuing a recommendation for medication laboratory monitoring for R24. In relation to as needed Lorazepam parameters; consulting pharmacist indicated target symptoms and frequency of symptoms had not been identified yet as evidenced on the February 2015 MAR, and pharmacist said the as needed Lorazepam was initially started on 6/17/14.

Lacked evidence of identification and monitoring of target behaviors and target symptoms for the use of antianxiety and antidepressant and lacked analysis of data to determine if the medications and interventions were effective:

R21 had diagnosis of anxiety and depression according to facility admission record dated 12/25/10.

R21 was identified on the significant change

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21535	Continued From page 55 Minimum Data Set (MDS), an assessment dated 1/7/15, to have cognition intact, moods score of 15 including moods of little interest, feeling depressed, trouble sleeping, tired, poor appetite, feel bad about self, no behaviors, and received antianxiety medication. Document review of care area assessment (CAA) for mood dated 1/20/15, stated R21"endorses some mood indicators but voices a desire not to change anything at this time as she feels mood is improving. Mood is addressed in care plan d/t (due to) mood issues." CAA for psychotropic medication dated 1/20/15, read, "Psychotropic med (medication) use triggered d/t (due to) ativan use for longstanding anxiety problems." CAA identified R21 started on antidepressant medication. CAA identified psychotropic medication use was addressed in the care plan due to antianxiety and antidepressant use. Document review of physician orders report dated 1/19/15 to 2/19/15, revealed orders for lorazepam 0.5 milligrams daily for anxiety disorder, with a start date of 6/13/14; lorazepam 1 milligram two times a day for anxiety disorder, with a start date of 6/13/14; and lorazepam 0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14. The same physician order report had physician orders for Zoloft 50 milligrams once an evening for anxiety, with a start date of 1/16/15. Document review of facility medication administration record dated 1/1/15 to 1/30/15, revealed R21 received lorazepam (Ativan) and Zoloft as ordered. During observations on 2/17/15, at 10:30 a.m. and 2/18/15, at 12:55 p.m., R21 sat in a recliner	21535		

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	00125	A. BUILDING: _____ B. WING _____	02/20/2015

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21535	Continued From page 56 in room. No moods or behaviors were noted at that time. R21's care plan dated 3/5/14 identified a problem of psychotropic medication use due to received lorazepam for diagnosis of anxiety. Approaches identified included monitor mood and response to medications. Care plan dated 1/10/12, identified a problem of mood/behavior, has a longstanding history of chronic anxiety and insomnia. Approaches included Ativan as scheduled and as needed, observe for side effects and worsening anxiety, report to social worker, case manager, and charge nurse changes in mood or behavior. During interview on 2/19/15, at 10:45 a.m., RN-B verified the facility did not identify or monitor target moods or response to medications. RN-B stated the facility knew the medication was effective by "Talking with the nurses." RN-B stated the facility quarterly mood and behavior charting on the MDS assessment was the facility monitoring of moods and behaviors. RN-B stated the facility did not document an analysis or summary note of effectiveness of the medication. RN-B stated she reviewed moods and behaviors by "Talking with nurses" and the summary was "Done in my head." However, it was not reproducible to evaluate content for accuracy. During interview on 2/19/15, at 4:15 p.m., director of nursing stated the facility had no medication related policies. Lack of clear parameters to use of antianxiety medication use: R21 had diagnosis of anxiety and depression according to facility admission record dated 12/25/10.	21535		

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21535	Continued From page 57 R21 was identified on the significant change MDS, an assessment dated 1/7/15, to have cognition intact, moods score of 15 including moods of little interest, feeling depressed, trouble sleeping, tired, poor appetite, feel bad about self, no behaviors, and received antianxiety medication. Document review of care area assessment (CAA) for mood dated 1/20/15, stated R21 "endorses some mood indicators but voices a desire not to change anything at this time as she feels mood is improving. Mood is addressed in care plan d/t [due to] mood issues." CAA for psychotropic medication dated 1/20/15, read, "Psychotropic med [medication] use triggered d/t ativan use for long standing anxiety problems." CAA identified R21 started on antidepressant medication. CAA identified psychotropic medication use was addressed in the care plan due to antianxiety and antidepressant use. Document review of physician orders report dated 1/19/15 to 2/19/15, revealed orders for lorazepam 0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14. Document review of facility as needed medication administration history revealed R21 received the following as needed lorazepam: 12/1/14 to -12/31/14-10 times; 1/1/15 - 1/31/15-3 times; 2/1/15 -2/18/15-1 time. The medication record identified as needed lorazepam was administered for sleep, nerves, agitation, anxiety, distressed, and resident request. During observations on 2/17/15, at 10:30 a.m. and 2/18/15, at 12:55 p.m., R21 sat in a recliner in room. No moods or behaviors were noted at that time.	21535		

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21535	Continued From page 58 R21's care plan dated 3/5/14 identified a problem of psychotropic medication use due to received lorazepam for diagnosis of anxiety. Approaches identified included monitor mood and response to medications. Care plan dated 1/10/12, identified a problem of mood/behavior, has a longstanding history of chronic anxiety and insomnia. Approaches included Ativan (lorazepam) as scheduled and as needed, observe for side effects and worsening anxiety, report to social worker, case manager, and charge nurse changes in mood or behavior. During interview on 2/19/15, at 2:30 p.m., RN-B stated staff administered as needed lorazepam for anxiety, after attempting non-pharmacological interventions, or administered lorazepam when R21 requested as needed lorazepam. RN-B verified the facility lacked specific identification of symptoms of anxiety in order to administer as needed lorazepam. During interview on 2/19/15, at 4:15 p.m., director of nursing stated the facility had no medication related policies. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage for prophylactic medication for urinary tract infections, to ensure that psychoactive medications are being monitored for effectiveness and to identify parameters for as needed medications for antianxiety medications. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations.	21535		

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21535	Continued From page 59 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure a bottle of Aplisol (tuberculin testing solution) was discarded 30 days after being opened. This has the potential to effect new resident admissions and new employees hired. Findings included: On 2/19/15, at 11:50 a.m. during a medication storage tour with registered nurse (RN)-B revealed an opened bottle of Aplisol (tuberculin testing solution) with an open date of 11/1/14 in the medication storage room refrigerator. RN-B verified the date on the bottle and stated the vial should have been discarded 30 days after open date (December 1, 2014). The Aplisol package insert read, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. Failure to store and handle Aplisol as recommended may result in loss of potency and inaccurate test results." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise	21620	Corrected	3/31/15

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21620	Continued From page 60 policies and procedures to ensure medications are dated when opened. The director of nursing could educate nursing staff. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview review the facility failed to ensure equipment used for hygiene assessed needs were kept in a state of good repair and clean for 4 of 4 resident (R28, R42, R53, R55) who used a portable commode and also failed to maintain wheelchair upholstery in a state of good repair for 1 of 3 residents (R24) who utilized a wheelchairs for movement. Findings include: An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and housekeeping director (HD)-A. Soiled commodes: R28 located in room 120 had a portable commode set over the toilet. The portable commode was observed to have cracked plastic arm rests and a severely stained bucket to be	21685	Corrected	3/31/15

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21685	Continued From page 61 soiled with debris and rust on metal. It was learned that R42 in room 121 used this same portable commode. R58 located in room 135 and R55 located in room 137 used the same portable commode which was observed to have a chipped plastic seat and rusty areas on the legs. Also in bathroom of R58 and R55 the grab bars were worn and rust was noted on the metal. During an interview on 2/19/15 at 1:30 p.m. the HD-A stated she felt these were not cleanable surfaces. Wheelchair upholstery torn and soiled: R24 located in in room 130B on 2/17/15 at 11:40 a.m. had a wheel chair that was observed to be soiled with debris, and the arms of wheel chair had vinyl missing exposing the foam underneath. During an interview on 2/19/15 at 1:30 p.m. the maintenance director stated staff have a procedure to notify him of wheelchair issues and is unaware of this wheelchair needing to be fixed. SUGGESTED METHOD OF CORRECTION: The facility administrator or designee could review and revise policies and procedures in relation to the facility's preventative and ongoing maintenance and housekeeping program. The administrator or designee could could do weekly/monthly audits for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21685		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and	21695		3/31/15

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21695	Continued From page 62 comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a clean, comfortable and homelike environment for several resident rooms. Findings include: An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and the housekeeping director (HD-A. Rooms 107, 135, 124, 128, 129, 131, 137, were observed to have a buildup of black substance and several windows had moisture noted. During the tour the maintenance director stated this was dirt on the insulation and MD-A stated Room 107 had a humidifier which caused water on windows. It was also noted the outside temperature was around 0 degrees Fahrenheit. The administrator was interviewed on 2/19/15 at 4:00 p.m. He stated that he was aware of the moisture on windows as they are getting old and need replacing. The dining room/solarium had missing mop boards (had not been replaced after painting walls recently) and damaged plaster. The south wall had missing plaster and paint. Written information provided by MD-A on 2/19/15 indicated the dining room/solarium had been recently repainted. The ceiling in the dining room had black substances over the majority of the surface and around the vents. MD-A was interviewed on 2/19/15 at 1:30 p.m. and stated he had plans to replace and lower the ceiling in the solarium, but that nothing had been finalized and no bids have been obtained. The administrator was	21695	Corrected	

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21695	Continued From page 63 interviewed on 2/19/15 at 4:00 p.m. and stated he had plans to replace the lighting in the dining room, and repaint the ceiling. Bathroom floors in rooms 105, 107, 120, 121, 124, 136, had black debris behind toilet or floor with debris. During an interview on 2/19/15 at 1:30 p.m. MD-A stated the toilets in the bathrooms had been replaced, and that the black areas was probably from the old toilets. He added they had not gotten the spots up. There was a strong smell of urine in bathroom of room 135. Observed hanging over the bathroom door two catheter bags each in a pillow case. The resident had been discharged to the hospital two day previously. During an interview on 2/19/15 at 1:30 p.m. the housekeeping director stated the catheter bags were washed per procedure and stored in the pillow cases. She stated they should have been thrown away when the resident left the building. SUGGESTED METHOD OF CORRECTION: The facility administrator or designee could review and revise policies and procedures in relation to the facility's preventative and ongoing maintenance and housekeeping program. The administrator or designee could could do weekly/monthly audits for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21695		