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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ID99

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00885

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245596**
2.STATE VENDOR OR MEDICAID NO.
(L2) **201042900**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTH SHORE CARE CENTER**
(L4) **1307 SOUTH SHORE DRIVE PO BOX 69**
(L5) **WORTHINGTON, MN** (L6) **56187**

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 **7/28/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 07/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/25/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245596

July 29, 2014

Ms. Barbara Atchison, Administrator
South Shore Care Center
1307 South Shore Drive Po Box 69
Worthington, Minnesota 56187

Dear Ms. Atchison:

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 July 22, 2014 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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
Telephone: (651) 201-4112
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 29, 2014

Ms. Barbara Atchison, Administrator
South Shore Care Center
1307 South Shore Drive PO Box 69
Worthington, Minnesota 56187

RE: Project Number S5596024

Dear Ms. Atchison:

On June 26, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 13, 2014. 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 July 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 22, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 13, 2014, effective July 22, 2014 and therefore remedies outlined in our letter to you dated June 26, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245596	A. Building B. Wing	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **07/10/2014**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/10/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/10/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/10/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **07/10/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/10/2014**	ID Prefix **F0363** Reg. # **483.35(c)** LSC	Correction Completed **07/01/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/10/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/10/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/10/2014**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **06/13/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **07/22/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GN/KFD	07/29/2014	10160	07/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/13/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245596	01 - MAIN BUILDING 01	7/22/2014

Name of Facility	Street Address, City, State, Zip Code
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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 Reg. # NFPA 101 LSC K0021	Correction Completed 07/01/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KFD	Date: 07/29/2014	Signature of Surveyor: 19251	Date: 07/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/10/2014		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: ID99

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00885

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245596**
2.STATE VENDOR OR MEDICAID NO.
(L2) **201042900**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTH SHORE CARE CENTER**
(L4) **1307 SOUTH SHORE DRIVE PO BOX 69**
(L5) **WORTHINGTON, MN** (L6) **56187**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 07/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(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
June 26, 2014

Ms. Barbara Atchison, Administrator
South Shore Care Center
1307 South Shore Drive PO Box 69
Worthington, Minnesota 56187

RE: Project Number S5596024

Dear Ms. Atchison:

On June 13, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
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 July 23, 2014, 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 July 22, 2014 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 September 13, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 13, 2014 (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
Division of Compliance Monitoring
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) 215-0541

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
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
	245596	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		7/10/14

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

Electronically Signed | 07/04/2014

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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	245596	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required notices upon termination of all Medicare part A skilled services for 3 of 3 residents (R51, R11 and R3) who met the qualification to receive Medicare services and were discharged from the facility. Findings include: NOTICE OF MEDICARE PROVIDER NON-COVERAGE: R51, R11, and R3 lacked evidence of receiving the Centers for Medicare and Medicaid Services (CMS) expedited decision, " Notice of Medicare Provider Non-Coverage" notice prior to discharge from Medicare services.	F 156	It is the facility's policy to provide the required notices to residents related to coverage and/or termination of Medicare Part A skilled services. There were no negative outcomes related to coverage or termination notices. The facility policy and procedure for providing appropriate notices, instructions and decisions have been reviewed and revised. CMS approved forms are now being used. Staff who is responsible for providing liability notices will be in-serviced on 7/10/14 to insure that requirements are met. The Director of Nursing will be responsible for training and auditing staff	

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F 156	Continued From page 3 R51 was discharged from Medicare on 4/10/14, due to electing hospice benefits, according to document review of R51's Skilled Nursing Facility Determination on Continued Stay. R51 used 10 Medicare days, according to resident liability notice list provided by the facility. R51 remained in the facility. The facility lacked evidence of providing R51 with the Centers for Medicare and Medicaid (CMS) expedited decision, "Notice of Medicare Provider Non-Coverage" which included instructions on how to contact the Quality Improvement Organization (QIO), an independent reviewer authorized by Medicare to review the facility decision to discharge from Medicare. R11 was discharged from Medicare on 10/29/13, due to lack of skilled nursing or rehabilitation progress, according to document review of R11's Skilled Nursing Facility Determination on Continued Stay. R11 used 8 Medicare days, according to resident liability notice list provided by the facility. R11 remained in the facility. The facility lacked evidence of providing R11 with the Centers for Medicare and Medicaid (CMS) expedited decision, "Notice of Medicare Provider Non-Coverage " which included instructions on how to contact the Quality Improvement Organization (QIO), an independent reviewer authorized by Medicare to review the facility decision to discharge from Medicare. R3 was discharged from Medicare on 5/29/14, due to lack of skilled nursing or rehabilitation progress, according to document review of R3's Skilled Nursing Facility Determination on Continued Stay. R3 used 29 Medicare days, according to resident liability notice list provided by the facility. R3 remained in the facility. The facility lacked evidence of providing R3 with the	F 156	compliance and provide the results of audits at the next Quality Assurance Committee meeting scheduled for 7/28/14. The QA Committee will determine if further interventions or monitoring are necessary.	

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F 156	Continued From page 4 Centers for Medicare and Medicaid (CMS) expedited decision, "Notice of Medicare Provider Non-Coverage" which included instructions on how to contact the Quality Improvement Organization (QIO), an independent reviewer authorized by Medicare to review the facility decision to discharge from Medicare. During interview on 6/13/14, at 1:59 p.m., registered nurse (RN)-C verified the facility lacked evidence of providing the "Notice of Medicare Provider Non-Coverage" for R51, R11, and R3. CENTERS FOR MEDICARE AND MEDICAID SERVICES SKILLED NURSING FACILITY ADVANCED BENEFICIARY NOTICE OR DENIAL LETTERS: R51 and R3 did not receive the approved CMS denial letter prior to discharge from Medicare services. The facility did not use the Centers for Medicare and Medicaid Services (CMS) approved Skilled Nursing Facility Advanced Beneficiary Notice or one of the five denial letters available on the Centers for Medicare and Medicaid (CMS) website. The CMS notice asked residents if they would want their bill submitted to Medicare or not submitted for review. The denial letter provided by the facility titled "Skilled Nursing Facility Determination on Continued Stay " lacked the following required information according to the CMS website: "This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for	F 156		

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F 156	Continued From page 5 the services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal." R51 was discharged from Medicare on 4/10/14, due to electing hospice benefits, according to document review of facility Skilled Nursing Facility Determination on Continued Stay. R51 used 10 Medicare days, according to resident liability notice list provided by the facility. R51 remained in the facility. Although the facility provided R51 with the Skilled Nursing Facility Determination on Continued Stay notice, the notice lacked instructions on submitting the facility bill to Medicare for review. R3 was discharged from Medicare on 5/29/14, due to lack of skilled nursing or rehabilitation progress, according to document review of R3's Skilled Nursing Facility Determination on Continued Stay. R3 used 29 Medicare days, according to resident liability notice list provided by the facility. R3 remained in the facility. Although the facility provided R3 with the Skilled Nursing Facility Determination on Continued Stay notice, the notice lacked instructions on submitting the facility bill to Medicare for review. During interview on 6/13/14, at 1:59 p.m., RN-C, verified these were the denial letters provided to R51 and R3. DENIAL LETTERS LACKED DECISION TO SUBMIT OR NOT SUBMIT BILL TO MEDICARE:	F 156		

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F 156	Continued From page 6 R51 was discharged from Medicare on 4/10/14, due to electing hospice benefits, according to document review of facility Skilled Nursing Facility Determination on Continued Stay. R51 used 10 Medicare days, according to resident liability notice list provided by the facility. R51 remained in the facility. Although the facility provided the Skilled Nursing Facility Determination on Continued Stay, the facility lacked evidence of R51's decision to submit or not submit the bill to Medicare. R11 was discharged from Medicare on 10/29/13, due to lack of skilled nursing or rehabilitation progress, according to document review of facility Skilled Nursing Facility Determination on Continued Stay. R11 used 8 Medicare days, according to resident liability notice list provided by the facility. R11 remained in the facility. Although the facility provided the Skilled Nursing Facility Determination on Continued Stay, the facility lacked evidence of R11 decision to submit or not submit the bill to Medicare. During interview on 6/13/14, at 1:45 p.m., accounts receivable (AR)-G stated she received the denial notice only if the decision was marked to submit the bill. During interview on 6/13/14, at 1:59 p.m., director of nursing verified R51 and R11, facility Skilled Nursing Facility Determination on Continued Stay lacked decision to submit or not submit the bill to Medicare for review. Director of nursing identified RN-C was responsible for the denial letters. During interview at that time, RN-C verified the lack of decision to submit or not submit the bill.	F 156		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	F 244		7/22/14

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F 244	Continued From page 7 When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review, the facility failed to ensure resident council concerns related to timely answering of call lights were addressed with a good faith attempt to be resolved. This also included family and resident interviews for 12 of 42 residents (R33 ' s family member [F-A], R27, R58, R1, R8, R78, R4, R75, R66, R3, R34 and R28) in the facility. Findings include: Resident Council Minutes were reviewed for April, May, and June 2014. Each monthly meeting minute ' s had old business related to call lights not being answered. The April minutes indicated the director of nursing (DON) stated that she would do audits and look for patterns. Meeting minutes of 5/7/14 and 6/4/14 documented current concerns related to call lights not being answered in a timely manner. The 6/4/14 meeting minutes indicated there were no specific times or patterns noted by the residents themselves but stated at times they noted a 40 minute wait for assistance. During an interview on 6/13/14 at 11:00 a.m. the social worker (SW)-A reviewed previous Resident Council Minutes and stated that in February 2014 a discussion of call lights was noted under old	F 244	It is the policy of the facility to insure that Resident Council concerns are addressed in a timely manner with a good faith attempt to be resolved. There were no negative outcomes related to extended response to call lights. The Resident Council meets monthly. Minutes of the previous month's meeting are reviewed and residents are asked if recommendations have been followed up on. The next Resident Council meeting is scheduled for July 10, 2014. The agenda will include call light response time with the goal of agreeing to a mutually acceptable expectation of call light response time. The facility will review call light response times weekly using the Arial call light reporting system. Response time greater than the goal established by the Resident Council will be investigated and addressed with staff and residents by the Director of Nurses. The Director of Nursing is responsible for monitoring for compliance. The Director of	

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F 244	Continued From page 8 business. R33's family member (FM)-A was interviewed on 6/10/14 at 2:42 p.m. and stated that it could take half an hour for her mother to have the call light answered and receive help. Review of R33's quarterly minimum data set (MDS) dated 4/8/14 revealed R33 required extensive assistance with activities of daily living. R27 was interviewed on 6/10/14 at 2:41 p.m. and stated he would have to wait up to 20 minutes for someone to answer the call light. Review of R27 ' s quarterly MDS dated 5/27/14 revealed R27 had diagnoses of dementia, anxiety, and depression and required extensive assist with activities of daily living. R58 was interviewed on 6/10/14 at 9:18 a.m. and stated sometimes had to wait a while and that it had been an hour or so. R58 felt the evenings were worse around the time R58 wanted to go to bed. R1 was interviewed on 6/10/14 at 8:46 a.m. and stated that she has had to wait for up to 30 minutes for someone to come to answer the call light. R1 added if a nursing assistant was giving a bath, some nurses would not answer the call lights. Review of R1's quarterly MDS dated 3/25/14 revealed R1 had heart failure and required extensive assistance with activities of daily living. R8 was interviewed on 6/10/14 at 8:50 a.m. R8 stated that she has had to wait as long as an hour in the bathroom and knew that staff didn't mean to do that, but it happened. Usually happened in the morning when getting up and dressed for the	F 244	Nursing will audit call light response times 3 times a week for the next 30 days, determine the cause for extended response times and meet with staff and residents to achieve a mutually acceptable solution. The results of audits will be reviewed by the Quality Assurance Committee at its next quarterly meeting scheduled for 7/28/14. The QA Committee will determine if further interventions or monitoring are necessary.	

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F 244	Continued From page 9	F 244		

day. R8 added an hour was a long time to sit in there (referring to the sitting on the toilet for an hour.) Review of R8's 5 day MDS dated 4/18/14 revealed R8 had diagnoses of anxiety, depression, and history of urinary tract infections and required extensive assistance with activities of daily living.

The facility provided the call light audit report for 6/11/14 and the report indicated a total of 232 call lights had been alarmed and cleared between 12:00 a.m. and 11:59 p.m. on 6/11/14. The report indicated an average answer time on 4 and ¾ minutes; however, 13 or 5.6% of the time the alarm sounded greater than 20 minutes before responded to. The longer waits did not have a time of day patterns and occurred for residents in their rooms, in the bathroom, or on the patio.

R33 was designated on the call light report indicated R33 waited 26 minutes on one occasion on 6/11/14. This occurred during the middle of the afternoon. Review of R33's quarterly minimum data set (MDS) dated 4/8/14 revealed R33 required extensive assistance with activities of daily living. On 6/12/14 from 7:55 a.m. to 10:10 a.m. R33 was observed sitting in a recliner, but would not respond when spoken too. At 10:10 a.m. she was noted to be sleeping in the chair. The care conference review dated 4/22/14 indicated R33 required assist of one for transfers and mobility.

R78 was designated on the call light report which indicated that R78 waited 20 to 27 minutes on two occasions. The report indicated the alarms were turned on both in the morning and in the evening. R78 was observed on 6/12/14 at 8:00 a.m. lying in bed. The care plan dated 5/31/14 indicated

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R78 required physical assistance from staff to sit up in bed and assistance to boost up in bed. On 6/13/14 at 3:00 p.m. R78 stated that " they always answer the light" but added sometimes it takes a long time. R78 stated that she had been a director of nursing and had Parkinson's disease.

R4 was designated on the call light report indicated R4 experienced a long wait of 21 minutes on 6/11/14. R4's significant change MDS dated 5/22/14 indicated R4 had arthritis and required extensive assistance with activities of daily living.

R75 was designated on the call light report and also shared a companion room with R4. The call report indicated R75 had a call light alarm on for 27 minutes. R75 ' s significant change MDS dated 4/11/14 indicated R75 experienced pulmonary disease and impaired vision and required extensive assistance with activities of daily living. The call light audit report also indicated the bathroom shared by R75 and R4 had a call light alarmed for 30 minutes.

R66 was designated on the call light audit report dated 6/14/14 indicated R66 had to wait 23 minutes for the call light to be answered. R66 had an admission MDS dated 5/12/14 that indicated R66 had diagnoses that included cardiac issues, arthritis, and hip fracture. The MDS also indicated R66 required extensive assistance with activities of daily living.

R3 was indicated on the call light audit report indicated R3 had call light waits of 28 and 33 minutes and also bathroom call light waits of 19 and 32 minutes. R3 ' s 30 day PPS MDS dated

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F 244	Continued From page 11 5/9/14 indicated R3 required extensive assistance with activities of daily living and had diagnoses that included stroke and hemiplegia. R34 was indicated on the call light audit report of 6/11/14 indicated R34 waited 34 minutes for the call light to be answered. R34 was observed on 6/10/14 at 9:50 a.m. and 10:55 a.m. lying in bed. The bed was in a low position, the mattress was lipped, and a fall mat was on the floor. At 11:20 a.m. the nursing assistant (NA) - F stated staff needed to anticipate R34 ' s needs since R34 did not speak English. The quarterly MDS dated 4/18/14 indicated R34 required extensive assist with activities of daily living. R28 was included on the call light report and had experienced call lights wait times that ranged from 23 to 34 minutes. The quarterly MDS dated 4/29/14 indicated R28 had anxiety disorder and required extensive assistance with activities of daily living. The director of nursing (DON) was interviewed on 6/13/14 at 9:15 a.m. DON stated she felt the call light should be answered within the first 10 minutes. She indicated she was aware of the resident concerns related to call lights not being answered for long periods of time and had done some audits. The only audit she could locate was completed in April 2014 and that audit identified longer answering response in the evening. The DON stated the facility had a system in place to identify residents that had complained about call light answering to alert staff of the problem. The DON also stated that after 5 minutes the nurse and then the supervisor would be alerted to the call light alarmed and they should then be responsible to answer the resident's call light.	F 244		

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F 244	Continued From page 12 At 9:57 a.m. on 6/13/14 the registered nurse (RN)-C clinical manager indicated that she would receive an audible page for a call light not answered after 5 minutes. RN-C would then audibly page a nursing assistant of the need to answer the call light. The pager system would keep notifying RN-C until the call light was answer. RN-C stated she would sometimes answer the call light if she was not busy. The social worker (SW)-A was interviewed on 6/13/14 at 11:00 a.m. She indicated the resident council complaint process would be for the department heads to investigate and respond. SW-A stated that in June 2014 a more in depth audit would need to be completed with more staff members having access to the call light audit system.	F 244		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		7/10/14

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	245596	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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F 280	Continued From page 13 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include current fall interventions and mobility status for 1 of 3 residents (R51) reviewed for accidents. Findings include: R51 had been observed lying in bed and a floor mat had been on the floor beside the bed on 6/10/14, at 8:34 a.m. On 6/12/14, at 7:41 a.m., R51 had been observed lying in bed and a floor mat had been on the floor beside the bed. On 6/12/14, at 9:52 a.m., nursing assistant (NA)-F and NA-A had transferred R51 from wheelchair to bed and had used a Hoyer mechanical lift to transfer R51. At time of observation a tab alarm had laid on R51's night stand and a lipped mattress had been on R51 ' s bed. R51 had been admitted on 8/1/12. R51's physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, hypertension and treatment order with order date of 3/5/14, Hoyer transfers for all mobility. R51 ' s significant change Minimum Data Set	F 280	It is the policy and procedure of the facility to revise care plans to include current status and interventions. The Interdisciplinary Team (IDT) is responsible for periodic review and updating of the residents' plans of care when there is a change in condition, when a desired outcome is not reached, when the resident has been readmitted to the facility and at least quarterly. R-51. The comprehensive plan of care was revised on 6/17/14 to reflect interventions incorporated related to potential for falls associated with cognitive impairment,weakness, and mobility deficit. The facility will review the policy on comprehensive care plan development and revision with staff at an in-service on 7/10/14. The Director of Nursing is responsible for monitoring for compliance. The results of monitoring will be provided to the Quality Assurance Committee at its next quarterly meeting scheduled for 7/28/14. The QACommittee will determine if further interventions or monitoring are necessary.	

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F 280	Continued From page 14 (MDS) dated 4/15/14, identified ambulation: none occurred in room /corridor and extensive assist of two for transfers. Review of R51's medication administration record dated 6/1/14 to 6/30/14, identified Hoyer transfers with A-Z for all mobility, start date of 3/5/14 and nights, a.m. and p.m. shifts signing for treatment. Review of the facility untitled page dated 4/22/14, provided by the facility identified subject; resident profile for R51, remember to always engage the self-release belt, do not leave resident unattended in room in wheelchair. R51's current care plan dated 11/19/13, identified problem self-care deficit: walking evidenced by needs assist of two for all ambulation with approaches of walk with therapy with assist of one and gait belt, remind resident when therapy is scheduled, assist in transfer of resident to therapy in wheelchair as needed and monitor for continued safety walking; two assist with gait belt. Problem potential for falls related to cognitive impairment, weakness, mobility deficit with interventions keep call light/bell within easy reach, respond promptly, tabs (no specification on where tabs to be), remind resident to request help if wants to get up, ambulate per therapy recommendation, encourage resident to wear glasses during waking hours and for all transfers and walking, toilet resident as requested and as scheduled, administer medications as ordered and monitor side effects, night light in room at night, 11/24/13 monitor location Arial alarm, 1/30/14 self- releasing seat alarm to wheelchair, is able to open seat belt with instruction, 5/9/14 toilet, check and change at 10:00 p.m.	F 280		

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F 280	Continued From page 15	F 280		

However the current care plan dated 11/19/13, had not identified R51 required Hoyer transfers with A-Z for all mobility, R51 is non-ambulatory, no specification regarding placement of tab alarm, mat on floor beside bed when R51 is in bed, lipped mattress, do not leave unattended in bathroom and room when in wheelchair.

During interview on 6/11/14, at 2:56 p.m., registered nurse (RN)-C had verified R51's current plan of care had no documentation regarding transfers and verified R51 is transferred with a Hoyer mechanical lift and two assist.

During interview on 6/12/14, at 9:56 a.m., NA-F had stated when asked what fall interventions were for R51, safety belt on wheelchair, tab alarm on bed, mat on floor, bed low position, lipped mattress and cannot leave alone in room.

During interview on 6/13/14, at 8:34 a.m., RN-C had stated interventions of fall mat had been started on 8/23/13, tab alarm for bed had started on 11/25/13 and do not leave unattended in bathroom and room when in wheelchair had started on 11/25/13.

During interview on 6/13/14, at 12:07 p.m., director of nursing stated would expect care plan be revised when make adjustments in care needs for resident, needs to be care planned.

Document review of the facility COMPREHENSIVE CARE PLAN DEVELOPMENT AND REVISION dated 9/13/13, read "Procedure: 7. The Unit Resident Care Coordinator will be accountable to insure that each resident plan of care accurately reflects the

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F 280	Continued From page 16 individualized needs of the resident. "	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan fall and toileting interventions for 1 of 3 residents (R51) reviewed for accidents. Findings include: R51 had been sitting in wheelchair in room at the end of the C unit and R51 ' s self-release belt on R51 ' s wheelchair had been hanging behind the back of R51 ' s wheelchair unattached during observation on 6/11/14, at 1:35 p.m. This surveyor informed staff person nursing assistant (NA)-A. NA-A at the time stated the self-release belt was used for an alarm so staff knows when R51 was trying to stand, and had been discontinued. Surveyor asked NA-A how changes are communicated and NA-A had replied through the communication book, Kiosk in computer and nursing assistant daily worksheet. NA-A verified at the time nursing assistant daily worksheet identified alarms, self-release belt for R51. At 1:48 p.m., NA-A had stated the self-release belt for R51 is to be in place and had not been stopped from being used.	F 282	It is the policy and procedure of the facility to implement individualized care plans for each resident. The IDT is responsible for periodic review and updating of the residents' plans of care when there is a change in condition, when a desired outcome is not reached, when the resident has been readmitted to the facility and at least quarterly. R-51 comprehensive plan of care was revised on 6/17/14 to reflect interventions incorporated related to potential for falls associated with cognitive impairment,weakness, and mobility deficit. Placement of the self-release seat belt while up in the wheelchair and released during supervised activities was implemented to alert staff to unsafe independent movements and avoid potential for recurrent falls associated with this resident diminished cognition. The nursing assistant assignment sheets provide staff education as to the	7/10/14

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F 282	Continued From page 17 During continuous observation on 6/12/14, at 8:28 a.m., R51 sitting in wheelchair in room end of C unit, 8:46 a.m., staff person had been assisting R51 to eat breakfast at table in room end of C unit, 8:49 a.m., R51 remains sitting at table in room end of C unit, breakfast tray had been removed. At 9:09 a.m., R51 remains the same. At 9:20 a.m., R51 remains the same. At 9:52 a.m., NA-F approached R51 and asked R51 if wanted to lie down in bed, NA-F and NA-A had transferred R51 from wheelchair to bed and had used a Hoyer mechanical lift to transfer R51. At time of observation a tab alarm had laid on R51 ' s night stand. NA-F had stated at the time when asked what fall interventions were for R51, safety belt on wheelchair, tab alarm on bed, mat on floor, bed low position, lipped mattress and cannot leave alone in room. NA-F had left R51's room after R51 had been transferred into bed. NA-A proceeded to check incontinent product R51 had in place and stated the incontinent product was dry. NA-A placed call light in reach of R51, put be in low position and placed fall mat on floor beside bed. Tab alarm remained placed on night stand and NA-A had shut light off in room and walked out of R51's room. Surveyor intervened at the time and asked NA-A if the Tab alarm was to be on R51 when in bed. NA-A stated if I had seen one I would have hooked it to resident, NA-A checked R51's bed and stated I do not see an alarm for bed. Surveyor intervened and asked NA-A about the tab alarm sitting on R51's night stand and NA-A verified at the time tab alarm should be on R51 when in bed. R51's physician orders dated 5/7/14, identified diagnoses of but not limited to dementia and hypertension. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified toilet	F 282	self-release belt when up in wheelchair and may release during supervised activities. The assignment sheet also has been coded that R-51 is a fall risk and not to be left alone in wheelchair in room. Care plan was updated 6/17/14 to reflect R-51 individualized toileting needs. Nursing assistant assignment sheets were updated to reflect need to offer toileting before and after meals, upon rising, and pm to promote maximum urinary continence. The facility will provide in-service education to responsible staff on 7/10/14 to review the necessity of following each resident's comprehensive plan of care. Unit charge nurses are responsible for monitoring for compliance. The results of monitoring will be provided to the Quality Assurance Committee at its next quarterly meeting scheduled for 7/10/14. The QA Committee will determine if further interventions or monitoring are necessary.	

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F 282	Continued From page 18 extensive assist of two. R51's current care plan dated 11/19/13, identified problem potential for falls related to cognitive impairment, weakness, mobility deficit with interventions of but not limited to keep call light/bell within easy reach, tabs, toilet resident as requested and as scheduled, 1/30/14 self-releasing seat alarm to wheelchair, is able to open seat belt with instruction. Problem potential for alteration in urinary elimination, r/t urinary retention and recent removal of long time indwelling catheter with interventions of but not limited to initiate voiding schedule to coordinate with intake: i.e. after meals. Problem incontinent of bowel related to cognitive impairment, loss of sphincter control, goal bowel management program: R51 will show improved bowel continence evidenced by fewer episode of bowel incontinence with interventions of but not limited to assist to commode or toilet after each meal and as needed. Document review of the facility untitled page dated 4/22/14, provided by the facility identified subject; resident profile for R51, remember to always engage the self-release belt. During interview on 6/11/14, at 2:23 p.m. licensed practical nurse (LPN)-C had stated R51 is supposed to have the self-release belt in place when R51 is in wheelchair. During interview on 6/12/14, at 10:12 a.m., NA-A had verified toilet had not been offered to R51 when NA-A had checked R51 ' s incontinent product. During interview on 6/13/14, at 8:34 a.m., RN-C	F 282		

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F 282	Continued From page 19 had stated interventions of tab alarm for bed had started on 11/25/13. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated would expect to offer the toilet, tab alarm and self-release belt to be in place as that is part of R51's plan of care. Policy regarding following the care plan had been requested at the time and none had been provided.	F 282		
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 ensure nail care was provided for 2 of 3 residents (R76, R51) reviewed for activities of daily living and failed to remove facial hair for 1 of 1 residents (R66) reviewed in the sample with facial hair. Findings include: LACK OF NAIL CARE: R76 was observed on 6/10/14, at 8:57 a.m., and R76 ' s finger nails were long and soiled. Again on 6/12/14, at 8:20 a.m., R76 finger nails were observed to be untrimmed and soiled under the nails.	F 312	It is the facility's policy that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #76 and #51 were provided nail care immediately upon identification that nail care had not been provided. Resident #66 had her facial hair removed by staff as requested by the resident during interview by Director of Nursing. The facility procedure for personal grooming was reviewed and revised on	7/10/14

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F 312	Continued From page 20 R76 ' s admission Minimum Data Set (MDS), an assessment dated 4/17/14, revealed R76 had moderate cognitive impairment and required extensive assistance from one staff for personal hygiene. R76 ' s care plan dated 4/25/14, directed staff that R76 had self-care deficit with interventions that included extensive assist of 1-2 staff for personal hygiene During interview on 6/12/14, at 1:58 p.m., director of nursing verified the untrimmed and soiled finger nails. Director of nursing stated she expected staff to provide nail care daily and to ensure nails were clean. Also R76 was interviewed at 6/12/14 at 2:00 p.m. and said that they would like staff to trim their finger nails. During interview on 6/13/14, at 11:08 a.m., nursing assistant-B (NA-B) stated she cleaned and trimmed finger nails on bath day and as needed. Document review of facility Care of Fingernails/Toenails policy dated revised 4/07, read, "Purpose The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections." "General Guidelines 1. Nail care includes daily cleaning and regular trimming." R51 was observed on 6/10/14, at 10:22 a.m., and noted to have untrimmed fingernails. This was also observed on 6/11/14, at 9:04 a.m. and again on 6/11/14, at 1:35 p.m. During observation on 6/13/14, at 8:20 a.m.,	F 312	6/19/14. Staff will now document on the skin care alert document that nail care (personal grooming) was provided. The updated procedure for personal grooming will be reviewed with responsible staff at an in-service on 7/10/14. Unit charge nurses are responsible for monitoring for compliance. The Director of Nursing will randomly audit through rounding on nursing units to insure that necessary services to maintain good grooming are provided with resident cares. The results of monitoring will be provided to the Quality Assurance Committee at its next quarterly meeting scheduled for 7/28/14. The QA Committee will determine if further interventions or monitoring are necessary.	

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F 312	Continued From page 21 nursing assistant (NA)-B had stated no, when asked if R51 ' s fingernails appear trimmed. R51 had been admitted on 8/1/12. R51 ' s physician orders dated 5/7/14, identified diagnoses of but not limited to dementia and hypertension. R51 ' s significant change Minimum Data Set (MDS) dated 4/15/14 identified personal hygiene extensive assist of one person. R51's current care plan dated 11/19/13, identified problem self-care deficit personal hygiene related to impaired mobility, evidenced by needs daily help from another person with personal hygiene with interventions of but not limited to: nail care done each week by bath aide after 6, provide verbal cues as needed. Document review of facility bath sheet dated 6/3/14, identified R51's bath day Wednesday at 1:30 p.m. and identified R51 had received a whirlpool bath on 6/11/14, at 12:16 p.m. During resident interview on 6/13/14, at 9:21 a.m., R51 had stated regarding fingernails, the length is o.k., but the edges are sharp, feel them. I would like them trimmed. Surveyor at the time observed fingernails to be uneven with jagged edges. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated fingernails should be trimmed weekly on bath days at least and as needed, if resident is resistive to cares should come back, if refuses should chart refusal of care. FACIAL HAIR: R66 was observed on 6/12/14, at 8:05 a.m., with	F 312		

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F 312	Continued From page 22 approximate ½ inch to one inch long chin hairs, neatly dressed and eating breakfast in the dining room. During interview at that time, R66 stated she was already dressed and her cares were done for the day. R66 ' s admission Minimum Data Set (MDS), an assessment dated 5/12/14, revealed R66 had no cognitive impairment and required extensive assist of one staff for personal hygiene. Document review of the facility resident care plan dated 5/22/14, directed staff that R66 had self-care deficit and needed daily help from another person for personal hygiene. During observation and interview on 6/12/14, at 2:00 p.m., director of nursing verified R66 ' s long chin hairs. Director of nursing stated she expected staff to shave female facial hair daily or as needed. During interview on 6/12/14 at 2:02 p.m. R66 stated would like staff to remove chin hairs. During interview on 6/13/14, at 11:08 a.m., nursing assistant-B (NA-B) stated she shaved women with morning cares and on bath day.	F 312		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		7/10/14

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F 325	Continued From page 23 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to reassess a resident with significant weight loss for 1 of 1 resident (R41) discharged residents reviewed for nutrition. Findings include: R41 was admitted to the facility on 3/19/14 and discharged on 6/10/14 to the hospital. The care plan printed 4/2/14 indicated multiple sites of cancer, diabetes, hyperlipidemia, pain, foot ulcer. R41 weighed 174 pounds on 3/19/14, on 6/2/14 weighed 153 pounds or a loss of 21 pounds (12%) in about 6 weeks. Physician orders signed 5/20/14 indicated the resident had medications of lopid for hyperlipidemia, metformin and insulin for diabetes and house supplement. On 3/18/14 the facility obtained a telephone order for 1800 calorie American Diabetic Association (ADA) diet. On 3/26/14 the dietary progress note indicated R41 received a low concentrated sugar diet and his ideal body weight range was 149 to 183 pounds. The note indicated R41 was eating 95% of the meals, had no chewing or swallowing problems, and that dietary would monitor R41's weight, intakes, and labs. The admission Minimum Data Set (MDS) dated	F 325	It is the facility's policy to maintain acceptable parameters of nutritional status, such as body weight and protein levels;unless the resident's clinical condition demonstrates that this is not possible. R-41 was admitted to the facility on 3/19/14 and a nutritional assessment was completed by dietary consultant on 4/8/14 at which time R-41's "weight was identified as stable. Continue to monitor." Resident condition was determined to be declining on 5/20/14 during routine primary care physician (PCP)visit. On 5/30/14 weight loss was identified. A fax was sent to the PCP on 6/3/14 to communicate dietitian's recommendation to implement glucerna 2oz. bid with med pass. PCP approved recommendation. A comprehensive weight loss assessment tool was completed for R-41 on 7/1/14. Correspondence to the PCP regarding his explanation for significant weight loss was received and noted on 7/1/14 to indicate significant weight loss is result of multiple neoplasms and anticipated. The facility's policy on weight loss will be reviewed with staff at an in-service on 7/10/14. Focus will be on the importance of maintaining acceptable parameters of	

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F 325	Continued From page 24 3/26/14 noted R41 had a BIMS (brief interview of mental status) of 12 or impaired cognitive status. On 3/31/14 the Care Area Assessment for nutritional status noted: risk related to decreased intake and non-compliance to diet. On 4/8/14 the dietitian consulting report noted no nutritional concerns at this time. On 5/7/14 the facility notified the physician of an unstageable wound area on the coccyx, but not that the resident had lost 8 pounds the previous month. The physician recommended house supplement to increase protein intake. On 6/2/14 the dietitian consulting report noted recommend arginade, power potatoes and supplement with med pass. The dietitian did not indicate R41 had experienced a significant weight loss of 21 pounds (from 3/19/14 to 6/2/14) and now at the bottom of his ideal weight range nor that the resident had an open ulcer. There was no comprehensive weight loss assessment completed to determine the appropriate interventions for R41. Resident care plan printed 4/2/14 identified a problem of nutrition dated 3/26/14 with a goal of eat 75% of meals, maintain weight, and feed self. The plan include diet 1800 ADA and dietary supplements as ordered by physician, weight monthly, offer snacks TID Register nurse (RN)-D clinical care manager was interviewed on 6/13/14 at 12:20 p.m. and stated she was unsure why the resident had a significant weight loss. The dietary manager (DM) was interviewed on 6/13/14 at 1:07 p.m. DM indicated the resident	F 325	nutritional status such as body weight, and protein levels unless the resident's clinical condition demonstrates that this is not possible. The Resident Care Coordinators and members of the Risk Management Committee will be responsible to monitor for facility compliance with regards to weight loss. Reports of resident weight loss will be reviewed at the quarterly QA meetings. The next QA meeting is scheduled for 7/28/14. "The QA Committee will determine if further interventions or monitoring are needed.	

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F 325	Continued From page 25 received a room tray with a low concentrated sweets diet. The dietary department would give R41 power potatoes (cream cheese, protein powder, butter) every day at noon. DM stated R41 would also receive protein pudding for snacks or a shake. DM stated she was aware of R41 ' s weight loss because she monitored the weights in the computer system weekly. DM added the resident clinical care manager would notify the physician of the weight loss. DM stated that usually an unplanned weight loss sheet would be completed that included possible causes of weight loss and intakes, but could not find it for R41. DM stated that she was behind on her documentation related to resident changes. DM stated she thought the physician was notified of the significant weight loss.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		7/10/14

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F 329	Continued From page 26 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to attempt a gradual dose reduction of antipsychotic medication and/or reduction of psychotropic medication for 1 of 5 residents (R40) reviewed for unnecessary medication use; failed to clearly identify indications (resident specific signs and symptoms) for use of an antianxiety medication for 2 of 5 residents (R8, R51) reviewed for unnecessary medication use. Findings include: R40 was admitted to the facility 4/23/09, and had diagnosis that included anxiety/psychosis and depression, according to physician orders signed 5/20/14. The facility identified R40 on the annual Minimum Data Set (MDS), an assessment dated 4/22/14, to have no cognitive impairment, no moods, no behaviors, and received antipsychotic, antianxiety, and antidepressant medications. Document review of the resident care plan dated 5/12/09, directed staff R40 had problem of potential for side effects of psychotropic medications, with interventions that included monitor for side effects, monitor behavior each	F 329	It is the facility's policy that each resident's drug regimen be free from unnecessary drugs. Those being drugs used in excessive dose, excessive duration, without adequate monitoring, without adequate indications, in the presence of adverse consequences, or any combination of these reasons. R-40 receives Lorazapam, Sertraline, and Seroquel for diagnosis of obsessive compulsive disorder, major depressive disorder, psychosis and anxiety. These medications are managed by the Veteran's Administration (VA) psychiatrist. On 4/16/14 the facility contacted the VA psychiatrist regarding the consulting pharmacist's recommendation for gradual dose reduction (GDR) of psychotropic medications. The physician's response was that "patient needs to continue current medications, as reduction done in the past made recurrence in his anxiety, inability to function, with decompensation." The VA was contacted again on 6/13/14 and the psychiatrist indicated R-40 was stable on current medications, no indication for	

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F 329	Continued From page 27 shift and document. Resident care plan dated 5/12/09, revealed problem potential for mood alteration, with interventions that included monitor key times for triggering increased behavior. During observations on 6/10/14, at 9:55 a.m., R40 was observed to wheel self independently to a group activity. No moods or behaviors were observed. Observations on 6/10/14, at 12:30 p.m., R40 was independently eating lunch in the dining room. No moods or behaviors were observed. During resident interview on 6/10/14, at 12:45 p.m., no moods or behaviors were noted or observed. Document review of physician orders signed dated 5/20/14, revealed orders for lorazepam (Ativan) 0.25 milligrams every bedtime for anxiety, order date of 3/25/11; zoloft 200 milligrams every morning for depression, order date of 11/16/10; and Seroquel (psychotropic) 450 milligrams every bedtime for anxiety/psychosis, order date of 11/15/11. Document review of facility medication administration record for 5/1/14 to 5/31/14 and 6/1/14 to 6/11/14, revealed R40 received Ativan, Zoloft and Seroquel as ordered. During interview on 6/11/14, at 2:22 p.m., social services (SS)-A stated she reviewed mood and behavior monitoring weekly with the clinical managers and reviewed facility risk management team documentation with the team monthly. SS-A identified the following moods monitored included depression, anxiety and sleep disturbance. SS-A stated R40 had no target behaviors and no monitoring of behaviors. SS-A stated if R40 had	F 329	change. "He needs to be on current dose of medications, previous attempts of dose reduction resulted in severe deterioration. Patient and his family are fully aware of his condition and they "do not want any changes in his meds, as he tolerates them well, and denies any side effects." Based on documentation from the VA, GDR (gradual dose reduction) is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder. R-40 psychotropic medications are managed by the VA psychiatrist who has been monitoring this resident for a long time and has twice in the last two months provided documentation that GDR is clinically contraindicated. R-40's current medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or collaboration of physicians. R-8 had orders for Lorazepam 1 mg tid pm. Resident had no specific behaviors identified for use of Lorazepam. Antianxiety medication was reviewed by resident's primary physician on 6/23/14 with orders to discontinue this medication. Primary physician also reviewed antidepressant medications (Trazadone and Cymbalta) used for management of major depressive disorder and indicated that GDR of these medications is not justified at this time due to likelihood of recurrence of symptoms. R-8's medical diagnoses include depressive disorder.	

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F 329	Continued From page 28 behaviors, then they would monitor the behaviors. SS-A stated the monitoring of moods included nursing assistant documentation every shift in the facility computer system. SS-A verified every shift mood monitoring according to the mood symptoms detail report from 12/1/13 to 6/11/14, revealed there were no moods. Document review of facility social services charting assessment annual dated 4/22/14 identified the following: no incidents of depression and sleep disturbance in past 14 days and no behavioral issues. Document review of facility brief interview for mental status(BIMS) dated 10/22/13, revealed a score of 15/15-cognition intact, patient health questionnaire (PHQ-9) identified score of 3, less than minimal symptoms of depression, and no behaviors. Document review of facility brief interview for mental status(BIMS) dated 1/21/14, revealed a score of 15/15-cognition intact, social services behavior assessment-no behaviors, social services mood assessment, monitored depression, anxiety, sleep disturbances with no incidents of these moods, and PHQ-9 score of 0 (no depression). Document review of facility brief interview for mental status(BIMS) dated 4/22/14, revealed a score of 13/15-cognition intact, social services behavior assessment-no behaviors, social services mood assessment-monitored depression, anxiety, sleep disturbances with no incidents of these moods, and PHQ-9 score of 0 (no depression). Document review of Doctors Orders and Progress Notes dated 4/16/14, revealed	F 329	The Director of Nursing interviewed R-8 on 6/30/14 regarding mood/depression and use of dual anti-depressant therapies. Resident indicated that she is willing to attempt discontinuation of Citalopram and a fax was sent to her physician regarding discontinuation. R-51 had orders for Ativan 0.5mg po q4hr pm anxiety/restlessness. R-51 had no specific behaviors identified and upon review R-51 had not received Ativan for over 90 days. Order was obtained to discontinue per facility policy due to nonuse. R-51 is also on an anti-depressant, however anti-depressant (Remeron) is being used for management of weight loss and used as appetite enhancement. GDR is not recommended as resident has demonstrated weight loss and attempts to manage weight loss with anti-depressant has been advised by the physician. The facility does send a request to the primary care physicians to review psychotropic medications including GDR using a document titled Psychopharmacological Medication Review. This document is completed by the Resident Care Coordinators on each unit asking for physician's response. This document was reviewed and revised to aid the primary care physicians to review residents' current treatment plans and determine if adjustments in psychotropic medications	

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F 329	Continued From page 29 consultant pharmacist request for physician to address psychopharmacological medication review. Physician response dated same day, revealed R40 needed to continue current medications as reduction done in the past made recurrence in his anxiety instability with decompensation. The following facility Psychopharmacological Medication Reviews were attached to the physician response dated 4/16/14, each with review date of 2/6/14: Lorazepam 0.25 milligrams, order date-3/25/11, diagnosis-anxiety, comments-This is minimal dose, resident does well on this dose, reduction not advised by nursing. Zoloft 200 milligrams, order date-11/16/10, diagnosis-depression, comments- resident does well on this dose, reduction not advised from nursing. Seroquel 450 milligrams every bedtime, order date- 11/15/11, diagnosis-anxiety/psychosis, comments- resident does well on this dose, reduction not recommended by nursing. During interview on 6/12/14, at 3:13 p.m., registered nurse (RN)-C stated there had been no attempts at lowering the dose of Ativan and Zoloft or a gradual dose reduction of Seroquel. RN-C verified psychopharmacological medication reviews dated 2/6/14, were written by RN-C with the comment statement on each review-Ativan, Zoloft, and Seroquel, does well on this dose and dose reduction not recommended, were written by her. RN-C verified these reviews were sent to the psychiatrist and the statement from psychiatrist dated 4/16/14, to continue current medications, was based on that review.	F 329	are justified. The Director of Nursing reviewed this assessment tool with Resident Care Coordinators on 6/27/14 to insure compliance. The facility will have an in-service on 7/10/14 and staff will be provided guidance on insuring that each resident remain free from unnecessary medication. Licensed staff will be re-educated on identifying specific behaviors for psychotropic medications prior to administration of PRN medications and requirements for documenting effectiveness after administration. Resident Care Coordinators in conjunction with the pharmacy consultant will be responsible for monitoring facility compliance. The pharmacy consultant will be responsible for reporting compliance to the Quality Assurance Committee at each quarterly meeting. The next meeting is scheduled for 7/28/14. The QA Committee will determine the need for further interventions or monitoring.	

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F 329	Continued From page 30 Document review of Psychopharmacological Medication Review with review date of " 4/1/12, " physician signed order on " 4/3/13, " to decrease Seroquel from 450 milligrams to 400 milligrams and to monitor response. Although requested, the facility was unable to provide any further information related to dose reduction of Seroquel and return to 450 milligrams dosage. During interview on 6/13/14, at 8:30 a.m., director of nursing stated she expected an attempt at gradual dose reduction of psychotropic medications or clinical justification for no attempt. R8 received three antidepressant medicaations and there was no physician justification for the use of three antidepressant medications to be used at the same time. R8 had been admitted on 10/4/13. R8's physician orders dated 4/15/14, identified diagnoses of but not limited to MDD (major depressive disorder), anxiety, nervousness, agitation and osteoarthritis. R8 ' s five day Minimum Data Set (MDS) dated 4/18/14, identified mood score of five (symptoms of depression mild), no behaviors, had received scheduled and as needed pain medication, had received non medication interventions for pain, pain present occasionally, pain limited day to day activity, pain scale rate of eight. R8 ' s brief interview of mental status (BIMS) had been 15 out of 15 on the MDS and indicated cognitively intact. During review of R8's current physician orders dated 4/15/14, revealed orders for Cymbalta (an antidepressant medication) 20 mg (milligrams) every day for MDD, start date of 10/4/13, Trazodone (an antidepressant medication) 50 mg every bedtime for MDD, start date of 10/4/13,	F 329		

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F 329	Continued From page 31 citalopram (an antidepressant medication) 20 mg every day for MDD, start date 4/11/14, lorazepam (an anti-anxiety medication) one mg three times a day as needed for anxiety/nervousness/agitation, start date 10/4/13 and hydrocodone-acetaminophen (pain medication) 5/325 mg one to two tablets every six hours as needed for osteoarthritis. R8's current care plan dated 1/8/14, identified problem mood alteration related to depression, anxiety, grief, loss of role evidenced by feeling down at times, enter long term care, feeling tired, poor appetite, anxious, difficulty with concentration at times with intervention of but not limited to give medication as ordered and monitor for side effects. Problem potential for side effects of psychotropic medication with interventions of but not limited to monitor behavior on each shift and document, monitor and document response to medication monthly. Problem potential for alteration in comfort: pain related to lower back pain, leg pain and pain all over with interventions of but not limited to assess episodes of pain and evaluate effectiveness of interventions used, document effectiveness on PRN (as needed) MAR (medication administration record) and/or in interdisciplinary notes. Review of physician progress note dated 2/25/14, identified current medications of but not limited to Ativan (lorazepam), cymbalta, trazodone, but had no documentation regarding mood. Review of Southwestern Mental Health Center Medication Management progress note dated 3/4/14, identified diagnosis depressive disorder, medications Cymbalta and trazodone and continue with Cymbalta and trazodone. The above physician progress notes had no	F 329		

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F 329	Continued From page 32 documentation regarding justification for use of Cymbalta, trazodone and lorazepam that had start dates of 10/4/13 and no documentation of physician justification regarding starting third antidepressant medication citalopram on 4/11/14. Document review of R8 ' s medication administration record dated from 5/1/14 to 5/31/14 and from 6/1/14 to 6/30/14, identified R8 had been receiving citalopram 20 mg every day, Cymbalta 20 mg every day and trazodone 50 mg every bedtime, lorazepam one mg three times a day as needed and hydrocodone-acetaminophen 5/325 mg one to two tablets every six hours as needed. Document review of R8 ' s PRN Medication sheets dated from 5/1/14 through 6/12/14, identified R8 had received as needed lorazepam eight times and reasons for giving documented had been increased anxiety/increased anxiousness/I am nervous and response had not been documented regarding effectiveness of lorazepam four out of the eight times. Hydrocodone-acetaminophen medication had been given 13 times and six out of 13 doses had no documentation of effectiveness. Document review of the facility risk management team documentations: review dates 3/19/14 had not identified medication use of Cymbalta, lorazepam and trazodone medications, review date 4/17/14 had not identified medication use of lorazepam and citalopram (interview on 6/13/14, at 11:05 a.m., social worker (SW)-A had stated medication identified as citalopram with date of 12/23/13 reviewed had been Cymbalta and had been documented incorrectly as citalopram on the facility risk management team documentation	F 329		

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F 329	Continued From page 33 dated 4/17/14) and review date of 5/14/14, had not identified medication use of lorazepam, Cymbalta and citalopram medications. During interview on 6/13/14, at 10:29 a.m., licensed practical nurse (LPN)-D verified effectiveness of lorazepam and hydrocodone-acetaminophen medications had not been documented and verified reason documented for giving lorazeapm had been increased anxiety/anxiousness, however, resident specific anxiety symptoms not clearly identified when Ativan was given. LPN-D verified R8's care plan had no specific behaviors in regards to lorazepam medication use other than the word anxiety is documented on the care plan. During interview on 6/13/14, at 11:05 a.m., social worker (SW)-A had stated it is up to the resident care coordinator to bring all information to risk management meetings regarding medications a resident is receiving. SW-A verified the risk management team had not reviewed the use of citalopram and lorazepam for R8 and verified the risk management team had not identified specific resident symptoms of anxiety, nervousness and agitation related to lorazepam medication use. SW-A reviewed R8's chart and verified there had been no physician justification documented regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8's physician progress notes. During interview on 6/13/14, at 11:23 a.m., registered nurse (RN)-C verified there had been no physician justification documented regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8 ' s physician progress notes, just the diagnoses.	F 329		

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F 329	Continued From page 34 During interview on 6/13/14, at 12:21 p.m., director of nursing had stated she would expect use of citalopram and lorazepam medication to be reviewed and specific behaviors identified and care planned. Director of nursing had stated would expect physician justification to be documented regarding use of Cymbalta, trazodone, Ativan and why started citalopram. Director of nursing stated would expect effectiveness of as needed medications when given be documented and reason of anxiousness being documented for lorazepam medication being given as needed be more specific regarding what anxiousness is. R51 received ativan as needed (PRN) however, there was no resident specific anxiety signs and symptoms identified to determine it the medication was affective or not. R51 had been admitted on 8/1/12. R51 ' s physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, depression, anxiety, restlessness. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified mood: feeling down, depressed or hopeless, feeling tired or having little energy, moving or speaking slowly and behaviors of psychosis-delusional. R51 ' s brief interview of mental status (BIMS) had been 3 out of 15 on the MDS and indicated severe cognitive impairment. During review of R51's current physician orders dated 5/7/14, revealed an order for Ativan (an anti-anxiety medication) 0.5 mg (milligrams) every four hours as needed, diagnoses of anxiety and restlessness, start date 4/17/14.	F 329		

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F 329	Continued From page 35 R51 ' s current care plan dated 11/19/13, identified problem potential for mood alteration related to loss of function, feeling worthless, weepy at times, paranoid, resistive at times, lack of interest, verbal yelling, refusals, sleep disturbances and restless with intervention of but not limited to assess and monitor increased signs verbalization of depression daily, document on behavior flow sheets, review monthly at team meetings. Problem inappropriate behavior: physical, verbal, rejection related to cognitive, mood evidenced by spit, hit, pinch, slap, throws objects, threatens, yells, swears, refuses ADL (activities of daily living), bath, medications, treatments, labs and cares. However R51 ' s care plan had not identified specific symptoms of anxiety and restlessness related to Ativan medication use. Document review of the facility risk management team documentation review dates 4/17/14 and 5/14/14, had no documentation regarding Ativan medication. During interview on 6/13/14, at 10:50 a.m., social worker (SW)-A had stated she did not know R51 had an order for Ativan, but I should of. SW-A verified no mention of Ativan on R51 ' s current plan of care dated 11/19/13. SW-A verified risk management team had not reviewed the use of Ativan for R51 to identify specific behaviors related to medication use. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated would expect use of Ativan medication to be reviewed and specific behaviors identified and care planned.	F 329		

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F 329	Continued From page 36 Document review of the facility Psychotropic Drug Review Tool dated 8/4/05, read, "PURPOSE To assure that each resident receiving psychotropic medications are assessed routinely for benefit/risk and gradual dose reductions if not clinically contraindicated. It is the facilities policy that each resident ' s drug regimen remains free from unnecessary drugs and that gradual dose reductions are implemented unless clinically contraindicated. POLICY 3. The behavior management team will review all Psychotropic Drug Review Tools to assure their completion and that the facility is compliant with state regulations. PROCEDURE 4. Residents who are started on a new psychotropic medication will have a completed Psychotropic Drug Review Tool at initiation of therapy. The Resident Care Coordinator will be responsible to completion of this tool. 5. Members of the interdisciplinary team are responsible to assure that individualized problems, goals, and approaches are contained the resident plan of care."	F 329		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide adequate portions for 8 of 8 residents (R3, R11, R13, R27,	F 363	It is the facility's policy to meet the nutritional needs of residents in accordance with the recommended	7/1/14

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F 363	Continued From page 37 R34, R36, R58 and R75) in the sample who received mechanically altered diets. Findings include: R3, R11, R13, R27, R34, R36, R58 and R75 were dished foods by the cook who did not use the correct measured amount according to the meal menu. The meal menu for the day had meat was to be four ounces per resident serving. R3's bowl was filled with an undetermined amount of Swiss steak during observation of the meal preparation for R3 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R3. Cook-B had ground the Swiss steak and scooped portions into a bowl without measuring the amount. Review of the resident ' s medical record identified R3 as having a physician order for a national dysphagia diet II (NDD2) with ground meat. R11's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R11 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R11. Cook-B had pureed the Swiss steak and scooped into a bowl without measuring the amount. The Swiss steak was then served to R11. Review of the resident medical record identified R11 as having a physician order for a cardiac diet with pureed food. R13's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R13 on 6/11/14 at 11:07 a.m. observations were made of	F 363	dietary allowances of the Food and Nutrition Board of the National Research Council, NationalAcademy of Sciences. The plan of correction for the 8 residents identified will be the same for all residents in the facility. Dietary staff have been re-educated as to the correct method to prepare and serve mechanically altered foods in appropriate proportions and to measure these foods using appropriate utensils so as to provide appropriate nutritional servings as per each resident's individualized plan of care. Education was provided by the Consultant Dietitian on July 1, 2014. Henceforth, this training will be provided to all new dietary staff during orientation. The Dietary Supervisor is responsible for monitoring for compliance. The DS will monitor meal service 3 times per week for four weeks and then once a week on random shifts thereafter. The Consultant Dietitian will also monitor monthly for the next quarter and quarterly thereafter. The results of these random audits will be reviewed at the next quarterly Quality Assurance Meeting scheduled for July 28, 2014. The QA Committee will review and make recommendations for ongoing monitoring.	

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F 363	Continued From page 38 dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had pureed the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R13 as having a physician order for a NDD1 with pureed meat diet R27's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R27 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had ground the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R27 as having a physician order for an 1800 American Diabetes Association (ADA) diabetic diet with ground meat diet. R34's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R34 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had ground the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R34 as having a physician order for a NDD2 with ground meat diet R36's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R36 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had ground the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R36 as having a physician order for a	F 363		

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F 363	Continued From page 39 NDD2 with ground meat diet R58's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R58 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had pureed the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R58 as having a physician order for a NDD1 with purred meat diet. R75's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R75 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had ground the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R75 as having a physician order for a LCS (low concentrated sweets) with ground meat diet. During interview with cook-B on 6/11/14 11:10, she stated that she had placed 5 servings of Swiss steak for ground diets and then 3 servings of Swiss steak for pureed diets into food processor. She then stated that the foods were processed according to the consistency ordered. Cook-B further indicated that once food was the appropriate consistency she scooped unmeasured portions into bowls. During observation of food being proportioned, the bowls were observed to not contain equal amounts of prepared food. When surveyor asked if these portions were to be equal amounts. Cook - B verified that the above residents were to receive 4	F 363		

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F 363	Continued From page 40 ounce servings and that she did not measure the food prior to placing into the bowls. Interview with dietary manager (DM) on 6/11/14 at 11:12 a.m. verified that she had also observed mechanically altered foods were not measured at time of serving. DM then proceeded to re-measure to ensure amount served was correct. Observation of bowls of meat after DM had put the correct amount of food into the bowls were observed to be equal in amount in each bowl vs. when the cook put food into the bowls they looked unequal. Cook-B was then observed serving vegetables onto plates using a slotted spoon. DM went to cabinet and obtained the appropriate scoop spoon and told Cook-B she must measure portions being served. Review of the facility policy for pureed and ground foods dated 3/24/14, included:1) for ground meat the cook will put the number of servings in the food processor and grind it up and measure to get the numbers of servings that was put in the processor so they know how much to give the resident. 2) For the pureed diet the cook will put the number of serving in the food processor that is needed and will add some half and half or cream to puree it. 3) When the food is pureed the cook will then measure it out again so they know how much the resident is to receive.	F 363		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		7/10/14

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F 428	Continued From page 41 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to report irregularities to the physician and director of nursing during the monthly pharmacy review for 2 of 5 residents (R8 and R51) reviewed for unnecessary medication use. Findings include: R8 physician orders dated 4/15/14, identified diagnoses of but not limited to MDD (major depressive disorder), anxiety, nervousness, agitation and osteoarthritis. R8's five day Minimum Data Set (MDS) dated 4/18/14, identified mood score of five (symptoms of depression mild), no behaviors, had received scheduled and as needed pain medication, had received non medication interventions for pain, pain present occasionally, pain limited day to day activity, pain scale rate of eight. R8's brief interview of mental status (BIMS) had been 15 out of 15 on the MDS and indicated cognitively intact. During review of R8's current physician orders dated 4/15/14, revealed orders for Cymbalta (an antidepressant medication) 20 mg (milligrams) every day for MDD, start date of 10/4/13, Trazodone (an antidepressant medication) 50 mg every bedtime for MDD, start date of 10/4/13,	F 428	It is the facility's policy that the drug regimen of each resident be reviewed at least once a month by a licensed pharmacist and that any irregularities be reported to the Director of Nursing. The pharmacy consultant does review each resident's drug regimen each month and provide a report to the Director of Nursing and recommendations to physicians. The pharmacy consultant did provide correspondence to the primary physician and Director of Nursing with regards to R-8's need for review of Trazodone and Cymbalta and GDR on 5/28/14. On 6/23/14 the primary physician indicated that as R-8 just had a discontinuation of Lorazepam, a further reduction of psychotropic medications may cause relapse of symptoms. The pharmacy consultant visited the facility on 6/30/14 and focused on R-8's use of Celexa since 4/11/14. A fax was forwarded to the primary care physician to consider discontinuation of Celexa due to multiple anti-depressants being utilized and resident's willingness to attempt discontinuation of same. R-51 had orders for Ativan 0.5mg po q4	

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F 428	Continued From page 42 citalopram (Celexa) (an antidepressant medication) 20 mg every day for MDD, start date 4/11/14, lorazepam (an anti-anxiety medication) one mg three times a day as needed for anxiety/nervousness/agitation, start date 10/4/13 and hydrocodone-acetaminophen (pain medication) 5/325 mg one to two tablets every six hours as needed for osteoarthritis. Review of Southwestern Mental Health Center Medication Management progress note dated 3/4/14, identified diagnosis depressive disorder, medications Cymbalta and Trazodone and continue with Cymbalta and Trazodone. The third antidepressant Celexa was started on 4/11/14 and there was not documentation nor was any provided as to a physician ' s justification to use three antidepressant medications at the same time. Document review of R8's medication administration record dated from 5/1/14 to 5/31/14 and from 6/1/14 to 6/30/14, identified R8 had been receiving Celexa 20 mg every day, Cymbalta 20 mg every day and Trazodone 50 mg every bedtime, lorazepam one mg three times a day as needed and hydrocodone-acetaminophen 5/325 mg one to two tablets every six hours as needed. Document review of R8's PRN Medication sheets dated from 5/1/14 through 6/12/14, identified R8 had received as needed lorazepam eight times and reasons for giving documented had been increased anxiety/increased anxiousness/I am nervous and response had not been documented regarding effectiveness of lorazepam four out of the eight times. Hydrocodone-acetaminophen medication had been given 13 times and six out	F 428	prn pm anxiety/restlessness. R-51 had no specific behaviors identified and upon review R-51 had not received Ativan for over 90 days. Order was obtained to discontinue per facility policy due to nonuse. R-51 is also on an anti-depressant however anti-depressant (Remeron) being used for management of weight loss and used as appetite enhancement. GDR is not recommended as resident has demonstrated weight loss and attempts to manage weight loss with anti-depressant has been advised by the physician. The facility revised the policy and procedure for pharmacy consultant role and visits. The facility will review the pharmacy consultant's roles and responsibilities at an in-service on 7/10/14. Licensed staff will be provided education on the importance of reviewing and following up on the pharmacy consultant's recommendations in a timely manner. Licensed nurses will be instructed to alert the Resident Care Coordinator when consultant reports are not being acted on by the primary physician. The Director of Nursing will monitor for facility compliance and bring findings to the QA meetings. The next QA meeting is scheduled for 7/28/14. The QA Committee will determine the need for further interventions or monitoring.	

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F 428	Continued From page 43 of 13 doses had no documentation of effectiveness. During interview on 6/13/14, at 10:29 a.m., licensed practical nurse (LPN)-D verified effectiveness of lorazepam and hydrocodone-acetaminophen medications had not been documented and verified the reason/s documented for giving lorazepam had been increased anxiety/anxiousness, which were not resident specific signs or symptoms for R8. During interview on 6/13/14, at 12:21 p.m., director of nursing had stated would expect use of citalopram and lorazepam medication to be reviewed and specific behaviors identified and care planned. Director of nursing had stated would expect physician justification to be documented regarding use of three antidepressant medications being used for R8. Also would expect effectiveness of as needed medications when given are documented and reason of anxiousness being documented for lorazepam medication being given as needed be more specific regarding what anxiousness is. R51 received as needed antianxiety medication however, there were no resident specific sign or symptoms identified to determine if the antianxiety medication was affective or not. R51 ' s physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, depression, anxiety, restlessness. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified mood: feeling down, depressed or hopeless, feeling tired or having little energy, moving or speaking slowly and behaviors of psychosis-delusional. R51's brief	F 428		

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F 428	Continued From page 44 interview of mental status (BIMS) had been 3 out of 15 on the MDS and indicated severe cognitive impairment. During review of R51's current physician orders dated 5/7/14, revealed an order for Ativan (an anti-anxiety medication) 0.5 mg (milligrams) every four hours as needed, diagnoses of anxiety and restlessness, start date 4/17/14. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated would expect use of Ativan medication to be reviewed and specific behaviors identified for use of medication. During interview on 6/13/14, at 1:37 p.m., consultant pharmacist (CP)-C had stated would expect physician justification for use of more than one antidepressant medication used at the same time and to be documented twice in the first year then yearly thereafter and would expect specific behaviors be identified for use of psychotropic medications. Document review of the facility policy Medication Regimen Review dated 12/1/07, read, "Procedure: 2. Facility should ensure that the consultant pharmacist has access to: 2.4 Physician/Prescriber progress notes, nurses' notes, and other documents which may assist the Consultant Pharmacist in making a professional judgment as to whether or not irregularities exist in the medication regimen; and, 2.5 Any other necessary information, in accordance with Applicable Law."	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		7/10/14

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F 431	Continued From page 45 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure accurate medication labels for 2 of 25 medication labels	F 431	It is the facility's policy that drugs and biologicals used in the facility be labeled in accordance with currently accepted	

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F 431	Continued From page 46 reviewed for 2 of 7 residents (R40, R8) observed during medication pass; and failed to date medications when opened for 1 of 3 medication carts reviewed, which affected 3 of 3 residents (R7, R19, R6) reviewed during medication storage checks. Findings include: INACCURATE MEDICATION LABELS: R40's medication MouthKote artificial saliva) pharmacy label instructed one spray to mouth, however, while observations of the medication pass revealed R40 took three sprays. Although R40 received the physician ordered correct dosage, the pharmacy label had not been corrected to the most current physicians order for the past 2 1/2 years. R40 was admitted to the facility 4/23/09, and had diagnosis that included dry mouth, according to physician orders signed dated 5/20/14. Document review of current physician orders signed dated 5/20/14, revealed orders for artificial saliva orally three sprays to mouth three times a day. Observations of the medication pass on 6/10/14, at 12:38 p.m., revealed licensed practical nurse (LPN)-A handed MouthKote to R40, who sprayed three sprays into mouth. Document review of pharmacy medication label revealed artificial saliva; dispense date of 9/29/13, and directions to "Use 1 spray into mouth orally three times a day for dry mouth."	F 431	professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. When orders change between refills, the facility attaches a "change in direction" label to medication container. On occasion the labels have fallen off before the refill arrives. Change in direction labels will be secured with clear tape to insure the labels stay on until the medication is refilled. R-40's current order for saliva spray indicates he is to receive three sprays to mouth three times a day. The facility attached a "change in direction" label to this medication as per facility policy on 6/13/14. Review of the medication cart on 6/26/14 showed the change in direction label was still affixed to the artificial saliva medication. R-8 Novalog bottle did not match the MAR. A "change in direction label see MAR" was placed on the current Novalog bottle per facility policy. R #7, #19, and #6 had medication vials which did not have the facility open date present on the vial. The facility placed open dates on each multi-dose vial in accordance with policy and standards on 6/27/14. The facility reviewed and revised the policy on medication administration to reflect State and Federal laws for storage and	

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F 431	Continued From page 47 During interview on 6/10/14, at 12:48 p.m., LPN-A verified the pharmacy medication label with dispense date of 9/29/13, instructed one mouth spray three times a day. During interview at that time, LPN-A verified current physician orders signed and dated 5/20/14, for artificial saliva, order date of 11/15/11, three sprays to mouth three times a day. During interview on 6/12/14, at 1:30 p.m., director of nursing stated she expected nurses checked medication labels with each medication pass. She stated she expected when medications were delivered to the facility, the nurse checked medication labels with physician orders at that time. She stated when medication orders changed; she expected the nurse placed a "direction change" sticker on the medication container. Document review of facility medication administration record 6/1/14-6/9/14, revealed R40 received artificial saliva three sprays to mouth three times a day as physician ordered. Document review of facility policy Reordering, Changing, and Discontinuing Orders, revision dated 1/1/13, page 80, #3.5 "If Pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand: 3.5.1 Pharmacy should discontinue the original order; 3.5.2 Facility Physician/Prescriber should write the new order with new directions and Facility should enter the new order on the appropriate Medication Record Forms; and, 3.5.3 If permitted by Applicable Law, Facility should notify Pharmacy not to send the medication by attaching a "Change in Directions" sticker to the	F 431	guidelines for identification when an opened vial has expired and needs to be re-ordered. The revised policy and procedure for medication administration will be reviewed with nursing staff at an inservice on 7/10/14. The Resident Care Coordinators will be responsible for monitoring facility compliance for medication administration and report to the Director of Nursing any concerns identified. The QA Committee will review concerns and determine the need for further interventions or monitoring. The next QA meeting is scheduled for 7/28/14.	

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F 431	Continued From page 48 existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container. Facility may order from Pharmacy bulk rolls of "Change in Directions" stickers." During telephone interview on 6/13/14, at 1:37 p.m., consultant pharmacist-C stated he expected the label to be updated with the current order. He stated the pharmacy provided change of direction stickers for the facility to use to alert their staff of order changes. R8's insulin vial label was not updated to reflect the physician order change. During observation of medication administration on 6/12/14, at 11:02 a.m., licensed practical nurse (LPN)-B verified R8's Novolog insulin vial label had directions to administer 30 units three times a day and sliding scale. LPN-B had stated the orders had changed, R8 only receives sliding scale now and I'll put a sticker on bottle (regarding order change). During review of R8's physician telephone order dated 5/4/14, identified order discontinue 30 units Novolog at meals. Moderate sliding scale only, call provider below 60, over 400, 60 to 150 give 0 units, 151 to 200 give 4 units, 201 to 250 give 6 units, 251 to 300 give 8 units, 301-350 give 10 units and 351 to 400 give 12 units. Document review of R8 ' s medication administration record dated from 6/1/14 to 6/30/14, identified R8 had received sliding scale Novolog insulin and start date of order had been 5/4/14. During interview on 6/12/14, at 11:28 a.m., LPN-B	F 431		

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F 431	Continued From page 49 verified label on Novolog insulin vial had incorrect orders on label and no sticker had been placed on bottle to identify order change. During interview on 6/13/14, at 1:37 p.m., consultant pharmacist-C stated in regards to incorrect directions on label of Novolog insulin he would expect label to be updated, we provide the home with stickers to place over label see MAR (medication administration record) or chart for new directions. During interview on 6/13/14, 12:01 p.m., director of nursing had stated in regards to incorrect directions on label of Novolog insulin she would expect flag (sticker to alert staff to check physician orders as a change was done) to be put on bottle see MAR for order change. MEDICATIONS DATED WHEN OPENED: During medication storage checks the following was noted: R7 ' s Roxanol 20 mg [milligram]/ml [milliliter] 0.25 ml po/sl [sublingual] TID [three times per day.] The bottle was stored in the locked narcotic cabinet and no date as to when bottle had been opened. Twenty five ml left in bottle and verified by RN-A and found on 6/11/14 at 2:36 p.m. R19 ' s medication Humalog Observation Insulin was in drawer of medication cart opened and no date as to when opened, this was noted on 6/11/14 at 2:40 p.m. R6 has an order for Novolog 100 u [units]/ml SQ [subcutaneous] TID AC [before meals] according to sliding scale. Bottle was in drawer of medication cart opened and no date found as to	F 431		

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F 431	Continued From page 50 when it was opened. The medication was found on 6/11/14 at 2:40 p.m. and verified by RN-A. Review of policy: 5.3 Storage and Expiration Dating of medications; Biological's, Syringes and Needles revised 5/10/10; 01/01/13 page 2 of 3: #5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Omnicare Pharmacy Services: Medication Expiration Dates with effective date of 11/27/13: Insulin: 30 days after opening at room temperature. Medication Type: REMEMBER ALL MEDICATIONS ON THIS LIST MUST HAVE AN OPEN DATE PRESENT. Multi-Dose Vials: All multi-dose vials should be dated and initialed when opened by licensed staff.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		7/10/14

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F 441	Continued From page 51 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene and glove use to prevent the spread of infection during wound care for 1 of 1 resident (R78) who received a wound treatment. Findings include: R78 was observed on 6/12/14 at 8:43 a.m. during a wound dressing change by registered nurse (RN)-E to the laceration on R78's right forearm. RN-E washed her hands and donned exam gloves. RN-E removed the foam dressing with	F 441	It is the facility's policy that staff will implement hand hygiene (hand washing)practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination. The nurse who provided wound care to R78 did indicate to the surveyor observing that she had made an error in procedure. The appropriate procedure for aseptic wound care has been reviewed with the nurse.	

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F 441	Continued From page 52 visible drainage on the dressing from the right forearms, discarded the dressing and changed the exam gloves but did not wash her hands. RN-E donned a clean pair of gloves and sprayed the area with wound cleanser and dried the laceration and surrounding area with clean gauze. RN-E did not wash her hands or change her gloves before applying the new sterile foam dressing. During an interview on 6/12/14 at 8:50 a.m. RN-E verified she had not changed her gloves before the application of the new dressing. On 6/6/14 the physician order for laceration right forearm and wash daily and dressing change daily with 4 X 4 Mepilex Border dressing. Change if soiled or saturated. Observe for worsening signs of infection. On 6/13/14 the physician noted dressing changed daily. Clear drainage. Mild slough. Physician orders included: continue daily dressing change. Wash daily with saline. Do not use hydrogen peroxide. Apply dressing daily to wound after cleaning. Policy/procedure entitled Non-Sterile Dressing Change (undated) was provided. The procedure directed (#9 and #10) remove the dressing and place in a trash bag. The procedure then directed " remove gloves, wash hands, and apply new gloves." The procedure (#12, #13, and #14) directed that after cleaning the wound with normal saline or prescribed cleanser and patting the area dry, the nurse is to "remove gloves, wash hands, and apply new gloves." The director of nursing was interviewed on 6/12/14 at 2:30 p.m. and stated gloves should have been changed before touching the sterile	F 441	The procedure for Aseptic Wound Care has been revised to include an audit tool to monitor wound care practices to insure an environment which maintains an infection control program which prevents, recognizes,and controls, to the extent possible, the onset and spread of infections within the facility. The procedure for Aseptic Wound Care and importance of establishing and maintaining an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of transmission of disease and infection will be reviewed with staff at an in-service on 7/10/14. The Infection Control Coordinator and Director of Nursing will be responsible to monitor for compliance and to insure that wound care audits are completed randomly on licensed staff. The Director of Nursing will report on compliance to the Quality Assurance Committee. The Quality Assurance Committee will determine if further interventions or monitoring are necessary. The next QA meeting is scheduled for 7/28/14.	

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F 441	Continued From page 53 dressing.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the clothing/linen tumbler dryers were in good and safe working order and fixed when temperature was hot enough to alter clothing color. Findings include: On 6/11/14 at 8:40 a.m. the dryer was noted to have the upper shield opened upward. The dryer was operating with clothing visible in the dryer drum. The laundry assistant (LA)-A was interviewed at that time and stated this was a gas dryer and the shield was left open to cool the dryer and provide more air. LA-A repeated the dryer was hot and needed more air and therefore the vent was left open. On 6/11/14 at 1:40 p.m. the laundry tour was conducted. The dryer (Huebsch Originator 75) was not operating, but the upper shield was opened. LA-A stated the open shield helps with the ignition of the dryer. And LA-A added that if the dryer got hot, then the clothing would discolor. The lint traps were checked on each dryer and they were coated with a blanket of lint. LA-A said the traps get cleaned once per day.	F 456	It is the facility□s policy to maintain all essential equipment in safe operating condition and according to manufacturers□ specifications. The facility respectfully disagrees with the statement in the third paragraph on page 54, "The administrator and environmental supervisor (ES) were interviewed on 6/11/14 at 4:35 p.m. ES stated the Huebsch Originator was one of the older dryers and that he knew the dryer would get hot." According to the ES, the same surveyor asked him the following day why he had not done anything about the dryer being too hot since he had stated that he knew about it. The ES said he did not recall making that statement. The surveyor replied "I wrote it down". The administrator was at the meeting on 6/11/14 with the surveyor and ES and does not recall the ES stating that he knew the dryer would get too hot. Rather, the administrator recalls the ES telling the surveyor that he was not aware of the overheating because no one had reported it to him. Neither the ES or administrator	6/13/14

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F 456	Continued From page 54 The administrator and environmental supervisor (ES) were interviewed on 6/11/14 at 4:35 p.m. ES stated the Huebsch Originator was one of the older dryers and ES knew the dryer would get too hot. The laundry was located on the lower level near the elevator and physical therapy. The laundry was located under residential wing 200. The laundry contained 3 gas dryers and 3 electric washers. The Huebsch Originator dryer manufacturer ' s manual was reviewed. Figure 36 in the manual had a schematic of the dryer with the upper shield in the open position indicating the flow of combustion air. During an interview on 6/12/14 at 12:10 P.M., ES indicated this meant the upper shield was to be open. The preventive maintenance instructions (pg 43) directed the lint was to be removed (no frequency) and " Failure to do so will allow a buildup of lint in this area to act as an insulator and cause overheating in the tumbler. " The facility's procedure dated 2002 was reviewed. The procedure directed that the lint was to be removed from the lint compartment daily. The Richard-Ewing Equipment Co. Inc. service invoice dated 6/12/14 read, "dryer was overheating. Had to replace thermostat. Also check limit thermostat. Replaced it checked out weak. The Richard-Ewing Equipment technician (tech) and environmental supervisor (ES) were	F 456	saw the surveyor write anything down during the interview on 6/11/14. A second surveyor was present at the 6/11/14 interview and was holding her laptop computer, however it was closed and she did not make any entries on it during the interview. In the spirit of cooperation, the facility submits the following plan of correction: The dryers were serviced on 6/12/14 by a qualified service technician. The dryer that was overheating was repaired. Note: All dryers are equipped with automatic shut off should there be an excessive lint build up. Laundry staff has been re-educated as to the correct procedure and schedule for cleaning lint filters and the importance of reporting problems and concerns about equipment to the ES or Maintenance Supervisor in a timely manner. The Maintenance Supervisor will audit for compliance on a daily basis for 4 weeks. If daily audits show that lint filters need more frequent cleaning the policy and procedure will be revised. The Maintenance Supervisor will report results of auditing to administrator who will review with Quality Assurance Committee which will determine need for further interventions and monitoring. The next meeting for the QA Committee is scheduled for 7/28/14.	

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interviewed on 6/12/14 at 12:10 p.m. Tech stated the thermostat " was not working Based on observation, interview, and document review the facility failed to ensure the clothing/linen tumbler dryers were in good working order.

Findings include:

On 6/11/14 at 8:40 a.m. the dryer was noted to have the upper shield opened upward. The dryer was operating with clothing visible in the dryer drum. The laundry assistant (LA)-A was interviewed at that time and stated this was a gas dryer and the shield was left open to cool the dryer and provide more air. LA-A repeated the dryer was hot and needed more air and therefore the vent was left open.

On 6/11/14 at 1:40 p.m. the laundry tour was conducted. The Huebsch Originator 75 was not operating, but the upper shield was opened. LA-A stated the open shield helps with the ignition of the dryer. And LA-A added that if the dryer got hot, then the clothing would discolor. During the laundry tour all three dryer vents were observed. All three dryers had a blanket of lint on the screen with lint also falling to the floor. LA-A stated she would clean out the lint screen daily.

The administrator and environmental supervisor (ES) were interviewed on 6/11/14 at 4:35 p.m. ES stated the Huebsch Originator was one of the older dryers and that he knew the dryer would get hot. The laundry was toured with ES on 6/12/14 at 9:30 a.m. No dryers were operating and each dryer had an individual gas shut off.

The laundry was located on the lower level near the elevator and physical therapy. The laundry

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F 456	Continued From page 56	F 456		

was located under residential wing 200. The laundry contained 3 gas dryers and 3 electric washers.

The Huebsch Originator dryer manufacturer ' s manual was reviewed. Figure 36 in the manual had a schematic of the dryer with the upper shield in the open position indicating the flow of combustion air. During an interview on 6/12/14 at 12:10 P.M., ES indicated this meant the upper shield was to be open. The preventive maintenance instructions (pg 43) directed the lint was to be removed (no frequency) and " Failure to do so will allow a buildup of lint in this area to act as an insulator and cause overheating in the tumbler. "

The facility ' s procedure dated 2002 was reviewed. The procedure directed that the lint was to be removed from the lint compartment daily.

The Richard-Ewing Equipment Co. Inc. service invoice dated 6/12/14 noted " dryer was overheating. Had to replace thermostat. Also check limit thermostat. Replaced it checked out weak.

The Richard-Ewing Equipment technician (tech) and environmental supervisor (ES) were interviewed on 6/12/14 at 12:10 p.m. Tech stated the thermostat " was not working " and he replaced it. Both Tech and ES stated the dryer manual allowed for the dryer to run with the top shield door open to allow air flow. Tech stated the towel discoloring during drying would occur because the thermostat was not working and the heat from the dryer was high. Tech stated there was a "risk" to using the dryer with the thermostat

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F 456	Continued From page 57 not operating correctly. Tech stated the risk was that without the thermostat working correctly, the dryer won ' t shut off when it reached a predetermined temperature and would keep heating to hotter temperatures. During the interview on 6/12/14 at 12:10 p.m. Tech stated lint accumulation was not a hazard, but would make for poor air flow and the dryer would use more electricity and more gas with the accumulation of lint. Tech indicated the lint compartment should be cleaned out 2 to 3 times a day, or after every so many loads.	F 456		
F 465 SS=F	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 ensure ceiling and mechanical air vents were clear of dust in 4 of 4 residential hallways; Also air vents, stove hood, and steam table pans were not routinely cleaned to maintain a clean and sanitary environment in the kitchen and this had the potential to affect all 42 residents who received prepared foods from the kitchen; Unpleasant and possibly harmful odors detected and not determined if harmful to residents or staff health. This also will affect 42 of 42 residents, staff and visitors to the facility. Findings include:	F 465	It is the facility□'s policy to maintain the physical environment in a safe, clean, and sanitary condition, free of undesirable or harmful odors. The ceiling grates on all identified wings have been cleaned by the Maintenance Supervisor and will be re-painted by 7/22/14. The AC grates have also been cleaned. The Maintenance Man will add regular cleaning and maintenance to his PM schedule. During the course of cleaning the grates	7/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 465	Continued From page 58 A facility tour was conducted with environmental supervisor (ES) on 6/11/14 at 9:55 a.m. Hallways A & B were noted to have black areas on all 10 ceiling grates. Also noted on Hallways A, B, C were ceiling air grates with a coat of dust and strands of dust that was moving when air movement. The Trane air condition unit on Hallway C and mechanical unit on Hallway D also were noted to have grates with coating of dust and strands of dust also moving when air was moving. ES was interviewed during a tour on 6/12/14 at 12:30 p.m. ES stated the Trane air conditioner unit and mechanical unit had filters changed every 30 days and should have the intake vent cleaned. ES verified these were dusty. ES stated the 10 ceiling grates on hallways A & B were part of the old system and had original air duct system that could have a history of moisture exposure from humidifiers. ES did not know if the black areas were from rust stains or something else like mold. ES also stated the other ceiling vent grates were to be cleaned every 30 days, but that they were currently dusty. On 6/13/14 at 8:50 a.m. ES stated that during the past year, he had not had the 10 black marred grates either washed or painted. ES stated he was not sure if that was ever done. During an interview on 6/13/14 at 11:00 a.m. ES stated that he used a ladder to check out the vents for the first time. ES thinks the black marks on the 10 grates could possibly be rust. An initial tour of the kitchen was conducted on 6/9/14 at 6:15 p.m. with the dietary aide (DA)-A. The observations were reviewed and verified with	F 465	on the air handling grates on the 400 wing the Maintenance Supervisor found that the motor in the unit was not working correctly. This could account for the musty odor identified by the surveyor. The unit has been repaired and no further unpleasant odors have been observed. The air handling/AC unit on the 100 wing was out of service at the time of the survey and the facility was in the process of seeking quotes to replace it. This is likely the cause for the unpleasant odors observed by the surveyors. A new unit was ordered on 6/30/14. Installation is scheduled for 7/10/14. The new air handing/AC unit is expected to remove any unpleasant odors. Once in place, the facility will assess for effectiveness. No other sources of odor have been identified. The Maintenance Supervisor is responsible for monitoring for compliance. Results of monitoring will be forwarded to the Administrator and in turn the Quality Assurance Committee for review and further recommendations. The next QA Committee meeting is scheduled for 7/28/14. It is the facility's policy to store, prepare,distribute, and serve food under sanitary conditions. The cooler fan was cleaned on 6/19/14 2014. The knobs on the oven and the stove were cleaned on 6/16/14. The vent	

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	245596	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

(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 465	Continued From page 59 dietary manager (DM)-A on 6/9/14 at 6:34 p.m. Observations during the tour include the following: The vented lower surface of the range hood (directly above cooking surface); was coated with a brown, sticky substance (grease) in addition to the glass fixtures which covered the light bulbs located under the hood. The surfaces and surrounding area of the knobs located on the front surface of the range were also coated with the brown, sticky substance. The cooling fan located in the refrigerated cooler showed a buildup of dust and debris on both the frame surface and piping of the unit. This fan circulates air around food stored in cooler. No food was observed to be uncovered. Insulated electrical wires attached to the back of the fan unit and running along the top food shelf were observed to be coated with debris. The storage room which contained paper products and dish covers had a large air vent about 1 foot square located directly above the top metal shelf on upper right side of the room. Interview of the DM on 6/9/14 at 6:50 p.m. verified that this open vent was part of the ventilation system for the elevator which transported person, etc. to other floors of the facility. This vent was observed to be open without any grates or coverings. It was also observed that approximately 3/4 of the opening was obstructed by boxes of straws which were sitting on top of the shelf. The surface of the opening and surrounding area were noted to have a thick layer of dust and debris buildup. DM-A on 6/9/14 at 6:34 had been interviewed and she verified the range hood was soiled with	F 465	in the store room was cleaned on 6/30/14. The exhaust vents above the ovens and grill in the kitchen were cleaned on 6/17/14. The Dietary Supervisor reviewed the policy for cleaning the hood quarterly to ensure that the vents stay clean. An in-service will be held on July 8, 2014 for all dietary staff to re-educate staff on policies/procedures for cleaning and documentation of the same. The Dietary Supervisor will be responsible for monitoring cleaning 3 times a week for the first month and then once a week every quarter on alternating shifts. The Consultant Dietitian will also monitor monthly for the next quarter and quarterly thereafter. The results of monitoring will be reviewed at the next quarterly Quality Assurance Meeting scheduled for 7/28/14. The QA Committee will review and make recommendations for ongoing monitoring.	

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	245596	A. BUILDING _____ B. WING _____	06/13/2014

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F 465	Continued From page 60	F 465		

grease buildup and that the range hood had been last cleaned professionally in January 2014. She also stated that maintenance was supposed to have been cleaning the range hood on a routine basis and that this had not been done.

A second interview with the dietary manager on 6/11/14, at 11:07 a.m. was performed and she was in attendance during observation of the meal service. During observation it was noted that steam table pans (food containing surfaces) have white residue in corners that does scratch off. The coffee machine was observed to have white and brown buildup noted on the drain surface.

Upon review of the dietary cleaning schedule which had been posted during the initial tour it was noted that there were multiple blanks present. This schedule included a weekly cleaning list for the day cook which included grill sides, back & drip tray; steam table; cooks counter; ovens wipe down daily, shelf below cook counter, etc.

A copy of the policy titled: Exhaust Hood Semi Annual PM MT06:04SA dated 2002: stated: Maintenance Tasks 1.) Check and clean grease and foreign material from interior of duct at hood connections. 2.) Check and clean grease and foreign material from interior of duct at access panels. 4.) Check and clean grease and foreign material from all visible and accessible duct/hood seams and joints. 5.) Clean hood grills and filers. UNPLEASANT OR HARMFUL ODORS DETECTED

On entrance to the building by way of the lower level entrance on the evening of 6/9/14 at 6:01 p.m. a strong sewer and musty odor was noted.

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	245596	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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F 465	Continued From page 61 The day had been warm and humid. On 6/13/14 at 7:55 a.m. the front entrance and lower level entrance had been entered. The weather the morning of 6/13/14 was cool and not humid. The main entrance again smelled musty. As the surveyor went from the main entrance to the 100 room wings the smell changed from musty to sewer and as you walked past the tub room and hallway near rooms 106, 107, 108, 109 it was a strong sewer type smell and again between the end of the hallway by the old house entrance again a smell of sewer was noted. The 400 wing (located on the lower level) was entered through the lower level door on 6/13/14 at 7:55 a.m. On entering the lower level resident unit a sewer smell was noted and dissipated by the nursing station. On 6/13/14 at 8:00 a.m. registered nurse (RN)-E was interviewed. RN-E stated she had noted the sewer and musty smell/s also other than when toileting needs of the resident were completed. At 8:01 a.m. RN-D stated she noted a musty smell when the air condition in her office turned on. At 8:03 a.m. housekeeper (H) - A stated that yes she was aware of a musty smell. The environmental supervisor (ES) was interviewed on 6/12/14 at 12:30 p.m. ES stated there had been a sewer odor in the past on the lower residential unit about 3 years ago and required fixing pipes in the wall. ES stated about 90 days ago he had purchased an air neutralizer/sanitizer to be used in the building to neutralize the toileting odors created by the resident ' s incontinence episodes. ES stated he did not smell the musty or sewer type odor	F 465		

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	245596	A. BUILDING _____ B. WING _____	06/13/2014

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SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187**

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F 465	Continued From page 62 because he had grown used to it.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE PO BOX 69** **WORTHINGTON, MN 56187**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on June 10, 2014. At the time of this survey, South Shore 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 Occupancies. 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 | 07/04/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE PO BOX 69** **WORTHINGTON, MN 56187**

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K 000	Continued From page 1 By email to: Marian.Whitney@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. South Shore Care Center is a two-story building with partial basement. The original building was constructed in 1962, with building additions constructed in 1964 and 1968. All are fully sprinklered, and were determined to be of Type I (332) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 42 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 021 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such	K 021		7/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	**1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187**

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K 021	Continued From page 2 doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide proper automatic smoke detection within 5 feet of 2 hazardous area room doors in accordance with 1999 NFPA 72, section 2-10.6.5.1.2. This deficient practice could affect the safety of all 42 residents. Finding include: On facility tour between 10:30 AM and 1:30 PM on 6/10/2014, observation revealed, that the repair shop and the boiler room doors located in the basement stairwell enclosure are held in the open position with magnetic hold-openers inter-connected to the buildings fire alarm system. There is no automatic smoke detectors with-in 5 feet of doors. This deficient practice was confirmed by the facility Maintenance Supervisor at the time of	K 021	It is the facility'□s policy that doors in exit passageways, stairway enclosures, horizontal exits, smoke barriers, and hazardous areas can only be held open by a device that automatically closes the door upon activation of the fire alarm system, smoke detector or sprinkler system. The smoke detectors in the basement stairwell enclosure were installed by ABC Automated Building Controls on 7/1/14. The Maintenance Supervisor is responsible for monitoring for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2014**

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K 021	Continued From page 3 discovery.	K 021		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
June 26, 2014

Ms. Barbara Atchison, Administrator
South Shore Care Center
1307 South Shore Drive PO Box 69
Worthington, Minnesota 56187

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5596024

Dear Ms. Atchison:

The above facility was surveyed on June 9, 2014 through June 13, 2014 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 me.

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
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00885	A. BUILDING: _____ B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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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
	00885	A. BUILDING: _____ B. WING _____	06/13/2014

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SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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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 June 9, 10, 11, 12 & 13, 2014, 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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	00885	A. BUILDING: _____ B. WING _____	06/13/2014

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SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE PO BOX 69 WORTHINGTON, MN 56187

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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 implement care plan fall and toileting interventions for 1 of 3 residents (R51) reviewed for accidents. Findings include: R51 had been sitting in wheelchair in room at the end of the C unit and R51 ' s self-release belt on R51 ' s wheelchair had been hanging behind the back of R51 ' s wheelchair unattached during observation on 6/11/14, at 1:35 p.m. This surveyor informed staff person nursing assistant (NA)-A. NA-A at the time stated the self-release belt was used for an alarm so staff knows when R51 was trying to stand, and had been discontinued. Surveyor asked NA-A how changes are communicated and NA-A had replied through the communication book, Kiosk in computer and nursing assistant daily worksheet. NA-A verified at the time nursing assistant daily worksheet identified alarms, self-release belt for R51. At	2 565		

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2 565	Continued From page 3 1:48 p.m., NA-A had stated the self-release belt for R51 is to be in place and had not been stopped from being used. During continuous observation on 6/12/14, at 8:28 a.m., R51 sitting in wheelchair in room end of C unit, 8:46 a.m., staff person had been assisting R51 to eat breakfast at table in room end of C unit, 8:49 a.m., R51 remains sitting at table in room end of C unit, breakfast tray had been removed. At 9:09 a.m., R51 remains the same. At 9:20 a.m., R51 remains the same. At 9:52 a.m., NA-F approached R51 and asked R51 if wanted to lie down in bed, NA-F and NA-A had transferred R51 from wheelchair to bed and had used a Hoyer mechanical lift to transfer R51. At time of observation a tab alarm had laid on R51 ' s night stand. NA-F had stated at the time when asked what fall interventions were for R51, safety belt on wheelchair, tab alarm on bed, mat on floor, bed low position, lipped mattress and cannot leave alone in room. NA-F had left R51's room after R51 had been transferred into bed. NA-A proceeded to check incontinent product R51 had in place and stated the incontinent product was dry. NA-A placed call light in reach of R51, put be in low position and placed fall mat on floor beside bed. Tab alarm remained placed on night stand and NA-A had shut light off in room and walked out of R51's room. Surveyor intervened at the time and asked NA-A if the Tab alarm was to be on R51 when in bed. NA-A stated if I had seen one I would have hooked it to resident, NA-A checked R51's bed and stated I do not see an alarm for bed. Surveyor intervened and asked NA-A about the tab alarm sitting on R51's night stand and NA-A verified at the time tab alarm should be on R51 when in bed. R51's physician orders dated 5/7/14, identified	2 565		

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2 565	Continued From page 4 diagnoses of but not limited to dementia and hypertension. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified toilet extensive assist of two. R51's current care plan dated 11/19/13, identified problem potential for falls related to cognitive impairment, weakness, mobility deficit with interventions of but not limited to keep call light/bell within easy reach, tabs, toilet resident as requested and as scheduled, 1/30/14 self-releasing seat alarm to wheelchair, is able to open seat belt with instruction. Problem potential for alteration in urinary elimination, r/t urinary retention and recent removal of long time indwelling catheter with interventions of but not limited to initiate voiding schedule to coordinate with intake: i.e. after meals. Problem incontinent of bowel related to cognitive impairment, loss of sphincter control, goal bowel management program: R51 will show improved bowel continence evidenced by fewer episode of bowel incontinence with interventions of but not limited to assist to commode or toilet after each meal and as needed. Document review of the facility untitled page dated 4/22/14, provided by the facility identified subject; resident profile for R51, remember to always engage the self-release belt. During interview on 6/11/14, at 2:23 p.m. licensed practical nurse (LPN)-C had stated R51 is supposed to have the self-release belt in place when R51 is in wheelchair. During interview on 6/12/14, at 10:12 a.m., NA-A had verified toilet had not been offered to R51 when NA-A had checked R51 ' s incontinent product.	2 565		

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2 565	Continued From page 5 During interview on 6/13/14, at 8:34 a.m., RN-C had stated interventions of tab alarm for bed had started on 11/25/13. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated would expect to offer the toilet, tab alarm and self-release belt to be in place as that is part of R51's plan of care. Policy regarding following the care plan had been requested at the time and none had been provided. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies and procedures for implementing care plan interventions. The administrator could educate staff to implement care plan interventions. The administrator or designee could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, 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.	2 570		

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2 570	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include current fall interventions and mobility status for 1 of 3 residents (R51) reviewed for accidents. Findings include: R51 had been observed lying in bed and a floor mat had been on the floor beside the bed on 6/10/14, at 8:34 a.m. On 6/12/14, at 7:41 a.m., R51 had been observed lying in bed and a floor mat had been on the floor beside the bed. On 6/12/14, at 9:52 a.m., nursing assistant (NA)-F and NA-A had transferred R51 from wheelchair to bed and had used a Hoyer mechanical lift to transfer R51. At time of observation a tab alarm had laid on R51's night stand and a lipped mattress had been on R51 ' s bed. R51 had been admitted on 8/1/12. R51's physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, hypertension and treatment order with order date of 3/5/14, Hoyer transfers for all mobility. R51 ' s significant change Minimum Data Set (MDS) dated 4/15/14, identified ambulation: none occurred in room /corridor and extensive assist of two for transfers. Review of R51's medication administration record	2 570		

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2 570	Continued From page 7 dated 6/1/14 to 6/30/14, identified Hoyer transfers with A-Z for all mobility, start date of 3/5/14 and nights, a.m. and p.m. shifts signing for treatment. Review of the facility untitled page dated 4/22/14, provided by the facility identified subject; resident profile for R51, remember to always engage the self-release belt, do not leave resident unattended in room in wheelchair. R51's current care plan dated 11/19/13, identified problem self-care deficit: walking evidenced by needs assist of two for all ambulation with approaches of walk with therapy with assist of one and gait belt, remind resident when therapy is scheduled, assist in transfer of resident to therapy in wheelchair as needed and monitor for continued safety walking; two assist with gait belt. Problem potential for falls related to cognitive impairment, weakness, mobility deficit with interventions keep call light/bell within easy reach, respond promptly, tabs (no specification on where tabs to be), remind resident to request help if wants to get up, ambulate per therapy recommendation, encourage resident to wear glasses during waking hours and for all transfers and walking, toilet resident as requested and as scheduled, administer medications as ordered and monitor side effects, night light in room at night, 11/24/13 monitor location Arial alarm, 1/30/14 self- releasing seat alarm to wheelchair, is able to open seat belt with instruction, 5/9/14 toilet, check and change at 10:00 p.m. However the current care plan dated 11/19/13, had not identified R51 required Hoyer transfers with A-Z for all mobility, R51 is non-ambulatory, no specification regarding placement of tab alarm, mat on floor beside bed when R51 is in bed, lipped mattress, do not leave unattended in	2 570		

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2 570	Continued From page 8 bathroom and room when in wheelchair. During interview on 6/11/14, at 2:56 p.m., registered nurse (RN)-C had verified R51's current plan of care had no documentation regarding transfers and verified R51 is transferred with a Hoyer mechanical lift and two assist. During interview on 6/12/14, at 9:56 a.m., NA-F had stated when asked what fall interventions were for R51, safety belt on wheelchair, tab alarm on bed, mat on floor, bed low position, lipped mattress and cannot leave alone in room. During interview on 6/13/14, at 8:34 a.m., RN-C had stated interventions of fall mat had been started on 8/23/13, tab alarm for bed had started on 11/25/13 and do not leave unattended in bathroom and room when in wheelchair had started on 11/25/13. During interview on 6/13/14, at 12:07 p.m., director of nursing stated would expect care plan be revised when make adjustments in care needs for resident, needs to be care planned. Document review of the facility COMPREHENSIVE CARE PLAN DEVELOPMENT AND REVISION dated 9/13/13, read "Procedure: 7. The Unit Resident Care Coordinator will be accountable to insure that each resident plan of care accurately reflects the individualized needs of the resident. " SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies and procedures for care plan revisions. The administrator could educate nursing staff to revise care plans. The administrator or designee	2 570		

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2 570	Continued From page 9 could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nail care was provided for 2 of 3 residents (R76, R51) reviewed for activities of daily living and failed to remove facial hair for 1 of 1 residents (R66) reviewed in the sample with facial hair. Findings include: LACK OF NAIL CARE: R76 was observed on 6/10/14, at 8:57 a.m., and R76 ' s finger nails were long and soiled. Again on 6/12/14, at 8:20 a.m., R76 finger nails were observed to be untrimmed and soiled under the nails. R76 ' s admission Minimum Data Set (MDS), an assessment dated 4/17/14, revealed R76 had moderate cognitive impairment and required extensive assistance from one staff for personal	2 860		

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2 860	Continued From page 10 hygiene. R76 ' s care plan dated 4/25/14, directed staff that R76 had self-care deficit with interventions that included extensive assist of 1-2 staff for personal hygiene During interview on 6/12/14, at 1:58 p.m., director of nursing verified the untrimmed and soiled finger nails. Director of nursing stated she expected staff to provide nail care daily and to ensure nails were clean. Also R76 was interviewed at 6/12/14 at 2:00 p.m. and said that they would like staff to trim their finger nails. During interview on 6/13/14, at 11:08 a.m., nursing assistant-B (NA-B) stated she cleaned and trimmed finger nails on bath day and as needed. Document review of facility Care of Fingernails/Toenails policy dated revised 4/07, read, "Purpose The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections." "General Guidelines 1. Nail care includes daily cleaning and regular trimming." R51 was observed on 6/10/14, at 10:22 a.m., and noted to have untrimmed fingernails. This was also observed on 6/11/14, at 9:04 a.m. and again on 6/11/14, at 1:35 p.m. During observation on 6/13/14, at 8:20 a.m., nursing assistant (NA)-B had stated no, when asked if R51 ' s fingernails appear trimmed. R51 had been admitted on 8/1/12. R51 ' s physician orders dated 5/7/14, identified diagnoses of but not limited to dementia and	2 860		

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2 860	Continued From page 11 hypertension. R51 ' s significant change Minimum Data Set (MDS) dated 4/15/14 identified personal hygiene extensive assist of one person. R51's current care plan dated 11/19/13, identified problem self-care deficit personal hygiene related to impaired mobility, evidenced by needs daily help from another person with personal hygiene with interventions of but not limited to: nail care done each week by bath aide after 6, provide verbal cues as needed. Document review of facility bath sheet dated 6/3/14, identified R51's bath day Wednesday at 1:30 p.m. and identified R51 had received a whirlpool bath on 6/11/14, at 12:16 p.m. During resident interview on 6/13/14, at 9:21 a.m., R51 had stated regarding fingernails, the length is o.k., but the edges are sharp, feel them. I would like them trimmed. Surveyor at the time observed fingernails to be uneven with jagged edges. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated fingernails should be trimmed weekly on bath days at least and as needed, if resident is resistive to cares should come back, if refuses should chart refusal of care. FACIAL HAIR: R66 was observed on 6/12/14, at 8:05 a.m., with approximate ½ inch to one inch long chin hairs, neatly dressed and eating breakfast in the dining room. During interview at that time, R66 stated she was already dressed and her cares were done for the day. R66 ' s admission Minimum Data Set (MDS), an	2 860		

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2 860	Continued From page 12 assessment dated 5/12/14, revealed R66 had no cognitive impairment and required extensive assist of one staff for personal hygiene. Document review of the facility resident care plan dated 5/22/14, directed staff that R66 had self-care deficit and needed daily help from another person for personal hygiene. During observation and interview on 6/12/14, at 2:00 p.m., director of nursing verified R66 ' s long chin hairs. Director of nursing stated she expected staff to shave female facial hair daily or as needed. During interview on 6/12/14 at 2:02 p.m. R66 stated would like staff to remove chin hairs. During interview on 6/13/14, at 11:08 a.m., nursing assistant-B (NA-B) stated she shaved women with morning cares and on bath day. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures for performing activities of daily living, such as nail care. The director of nursing could educate all staff to provide nail care. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21050	MN Rule 4658.0625 Subp. 1 Menus; Meal Planning Subpart 1. Menu planning. All menus must be planned in advance, dated, and followed. Any changes in the meals actually served must be of equal nutritional value. The general menu for a	21050		

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21050	Continued From page 13 seven-day period must be posted prior to the start of that seven-day period at a location readily accessible to residents, and any changes to the general menu must be noted on that posted menu. All menus and any changes for the current and following seven-day periods must be posted in the dietary area. Records of menus and of foods purchased must be filed for six months. A variety of foods must be provided. A file of tested recipes adjusted to a yield appropriate for the size of the home must be maintained. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not provide adequate portions for 8 of 8 residents (R3, R11, R13, R27, R34, R36, R58 and R75) in the sample who received mechanically altered diets. Findings include: R3, R11, R13, R27, R34, R36, R58 and R75 were dished foods by the cook who did not use the correct measured amount according to the meal menu. The meal menu for the day had meat was to be four ounces per resident serving. R3's bowl was filled with an undetermined amount of Swiss steak during observation of the meal preparation for R3 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R3. Cook-B had ground the Swiss steak and scooped portions into a bowl without measuring the amount. Review of the resident ' s medical record identified R3 as having a physician order for a national dysphagia diet II (NDD2) with ground meat.	21050		

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21050	Continued From page 14 R11's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R11 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R11. Cook-B had pureed the Swiss steak and scooped into a bowl without measuring the amount. The Swiss steak was then served to R11. Review of the resident medical record identified R11 as having a physician order for a cardiac diet with pureed food. R13's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R13 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had pureed the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R13 as having a physician order for a NDD1 with pureed meat diet R27's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R27 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had ground the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R27 as having a physician order for an 1800 American Diabetes Association (ADA) diabetic diet with ground meat diet. R34's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R34 on 6/11/14 at 11:07 a.m. observations were made of	21050		

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21050	Continued From page 15 dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had ground the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R34 as having a physician order for a NDD2 with ground meat diet R36's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R36 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had ground the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R36 as having a physician order for a NDD2 with ground meat diet R58's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R58 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had pureed the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R58 as having a physician order for a NDD1 with purred meat diet. R75's bowl was filled with an undetermined amount of Swiss steak which was noted during observation of the meal preparation for R75 on 6/11/14 at 11:07 a.m. observations were made of dietary cook-B preparing the dinner meal of Swiss steak for R. Cook-B had ground the Swiss steak and scooped into a bowl without measuring the amount. Review of the medical record identified R75 as having a physician order for a LCS (low concentrated sweets) with ground meat diet.	21050		

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21050	Continued From page 16 During interview with cook-B on 6/11/14 11:10, she stated that she had placed 5 servings of Swiss steak for ground diets and then 3 servings of Swiss steak for pureed diets into food processor. She then stated that the foods were processed according to the consistency ordered. Cook-B further indicated that once food was the appropriate consistency she scooped unmeasured portions into bowls. During observation of food being proportioned, the bowls were observed to not contain equal amounts of prepared food. When surveyor asked if these portions were to be equal amounts. Cook - B verified that the above residents were to receive 4 ounce servings and that she did not measure the food prior to placing into the bowls. Interview with dietary manager (DM) on 6/11/14 at 11:12 a.m. verified that she had also observed mechanically altered foods were not measured at time of serving. DM then proceeded to re-measure to ensure amount served was correct. Observation of bowls of meat after DM had put the correct amount of food into the bowls were observed to be equal in amount in each bowl vs. when the cook put food into the bowls they looked unequal. Cook-B was then observed serving vegetables onto plates using a slotted spoon. DM went to cabinet and obtained the appropriate scoop spoon and told Cook-B she must measure portions being served. Review of the facility policy for pureed and ground foods dated 3/24/14, included:1) for ground meat the cook will put the number of servings in the food processor and grind it up and measure to get the numbers of servings that was put in the processor so they know how much to give the resident. 2) For the pureed diet the cook will put	21050		

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21050	Continued From page 17 the number of serving in the food processor that is needed and will add some half and half or cream to puree it. 3) When the food is pureed the cook will then measure it out again so they know how much the resident is to receive. SUGGESTED METHOD OF CORRECTION: The registered dietician could review and revise policies and procedures related to serving foods of appropriate proportions using appropriate measuring utensils. The registered dietician could inservice dietary staff to serve appropriate proportions with correct utensils. The certified dietary manager could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21050		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of	21390		

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21390	Continued From page 18 employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene and glove use to prevent the spread of infection during wound care for 1 of 1 resident (R78) who received a wound treatment. Findings include: R78 was observed on 6/12/14 at 8:43 a.m. during a wound dressing change by registered nurse (RN)-E to the laceration on R78's right forearm. RN-E washed her hands and donned exam gloves. RN-E removed the foam dressing with visible drainage on the dressing from the right forearms, discarded the dressing and changed the exam gloves but did not wash her hands. RN-E donned a clean pair of gloves and sprayed the area with wound cleanser and dried the laceration and surrounding area with clean gauze. RN-E did not wash her hands or change her gloves before applying the new sterile foam dressing. During an interview on 6/12/14 at 8:50 a.m. RN-E verified she had not changed her gloves before the application of the new dressing.	21390		

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21390	Continued From page 19 On 6/6/14 the physician order for laceration right forearm and wash daily and dressing change daily with 4 X 4 Mepilex Border dressing. Change if soiled or saturated. Observe for worsening signs of infection. On 6/13/14 the physician noted dressing changed daily. Clear drainage. Mild slough. Physician orders included: continue daily dressing change. Wash daily with saline. Do not use hydrogen peroxide. Apply dressing daily to wound after cleaning. Policy/procedure entitled Non-Sterile Dressing Change (undated) was provided. The procedure directed (#9 and #10) remove the dressing and place in a trash bag. The procedure then directed " remove gloves, wash hands, and apply new gloves." The procedure (#12, #13, and #14) directed that after cleaning the wound with normal saline or prescribed cleanser and patting the area dry, the nurse is to "remove gloves, wash hands, and apply new gloves." The director of nursing was interviewed on 6/12/14 at 2:30 p.m. and stated gloves should have been changed before touching the sterile dressing. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies to ensure proper infection control procedures were followed for wound care. The director of nursing could educate nursing staff on infection control procedures for wound care. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

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21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility had a Tuberculosis (TB) Infection Control Program that included a team/person responsible for oversight of the program, written TB infection control procedures, and health care worker education. Findings include: Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 directed facilities to have a written tuberculosis (TB) infection control procedure. The written procedures were to include: 1) early recognition of signs and symptoms of TB by staff and the	21426		

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21426	Continued From page 21 staff role in the facility ' s TB infection control program. 2) isolation procedure for potentially infectious TB patients in an airborne infection isolation room if available or in a separate room with door shut if the facility did not have an airborne isolation room. 3) referral and transfer procedure to a setting equipped to evaluate and treat potentially infectious TB patients. South Shore Care Center had policies dated September 2012 related to procedure for Tuberculosis Resident Screening and Tuberculosis Employee Screening that directed the use of symptom screening, 2-step tuberculin skin test (TST), and chest x-rays as needed. The facility also had a policy related to Tuberculosis Risk Assessment dated 8/1/13 that directed the TB risk assessment was to be done annually and was last completed in 2013. The Tuberculosis Resident Screening policy dated 9/4/12 provided 6/10/14 did not designate responsibility for the TB program. The Tuberculosis Resident Screening policy dated 9/4/12 provided 6/13/14 identified the director of nursing or her designated alternative as responsible for monitoring/surveillance for resident identified to have confirmed active TB. Review the provided policies did not reveal an active written Tuberculosis Control Program that included the team/person responsible for the TB infection control program, staff recognition and staff role in the management of the program, isolation procedures for potentially infectious TB patients, and a referral system/setting equipment to evaluate and treat potentially infectious TB patients. Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 directed facilities to provide all health care workers (HCW) with training at the time of hire and annually or as needed. No documentation related to HCW education was provided.	21426		

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21426	Continued From page 22 The facility had designated registered nurse (RN)-B as the contact person for infection control questions. On 6/11/14 at 3:18 p.m. RN-B was interviewed related to the facility's TB program. RN-B stated she was not aware of the facility's use of volunteers and if they needed TST and that she was not aware of the areas related to the Regulations for Tuberculosis Control in Minnesota Health Care Settings. The Director of nursing (DON) was interviewed on 6/13/14 at 2:38 p.m. DON stated the facility had a couple of separate policies related to Tuberculosis that had been provided and that she did not have a policy related to staff training. DON stated she did not know the last education held for HCW related to TB. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review the Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 and use the regulations to revise/develop and implement a tuberculosis infection control program. The director of nursing or designee could educate all appropriate staff on these policies and procedures and staff role in the management of the TB infection control program. The DON or her designee could provide in service training to health care workers related to tuberculosis. The DON or designee could develop a monitoring system to ensure ongoing compliance with the regulations. TIME PERIOD: Twenty-one (21) days.	21426		
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		

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21530	Continued From page 23 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: Based on interview and document review, the	21530		

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21530	Continued From page 24 consulting pharmacist failed to report irregularities to the physician and director of nursing during the monthly pharmacy review for 2 of 5 residents (R8 and R51) reviewed for unnecessary medication use. Findings include: R8 physician orders dated 4/15/14, identified diagnoses of but not limited to MDD (major depressive disorder), anxiety, nervousness, agitation and osteoarthritis. R8's five day Minimum Data Set (MDS) dated 4/18/14, identified mood score of five (symptoms of depression mild), no behaviors, had received scheduled and as needed pain medication, had received non medication interventions for pain, pain present occasionally, pain limited day to day activity, pain scale rate of eight. R8's brief interview of mental status (BIMS) had been 15 out of 15 on the MDS and indicated cognitively intact. During review of R8's current physician orders dated 4/15/14, revealed orders for Cymbalta (an antidepressant medication) 20 mg (milligrams) every day for MDD, start date of 10/4/13, Trazodone (an antidepressant medication) 50 mg every bedtime for MDD, start date of 10/4/13, citalopram (Celexa) (an antidepressant medication) 20 mg every day for MDD, start date 4/11/14, lorazepam (an anti-anxiety medication) one mg three times a day as needed for anxiety/nervousness/agitation, start date 10/4/13 and hydrocodone-acetaminophen (pain medication) 5/325 mg one to two tablets every six hours as needed for osteoarthritis. Review of Southwestern Mental Health Center Medication Management progress note dated	21530		

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21530	Continued From page 25 3/4/14, identified diagnosis depressive disorder, medications Cymbalta and Trazodone and continue with Cymbalta and Trazodone. The third antidepressant Celexa was started on 4/11/14 and there was not documentation nor was any provided as to a physician ' s justification to use three antidepressant medications at the same time. Document review of R8's medication administration record dated from 5/1/14 to 5/31/14 and from 6/1/14 to 6/30/14, identified R8 had been receiving Celexa 20 mg every day, Cymbalta 20 mg every day and Trazodone 50 mg every bedtime, lorazepam one mg three times a day as needed and hydrocodone-acetaminophen 5/325 mg one to two tablets every six hours as needed. Document review of R8's PRN Medication sheets dated from 5/1/14 through 6/12/14, identified R8 had received as needed lorazepam eight times and reasons for giving documented had been increased anxiety/increased anxiousness/I am nervous and response had not been documented regarding effectiveness of lorazepam four out of the eight times. Hydrocodone-acetaminophen medication had been given 13 times and six out of 13 doses had no documentation of effectiveness. During interview on 6/13/14, at 10:29 a.m., licensed practical nurse (LPN)-D verified effectiveness of lorazepam and hydrocodone-acetaminophen medications had not been documented and verified the reason/s documented for giving lorazepam had been increased anxiety/anxiousness, which were not resident specific signs or symptoms for R8.	21530		

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21530	Continued From page 26 During interview on 6/13/14, at 12:21 p.m., director of nursing had stated would expect use of citalopram and lorazepam medication to be reviewed and specific behaviors identified and care planned. Director of nursing had stated would expect physician justification to be documented regarding use of three antidepressant medications being used for R8. Also would expect effectiveness of as needed medications when given are documented and reason of anxiousness being documented for lorazepam medication being given as needed be more specific regarding what anxiousness is. R51 received as needed antianxiety medication however, there were no resident specific sign or symptoms identified to determine if the antianxiety medication was affective or not. R51 ' s physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, depression, anxiety, restlessness. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified mood: feeling down, depressed or hopeless, feeling tired or having little energy, moving or speaking slowly and behaviors of psychosis-delusional. R51's brief interview of mental status (BIMS) had been 3 out of 15 on the MDS and indicated severe cognitive impairment. During review of R51's current physician orders dated 5/7/14, revealed an order for Ativan (an anti-anxiety medication) 0.5 mg (milligrams) every four hours as needed, diagnoses of anxiety and restlessness, start date 4/17/14. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated would expect use of Ativan medication to be reviewed and specific	21530		

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21530	Continued From page 27 behaviors identified for use of medication. During interview on 6/13/14, at 1:37 p.m., consultant pharmacist (CP)-C had stated would expect physician justification for use of more than one antidepressant medication used at the same time and to be documented twice in the first year then yearly thereafter and would expect specific behaviors be identified for use of psychotropic medications. Document review of the facility policy Medication Regimen Review dated 12/1/07, read, "Procedure: 2. Facility should ensure that the consultant pharmacist has access to: 2.4 Physician/Prescriber progress notes, nurses' notes, and other documents which may assist the Consultant Pharmacist in making a professional judgment as to whether or not irregularities exist in the medication regimen; and, 2.5 Any other necessary information, in accordance with Applicable Law." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure the consultant pharmacist identified and reported medication irregularities including indications for use and monitoring effectiveness. The director of nursing could educate all nursing staff on the policies and procedures. The Quality Assurance Committee could monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		

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21535	Continued From page 28 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: 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 observation, interview and document review, the facility failed to attempt a gradual dose reduction of antipsychotic medication and/or reduction of psychotropic medication for 1 of 5 residents (R40) reviewed for unnecessary medication use; failed to clearly identify indications (resident specific signs and symptoms) for use of an antianxiety medication for 2 of 5 residents (R8, R51) reviewed for unnecessary medication use. Findings include:	21535		

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21535	Continued From page 29 R40 was admitted to the facility 4/23/09, and had diagnosis that included anxiety/psychosis and depression, according to physician orders signed 5/20/14. The facility identified R40 on the annual Minimum Data Set (MDS), an assessment dated 4/22/14, to have no cognitive impairment, no moods, no behaviors, and received antipsychotic, antianxiety, and antidepressant medications. Document review of the resident care plan dated 5/12/09, directed staff R40 had problem of potential for side effects of psychotropic medications, with interventions that included monitor for side effects, monitor behavior each shift and document. Resident care plan dated 5/12/09, revealed problem potential for mood alteration, with interventions that included monitor key times for triggering increased behavior. During observations on 6/10/14, at 9:55 a.m., R40 was observed to wheel self independently to a group activity. No moods or behaviors were observed. Observations on 6/10/14, at 12:30 p.m., R40 was independently eating lunch in the dining room. No moods or behaviors were observed. During resident interview on 6/10/14, at 12:45 p.m., no moods or behaviors were noted or observed. Document review of physician orders signed dated 5/20/14, revealed orders for lorazepam (Ativan) 0.25 milligrams every bedtime for anxiety, order date of 3/25/11; zoloft 200 milligrams every morning for depression, order date of 11/16/10; and Seroquel (psychotropic) 450 milligrams every bedtime for anxiety/psychosis, order date of 11/15/11.	21535		

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21535	Continued From page 30 Document review of facility medication administration record for 5/1/14 to 5/31/14 and 6/1/14 to 6/11/14, revealed R40 received Ativan, Zoloft and Seroquel as ordered. During interview on 6/11/14, at 2:22 p.m., social services (SS)-A stated she reviewed mood and behavior monitoring weekly with the clinical managers and reviewed facility risk management team documentation with the team monthly. SS-A identified the following moods monitored included depression, anxiety and sleep disturbance. SS-A stated R40 had no target behaviors and no monitoring of behaviors. SS-A stated if R40 had behaviors, then they would monitor the behaviors. SS-A stated the monitoring of moods included nursing assistant documentation every shift in the facility computer system. SS-A verified every shift mood monitoring according to the mood symptoms detail report from 12/1/13 to 6/11/14, revealed there were no moods. Document review of facility social services charting assessment annual dated 4/22/14 identified the following: no incidents of depression and sleep disturbance in past 14 days and no behavioral issues. Document review of facility brief interview for mental status(BIMS) dated 10/22/13, revealed a score of 15/15-cognition intact, patient health questionnaire (PHQ-9) identified score of 3, less than minimal symptoms of depression, and no behaviors. Document review of facility brief interview for mental status(BIMS) dated 1/21/14, revealed a score of 15/15-cognition intact, social services behavior assessment-no behaviors, social services mood assessment, monitored	21535		

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21535	Continued From page 31 depression, anxiety, sleep disturbances with no incidents of these moods, and PHQ-9 score of 0 (no depression). Document review of facility brief interview for mental status(BIMS) dated 4/22/14, revealed a score of 13/15-cognition intact, social services behavior assessment-no behaviors, social services mood assessment-monitored depression, anxiety, sleep disturbances with no incidents of these moods, and PHQ-9 score of 0 (no depression). Document review of Doctors Orders and Progress Notes dated 4/16/14, revealed consultant pharmacist request for physician to address psychopharmacological medication review. Physician response dated same day, revealed R40 needed to continue current medications as reduction done in the past made recurrence in his anxiety instability with decompensation. The following facility Psychopharmacological Medication Reviews were attached to the physician response dated 4/16/14, each with review date of 2/6/14: Lorazepam 0.25 milligrams, order date-3/25/11, diagnosis-anxiety, comments-This is minimal dose, resident does well on this dose, reduction not advised by nursing. Zoloft 200 milligrams, order date-11/16/10, diagnosis-depression, comments- resident does well on this dose, reduction not advised from nursing. Seroquel 450 milligrams every bedtime, order date- 11/15/11, diagnosis-anxiety/psychosis, comments- resident does well on this dose, reduction not recommended by nursing. During interview on 6/12/14, at 3:13 p.m.,	21535		

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registered nurse (RN)-C stated there had been no attempts at lowering the dose of Ativan and Zoloft or a gradual dose reduction of Seroquel. RN-C verified psychopharmacological medication reviews dated 2/6/14, were written by RN-C with the comment statement on each review-Ativan, Zoloft, and Seroquel, does well on this dose and dose reduction not recommended, were written by her. RN-C verified these reviews were sent to the psychiatrist and the statement from psychiatrist dated 4/16/14, to continue current medications, was based on that review.

Document review of Psychopharmacological Medication Review with review date of " 4/1/12, " physician signed order on " 4/3/13, " to decrease Seroquel from 450 milligrams to 400 milligrams and to monitor response. Although requested, the facility was unable to provide any further information related to dose reduction of Seroquel and return to 450 milligrams dosage.

During interview on 6/13/14, at 8:30 a.m., director of nursing stated she expected an attempt at gradual dose reduction of psychotropic medications or clinical justification for no attempt.

R8 received three antidepressant medicaations and there was no physician justification for the use of three antidepressant medications to be used at the same time.

R8 had been admitted on 10/4/13. R8's physician orders dated 4/15/14, identified diagnoses of but not limited to MDD (major depressive disorder), anxiety, nervousness, agitation and osteoarthritis. R8 ' s five day Minimum Data Set (MDS) dated 4/18/14, identified mood score of five (symptoms of depression mild), no behaviors, had received scheduled and as needed pain medication, had

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received non medication interventions for pain, pain present occasionally, pain limited day to day activity, pain scale rate of eight. R8 ' s brief interview of mental status (BIMS) had been 15 out of 15 on the MDS and indicated cognitively intact.

During review of R8's current physician orders dated 4/15/14, revealed orders for Cymbalta (an antidepressant medication) 20 mg (milligrams) every day for MDD, start date of 10/4/13, Trazodone (an antidepressant medication) 50 mg every bedtime for MDD, start date of 10/4/13, citalopram (an antidepressant medication) 20 mg every day for MDD, start date 4/11/14, lorazepam (an anti-anxiety medication) one mg three times a day as needed for anxiety/nervousness/agitation, start date 10/4/13 and hydrocodone-acetaminophen (pain medication) 5/325 mg one to two tablets every six hours as needed for osteoarthritis.

R8's current care plan dated 1/8/14, identified problem mood alteration related to depression, anxiety, grief, loss of role evidenced by feeling down at times, enter long term care, feeling tired, poor appetite, anxious, difficulty with concentration at times with intervention of but not limited to give medication as ordered and monitor for side effects. Problem potential for side effects of psychotropic medication with interventions of but not limited to monitor behavior on each shift and document, monitor and document response to medication monthly. Problem potential for alteration in comfort: pain related to lower back pain, leg pain and pain all over with interventions of but not limited to assess episodes of pain and evaluate effectiveness of interventions used, document effectiveness on PRN (as needed) MAR (medication administration record) and/or in

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21535	Continued From page 34 interdisciplinary notes. Review of physician progress note dated 2/25/14, identified current medications of but not limited to Ativan (lorazepam), cymbalta, trazodone, but had no documentation regarding mood. Review of Southwestern Mental Health Center Medication Management progress note dated 3/4/14, identified diagnosis depressive disorder, medications Cymbalta and trazodone and continue with Cymbalta and trazodone. The above physician progress notes had no documentation regarding justification for use of Cymbalta, trazodone and lorazepam that had start dates of 10/4/13 and no documentation of physician justification regarding starting third antidepressant medication citalopram on 4/11/14. Document review of R8 ' s medication administration record dated from 5/1/14 to 5/31/14 and from 6/1/14 to 6/30/14, identified R8 had been receiving citalopram 20 mg every day, Cymbalta 20 mg every day and trazodone 50 mg every bedtime, lorazepam one mg three times a day as needed and hydrocodone-acetaminophen 5/325 mg one to two tablets every six hours as needed. Document review of R8 ' s PRN Medication sheets dated from 5/1/14 through 6/12/14, identified R8 had received as needed lorazepam eight times and reasons for giving documented had been increased anxiety/increased anxiousness/I am nervous and response had not been documented regarding effectiveness of lorazepam four out of the eight times. Hydrocodone-acetaminophen medication had been given 13 times and six out of 13 doses had no documentation of effectiveness.	21535		

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21535	Continued From page 35 Document review of the facility risk management team documentations: review dates 3/19/14 had not identified medication use of Cymbalta, lorazepam and trazodone medications, review date 4/17/14 had not identified medication use of lorazepam and citalopram (interview on 6/13/14, at 11:05 a.m., social worker (SW)-A had stated medication identified as citalopram with date of 12/23/13 reviewed had been Cymbalta and had been documented incorrectly as citalopram on the facility risk management team documentation dated 4/17/14) and review date of 5/14/14, had not identified medication use of lorazepam, Cymbalta and citalopram medications. During interview on 6/13/14, at 10:29 a.m., licensed practical nurse (LPN)-D verified effectiveness of lorazepam and hydrocodone-acetaminophen medications had not been documented and verified reason documented for giving lorazeapm had been increased anxiety/anxiousness, however, resident specific anxiety symptoms not clearly identified when Ativan was given. LPN-D verified R8's care plan had no specific behaviors in regards to lorazepam medication use other than the word anxiety is documented on the care plan. During interview on 6/13/14, at 11:05 a.m., social worker (SW)-A had stated it is up to the resident care coordinator to bring all information to risk management meetings regarding medications a resident is receiving. SW-A verified the risk management team had not reviewed the use of citalopram and lorazepam for R8 and verified the risk management team had not identified specific resident symptoms of anxiety, nervousness and agitation related to lorazepam medication use. SW-A reviewed R8's chart and verified there had been no physician justification documented	21535		

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21535	Continued From page 36 regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8's physician progress notes. During interview on 6/13/14, at 11:23 a.m., registered nurse (RN)-C verified there had been no physician justification documented regarding use of Cymbalta, trazodone, lorazepam and citalopram in R8 ' s physician progress notes, just the diagnoses. During interview on 6/13/14, at 12:21 p.m., director of nursing had stated she would expect use of citalopram and lorazepam medication to be reviewed and specific behaviors identified and care planned. Director of nursing had stated would expect physician justification to be documented regarding use of Cymbalta, trazodone, Ativan and why started citalopram. Director of nursing stated would expect effectiveness of as needed medications when given be documented and reason of anxiousness being documented for lorazepam medication being given as needed be more specific regarding what anxiousness is. R51 received ativan as needed (PRN) however, there was no resident specific anxiety signs and symptoms identified to determine it the medication was affective or not. R51 had been admitted on 8/1/12. R51 ' s physician orders dated 5/7/14, identified diagnoses of but not limited to dementia, depression, anxiety, restlessness. R51's significant change Minimum Data Set (MDS) dated 4/15/14, identified mood: feeling down, depressed or hopeless, feeling tired or having little energy, moving or speaking slowly and behaviors of psychosis-delusional. R51 ' s brief interview of mental status (BIMS) had been 3 out	21535		

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21535	Continued From page 37 of 15 on the MDS and indicated severe cognitive impairment. During review of R51's current physician orders dated 5/7/14, revealed an order for Ativan (an anti-anxiety medication) 0.5 mg (milligrams) every four hours as needed, diagnoses of anxiety and restlessness, start date 4/17/14. R51 ' s current care plan dated 11/19/13, identified problem potential for mood alteration related to loss of function, feeling worthless, weepy at times, paranoid, resistive at times, lack of interest, verbal yelling, refusals, sleep disturbances and restless with intervention of but not limited to assess and monitor increased signs verbalization of depression daily, document on behavior flow sheets, review monthly at team meetings. Problem inappropriate behavior: physical, verbal, rejection related to cognitive, mood evidenced by spit, hit, pinch, slap, throws objects, threatens, yells, swears, refuses ADL (activities of daily living), bath, medications, treatments, labs and cares. However R51 ' s care plan had not identified specific symptoms of anxiety and restlessness related to Ativan medication use. Document review of the facility risk management team documentation review dates 4/17/14 and 5/14/14, had no documentation regarding Ativan medication. During interview on 6/13/14, at 10:50 a.m., social worker (SW)-A had stated she did not know R51 had an order for Ativan, but I should of. SW-A verified no mention of Ativan on R51 ' s current plan of care dated 11/19/13. SW-A verified risk management team had not reviewed the use of	21535		

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21535	Continued From page 38 Ativan for R51 to identify specific behaviors related to medication use. During interview on 6/13/14, at 12:07 p.m., director of nursing had stated would expect use of Ativan medication to be reviewed and specific behaviors identified and care planned. Document review of the facility Psychotropic Drug Review Tool dated 8/4/05, read, "PURPOSE To assure that each resident receiving psychotropic medications are assessed routinely for benefit/risk and gradual dose reductions if not clinically contraindicated. It is the facilities policy that each resident ' s drug regimen remains free from unnecessary drugs and that gradual dose reductions are implemented unless clinically contraindicated. POLICY 3. The behavior management team will review all Psychotropic Drug Review Tools to assure their completion and that the facility is compliant with state regulations. PROCEDURE 4. Residents who are started on a new psychotropic medication will have a completed Psychotropic Drug Review Tool at initiation of therapy. The Resident Care Coordinator will be responsible to completion of this tool. 5. Members of the interdisciplinary team are responsible to assure that individualized problems, goals, and approaches are contained the resident plan of care." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures for unneccessary medications. Director of nursing could educate staff. Director of nursing could monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

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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, interview, and document review, the facility failed to ensure accurate medication labels for 2 of 25 medication labels reviewed for 2 of 7 residents (R40, R8) observed during medication pass; and failed to date medications when opened for 1 of 3 medication carts reviewed, which affected 3 of 3 residents (R7, R19, R6) reviewed during medication storage checks. Findings include: INACCURATE MEDICATION LABELS: R40's medication MouthKote artificial saliva) pharmacy label instructed one spray to mouth, however, while observations of the medication pass revealed R40 took three sprays. Although R40 received the physician ordered correct dosage, the pharmacy label had not been corrected to the most current physicians order for the past 2 1/2 years. R40 was admitted to the facility 4/23/09, and had diagnosis that included dry mouth, according to physician orders signed dated 5/20/14. Document review of current physician orders signed dated 5/20/14, revealed orders for artificial saliva orally three sprays to mouth three times a day.	21620		

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21620	Continued From page 40 Observations of the medication pass on 6/10/14, at 12:38 p.m., revealed licensed practical nurse (LPN)-A handed MouthKote to R40, who sprayed three sprays into mouth. Document review of pharmacy medication label revealed artificial saliva; dispense date of 9/29/13, and directions to "Use 1 spray into mouth orally three times a day for dry mouth." During interview on 6/10/14, at 12:48 p.m., LPN-A verified the pharmacy medication label with dispense date of 9/29/13, instructed one mouth spray three times a day. During interview at that time, LPN-A verified current physician orders signed and dated 5/20/14, for artificial saliva, order date of 11/15/11, three sprays to mouth three times a day. During interview on 6/12/14, at 1:30 p.m., director of nursing stated she expected nurses checked medication labels with each medication pass. She stated she expected when medications were delivered to the facility, the nurse checked medication labels with physician orders at that time. She stated when medication orders changed; she expected the nurse placed a "direction change" sticker on the medication container. Document review of facility medication administration record 6/1/14-6/9/14, revealed R40 received artificial saliva three sprays to mouth three times a day as physician ordered. Document review of facility policy Reordering, Changing, and Discontinuing Orders, revision dated 1/1/13, page 80, #3.5 "If Pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and	21620		

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21620	Continued From page 41 there is adequate supply on hand: 3.5.1 Pharmacy should discontinue the original order; 3.5.2 Facility Physician/Prescriber should write the new order with new directions and Facility should enter the new order on the appropriate Medication Record Forms; and, 3.5.3 If permitted by Applicable Law, Facility should notify Pharmacy not to send the medication by attaching a "Change in Directions" sticker to the existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container. Facility may order from Pharmacy bulk rolls of "Change in Directions" stickers." During telephone interview on 6/13/14, at 1:37 p.m., consultant pharmacist-C stated he expected the label to be updated with the current order. He stated the pharmacy provided change of direction stickers for the facility to use to alert their staff of order changes. R8's insulin vial label was not updated to reflect the physician order change. During observation of medication administration on 6/12/14, at 11:02 a.m., licensed practical nurse (LPN)-B verified R8's Novolog insulin vial label had directions to administer 30 units three times a day and sliding scale. LPN-B had stated the orders had changed, R8 only receives sliding scale now and I'll put a sticker on bottle (regarding order change). During review of R8's physician telephone order dated 5/4/14, identified order discontinue 30 units Novolog at meals. Moderate sliding scale only, call provider below 60, over 400, 60 to 150 give 0 units, 151 to 200 give 4 units, 201 to 250 give 6 units, 251 to 300 give 8 units, 301-350 give 10	21620		

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21620	Continued From page 42 units and 351 to 400 give 12 units. Document review of R8 ' s medication administration record dated from 6/1/14 to 6/30/14, identified R8 had received sliding scale Novolog insulin and start date of order had been 5/4/14. During interview on 6/12/14, at 11:28 a.m., LPN-B verified label on Novolog insulin vial had incorrect orders on label and no sticker had been placed on bottle to identify order change. During interview on 6/13/14, at 1:37 p.m., consultant pharmacist-C stated in regards to incorrect directions on label of Novolog insulin he would expect label to be updated, we provide the home with stickers to place over label see MAR (medication administration record) or chart for new directions. During interview on 6/13/14, 12:01 p.m., director of nursing had stated in regards to incorrect directions on label of Novolog insulin she would expect flag (sticker to alert staff to check physician orders as a change was done) to be put on bottle see MAR for order change. MEDICATIONS DATED WHEN OPENED: During medication storage checks the following was noted: R7 ' s Roxanol 20 mg [milligram]/ml [milliliter] 0.25 ml po/sl [sublingual] TID [three times per day.] The bottle was stored in the locked narcotic cabinet and no date as to when bottle had been opened. Twenty five ml left in bottle and verified by RN-A and found on 6/11/14 at 2:36 p.m.	21620		

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21620	Continued From page 43 R19 ' s medication Humalog Observation Insulin was in drawer of medication cart opened and no date as to when opened, this was noted on 6/11/14 at 2:40 p.m. R6 has an order for Novolog 100 u [units]/ml SQ [subcutaneous] TID AC [before meals] according to sliding scale. Bottle was in drawer of medication cart opened and no date found as to when it was opened. The medication was found on 6/11/14 at 2:40 p.m. and verified by RN-A. Review of policy: 5.3 Storage and Expiration Dating of medications; Biological's, Syringes and Needles revised 5/10/10; 01/01/13 page 2 of 3: #5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Omnicare Pharmacy Services: Medication Expiration Dates with effective date of 11/27/13: Insulin: 30 days after opening at room temperature. Medication Type: REMEMBER ALL MEDICATIONS ON THIS LIST MUST HAVE AN OPEN DATE PRESENT. Multi-Dose Vials: All multi-dose vials should be dated and initialed when opened by licensed staff. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure accurate medication labels, medications dated when opened, and destruction of controlled substances. The director of nursing could educate nursing staff. The director of nursing could monitor staff compliance.	21620		

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21620	Continued From page 44 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, the facility failed to ensure ceiling and mechanical air vents were clear of dust in 4 of 4 residential hallways; Also air vents, stove hood, and steam table pans were not routinely cleaned to maintain a clean and sanitary environment in the kitchen and this had the potential to affect all 42 residents who received prepared foods from the kitchen; Unpleasant and possibly harmful odors detected and not determined if harmful to residents or staff health. This also will affect 42 of 42 residents, staff and visitors to the facility. Findings include: A facility tour was conducted with environmental supervisor (ES) on 6/11/14 at 9:55 a.m. Hallways A & B were noted to have black areas on all 10 ceiling grates. Also noted on Hallways A, B, C were ceiling air grates with a coat of dust and strands of dust that was moving when air	21685		

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21685	Continued From page 45 movement. The Trane air condition unit on Hallway C and mechanical unit on Hallway D also were noted to have grates with coating of dust and strands of dust also moving when air was moving. ES was interviewed during a tour on 6/12/14 at 12:30 p.m. ES stated the Trane air conditioner unit and mechanical unit had filters changed every 30 days and should have the intake vent cleaned. ES verified these were dusty. ES stated the 10 ceiling grates on hallways A & B were part of the old system and had original air duct system that could have a history of moisture exposure from humidifiers. ES did not know if the black areas were from rust stains or something else like mold. ES also stated the other ceiling vent grates were to be cleaned every 30 days, but that they were currently dusty. On 6/13/14 at 8:50 a.m. ES stated that during the past year, he had not had the 10 black marred grates either washed or painted. ES stated he was not sure if that was ever done. During an interview on 6/13/14 at 11:00 a.m. ES stated that he used a ladder to check out the vents for the first time. ES thinks the black marks on the 10 grates could possibly be rust. An initial tour of the kitchen was conducted on 6/9/14 at 6:15 p.m. with the dietary aide (DA)-A. The observations were reviewed and verified with dietary manager (DM)-A on 6/9/14 at 6:34 p.m. Observations during the tour include the following: The vented lower surface of the range hood (directly above cooking surface); was coated with a brown, sticky substance (grease) in addition to the glass fixtures which covered the light bulbs	21685		

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21685	Continued From page 46	21685		

located under the hood. The surfaces and surrounding area of the knobs located on the front surface of the range were also coated with the brown, sticky substance. The cooling fan located in the refrigerated cooler showed a buildup of dust and debris on both the frame surface and piping of the unit. This fan circulates air around food stored in cooler. No food was observed to be uncovered. Insulated electrical wires attached to the back of the fan unit and running along the top food shelf were observed to be coated with debris.

The storage room which contained paper products and dish covers had a large air vent about 1 foot square located directly above the top metal shelf on upper right side of the room. Interview of the DM on 6/9/14 at 6:50 p.m. verified that this open vent was part of the ventilation system for the elevator which transported person, etc. to other floors of the facility. This vent was observed to be open without any grates or coverings. It was also observed that approximately 3/4 of the opening was obstructed by boxes of straws which were sitting on top of the shelf. The surface of the opening and surrounding area were noted to have a thick layer of dust and debris buildup.

DM-A on 6/9/14 at 6:34 had been interviewed and she verified the range hood was soiled with grease buildup and that the range hood had been last cleaned professionally in January 2014. She also stated that maintenance was supposed to have been cleaning the range hood on a routine basis and that this had not been done.

A second interview with the dietary manager on 6/11/14, at 11:07 a.m. was performed and she was in attendance during observation of the meal

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21685	Continued From page 47 service. During observation it was noted that steam table pans (food containing surfaces) have white residue in corners that does scratch off. The coffee machine was observed to have white and brown buildup noted on the drain surface. Upon review of the dietary cleaning schedule which had been posted during the initial tour it was noted that there were multiple blanks present. This schedule included a weekly cleaning list for the day cook which included grill sides, back & drip tray; steam table; cooks counter; ovens wipe down daily, shelf below cook counter, etc. A copy of the policy titled: Exhaust Hood Semi Annual PM MT06:04SA dated 2002: stated: Maintenance Tasks 1.) Check and clean grease and foreign material from interior of duct at hood connections. 2.) Check and clean grease and foreign material from interior of duct at access panels. 4.) Check and clean grease and foreign material from all visible and accessible duct/hood seams and joints. 5.) Clean hood grills and filers. UNPLEASANT OR HARMFUL ODORS DETECTED On entrance to the building by way of the lower level entrance on the evening of 6/9/14 at 6:01 p.m. a strong sewer and musty odor was noted. The day had been warm and humid. On 6/13/14 at 7:55 a.m. the front entrance and lower level entrance had been entered. The weather the morning of 6/13/14 was cool and not humid. The main entrance again smelled musty. As the surveyor went from the main entrance to the 100 room wings the smell changed from musty to sewer and as you walked past the tub room and hallway near rooms 106, 107, 108, 109	21685		

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21685	Continued From page 48 it was a strong sewer type smell and again between the end of the hallway by the old house entrance again a smell of sewer was noted. The 400 wing (located on the lower level) was entered through the lower level door on 6/13/14 at 7:55 a.m. On entering the lower level resident unit a sewer smell was noted and dissipated by the nursing station. On 6/13/14 at 8:00 a.m. registered nurse (RN)-E was interviewed. RN-E stated she had noted the sewer and musty smell/s also other than when toileting needs of the resident were completed. At 8:01 a.m. RN-D stated she noted a musty smell when the air condition in her office turned on. At 8:03 a.m. housekeeper (H) - A stated that yes she was aware of a musty smell. The environmental supervisor (ES) was interviewed on 6/12/14 at 12:30 p.m. ES stated there had been a sewer odor in the past on the lower residential unit about 3 years ago and required fixing pipes in the wall. ES stated about 90 days ago he had purchased an air neutralizer/sanitizer to be used in the building to neutralize the toileting odors created by the resident ' s incontinence episodes. ES stated he did not smell the musty or sewer type odor because he had grown used to it. SUGGESTED METHOD OF CORRECTION: The environmental supervisor and director of nursing could review and revise policies and procedures to ensure a safe and clean environment and equipment in good working order. The environmental supervisor could educate all staff on the process. The Quality Assurance Committee could monitor staff compliance.	21685		

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21685	Continued From page 49 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		

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21800	Continued From page 50 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required notices upon termination of all Medicare part A skilled services for 3 of 3 residents (R51, R11 and R3) who met the qualification to receive Medicare services and were discharged from the facility. Findings include: NOTICE OF MEDICARE PROVIDER NON-COVERAGE: R51, R11, and R3 lacked evidence of receiving the Centers for Medicare and Medicaid Services (CMS) expedited decision, " Notice of Medicare Provider Non-Coverage" notice prior to discharge from Medicare services. R51 was discharged from Medicare on 4/10/14, due to electing hospice benefits, according to document review of R51's Skilled Nursing Facility Determination on Continued Stay. R51 used 10 Medicare days, according to resident liability notice list provided by the facility. R51 remained in the facility. The facility lacked evidence of providing R51 with the Centers for Medicare and Medicaid (CMS) expedited decision, "Notice of Medicare Provider Non-Coverage" which included instructions on how to contact the Quality Improvement Organization (QIO), an independent reviewer authorized by Medicare to review the facility decision to discharge from Medicare. R11 was discharged from Medicare on 10/29/13, due to lack of skilled nursing or rehabilitation progress, according to document review of R11's Skilled Nursing Facility Determination on	21800		

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21800	Continued From page 51 Continued Stay. R11 used 8 Medicare days, according to resident liability notice list provided by the facility. R11 remained in the facility. The facility lacked evidence of providing R11 with the Centers for Medicare and Medicaid (CMS) expedited decision, "Notice of Medicare Provider Non-Coverage " which included instructions on how to contact the Quality Improvement Organization (QIO), an independent reviewer authorized by Medicare to review the facility decision to discharge from Medicare. R3 was discharged from Medicare on 5/29/14, due to lack of skilled nursing or rehabilitation progress, according to document review of R3's Skilled Nursing Facility Determination on Continued Stay. R3 used 29 Medicare days, according to resident liability notice list provided by the facility. R3 remained in the facility. The facility lacked evidence of providing R3 with the Centers for Medicare and Medicaid (CMS) expedited decision, "Notice of Medicare Provider Non-Coverage" which included instructions on how to contact the Quality Improvement Organization (QIO), an independent reviewer authorized by Medicare to review the facility decision to discharge from Medicare. During interview on 6/13/14, at 1:59 p.m., registered nurse (RN)-C verified the facility lacked evidence of providing the "Notice of Medicare Provider Non-Coverage" for R51, R11, and R3. CENTERS FOR MEDICARE AND MEDICAID SERVICES SKILLED NURSING FACILITY ADVANCED BENEFICIARY NOTICE OR DENIAL LETTERS: R51 and R3 did not receive the approved CMS denial letter prior to discharge from Medicare	21800		

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21800	Continued From page 52 services. The facility did not use the Centers for Medicare and Medicaid Services (CMS) approved Skilled Nursing Facility Advanced Beneficiary Notice or one of the five denial letters available on the Centers for Medicare and Medicaid (CMS) website. The CMS notice asked residents if they would want their bill submitted to Medicare or not submitted for review. The denial letter provided by the facility titled "Skilled Nursing Facility Determination on Continued Stay " lacked the following required information according to the CMS website: "This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal." R51 was discharged from Medicare on 4/10/14, due to electing hospice benefits, according to document review of facility Skilled Nursing Facility Determination on Continued Stay. R51 used 10 Medicare days, according to resident liability notice list provided by the facility. R51 remained in the facility. Although the facility provided R51 with the Skilled Nursing Facility Determination on Continued Stay notice, the notice lacked instructions on submitting the facility bill to Medicare for review.	21800		

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21800	Continued From page 53 R3 was discharged from Medicare on 5/29/14, due to lack of skilled nursing or rehabilitation progress, according to document review of R3's Skilled Nursing Facility Determination on Continued Stay. R3 used 29 Medicare days, according to resident liability notice list provided by the facility. R3 remained in the facility. Although the facility provided R3 with the Skilled Nursing Facility Determination on Continued Stay notice, the notice lacked instructions on submitting the facility bill to Medicare for review. During interview on 6/13/14, at 1:59 p.m., RN-C, verified these were the denial letters provided to R51 and R3. DENIAL LETTERS LACKED DECISION TO SUBMIT OR NOT SUBMIT BILL TO MEDICARE: R51 was discharged from Medicare on 4/10/14, due to electing hospice benefits, according to document review of facility Skilled Nursing Facility Determination on Continued Stay. R51 used 10 Medicare days, according to resident liability notice list provided by the facility. R51 remained in the facility. Although the facility provided the Skilled Nursing Facility Determination on Continued Stay, the facility lacked evidence of R51's decision to submit or not submit the bill to Medicare. R11 was discharged from Medicare on 10/29/13, due to lack of skilled nursing or rehabilitation progress, according to document review of facility Skilled Nursing Facility Determination on Continued Stay. R11 used 8 Medicare days, according to resident liability notice list provided by the facility. R11 remained in the facility. Although the facility provided the Skilled Nursing Facility Determination on Continued Stay, the facility lacked evidence of R11 decision to submit or not submit the bill to Medicare.	21800		

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	00885	A. BUILDING: _____ B. WING _____	06/13/2014

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21800	Continued From page 54 During interview on 6/13/14, at 1:45 p.m., accounts receivable (AR)-G stated she received the denial notice only if the decision was marked to submit the bill. During interview on 6/13/14, at 1:59 p.m., director of nursing verified R51 and R11, facility Skilled Nursing Facility Determination on Continued Stay lacked decision to submit or not submit the bill to Medicare for review. Director of nursing identified RN-C was responsible for the denial letters. During interview at that time, RN-C verified the lack of decision to submit or not submit the bill. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies and procedures to ensure staff provide the appropriate liability notices at the end of Medicare services and to ensure resident rights are acted upon. The administrator could educate all appropriate staff to provide the liability notices. The administrator could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on observation interview and document	21870		

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21870	Continued From page 55	21870		

review, the facility failed to ensure resident council concerns related to timely answering of call lights were addressed with a good faith attempt to be resolved. This also included family and resident interviews for 12 of 42 residents (R33 ' s family member [F-A], R27, R58, R1, R8, R78, R4, R75, R66, R3, R34 and R28) in the facility.

Findings include:

Resident Council Minutes were reviewed for April, May, and June 2014. Each monthly meeting minute ' s had old business related to call lights not being answered. The April minutes indicated the director of nursing (DON) stated that she would do audits and look for patterns. Meeting minutes of 5/7/14 and 6/4/14 documented current concerns related to call lights not being answered in a timely manner. The 6/4/14 meeting minutes indicated there were no specific times or patterns noted by the residents themselves but stated at times they noted a 40 minute wait for assistance. During an interview on 6/13/14 at 11:00 a.m. the social worker (SW)-A reviewed previous Resident Council Minutes and stated that in February 2014 a discussion of call lights was noted under old business.

R33's family member (FM)-A was interviewed on 6/10/14 at 2:42 p.m. and stated that it could take half an hour for her mother to have the call light answered and receive help. Review of R33's quarterly minimum data set (MDS) dated 4/8/14 revealed R33 required extensive assistance with activities of daily living.

R27 was interviewed on 6/10/14 at 2:41 p.m. and stated he would have to wait up to 20 minutes for someone to answer the call light. Review of R27 '

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21870	Continued From page 56 s quarterly MDS dated 5/27/14 revealed R27 had diagnoses of dementia, anxiety, and depression and required extensive assist with activities of daily living. R58 was interviewed on 6/10/14 at 9:18 a.m. and stated sometimes had to wait a while and that it had been an hour or so. R58 felt the evenings were worse around the time R58 wanted to go to bed. R1 was interviewed on 6/10/14 at 8:46 a.m. and stated that she has had to wait for up to 30 minutes for someone to come to answer the call light. R1 added if a nursing assistant was giving a bath, some nurses would not answer the call lights. Review of R1's quarterly MDS dated 3/25/14 revealed R1 had heart failure and required extensive assistance with activities of daily living. R8 was interviewed on 6/10/14 at 8:50 a.m. R8 stated that she has had to wait as long as an hour in the bathroom and knew that staff didn't mean to do that, but it happened. Usually happened in the morning when getting up and dressed for the day. R8 added an hour was a long time to sit in there (referring to the sitting on the toilet for an hour.) Review of R8's 5 day MDS dated 4/18/14 revealed R8 had diagnoses of anxiety, depression, and history of urinary tract infections and required extensive assistance with activities of daily living. The facility provided the call light audit report for 6/11/14 and the report indicated a total of 232 call lights had been alarmed and cleared between 12:00 a.m. and 11:59 p.m. on 6/11/14. The report indicated an average answer time on 4 and ¾ minutes; however, 13 or 5.6% of the time the	21870		

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21870	Continued From page 57 alarm sounded greater than 20 minutes before responded to. The longer waits did not have a time of day patterns and occurred for residents in their rooms, in the bathroom, or on the patio. R33 was designated on the call light report indicated R33 waited 26 minutes on one occasion on 6/11/14. This occurred during the middle of the afternoon. Review of R33's quarterly minimum data set (MDS) dated 4/8/14 revealed R33 required extensive assistance with activities of daily living. On 6/12/14 from 7:55 a.m. to 10:10 a.m. R33 was observed sitting in a recliner, but would not respond when spoken too. At 10:10 a.m. she was noted to be sleeping in the chair. The care conference review dated 4/22/14 indicated R33 required assist of one for transfers and mobility. R78 was designated on the call light report which indicated that R78 waited 20 to 27 minutes on two occasions. The report indicated the alarms were turned on both in the morning and in the evening. R78 was observed on 6/12/14 at 8:00 a.m. lying in bed. The care plan dated 5/31/14 indicated R78 required physical assistance from staff to sit up in bed and assistance to boost up in bed. On 6/13/14 at 3:00 p.m. R78 stated that " they always answer the light" but added sometimes it takes a long time. R78 stated that she had been a director of nursing and had Parkinson's disease. R4 was designated on the call light report indicated R4 experienced a long wait of 21 minutes on 6/11/14. R4's significant change MDS dated 5/22/14 indicated R4 had arthritis and required extensive assistance with activities of daily living.	21870		

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21870	Continued From page 58 R75 was designated on the call light report and also shared a companion room with R4. The call report indicated R75 had a call light alarm on for 27 minutes. R75 ' s significant change MDS dated 4/11/14 indicated R75 experienced pulmonary disease and impaired vision and required extensive assistance with activities of daily living. The call light audit report also indicated the bathroom shared by R75 and R4 had a call light alarmed for 30 minutes. R66 was designated on the call light audit report dated 6/14/14 indicated R66 had to wait 23 minutes for the call light to be answered. R66 had an admission MDS dated 5/12/14 that indicated R66 had diagnoses that included cardiac issues, arthritis, and hip fracture. The MDS also indicated R66 required extensive assistance with activities of daily living. R3 was indicated on the call light audit report indicated R3 had call light waits of 28 and 33 minutes and also bathroom call light waits of 19 and 32 minutes. R3 ' s 30 day PPS MDS dated 5/9/14 indicated R3 required extensive assistance with activities of daily living and had diagnoses that included stroke and hemiplegia. R34 was indicated on the call light audit report of 6/11/14 indicated R34 waited 34 minutes for the call light to be answered. R34 was observed on 6/10/14 at 9:50 a.m. and 10:55 a.m. lying in bed. The bed was in a low position, the mattress was lipped, and a fall mat was on the floor. At 11:20 a.m. the nursing assistant (NA) - F stated staff needed to anticipate R34 ' s needs since R34 did not speak English. The quarterly MDS dated 4/18/14 indicated R34 required extensive assist with activities of daily living.	21870		

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21870	Continued From page 59 R28 was included on the call light report and had experienced call lights wait times that ranged from 23 to 34 minutes. The quarterly MDS dated 4/29/14 indicated R28 had anxiety disorder and required extensive assistance with activities of daily living. The director of nursing (DON) was interviewed on 6/13/14 at 9:15 a.m. DON stated she felt the call light should be answered within the first 10 minutes. She indicated she was aware of the resident concerns related to call lights not being answered for long periods of time and had done some audits. The only audit she could locate was completed in April 2014 and that audit identified longer answering response in the evening. The DON stated the facility had a system in place to identify residents that had complained about call light answering to alert staff of the problem. The DON also stated that after 5 minutes the nurse and then the supervisor would be alerted to the call light alarmed and they should then be responsible to answer the resident's call light. At 9:57 a.m. on 6/13/14 the registered nurse (RN)-C clinical manager indicated that she would receive an audible page for a call light not answered after 5 minutes. RN-C would then audibly page a nursing assistant of the need to answer the call light. The pager system would keep notifying RN-C until the call light was answer. RN-C stated she would sometimes answer the call light if she was not busy. The social worker (SW)-A was interviewed on 6/13/14 at 11:00 a.m. She indicated the resident council complaint process would be for the department heads to investigate and respond. SW-A stated that in June 2014 a more in depth audit would need to be completed with more staff	21870		

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21870	Continued From page 60 members having access to the call light audit system. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies and procedures related to grievances and resolution of grievances. The administrator could educate all staff on the process. The Quality Assurance Committee could monitor staff comnpliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		