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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: IERR
Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245184**

2. STATE VENDOR OR MEDICAID NO. (L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER EAST HEALTH SERVICES**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

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) **05/12/2006**

6. DATE OF SURVEY **06/14/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **116** (L18)

13.Total Certified Beds **116** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(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 :
Jennifer Kilsrud HFE NE II 06/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **09/01/1972** (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 **06/26/2017** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245184

June 28, 2017

Mr. Jon Richardson, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Dear Mr. Richardson:

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 May 28, 2017 the above facility is certified for:

116 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 116 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2017

Mr. Jon Richardson, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Number S5184029

Dear Mr. Richardson:

On May 5, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 10, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for an extended survey completed on April 18, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On June 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on April 18, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 28, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on April 18, 2017, as of May 28, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 28, 2017.

However, as we notified you in our letter of May 5, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 18, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of June 28, 2017:

- Civil money penalty for the deficiencies cited at F225, F226 and F314. (42 CFR 488.430 through 488.444)

An equal opportunity employer.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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(L5) **ROCHESTER, MN** (L6) **55904**

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6. DATE OF SURVEY **04/18/2017** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
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8. ACCREDITATION STATUS: __ (L10)
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FISCAL YEAR ENDING DATE: (L35) **09/30**

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To (b) :

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

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

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

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17. SURVEYOR SIGNATURE Date :
Jennifer Kilsrud HFE NE II 05/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kami Fiske-Downing Program Rep. 06/26/2017 (L20)

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

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____ 2. Facility is not Eligible
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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
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INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

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29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/26/2017** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 5, 2017

Mr. Jon Richardson, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Number S5184029

Dear Mr. Richardson:

On April 18, 2017, an extended 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.24, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate

jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on April 14, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731 Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 10, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F225. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.24, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. ***If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.***

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Rochester East Health Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 18, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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

If substantial compliance with the regulations is not verified by July 18, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on April 10, 2017, through April 18, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F225 related to the facility's failed response to a resident's allegation of verbal abuse. The facility failed to thoroughly investigate, and failed to protect residents during an investigation. The IJ began on 4/11/17 when the facility became aware of a resident's alleged verbal abuse by facility staff. The administrator and director of nursing were notified of the IJ on 4/13/17, at 5:38 p.m. The immediate jeopardy was removed on 4/14/17, at 1:49 p.m. An extended survey was conducted by he Minnesota Department of Health from April 14, 2017 through April 18, 2017. 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 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance	F 166		5/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed; TITLE; (X6) DATE 05/17/2017

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
	245184	A. BUILDING ______ B. WING ______	04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(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 166	Continued From page 1 with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those	F 166		

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grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

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F 166	Continued From page 3 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act and implement a resolution for a known grievance for 1 of 1 resident (R11) interviewed for resident council. Findings include: R11's annual Minimum Data Set (MDS) dated 2/20/2017, identified R11 had intact cognition and required extensive assistance with dressing. During interview on 4/11/2017, at 7:35 p.m. R11 stated she wanted her clothing washed separately from other residents clothing so it does not come back with an odor. R11 stated she had been requesting this for the past couple months, however, her clothes were still being washed with the other residents clothing and coming back, "Pewie, Pewie." R11 stated the staff were aware she wanted her clothing washed separately, however, R11 had been told by the current laundry staff they would not accommodate that specific preference adding this made her, "Not very happy." Facility provided Resident Council Minutes dated 01/03/2017, identified R11 attended the meeting. The form identified several different department sections with various comments and requests. A section labeled, "Laundry," contained a hand written note which identified, " [R11] -clothes not being washed separately." The minutes did not identify any plan to address R11's identified	F 166	This Plan of Correction is submitted as required under Federal and State regulation and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. F166 1. Resident R11 was interviewed by the social worker. The administrator reviewed grievance with Housekeeping Manager. Resident's clothes are being washed separately at her request. 2. Facility residents have the potential to be affected by this practice. 3. Social Services Director met with the Activities Director to review the process for forwarding concerns/grievances brought forth at Resident Council Meetings. Grievance policy and procedure was reviewed with the Activity Director. Facility staff will have completed this	

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F 166	Continued From page 4 concern. Facility provided Resident Council Minutes dated 02/07/2017, identified R11 again attended the meeting. The form again identified a section labeled, " Laundry/Housekeeping," which contained a hand written note which identified, "[R11]-needs clothes washed separately." The minutes did not identify any plan to address R11's repeated voiced concern. During interview on 04/13/2017, at 9:03 a.m. nursing assistant (NA)-O stated she had worked with R11 several times and was aware R11 wanted her laundry washed separately. However, R11's laundry was not being washed separately from the other residents because then everyone would want it done that way, too. Further, NA-O stated R11 complains of her laundry's odor when washed with other resident's belongings and laundry staff was aware of this. On 04/13/2017, at 11:06 a.m. housekeeping manager (HM)-A and district manager (DM)-B were interviewed regarding R11's laundry. HM-A stated she spoke with R11, "A couple months ago," about her repeated requests to have her laundry done separately, however, it was still being washed with the other residents because others would want it done that way as well and we're, "Just not doing that." DM-B stated he was unaware of R11's request, however, added it would be up to HM-A to either implement or deny R11's request. On 4/13/2017, at 2:01 p.m. licensed social worker (LSW)-A and administrator were interviewed. LSW-A stated she was the facility designated grievance official and a grievance would be,	F 166	education by May 28, 2017. PRN staff will complete the education prior to his/her first scheduled shift. Inservicing will be ongoing as needed. 4.The administrator and Social Worker will monitor compliance through random resident/family/staff interviews 3 x weekly and review of resident council minutes monthly, both for a minimum of 3 months or until compliance is achieved. Results of interviews and audits will be brought to QAPI monthly for review and recommendation.	

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F 166	Continued From page 5 "Anything that residents voice that they have concerns about." LSW-A stated staff were expected to notify her with any grievances so they could be resolved, however, R11's laundry concern had never been brought forward to her so it had not been addressed through the facility grievance procedure. LSW-A stated she felt they, "Need to do some education with staff." Further, the administrator stated if residents wanted their laundry washed separately, the requests would be honored. A facility Grievance Guideline policy dated 11/14/16, identified all residents have the right to voice grievances and all employees are responsible ensuring customer satisfaction. The policy directed staff to complete a "Grievance Form," or, "Department Response Forms," for concerns noted during resident council. Further, the policy directed grievances would be investigated and resolved within 5 working days with decisions and outcomes being documented accordingly.	F 166		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of	F 167		5/28/17

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F 167	Continued From page 6 the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the State survey inspection results were readily available. This had potential to affect all 95 residents, visitors and staff who could wish to review the information. Findings include: During the initial tour of the facility on 4/10/17, at 8:18 a.m. a brown colored sign was affixed to the nurses station desk by the main entrance which read, "MDH Golden Living Center Rochester East Standard Survey Results." Above the sign was several stacked blue colored binders and a black plastic tray which contained several various colored papers. To the right side of the stacked binders was a large package with a shipping label. Upon review, the blue binder on the bottom of the stack was labeled, "Survey Results 2016." The survey results inside were dated 7/20/16. The survey results were not accessible without	F 167	F 167 1. The survey book was moved to a location on the counter that will not be blocked by the nurse's medication cart or other items on the desk. The sign indicating that the information is available was also moved to the new location with the survey binder. All required information is available. 2. Facility residents have the potential to be affected by this practice. 3. Facility staff were inserviced as to the survey book's new location and that it needs to be kept free of clutter by the Administrator/Social Worker and/or designee. The resident council was also informed of the new location of the survey book by the Activity Director. Current facility staff will have completed this	

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F 167	Continued From page 7 having to move the other stacked binders and black plastic paper tray with various papers. On 4/10/17 at 10:03 a.m. the survey results remained on the nursing station desk with the stacked binders and plastic tray sitting on top of the results. In addition, registered nurse (RN)-E had a medication cart sitting in front of the sign and survey results with a medication administration record (MAR) opened with the cover flipped over on top of the stacked binders. The signage and survey results were no longer visible as they were blocked by the medication cart. Further, on 4/10/17, 3:14 p.m. (over six hours later) the survey results remained sitting on the nurses station desk with aforementioned items stacked on top. On 4/10/17, at 3:21 p.m. RN-E observed the survey results with the surveyor and stated they were not readily accessible as they were obscured with other binders and a plastic paper tray. RN-E stated she had been asked about the location of the survey results from others in the past and occasionally had noticed them being obscured before with items being stacked on top of them. When interviewed on 4/13/17, at 12:31 p.m. the director of nursing (DON) stated the nurses station desk should be kept clean so the survey results were readily available at all times for residents or visitors to review. A facility policy on survey results accessibility was requested, but none was provided.	F 167	education by May 28, 2017. PRN staff will complete the education prior to his/her first scheduled shift. Inservicing will be ongoing as needed. 4. The Administrator/Social Worker/ and/or designee will monitor compliance through observation on daily rounds x 3 weekly for a minimum of 3 months or until compliance is achieved. Results of these observations will be brought to QA/PI monthly for review and recommendations.	

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F 176	Continued From page 8	F 176		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe administration of medications for 2 of 2 residents (R18 and R195), who had been assessed unable to self-administer medications safely and 1 of 1 resident (R58), who had not been assessed to self-administer medications. Finding include: R18's Admission Record, dated 4/13/17, included diagnosis of dementia without behavioral disturbance. On 4/10/17, at 11:02 a.m. R18 was observed to be seated in a wheelchair in his room, sleeping with headphones on. Oral medications (eight pills) were observed to be in a plastic medication cup on R18's bedside tray table. No licensed staff were present in R18's room. At 11:04 a.m., registered nurse (RN)-C confirmed eight pills were in a medication cup on R18's bedside tray table. RN-C woke R18 up and directed R18 to take his medications. RN-C stated R18 was not able to self administer his own medications. RN-C stated he had taken the medications into R18's room 10 to 15 minutes ago. RN-C stated the medications were R18's 8:00 a.m. medications and were aspirin, multivitamin, Lasix (diuretic), losartan potassium (angiotensin	F 176	R176 1. R18, R195, R58 were reassessed for self-medication administration. The nurse involved was inserviced on self-administration of medications, procedure for administration of nebulizers, and medication pass times. 2. Facility residents have the potential to be affected by these practices. 3. The policy for medication administration times has been reviewed with the facility Medical Director and updated to a policy to promote resident-centered medication pass times. Facility residents who receive their nebulizer treatments have had a self-administration of medications assessment completed and care plans updated accordingly. Facility nurses and medication aides were inserviced by the Director of Nursing/designee on self-administration of medications, specifically nebulizer treatments, as well as medication pass times. Current nurses and medication aides will have completed this education by May 28, 2017. PRN licensed staff will complete the education prior to his/her first scheduled shift.	5/28/17

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F 176	Continued From page 9 receptor blocker), Lipitor (statin), protonix (proton pump inhibitor), donepezil (enzyme blocker) and citalopram (antidepressant). R18's medication administration record (MAR) dated 4/17, identified the medications were scheduled to be given at 8:00 a.m. except the protonix was scheduled to be given at 7:00 a.m. R18's quarterly interdisciplinary resident review dated 2/6/17 identified, does the resident wish to self administer medications? If yes, proceed to self administration assessment. Response documented was no. On 4/13/17, at 3:26 p.m. the director of nursing (DON) stated R18 would not be able to self administer medications. The DON stated she would expect staff to ensure the resident had taken the medications. R195's Admission Record, dated 4/13/17, included diagnosis of dementia without behavioral disturbance. On 4/10/17, at 11:32 a.m. R195 was observed to be laid in bed. Nebulizer equipment with a mask attached was observed to be laid on top of a blanket covering R195 and the medication cup attached to the mask was dry. The nebulizer machine was running. R195 stated he did not know when he had last had medication from the nebulizer. No licensed staff were present in R195 room or in clear view of R195. At 11:37 a.m., RN-C was alerted by the surveyor and as RN-C was walking down the hall towards R195's room, RN-C stated, "Oh it is his neb isn't it." RN-C entered R195's room and turned the nebulizer machine off. RN-C stated R195 was not able to	F 176	Inservices will be ongoing as needed. 4. The Director of Nursing/designee will monitor compliance through observations on rounds of medication administration and MAR(medication administration records) 3 x weekly for a minimum of 3 months or until compliance is achieved. Results of observations and audits will be brought to QA/PI monthly for review and recommendations.	

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self administer his medications. RN-C stated he had started the nebulizer medication treatment for R195 around 11:15 a.m. and the medication was R195's 8:00 a.m. scheduled DuoNeb solution (bronchodilator).

R195's MAR identified DuoNeb solution 0.5-2.5 - 3 mg (milligrams)/3 ml (milliliters) inhale 3 ml four times a day scheduled times of 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.

R195's admission clinical health status assessment dated 4/7/17 identified, does the resident wish to self administer medications? If yes, proceed to self administration assessment. Response documented was no.

On 4/13/17, at 3:26 p.m. the DON stated R195 would not be able appropriate to self administer medications. The DON stated she would expect staff to ensure the resident had taken the medication. Staff should remain in the room with the resident or just outside the room, seeing the resident during administration of the nebulizer medication treatment.
R58's quarterly Minimum Data Set (MDS) dated 02/20/2017, identified R58 had moderate cognitive impairment.

R58's evaluation for Self-Administration of Medications dated 11/17/2016, identified evaluation criteria to be used to determine if someone is capable to self administer medication. However, all the criteria had a black line drawn through and the letters, "N/A [not applicable]" written above the line.

During observation on 4/13/2017, at 3:08 p.m. R58 was seated in her room in her wheelchair

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with her head down, eyes closed and glasses hanging from her face. A nebulizer machine was running which was connected to a mask in R58's right hand. There was no staff in the room.

When interviewed on 04/13/17 at 3:10 p.m. licensed practical nurse (LPN)-I stated R58 does not self administer her medications because he goes back and checks on her. LPN-I stated the nebulizer machine had been running for approximately seven minutes, but he was unable to determine how much of the medication R58 received before removing the nebulizer mask as it was now dry with no solution left inside. Further, LPN-I stated R58 had not been assessed to self administer medications to his knowledge.

R58's signed physician's orders dated 03/27/2017, identified R58 received nebulizer four times a day for Chronic Obstructive Pulmonary Disease. The signed physicians orders lacked any direction or indication R58 was able to self administer her own nebulizer.

R58's care plan dated 3/30/2017, identified R58 had COPD with generalized discomfort and directed staff to, "Administer medications as ordered. Monitor and document for effectiveness." The care plan lacked any direction or indication R58 was safe to administer her own nebulizer.

During interview on 4/14/2017 at 2:58 p.m. the director of nursing stated resident should be assessed for ability to self administer medications,physicians orders obtained and care planned accordingly. Further if a resident had no order to self administer medications for a nebulizer treatment , the nurse would need to be

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F 176	Continued From page 12 able to visually monitor the resident during the treatment. During interview on 4/14/2017 at 3:51 p.m. LPN-C stated R58 was determined to be unsafe to self administer her own medications which is why he drew line through he assessment criteria. Further, LPN-C stated R58 remained unsafe to self administer her medications as of this day. The facility policy Self Administration of Medication, dated 6/15, indicated procedure B. If the resident indicates no desire to self-administer medications, this is documented in the appropriate place in the resident's medical record, and the resident is deemed to have deferred this right to the facility.	F 176		
F 225 SS=J	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or	F 225		5/28/17

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misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance

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F 225	Continued From page 14 with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure an allegation of verbal abuse was thoroughly investigated, and failed to ensure protection of residents during an investigation for 1 of 1 residents (R42) who had reported verbal abuse. This resulted in an immediate jeopardy situation. The immediate jeopardy (IJ) began on 4/11/17 when the facility became aware of R42's allegations of allegation of verbal abuse. Although the facility was aware of the incidents of alleged abuse on 4/11/17, they failed to conduct a thorough investigation and failed to protect R42 and others during the investigation. The alleged perpetrator was assigned to another unit and was allowed to work independently. The IJ was identified on 4/13/17 and the administrator and director of nursing were notified of the IJ situation at 5:38 p.m. on 4/13/17. The immediate jeopardy was removed on 4/14/17, at 1:49 p.m., but non-compliance remained at the lower scope and severity of a D. Findings include: Interview with R42 on 4/10/17, at 1:11 p.m.., stated three to four nights prior to this date (4/6/17 or 4/7/17) a nursing assistant (NA)-D had placed her call light where she couldn't find it and had been yelling and swearing at her. R42 stated she had reported this incident to the facility staff. R42 stated she was worried NA-D would be	F 225	F225 1. The self-report involving R42 and the incident from 4/10/17 was submitted to the OHFC on 4/11/17 at 2:30pm by the Director of Nursing. On 4/13/17 a self-report involving R42 was made after learning about a prior incident 4/6 or 4/7/17. R42 was re-interviewed by the DON and the Social Services Director on 4/13/17 regarding the incident. She states she felt safe. She was offered counseling. Interviews with interviewable facility residents began on 4/13/17 by Social Services and Director of Nursing regarding care, treatment, how they are spoken to by staff and their feelings of safety. No additional concerns were identified. Statements were obtained from staff on-duty at the time of the alleged incident by Social Services, DON, and ED beginning on 4/11/17 through 4/13/17. The CNA involved in the alleged incidents was formally suspended indefinitely by the Human Resources Specialist on 4/13/17 pending the outcome of the investigation. The grievance log and previous self-reports were reviewed by the Executive Director on 4/13/17 looking for patterns and complaints involving abuse and incidents involving the employee. None were found. The Medical Director was notified of alleged incident on 4/13/17	

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mean to her and stated staff wasn't very nice to her that night. Even though R42 had reported this allegation of abuse, the facility had not operationalized their abuse/neglect policy and no protection was provided to R42 and other residents who may receive care from the alleged perpetrator, NA-D. In addition, the facility failed to comprehensively investigate the allegation.

Interview with R42 on 4/11/17, at 11:39 a.m. stated NA-D had gotten into a yelling match with R42 again last night when NA-D had administered her medications. R42 stated NA-D had not provided her water to take with her medications. R42 stated she had not reported this incident to any staff yet. R42 stated she felt NA-D "took her anger out" on her [R42].

On 4/11/17, at 11:58 a.m. the director of nursing (DON) was notified of R42's allegations that NA-D had verbally abused her. The first alleged to have occurred on 4/6/17, and the second allegation from the previous night shift which had been reported that morning by R42 to the surveyor. The DON verified NA-D was a nursing assistant.

R42's diagnosis found on Admission Record dated 4/14/17, included major depressive disorder, type 2 diabetes with diabetic neuropathy and heart failure, and others.

R42 has a BIMS (brief interview for mental status) score of 12 out of 15 which indicates R42 to have moderate cognitive impairment; last dated 3/6/17.

Comprehensive care plan with print date 4/14/17, indicates R42 to have a self-care deficit related to impaired mobility which requires the assistance of

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by DON. 4/13/17 - The Regional Vice President, Executive Director and DON reviewed the abuse policy to monitor that the AOC plan was in compliance and to ensure that the abuse policy is being followed.
The accused employee's HR record was reviewed including her criminal background report and any disciplinary actions (none were found)- for potential issues and patterns (none were found) by the Regional Vice President on 4/13/17.
4/13/17 - Facility staff's HR records were reviewed for compliance with criminal background and to identify any issues by the HR Specialist. No issues were identified. R42 discharged from the facility 4/17/17.

2. Facility residents have the potential to be affected by this practice.

3. The Regional Vice President for North Shore Healthcare re-inserviced the Executive Director and Director of Nursing on the Abuse and Neglect policy and procedure, appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin, and misappropriation of resident property. Education included definitions of abuse, neglect, and misappropriation, response to allegations of abuse, and reporting of any suspected abuse on 4/13/17. Working staff on 4/13/17 were re-educated on the Abuse and Neglect policy and procedure, appropriate steps to prevent the occurrence of abuse, neglect, and injuries of unknown origin, and misappropriation

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one staff for dressing, grooming and bathing. R42 transfers with a mechanical lift and staff assistance of one. Also includes alteration in mood and behaviors as evidence by diagnosis of major depressive disorder. Currently utilize psychotropic medication for this diagnosis. On occasion becomes upset and tearful and makes statements that she feels like no one likes her and that no one wants her here. Will hit and yell at staff when frustrated, can be manipulative at times. Can become very upset at staff when not toileted immediately date initiated 12/14/15. The care plan did not identify any concerns related to R42 making false accusations of staff abuse/neglect or misusing the grievance process.

When interviewed on 4/11/17, at 5:11 p.m., R42 stated no one from the facility staff had followed up with her regarding her concerns about NA-D's verbal abuse/yelling at her.

During an interview with licensed practical nurse (LPN)-D on 4/12/17, at 4:00 a.m., LPN-D stated she was aware that R42 had expressed concerns about staff including a nurse manager, aides and nurses being verbally abusive towards her. LPN-D stated she had talked with the DON following her shifts about the complaints of R42 in the past. LPN-D would not give specific examples of verbal abuse when asked to clarify what "verbal abuse" meant. LPN-D stated the DON had called her on 4/11/17, to ask her about the NA-D having administered R42's medications without offering water. LPN-D stated she herself was the one who had administered R42's medications during the night shift and denied allowing NA-D to administer any medications. In addition, LPN-D denied having heard any yelling between R42 and NA-D. LPN-D said she would

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of resident property by the ADON, DON and/or Social Service Director. Off-duty staff were notified by the DON and ADON to meet with the ADON prior to working to receive the Abuse In-service training. Oncoming staff on each shift was not allowed to begin work until they met with the ADON to receive the Abuse in-service training. The inservice included education on Abuse and Neglect policy and procedure, appropriate steps to prevent the occurrence of abuse, neglect, and injuries of unknown origin and misappropriation of resident property. Inservice also included definitions of abuse, neglect, and misappropriation, response to allegations of abuse, and reporting of any suspected abuse. The DON and/or ADON will continue to inservice facility staff regarding abuse and neglect on hire, every quarter and ongoing as needed.

4. The Administrator or designee will interview 5 residents per week for 4 weeks regarding staff treatment and will review the grievance log for any potential incidents. All negative findings will be corrected immediately. After the 4 weeks, the administrator will monitor compliance through random resident interviews 3 x weekly and review resident council minutes monthly for a minimum of 3 months or until compliance is achieved. The Administrator will report monthly to QA/PI any allegations of abuse or neglect for review and recommendations.

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expect an aide to come and tell her if there were any concerns with a resident. LPN-D stated NA-D had not told her of any incident occurring the night of 4/11/17.

During a follow-up interview with LPN-D at 5:48 a.m. on 4/12/17, regarding abuse protocols, LPN-D stated whenever a staff member yells at R42 she has the staff write down what happened and then she speaks with that specific staff member. LPN-D stated she does this because even if the staff member thinks they are in the right, they are wrong. LPN-D stated she then gives the written material to the DON. LPN-D stated she has the staff write down what happened so that it is in their own words. LPN-D stated she hasn't witnessed any staff yelling at R42 but when R42 has told LPN-D about staff yelling at her, she will talk with that staff member directly. I document it as a behavior and report the incident. LPN-D stated, "I don't want the State of Minnesota to know we have staff clashing with residents, I want the DON to address it."

During interview with NA-D on 4/12/17, at 5:05 a.m., NA-D stated she is usually assigned to the second floor when she works but because of a resident concern had been moved to the first floor for the current night shift. NA-D stated, "R42 had told someone that I gave her medications and that I refused to give her water. The DON called yesterday but I wasn't able to call back so she came in and talked to me when my shift started." NA-D then described her perspective of the incident regarding R42's allegation from the previous night shift. NA-D stated she had followed LPN-D into R42's room after her medications had been administered to offer R42 repositioning. NA-D stated R42 was upset with

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her because she wanted more water and NA-D stated she hadn't noticed the water was almost gone. NA-D stated she'd left the room and R42 had begun yelling. NA-D said when she went back into R42's room she'd told her, "you can't yell because other residents complain about the noise." NA-D stated she had reported the issue to LPN-D, about R42 yelling and about the other residents complaining of the noise, during that same night shift (the night shift starting on 4/10/17 and ending early a.m. 4/11/17) .

R42 was interviewed again on 4/12/17, at 7:05 a.m. at which time she again stated no facility staff had followed up with her regarding her allegations about the staff yelling at her, or refusing to give her water to swallow her medications.

During interview with social worker (SW)-B at 11:04 a.m. on 4/12/17, SW-B stated she had not spoken with R42 this week and was unaware of any concerns R42 had related to any verbal abuse of staff having yelled at R42.

On 4/12/17, at 12:15 p.m. the administrator verified during interview that no Abuse/Neglect reports had been filed to the Office of Health Facility Compliance (OHFC) in regards to R42's alleged verbal abuse.

The director of nursing (DON) was interviewed on 4/13/17, at 8:34 a.m. The DON stated she was first made aware of R42's alleged abuse from NA-D, one from 4/6/17 and the second from the 4/10/17 night shift, when the surveyor had reported the incidents to her on 4/11/17. The DON stated once she was notified of these allegations, she'd informed the administrator and

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F 225	Continued From page 19 had attempted to call both LPN-D and NA-D who had worked the night shifts when the alleged verbal abuses had occurred. The DON stated neither LPN-D nor NA-D had answered their phones, so she'd left messages for both of them to return her phone call. The DON stated she had heard back from LPN-D and who had denied hearing any yelling, and had denied knowing about any negative interactions that had occurred between R42 and NA-D. The DON stated she'd reported the allegation of verbal abuse to the state department (OHFC) around 2:30 p.m. on 4/11/17. The DON stated she was unable to get a hold of NA-D by telephone so she'd come into the facility at 10:00 p.m. on 4/11/17 to speak with NA-D before NA-D started her night shift. The DON stated she'd reassigned NA-D to the first floor for that shift. The DON further stated NA-D had denied administering medications to R42, and had informed her R42 was yelling at her [NA-D] about not having water to drink. The DON stated she'd spoken with R42 to let her know that NA-D would not be working on the 2nd floor the night of 4/11/17, but had not documented the conversation. When asked whether she had interviewed R42 in regards to the investigation of alleged verbal abuse, the DON stated she had not. The DON stated she'd spoken with LPN-D and NA-D and based on their interviews had determined the allegation of verbal abuse was unsubstantiated and her investigation was complete. The DON also said that NA-D had left her a hand written note dated 4/13/17, regarding the incident which occurred on the night shift of 4/10/17 between she and R42. The DON said after hving read NA-D's note, she would be looking at changing NA-D's work assignment. The DON stated she felt R42's allegations were a result of R42 being frustrated about not wanting	F 225		

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to be in the facility. When asked for documentation related to her investigation, the DON stated her notes were all on separate pieces of paper as she hadn't had time to complete the investigation form. The DON provided a copy of the note left from NA-D describing the incident which had occurred on the night shift of 4/10/17. When asked whether she'd heard about R42's allegation of verbal abuse from 4/6/17, the DON denied hearing from LPN-D concerning any other incidents involving staff yelling at R42. Further, the DON denied finding any other documentation of incidents involving staff yelling at R42.

The note NA-D had given to the DON regarding the allegation of verbal abuse from the night shift of 4/10/17, was reviewed. The note was dated 4/13/17 and indicated R42 had been upset and uncomfortable which resulted in R42 requiring to be repositioned multiple times. The note indicated NA-D had responded to R42's call light 16 times between 10:00 p.m. and 1:00 a.m. NA-D had further indicated R42 was yelling at her and calling her names. NA-D indicated she'd told R42 she wouldn't engage in her behavior and would return to the resident's room once R42 had calmed down. NA-D also indicated she'd left the room to answer another resident's call light and R42 had begun yelling about the call light. NA-D indicated that when she'd entered R42's room, R42 was attempting to throw herself on the floor and that R42 had thrown her pillows and sheets on the floor. NA-D's notes indicated R42 had threatened to sue her [NA-D], and that R42 had told NA-D she was going to throw herself on the floor and report that NA-D pushed her, so NA-D would get fired. NA-D indicated R42 continued to attempt to throw herself on the floor and that

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NA-D had told R42 if she wanted to throw herself on the floor there was no way NA-D could prevent it, and would not try to break the fall. NA-D's note indicated that she'd left the room then to get assistance from another staff with repositioning. NA-D indicated R42 expressed feeling that staff were treating her awful and couldn't wait to leave the facility. NA-D also documented in the note that she had notified LPN-D and LPN-G who had both been on duty. NA-D indicated NA-G and LPN-G had answered R42's call light for the rest of the shift.

During interview with R42 on 4/13/17, at 9:05 a.m., R42 stated no one had followed up with her regarding her concerns related to NA-D regarding the 4/10/17 allegation of abuse. R42 reitereated she had been hollering out for help because she needed water and her tray table was in the middle of the room instead of beside her bed. R42 stated NA-D entered the room and told her she'd been in there 12 times. R42 stated NA-D, "gave me a sermon." R42 stated she kept hollering and hollering last night because she was tangled up in her sheets and no one would come in and help her. NA-D stated LPN-G entered the room and told R42, that she wouldn't send NA-D in "because she's had enough of you" and that she hadn't been very nice to NA-D. R42 stated although she felt safe in the facility, she felt "like a heel, like I'm not much" when staff are yelling at her.

Facility call light reports were requested, but the facility reported they had none available.

During interview with the administrator at 9:23 a.m. on 4/13/17, the administrator stated the allegation of verbal abuse which occurred the

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F 225	Continued From page 22 night of 4/10/17 had been reported to him. The administrator said initially upon hearing of the allegation, the administrator had been told LPN-D and NA-D had been telephoned but because they worked the night before hadn't been able to be reached. The administrator stated he had been told other residents on the floor had been interviewed regarding the allegation and the report was that R42 was the one yelling and no one had heard any yelling from staff. The administrator described R42 as very abusive to staff and manipulative. The administrator stated he wasn't sure who'd completed the interviews and was unsure whether R42 had been interviewed regarding the allegation of verbal abuse. He stated it was difficult to take R42 as a viable source due to her lying, manipulating and threatening to get staff in trouble. The administrator stated he felt 42's goal was to "get us into trouble, that's my belief, she's a bright woman and she understands that this is going to happen." Then the administrator stated because the allegation was against a nursing assistant, he hadn't taken the lead for the investigation, but instead left it to the DON and SW to complete. He stated he personally had not interviewed any staff related to the allegation and stated the DON had notified him of who had been interviewed. The administrator stated a complete investigation should include interviewing all those involved in the allegation; other staff, other residents, and definitely the resident making the allegation. The administrator stated he was unaware NA-D had worked with R42 on 4/10/17, and stated that wasn't a good idea because he would have liked to protect NA-D. He stated with where the facility was in their investigation, and because of other resident interviews, it contradicted what R42 had alleged. The administrator stated if they had any	F 225		

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evidence that allegation was true they would have suspended NA-D immediately. Finally, the administrator stated at this time he did not feel the investigation was complete.

On 4/13/17 at 11:01 a.m. the DON was observed on 2nd floor interviewing residents in regards to the alleged verbal abuse that had occurred on the 4/10/17 night shift. The DON was again asked for for any documenation including investigation notes in regards to R42's alleged verbal abuse. At that time, the DON stated they had just started interviewing other residents and that was what she was working on. Later that day, upon receiving copies of the investigative notes, it was noted the notes included minimal information from LPN-D and NA-D dated 4/11/17. The interview notes were dated 4/13/17, indicating other staff and residents, including R42, had been interviewed at around 10:30 a.m. that day. The interview notes did not indicate names of staff/residents and were unspecific as to time/dates conducted.

During an additional interview with the administrator and SW-A on 4/13/17, at 2:06 p.m., they who were asked how the facility ensured protection of residents during an investigation of an alleged abuse/neglect. They both stated they would want to interview other residents to see whether they had experienced any negative experiences with that staff member. They said if they think it is more of a grievance versus abuse, they might just remove the staff member from working with that resident. SW-A said, "We would keep them separated until we determined whether the claim was substantiated or not." They further stated if they had somebody they believed was being verbally abusive they would not just

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move them to another floor. The administrator stated they'd determined through investigation that it was actually R42 that had abused NA-D, and that this had been determined before NA-D had returned to work on Tuesday 4/11/17. However, the administrator also stated the investigation was not complete, because they still had more people to talk to. He said, "what we have determined is that [R42] is being abusive towards [NA-D] and is continuing her assault through this complaint. The only evidence that we have found so far was no co-workers heard [NA-D] yelling, and the residents were upset with [R42] for yelling with [NA-D]." He further stated a suspension of a staff member is done immediately upon notification of an allegation, and added the employee would be "suspended until we can determine if the allegation is unsubstantiated." He said if an allegation was substantiated, they would terminate the employee.

During interview with NA-G on 4/13/17, at 3:22 p.m., NA-G stated she'd worked the night shift with NA-D on 4/10/17 and had assisted NA-D with repositioning R42. NA-G stated upon entering the room, R42 had been upset and had thrown everything on the floor and was almost falling out of bed. NA-G stated when she was in the room NA-D was quiet and wasn't yelling. NA-G stated she'd assisted with repositioning R42 and had left the room to go back to her wing and answer other call lights. NA-G stated when she was finished assisting other residents she'd seen NA-D crying. NA-G stated she'd then been instructed to work with R42 for the rest of the evening. NA-G stated she had no concerns related to R42 the rest of the night.

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F 225	Continued From page 25 The immediate jeopardy that began on 4/11/17, was removed on 4/14/17, when the facility removed the staff alleged to have verbally abused R42 from work pending an investigation; the DON and Social Services Director re-interviewed the resident involved and intiated interviews with other residents regarding any allegations of abuse or neglect; and education was intiated for all staff as they reported to work regarding the facility's abuse/neglect policies to assure adequate investigation and protection of residents during an investigation would be initiated. Noncompliance remained at the lower scope and severity level of a D (actual or potential for minimal harm/discomfort) because the facility provided an immediate removal plan but had not met as an interdisciplinary group to implement measures to sustain continued compliance.	F 225		
F 226 SS=F	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to	F 226		5/28/17

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F 226	Continued From page 26 the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to ensure their abuse prevention policy and procedure was operationalized for 1 of 1 resident (R42) who was investigated for an alleged verbal abuse. In addition the facility failed to ensure abuse policy and procedure was implemented to ensure staff reference checks were completed for 2 of 6 employees (E-B and E-A) and failed to incorporate into their policy the required Dementia management and resident abuse prevention. This had the potential to effect all resident in the facility. Findings include: The facility's policy Investigation and Reporting of Alleged Violations of Federal and State Laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property with review date 11/18/2016 included: "Reporting- It is the responsibility of each	F 226	F226 1. The self-report involving R42 and the incident from 4/10/17 was submitted to the OHFC on 4/11/17 at 2:30pm by the Director of Nursing. On 4/13/17 a self-report involving R42 was made after learning about a prior incident 4/6 or 4/7/17. R42 was re-interviewed by the DON and the Social Services Director on 4/13/17 regarding the incident. She states she felt safe. She was offered counseling. Interviews with interviewable facility residents began on 4/13/17 by Social Services and Director of Nursing regarding care, treatment, how they are spoken to by staff and their feelings of safety. No additional concerns were identified. Statements were obtained from staff on-duty at the time of the alleged incident by Social Services, DON, and ED beginning on 4/11/17 through 4/13/17.	

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F 226	Continued From page 27 individual employee to immediately report any reasonable suspicion of a crime, and all allegations of mistreatment, neglect, abuse, injury of unknown origin and/or misappropriation of resident property to the designated supervisor in charge at the time. Employee may also elect to report directly to the center/locations ED (executive director) or DNS (director of nursing services). For purposes of reporting "immediately" means as soon as possible but not to exceed two (2) hours in the event of serious injury or death of patient involved in a report, or twenty-four (24) hours for all other reports, or shorter if State law/regulations require a report within a shorter timeframe. ...The ED ...shall ensure that alleged violations are reported promptly to the regional/area Vice President. ...The contact with attending physician shall be documented...Investigation & Documentation- All investigations shall be conducted by the ED or designee unless there is a conflict of interest or they are implicated in the alleged violations. In the event an alleged violation occurs when none of these people are available, the manager in charge is responsible for initiating the investigation procedure unless there is a conflict of interest or the person is implicated in the alleged violations. The investigation shall include interviews of employees, visitors, residents, volunteers and vendors who may have knowledge of the alleged incident. Factual information only should be documented, not assumptions, speculation or conclusions. Written statements from involved parties may be requested. The medical report should be reviewed to determine the resident's past history and condition and its relevance to the alleged violation. Documentation in the medical record shall be made where necessary for continuity of	F 226	The CNA involved in the alleged incidents was formally suspended indefinitely by the Human Resources Specialist on 4/13/17 pending the outcome of the investigation. The grievance log and previous self-reports were reviewed by the Executive Director on 4/13/17 looking for patterns and complaints involving abuse and incidents involving the employee. None were found. The Medical Director was notified of alleged incident on 4/13/17 by DON. 4/13/17 - The Regional Vice President, Executive Director and DON reviewed the abuse policy to monitor that the AOC plan was in compliance and to ensure that the abuse policy is being followed. The accused employee's HR record was reviewed including her criminal background report and any disciplinary actions (none were found)- for potential issues and patterns (none were found) by the Regional Vice President on 4/13/17. 4/13/17 - Facility staff's HR records were reviewed for compliance with criminal background and to identify any issues by the HR Specialist. No issues were identified. R42 discharged from the facility 4/17/17. 2. Facility residents have the potential to be affected by this practice. 3. The Regional Vice President for North Shore Healthcare re-inserviced the Executive Director and Director of Nursing on the Abuse and Neglect policy and procedure, appropriate steps to prevent the occurrence of abuse, neglect, injuries	

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F 226	Continued From page 28 care for the resident. Federal law requires the center/location to have evidence of investigations of alleged violations. The investigation report or state required form shall be completed after the investigation is complete and provide to survey agencies when requested or required by state or federal law. This form shall be maintained in a secure administrative file. It is not part of the medical record or employee personnel file...Corrective Action- The center/location shall make reasonable efforts to determine the cause of the alleged violation and take corrective action consistent with the investigation findings and to eliminate any ongoing dangers to resident." During interview with R42 on 4/10/17, at 1:11 p.m., she stated three to four nights prior to this date (4/6/17 or 4/7/17) a nursing assistant (NA)-D had placed her call light where she couldn't find it and had been yelling and swearing at her. R42 stated she had reported this incident to the facility staff. R42 stated she was worried NA-D would be mean to her and stated staff wasn't very nice to her that night. During an interview with R42 on 4/11/17, at 11:39 a.m., she stated NA-D had gotten into a yelling match with R42 again last night when NA-D had administered her medications. R42 stated NA-D had not provided her water to take with her medications. R42 stated she had not reported this incident to any staff yet. R42 stated she felt NA-D "took her anger out" on her [R42]. On 4/11/17, at 11:58 a.m. the director of nursing (DON) was notified of R42's allegations that NA-D had verbally abused her. The first alleged to have occurred on 4/6/17, and the second	F 226	of unknown origin, and misappropriation of resident property. Education included definitions of abuse, neglect, and misappropriation, response to allegations of abuse, and reporting of any suspected abuse on 4/13/17. Working staff on 4/13/17 were re-educated on the Abuse and Neglect policy and procedure, appropriate steps to prevent the occurrence of abuse, neglect, and injuries of unknown origin, and misappropriation of resident property by the ADON, DON and/or Social Service Director. Off-duty staff were notified by the DON and ADON to meet with the ADON prior to working to receive the Abuse In-service training. Oncoming staff on each shift was not allowed to begin work until they met with the ADON to receive the Abuse in-service training. The inservice included education on Abuse and Neglect policy and procedure, appropriate steps to prevent the occurrence of abuse, neglect, and injuries of unknown origin and misappropriation of resident property. Inservice also included definitions of abuse, neglect, and misappropriation, response to allegations of abuse, and reporting of any suspected abuse. The DON and/or ADON will continue to inservice facility staff regarding abuse and neglect on hire, every quarter and ongoing as needed. 4. The Administrator or designee will interview 5 residents per week for 4 weeks regarding staff treatment and will review the grievance log for any potential incidents. All negative findings will be	

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allegation from the previous night shift which had been reported that morning by R42 to the surveyor. The DON verified NA-D was a nursing assistant.

When interviewed on 4/11/17, at 5:11 p.m., R42 stated no one from the facility staff had followed up with her regarding her concerns about NA-D's verbal abuse/yelling at her.

During an interview with licensed practical nurse (LPN)-D on 4/12/17, at 4:00 a.m., LPN-D stated she was aware that R42 had expressed concerns about staff including a nurse manager, aides and nurses being verbally abusive towards her. LPN-D stated she had talked with the DON following her shifts about the complaints of R42 in the past. LPN-D would not give specific examples of verbal abuse when asked to clarify what "verbal abuse" meant. LPN-D stated the DON had called her on 4/11/17, to ask her about the NA-D having administered R42's medications without offering water. LPN-D stated she herself was the one who had administered R42's medications during the night shift and denied allowing NA-D to administer any medications. In addition, LPN-D denied having heard any yelling between R42 and NA-D. LPN-D said she would expect an aide to come and tell her if there were any concerns with a resident. LPN-D stated NA-D had not told her of any incident occurring the night of 4/11/17.

During interview with NA-D on 4/12/17 at 5:05 a.m., NA-D stated she is usually assigned to the second floor when she works but because of a resident concern had been moved to the first floor for the current night shift. NA-D stated, "R42 had told someone that I gave her medications and

Provider's Plan of Correction (F 226):

corrected immediately. After the 4 weeks, the administrator will monitor compliance through random resident interviews 3 x weekly and review resident council minutes monthly for a minimum of 3 months or until compliance is achieved. The Administrator will report monthly to QA/PI any allegations of abuse or neglect for review and recommendations.
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that I refused to give her water. The DON called yesterday but I wasn't able to call back so she came in and talked to me when my shift started." NA-D then described her perspective of the incident regarding R42's allegation from the previous night shift. NA-D stated she had followed LPN-D into R42's room after her medications had been administered to offer R42 repositioning. NA-D stated R42 was upset with her because she wanted more water and NA-D stated she hadn't noticed the water was almost gone. NA-D stated she'd left the room and R42 had begun yelling. NA-D said when she went back into R42's room she'd told her, "you can't yell because other residents complain about the noise." NA-D stated she had reported the issue to LPN-D, about R42 yelling and about the other residents complaining of the noise, during that same night shift (the night shift starting on 4/10/17 and ending early a.m. 4/11/17) .

R42 was interviewed again on 4/12/17, at 7:05 a.m. at which time she again stated no facility staff had followed up with her regarding her allegations about the staff yelling at her, or refusing to give her water to swallow her medications.

LPN-C, the nurse manager for the entire second floor, was interviewed at 8:29 a.m. on 4/12/17. When asked whether he had any knowledge of R42's allegation of abuse, LPN-C acknowledged R42 had stated there was an argument between she and an aide and that the aide had brought in a cup of medication and did not give her water.

During interview with social worker (SW)-B at 11:04 a.m. on 4/12/17, SW-B stated she had not spoken with R42 this week and was unaware of

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any concerns R42 had related to any verbal abuse of staff having yelled at R42.

On 4/12/17, at 12:15 p.m. the administrator verified during interview that no Abuse/Neglect reports had been filed to the Office of Health Facility Compliance (OHFC) in regards to R42's alleged verbal abuse.

The director of nursing (DON) was interviewed on 4/13/17, at 8:34 a.m. The DON stated she was first made aware of R42's alleged abuse from NA-D, one from 4/6/17 and the second from the 4/10/17 night shift, when the surveyor had reported the incidents to her on 4/11/17. The DON stated once she was notified of these allegations, she'd informed the administrator and had attempted to call both LPN-D and NA-D who had worked the night shifts when the alleged verbal abuses had occurred. The DON stated neither LPN-D nor NA-D had answered their phones, so she'd left messages for both of them to return her phone call. The DON stated she had heard back from LPN-D and who had denied hearing any yelling, and had denied knowing about any negative interactions that had occurred between R42 and NA-D. The DON stated she'd reported the allegation of verbal abuse to the state department (OHFC) around 2:30 p.m. on 4/11/17. The DON stated she was unable to get a hold of NA-D by telephone so she'd come into the facility at 10:00 p.m. on 4/11/17 to speak with NA-D before NA-D started her night shift. The DON stated she'd reassigned NA-D to the first floor for that shift. The DON further stated NA-D had denied administering medications to R42, and had informed her R42 was yelling at her [NA-D] about not having water to drink. The DON stated she'd spoken with R42 to let her know that

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F 226	Continued From page 32 NA-D would not be working on the 2nd floor the night of 4/11/17, but had not documented the conversation. When asked whether she had interviewed R42 in regards to the investigation of alleged verbal abuse, the DON stated she had not. The DON stated she'd spoken with LPN-D and NA-D and based on their interviews had determined the allegation of verbal abuse was unsubstantiated and her investigation was complete. The DON also said that NA-D had left her a hand written note dated 4/13/17, regarding the incident which occurred on the night shift of 4/10/17 between she and R42. The DON said after having read NA=D's note, she would be looking at changing NA-D's work assignment. The DON stated she felt R42's allegations were a result of R42 being frustrated about not wanting to be in the facility. When asked for documentation related to her investigation, the DON stated her notes were all on separate pieces of paper as she hadn't had time to complete the investigation form. The DON provided a copy of the note left from NA-D describing the incident which had occurred on the night shift of 4/10/17. When asked whether she'd heard about R42's allegation of verbal abuse from 4/6/17, the DON denied hearing from LPN-D concerning any other incidents involving staff yelling at R42. Further, the DON denied finding any other documentation of incidents involving staff yelling at R42. During interview with R42 on 4/13/17, at 9:05 a.m., R42 stated no one had followed up with her regarding her concerns related to NA-D regarding the 4/10/17 allegation of abuse. R42 reiterated she had been hollering out for help because she needed water and her tray table was in the middle of the room instead of beside her bed. R42 stated	F 226		

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F 226	Continued From page 33 NA-D entered the room and told her she'd been in there 12 times. R42 stated NA-D, "gave me a sermon." R42 stated she kept hollering and hollering last night because she was tangled up in her sheets and no one would come in and help her. NA-D stated LPN-G entered the room and told R42, that she wouldn't send NA-D in "because she's had enough of you" and that she hadn't been very nice to NA-D. R42 stated although she felt safe in the facility, she felt "like a heel, like I'm not much" when staff are yelling at her. During interview with the administrator at 9:23 a.m. on 4/13/17, the administrator stated the allegation of verbal abuse which occurred the night of 4/10/17 had been reported to him. The administrator said initially upon hearing of the allegation, the administrator had been told LPN-D and NA-D had been telephoned but because they worked the night before hadn't been able to be reached. The administrator stated he had been told other residents on the floor had been interviewed regarding the allegation and the report was that R42 was the one yelling and no one had heard any yelling from staff. The administrator described R42 as very abusive to staff and manipulative. The administrator stated he wasn't sure who'd completed the interviews and was unsure whether R42 had been interviewed regarding the allegation of verbal abuse. He stated it was difficult to take R42 as a viable source due to her lying, manipulating and threatening to get staff in trouble. The administrator stated he felt 42's goal was to "get us into trouble, that's my belief, she's a bright woman and she understands that this is going to happen." Then the administrator stated because the allegation was against a nursing assistant, he	F 226		

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hadn't taken the lead for the investigation, but instead left it to the DON and SW to complete. He stated he personally had not interviewed any staff related to the allegation and stated the DON had notified him of who had been interviewed. The administrator stated a complete investigation should include interviewing all those involved in the allegation; other staff, other residents, and definitely the resident making the allegation. The administrator stated he was unaware NA-D had worked with R42 on 4/10/17, and stated that wasn't a good idea because he would have liked to protect NA-D. He stated with where the facility was in their investigation, and because of other resident interviews, it contradicted what R42 had alleged. The administrator stated if they had any evidence that allegation was true they would have suspended NA-D immediately. Finally, the administrator stated at this time he did not feel the investigation was complete.

During an additional interview with the administrator and SW-A on 4/13/17, at 2:06 p.m., they who were asked how the facility ensured protection of residents during an investigation of an alleged abuse/neglect. They both stated they would want to interview other residents to see whether they had experienced any negative experiences with that staff member. They said if they think it is more of a grievance versus abuse, they might just remove the staff member from working with that resident. SW-A said, "We would keep them separated until we determined whether the claim was substantiated or not." They further stated if they had somebody they believed was being verbally abusive they would not just move them to another floor. The administrator stated they'd determined through investigation that it was actually R42 that had abused NA-D,

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F 226	Continued From page 35 and that this had been determined before NA-D had returned to work on Tuesday 4/11/17. However, the administrator also stated the investigation was not complete, because they still had more people to talk to. He said, "what we have determined is that [R42] is being abusive towards [NA-D] and is continuing her assault through this complaint. The only evidence that we have found so far was no co-workers heard [NA-D] yelling, and the residents were upset with [R42] for yelling with [NA-D]." He further stated a suspension of a staff member is done immediately upon notification of an allegation, and added the employee would be "suspended until we can determine if the allegation is unsubstantiated." He said if an allegation was substantiated, they would terminate the employee. During a follow up interview with the administrator on 4/17/17, at 8:36 a.m., the administrator was asked for the investigation report documentation for the allegation that had been reported to the State agency. The investigative notes provided did not include any documented interviews with NA-D or with R42. E-A was found not to have had an employee reference check before working independently with residents based upon an interview on 4/13/17 at 3:34 p.m.,with human resources (HR)-A who stated reference checks were not completed for E-A as she did not enter any references into the system to be checked. HR-A stated the previous company used the skilled survey 360 to complete reference checks. HR-A stated reference checks were a part of the hiring process and with the ownership changes the facility was no longer using the skilled survey. HR-A stated she was unaware reference checks	F 226		

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had not been completed for E-A as she did not get emails from the company alerting her E-A did not enter any references to be checked.

During an interview on 4/14/2017, at 9:19 a.m. HM-A verified the facility failed to follow the abuse policy and procedure to complete reference checks for E-A as a part of their employee screening process for new hires. HM-A stated E-A did not enter references to be checked and I did not follow-up on references as a part of the hiring process.

The Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, policy, dated 11/18/16, included,
Screening: All applicants for employment in the Company shall at minimum, have the following screening checks conducted:
1. Reference checks with the current and/or past employer.
2. Appropriate licensing board or registry check.
3. Drug testing per Company policy.
4. Fingerprinting as required by state law.
5. Criminal background check pursuant to Company policy or state law.
The DNS, DOC (Department of Corrections), or Human Resources, depending on the Business Line, is responsible for the initial licensing and/or registry check, The ED, DOR, or Human Resources must ensure that all the above screening is accomplished and that the HR-213 and HR-166 are followed.

Review of the facility policy, Investigation and Reporting of Alleged Violations of Federal and

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F 226	Continued From page 37 State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, policy, dated 11/18/16, revealed the policy had not been updated to include training on Dementia management and abuse prevention. During an interview on 4/12/17, at 2:06 p.m. with the administrator and the social worker (SW)-A. The administrator stated there had been no modifications to the policy since 11/18/16. SW-A verified the abuse policy and procedure did not include dementia management and abuse prevention.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in a manner to promote dignity for 1 of 1 resident (R100) observed during a blood sugar check, and who was observed seated on a mechanical lift sling (used to transfer with a mechanical lift). Findings include: On 4/11/17, at 5:33 p.m., licensed practical nurse (LPN)-G was observed to enter R100's room. R100 was seated on a commode in her room. LPN-G stated to R100, "I am going to check your	F 241	F241 1. R100 is no longer a resident of this facility. Corrective actions taken during the survey include follow up with all nursing staff regarding resident cares and dignity while assisting and transferring, ADLs, and toileting needs. The nurse involved was inserviced regarding resident cares and dignity while assisting with transferring, ADLs, and toileting needs. 2. Facility residents have the potential to	5/28/17

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F 241	Continued From page 38 blood sugar." R100 asked LPN-G if she could wait until R100 got back into her chair and LPN-G indicated she would. At 5:34 p.m. nursing assistant (NA)-G and NA-J entered R100's room to assist R100 off the commode and into her wheelchair. LPN-G stated to R100, "could I check it (blood sugar) real quick before" indicating prior to R100 being moved from the commode. R100 stated, "Oh my God." LPN-G proceeded to check R100 blood sugar and R100 again stated, "Oh my God." LPN-G replied, "I know it's a pain and you do not like it." On 4/11/17, at 5:59 p.m., when asked why she didn't wait to check R100's blood sugar until after R100 was off the commode per the resident's request, LPN-G stated, "she [R100] will refuse over and over again. I asked if I could do it, and it was taking time for them to get her off the commode. She is one that screams a lot if things are not done right away, and will start throwing things and cussing." During interview with R100 on 4/12/17, at 6:52 a.m., R100 was questioned about having her bloods sugar checked while she was seated on the commode. R100 verified it bothered her, and stated "it's not good when they are grabbing all at once." On 4/13/17, at 3:31 p.m., the director of nursing acknowledged that since the resident had requested the nurse to wait to take her blood sugar until she'd been transferred from the commode to her chair, the nurse should have waited. During an observation at 2:14 p.m. on 4/10/17, R100 was seated in her wheelchair in the dining	F 241	be affected by these practices. 3. Facility residents requiring slings as a part of his or her transfer were reviewed. Any resident that required the sling to remain after the transfer had this information updated in his/her care plan with the rational for the sling remaining in place. Licensed nursing staff were educated on dignity concerns and awareness while providing ADLs, such as toileting and providing treatment such as blood glucose checks. Nursing staff received education by the Director of Nursing/designee on the use of slings for transfer of residents, specifically when the sling is to be left under the resident after the transfer is complete. Nursing staff were also educated on dignity issues while providing treatment during cares. Current nursing staff will have completed this education by May 28, 2017. PRN nursing staff will complete this education prior to his/her first scheduled shift. Inservices will be ongoing as needed. 4. The Director of Nursing/designee will monitor compliance through observation on rounds of sling usage, medication administration and MAR (medication administration records) 3 x weekly for a minimum of 3 months or until compliance is achieved. Results of observations and audits will be brought to QA/PI monthly for review and recommendations.	

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room with the lift sling she was sitting on visible beneath her.

On 4/11/17, at 5:12 p.m., R100 was observed sitting in her wheelchair with a visible sling underneath her. Staff were pushing R100's wheelchair down the hallway.

On 4/12/17, at 12:01 p.m., R100 was observed sitting in her wheelchair in the dining room and had a visible sling underneath her.

During interview with R100 on 4/12/17, at 12:01 p.m., the resident stated it bothered her to have the sling underneath her in the wheelchair, and that she would rather have the sling removed while in the wheelchair.

On 4/14/17, at 11:31 a.m. registered nurse (RN)-B stated the sling was supposed to be removed from underneath R100 after R100 was transferred into her wheelchair. RN-B stated, "I have always taught leaving a sling underneath a resident was a dignity concern. No one needs to know a lift is being used to transfer someone."

On 4/14/17, at 3:56 p.m. the director of nursing stated she would expect staff to remove the sling unless it was care planned to leave the sling underneath the resident.

The facility's policy, Resident Rights undated, included: Dignity- you have the right to be valued as an individual, to maintain and enhance your self-worth, to be treated with courtesy, respect and dignity, free from humiliation, harassment or threats, to be free from physical, sexual, mental, verbal and financial abuse, to be free from chemical and physical restraints and involuntary

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F 241	Continued From page 40 seclusion.	F 241		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents (R42 & R33) reviewed for choices received showers/baths according to their preference for bathing frequency. Findings include: R42 was admitted to the facility on 11/30/15 according to their admission sheet. R42's diagnosis found on the diagnosis report dated 11/30/15, indicates major depressive disorder, type 2 diabetes with diabetic neuropathy. R42 has a BIMS (brief interview for mental status)	F 242	F242 1. R42 and R33 have discharged from the facility. 2. Facility residents have the potential to be affected by this practice. 3. Current residents have had a review of their preferences for bathing type and frequency of bathing with care plans and care guides updated as needed. Bathing preferences will be reviewed at care conferences quarterly. New admissions are asked about bathing preferences during the admission process and reviewed at the 72 hours care conference.	5/28/17

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score of 12 out of 15 which indicates R42 to have moderate cognitive impairment; last dated 3/6/17.

Care plan with revision date of 4/3/17, indicates R42 to have a self-care deficit related to impaired mobility which requires the assistance of one staff for dressing, grooming and bathing. R42 transfers with a mechanical lift and staff assistance of one; impaired elimination related to incontinence.

Review of weekly skin documentation indicates R42 received a shower every Sunday morning.

Review of daily progress notes from December 2016 to April 2017, does not indicate discussions related to bathing frequency preferences.

Interview on 4/10/17, at 12:59 p.m. with R42 indicated she gets one shower a week but would prefer to bathe a couple times a week due to urinary incontinence.

Interview on 4/12/17, at 8:29 a.m. with licensed practical nurse (LPN)-C stated residents are asked their choices for bathing on admission and at every care conference. LPN-C stated there is a care conference form that is used during meetings where it is asked and identified resident preferences for bathing. LPN-C stated he was unaware R42 was requesting to be bathed more than once a week.

Reviewed care conference form. Only one form was located and dated 12/6/16. Care Conference Summary form does not indicate R42 was asked preferences on bathing frequency.

Interview on 4/12/17, at 11:04 a.m. with social worker (SW)-B stated if a resident brings up

F 242 (Plan of Correction)

Nursing staff received education by the Director of Nursing/designee on bathing preferences to include type of bathing and frequency of bathing and how to operate the whirlpool tubs. Inservices were completed by May 28, 2017. PRN staff will complete the education prior to his/her first scheduled shift. Inservices will be ongoing as needed.

4. The Director of Nursing/Social Services Director/designee will monitor compliance through 3 random audits of residents' care plans/care conference notes/interview with residents from each unit weekly for a minimum of 3 months or until compliance is achieved. The results of these audits will be brought to QA/PI monthly for review and recommendation.

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bathing preferences in a meeting or care conferences then we will discuss their choices.

Interview on 4/13/17, at 8:34 a.m. with director of nursing (DON) stated bathing preferences are discussed on admission. Typically bathing is set up for one a week unless they would like more. DON stated preferences are discussed at care conferences but did not know where this is documented. DON stated we do work with residents if they want more than one bath or shower a week.

Interview on 4/14/17, at 8:29 a.m. with LPN-C stated he had not followed up with R42 regarding her bathing frequency preferences. LPN-C stated there's no reason we can't offer more.

Interview on 4/14/17, at 3:51 p.m. with LPN-C stated he had not followed up with R42 regarding her bathing frequency preferences. LPN-C stated he looked at the aide care guide and it wouldn't cause an imbalance if we added another one during the week. LPN-C verified R42 receives scheduled bathing on Sunday mornings.

Policy titled, "Preservation of Resident Rights", dated 6/29/16, indicates the social services staff will act as a liaison between staff and residents to ensure appropriate communication is relayed to help residents make informed decision. The social services staff will gather information to assist residents in being able to make individual decisions and choices regarding activities, schedules and health care that reflects their interests and preferences for what they like to do and when they like to do it. Examples include bath schedules.
R33 was interviewed on 4/10/17 at 11:51 a.m.,

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and was asked, "Do you choose whether you take a shower, tub, or bed bath?" R33 replied, "No. I like the whirlpool better, stated he was able to have a whirlpool most of the time, but have of the problem was they (meaning staff) do not know how to run it."

R33's quarterly Minimum Data Set (MDS) dated 2/3/17; identified R33 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated R33 was cognitively intact.

During an interview on 4/14/2017, at 10:21 a.m. nursing assistant (NA)-A stated R33 gets baths and showers. NA-A stated she needed a lesson in how to run the whirlpool, so one day she gave R33 a shower instead of a bath a couple of weeks or month ago. NA-A stated she had asked for help in learning to run the whirlpool. NA-A stated she asked co-workers and management, and, "they say do this or do that and it is simple." NA-A stated she was not comfortable using the whirlpool, as she wants to use it right and stated she will give residents showers rather than baths, as she is not comfortable with it running the whirlpool. NA-A stated if she was assigned a resident that really needed a whirlpool she would ask a co-worker to do it for her. NA-A stated there are other staff that state they do not know how to use the whirlpool either and stated that is why I thought it would be good to get a demonstration for a group of us to show us how to run it. NA-A stated she asked the former staff educator to have an in-service on how to run the whirlpool as there was a bunch of us that do not know how to run the whirlpool. NA-A stated she was told maybe that could be done and stated the former staff educator stated she would look into it. NA-A stated the in-services was never provided. NA-A

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stated when residents or families ask why we do not provide whirlpools, "I tell them I would love to, but I need to know how to run the whirlpool right and that is why I give them showers."

During an interview on 4/14/2017, at 12:06 p.m., registered nurse (RN)-A staff were trained on using the whirlpools as a part of their orientation process upon hire. RN-A stated there has not been any training on the use of the whirlpools since he took this job in September 2016. RN-A stated no staff have come to him about not being comfortable using the whirlpools.

During an interview on 4/14/2017, 2:51 p.m., the director of nursing (DON) stated her expectation was staff had been orientated to the whirlpools and she expected staff to know how to use them. The DON stated, "If they have questions they are to ask peers or our staff development person on how to use them." The DON was asked, "If a nursing assistant asked the education staff member to complete an in-service on how to use the whirlpool, would you have expected training to have been provided to that staff member?" The DON replied, "Yes, she would have expected the training to have been provided to the staff member."

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F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		5/28/17

(c) Activities.

(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and

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F 248	Continued From page 45 individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide resident assessed activities for 2 of 3 residents (R56 & R100) who had cognitive impairment and observed not to be provided with activities. Findings Include: R56 was observed on 4/10/17, at 10:53 a.m., sitting in her wheelchair on her side of the room, the television was not on and there was no music playing in the room. R56 was observed on 4/11/17, at 12:00 p.m. in her wheelchair on her side of the room, the television was not on and there was no music playing in the room. R56's significant change Minimum Data Set (MDS) dated 3/29/17 indicated R56 had severe cognitive impairment, dementia, Parkinson's disease and aphasia. The MDS indicated R56 required total assistance with all activities of daily living. The MDS also included a staff assessment of daily and activity preferences, which indicated, R56 liked listening to music, being around animals such as pets and spending time outdoors. R56's Care Area Assessment (CAA) for psychosocial well-being included, "CAA triggered due to the resident not participating in her favorite activities over the look back period. CAA triggered due to resident not being able to complete her	F 248	R248 1. R100 has discharged from the facility. R56's care plan and care guide has been updated to ensure that he/she is provided with appropriate activities at an appropriate level. The Director of Activities has developed communication material for staff to ensure that R56's activity needs are met. 2. Cognitively impaired residents in the facility have the potential to be affected by this practice. 3. A review of cognitively impaired residents' charts for activity assessments has been completed. Care plans and care guides have been updated as needed. Facility nursing staff were inserviced by the Director of Nursing/designee on providing appropriate activities as care planned for cognitively impaired residents. MDS nurses and members of the Interdisciplinary team were re-educated on the requirement for proper completion of MDS and completing CAAs when necessary. Current nursing staff will have completed this education by May 28, 2017. PRN nursing staff will complete this education prior to his/her first scheduled shift. Inservices will be ongoing as	

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activities interview and the staff interview having to be conducted. Resident currently has diagnoses of Lewy Body Dementia, and Parkinson's disease. Resident has aphasia and is unable to make her needs known in any way whether verbal or non-verbal. Resident has a decreased level of consciousness and does not open her eyes often throughout the day. Staff will continue to talk to resident with all cares to increase her socialization. Staff will encourage the resident's family to visit with the resident. Resident does not currently participate in activities due to her advanced disease process. Staff will continue to provide resident with individualized activities as needed. Resident's family is active in her plan of care with no questions or concerns about activities at this time. Resident went off hospice on 3/29/17.

R56's care plan with a print date of 4/12/17, included, "I have a poor response to others and the environment limited ability to communicate, limited ability to react due to dementia w/ [with] Lewy Bodies. Goal: I will continue to receive visits from family members and hospice, and will attend music programs when I am awake." Interventions included: Call my name or gently touch my arm or hand to help me maintain awareness of the activity going on around me. Encourage me to maintain eye contact with you during 1:1 activities to help keep me focused on what you're doing Please help me participate in my favorite activities at my highest level.

R56's recreational; therapy attendance record revealed from 4/1/17 to 4/11/17, R56's activity was coded as television on the day shift eleven times and had a visitor one time.

needed.

4. The Director of Nursing/designee will monitor compliance through observations and random audits of cognitively impaired resident's medical records 3/x weekly for a minimum of 3 months or until compliance is achieved. Results of observations and audits will be brought to QA/PI monthly for review and recommendations.

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R56's recreational; therapy attendance record revealed from 3/1/17 to 3/31/17, R56's activity was coded as television thirty times, visitor seven times and independent socialization eight times.

R56's recreational; therapy attendance record revealed from 2/1/17 to 2/28/17, R56's activity was coded as television thirty-one times, visitor eight times, independent socialization three times and reminisce one time.

R56's recreational; therapy attendance record revealed from 1/1/17 to 1/31/17, R56's activity was coded as television thirty-three times and visitor ten times.

During an interview on 4/12/17, at 11:25 a.m., nursing assistant (NA)-A stated R56 stayed up on the third floor and did not go down to activities. NA-A stated she did not responded to many things anymore, we just make sure she is comfortable.

During an interview on 4/14/2017, at 9:40 a.m., NA-B stated R56 loved music and we usually try to put music on for her. NA-B stated you could tell by her gestures she is enjoying it, she will smile and her eyes look happy. NA-B stated R56 also liked to be read to and stated we have some books that we read that have 101 short stories.

During an interview on 4/12/2017, at 1:02 p.m., NA-C stated R56 did not participate in activities. NA-C stated the activity staff did not do any activities or 1:1 visits with her. NA-C stated she was not aware of any activities to provide to R56 in her room.

During an interview on 4/12/17, at 1:26 p.m.,

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licensed practical nurse (LPN)-A stated, I know that music and family visiting are things that she does participate in. LPN-A stated R56 participated in music in her room and on the first floor during facility activity programs. LPN-A stated R56's family was very involved, visit often and would have gatherings in her room.

During an interview on 4/12/17, at 10:53 a.m. activities (A)-A stated family preferred R56 to stay in her room at this point as she was on hospice cares. A-A stated I was told by family member (FM)-A did not even want her brought down stairs for any music programs. A-A stated R56 was currently not attending any activities programs at this time and stated they (staff) always have the television on in her room and that seemed to sooth her. A-A also stated the activity department was not providing any activities for R56 in her room. A-A stated R56 had daily visits from her husband and family members visited quite often. A-A also stated R56 was receiving activity services through hospice services like massage and chaplain visits. A-A stated she was unaware R56 had graduated from hospice services. A-A stated there was not a current goal at this time for activity participation for R56. A-A verified the activity care plan indicated R56 was receiving 1:1 activities and A-A stated the activity department were no longer providing 1:1 one visits to R56 per the care plan. A-A stated she did not document the conversation with FM-A that they did not want R56 to participate in activities and verified the care plan did not reflect families wishes for facility to not provide activities. A-A stated she did not discuss the activity department proving 1:1 visits for R56 with FM-A and stated FM-A had not stated they did not want 1:1 visits provided. A-A stated R56 had not received 1:1 visits from the

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activity department in the last year. A-A stated television on in R56's room and reminisce one time were the only activities provided by the facility for R56 in last three months. A-A stated if she would have been aware hospice services had ended for R56 she would have tried to set up some kind of 1:1 program for her.

During an interview on 4/12/17, at 11:48 a.m. A-A and A-B stated years ago family member (FM)-A used to visit her daily and actually did not feel comfortable with her around that many people and asked us not to bring her down to activities. A-A and A-B stated there was no documentation of this conversation and stated this has been for a while. A-A stated she must have been aware R56 was taken off hospice because she completed the significant change MDS on 3/29/17. A-A states the MDS activity assessment did not reflect R56 was not participating in activities per FM-A preference and stated R56's care plan did not reflect FM-A preference for R56 to not be provided activities.

During an interview on 4/14/17, at 8:33 a.m. FM-A stated staff members were not providing any activities for R56 that FM-A was aware of. FM-A stated was not opposed to activity staff completing 1:1 to one visits with R56 and stated staff could bring R56 downstairs to activities to listen to music programs, as she liked music. FM-A stated staff could provide any activities that they would want to for R56. FM-A stated was not sure how much she would be able to comprehend, but stated staff could provide activities to her.

During an interview on 4/14/2017, at 3:17 p.m. FM-A stated there was never a time FM-A had

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told activities staff not to provide activities for R56.
R100's significant change Minimum Data Set (MDS), dated 2/3/17, identified activity preference: books, newspaper, magazines to read important but cannot do, favorite activities very important, going outside very important, music somewhat important, keeping up with the news somewhat important, religion somewhat important, doing group activities not very important, being around animals not very important and moderate cognitive impairment.
R100's Admission Record, dated 4/17/17, included diagnosis of dementia without behavioral disturbance.

R100's current care plan included R110 preferred independent activities or spending time with my family rather than doing things in groups. Offer me activities and supplies for things I can do in my room. I have a history of depression, please include me in activities or at least offer them. Ask my family to bring in pictures and other familiar items from home to have near me for comfort and a sense of belonging. Have my Guardian Angel visit with me every week so I can voice any concerns or needs.

On 4/11/17, at 7:04 p.m., R100 was seated in her wheelchair in the dining room. A man with a guitar was singing and other residents were holding songbooks and singing along. R100 was sitting with her eyes closed and was not engaged in the activity. At 7:14 p.m., R100 was observed to be sitting in her wheelchair and a visitor was pushing R100 in her wheelchair. The visitor asked R100 if she wanted to go outside and R100 replied yeah, before it gets dark out.

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On 4/12/17, at 4:05 a.m., R100 was seated in her wheelchair in the dining room awake and the T.V. was on.

On 4/13/17, at 2:47 p.m., R100 was seated in her wheelchair in the dining room with other residents. A movie was playing. R100 was sleeping.

R100's Recreational Therapy Attendance Records dated from 10/1/16 through 3/31/17, identified the following activities were documented:
Month of 10/16: T.V. 25 days, outside six days, trivia 23 times, therapy one day, entertainment one day, snack one day.
Month of 11/2016: T.V. 30 days, visitor 23 times, outside four times, entertainment two times.
Month of 12/2016: T.V. 30 days, visitor 14 days, gift giving one day, social and snack one day.
Month of 1/2017: T.V. 25 days, visitor four days, movies one day, art one day, social two days, independent socialization five days.
Month of 2/2017: T.V. 27 days, visitor four days, social and snack one day, independent socialization 27 days.
Month of 3/2017: T.V. 28 days, visitor six days, independent socialization 28 days.

The sheets did not indicate for the activities if the resident was actively participating.

On 4/14/17, at 9:34 a.m., activity director (AD)-A and A-B stated for the activity outside was the family taking R100 outside when the weather was nice for fresh air. Visitor was the family and the family bringing the family dog in to visit. Independent socialization was R100 socializing with staff and family. The last couple of weeks

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R100 has started coming out for more activities, I think her children are encouraging her to participate more in activities. R100 was always in her room prior to return from last hospitalization (returned 4/2/17) and she mainly watched TV. We have always asked R100 to participate and have not had good results in the past. When queried if they had provided any one on one activities with R100 AD-A and A-B stated we have not been doing any one on ones with R100 for activities. We offer general activities to R100 and she refuses to join. We have not offered any one on one with reading and news. When queried if had provided independent activities in R100 room as music AD-A and A-B were unsure if R100 had a player in her room for music. When queried regarding the lack of documentation of refusals on the Recreational Therapy Attendance Sheets, AD-A and A-B confirmed refusals were not being documented. A-B stated we used to write in red and circle when a resident refused, but our hours were cut back in our department and we do not have time to document refusals anymore.

Review of the Recreation Services Guide: Individual Programming, dated 2009, included, Programming will be offered to all residents who are unable or choose not to attend group activities ...Structured individual interventions will be developed based on each resident's history and assessed needs and preferences. The individual program will be scheduled based on resident preference as to day, time of day and duration. Each resident's individual program will include interventions, which meet the resident's assessed social, emotional, physical, and cognitive functioning needs. Activities should be adapted in various ways to accommodate the resident's change in functioning due to physical or

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F 248	Continued From page 53 cognitive limitations.	F 248		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 279		5/28/17

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F 279	Continued From page 54 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and interview, the facility failed to develop a comprehensive care plan regarding urinary catheter use for bladder control for 1 of 1 resident (R103) who was admitted with an indwelling Foley catheter. Finding include: R103 was admitted to the facility on 1/2/17 and diagnosis of retention of urine, type two diabetes, dementia, and hearing loss according to the Admission Record. R103's annual Urinary Incontinence and	F 279	F279 1. R103 is no longer a resident at this facility. 2. Residents with urinary catheters have the potential to be affected by this practice. 3. Record reviews were completed for residents who currently have urinary catheters in place. Care plans were updated with specific information about the urinary catheter. Licensed nursing	

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F 279	Continued From page 55 indwelling catheter Care Area Assessment dated 1/12/17 indicated needing extensive assist with toileting and requires an indwelling catheter related to impaired mobility, diabetes, urinary urgency and neurogenic bladder. R103's current care plan with print date 4/17/17, directed staff to monitor/document/report signs and symptoms of urinary tract infection (UTI), offer fluids between meals and when rendering care, monitor/document/report signs and symptoms of dehydration. An untitled nursing assistant sheet, identified staff were to encourage fluids and document Foley catheter output. Document titled Clinical Document Copy-Primary Care Internal Medicine dated 1/9/17 reads family concerned about weight lost, poor appetite, not eating or drinking with reports of concentrated urine with a concern for dehydration. Decision made to send R103 sent via ambulance, as he requires fluid resuscitation. 2/8/17 R103 is to receive intravenous hydration in the skilled nursing facility. 3/7/17 reads R103 receiving intravenous fluids once a week to help maintain fluid status. Facilities treatment administration record monitors Foley output every shift start date 1/30/17 with low outputs. During an interview with the Registered, nurse (RN)-B and RN-A on 4/17/17 at 9:04 a.m. Stated the staff monitor the output on the certified nurse sheets. Surveyor updated RN-B that the outputs were low for someone with a catheter and frequent diarrhea. RN-B verified that R103 had been receiving weekly intravenous hydration. RN-B asked	F 279	staff received education by the Director of Nursing/designee on the use of urinary catheters, specifically care planning specific information about the resident's urinary catheter and interventions in place as a result of the urinary catheter. Current licensed nursing staff will have completed this education by May 28, 2017. PRN licensed nursing staff will complete this education prior to his/her first scheduled shift. Inservices will be ongoing as needed. 4. The Director of Nursing/designee will monitor compliance through 3 random audits weekly of residents with urinary catheters for a minimum of 3 months or until compliance is achieved. The results of these audits will be brought monthly to QA/PI for review and recommendations.	

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F 279	Continued From page 56 regarding intervention in placed for staff to be able to care for R103, regarding the catheter cares and hydration needs. During an interview with RN-A stated it is a nursing practice to know what to do, if we would put every intervention in the care plan than care plans would be many pages. Review of facility policy titled Catheter Care; Indwelling Catheter dated last reviewed 8-9-16 reads: Care plan documentation guidelines; Enter the catheter care as an approach under the appropriate underlying problem on the residents care plan.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 280		5/28/17

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F 280	Continued From page 57 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280		

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F 280	Continued From page 58 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was revised to include target behaviors and changes in behavior for the use of antidepressant and antianxiety medications for 1 of 5 residents (R100) reviewed for unnecessary medication use. Findings include: R100's current care plan included: Takes an antidepressant medication related to depressive disorder. Administer medication as ordered. Monitor/document effectiveness anti-depressant medication. Monitor/document/report adverse side effects. Monitor/document/report any signs or symptoms of depression unaltered by my medication such as: increased sadness, irritability, anger, crying, expressions of shame, worthlessness, guilt, suicidal ideation, negative mood or comments,	F 280	F280 1. R100 has been discharged from the facility. 2. Residents taking psychotropic medications including antianxiety, antidepressant and antipsychotic - have the potential to be affected by this practice. 3. Care plans for residents taking psychotropic medications - including antianxiety, antidepressant, and antipsychotic - were reviewed for inclusion of target behaviors for these medication classes and updated as needed. Nursing staff received education by the Director of Nursing/designee on target behaviors and documentation of target behaviors for	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 59 increased agitation, disrupted sleep, fatigue, lethargy, lack of enjoyment in my usual activities, changes in my cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, seeking attention more than usual, overly concerned with my body functions, increased anxiety, need for constant reassurance. Obtain informed consent for use of psychoactive medication. My safety is at risk and there is a potential for abuse due to: I am adjusting to placement. I have a diagnosis of major depressive disorder and utilize psychotropic medications. I utilize staff assist. Administer Celexa for target behavior: refusing to leave room, flat affect, isolating. Administer Buspar for target behavior: refuses to cooperate with recommended plan of care. Explain what you are going to do before providing care. Please do not have me near others that I disturb. Please do not have me near others who disturb me. Please explain my environment to me if I do not understand what is going on around me. Please keep others out of my room that do not belong there. Please re-direct me when I wander into other rooms or areas that are unsafe for me. Please remove me from potentially dangerous situations. At risk for sleep pattern disturbance: has order for Melatonin and is currently taking. Interventions included: administer medication as ordered. Monitor for adverse signs and symptoms. Resident preferences for sleep hygiene accommodated. Sleep study completed on admission, quarterly, and PRN On 4/12/17, at 4:05 a.m., R100 was observed seated in her wheelchair in the dining room awake and talking on her phone.	F 280	residents on psychotropic medications - including antianxiety, antidepressant, and antipsychotic. Current nursing staff will have completed education by May 28, 2017. PRN nursing staff will complete the education prior to his/her first scheduled shift. Inservicing will be ongoing as needed. 4. The Director of Nursing/designee will monitor compliance through 3 random audits weekly of behavior documentation and care plans for residents on antianxiety, antidepressant, or antipsychotic medication for a minimum of 3 months or until compliance is achieved. The results of these audits will be brought to monthly to QA/PI for review and recommendations.	

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LACK OF IDENTIFIED TARGET BEHAVIORS FOR USE OF AN ANTIPSYCHOTIC MEDICATION:

R100's record identified on 3/28/17 Risperdal 0.25 mg was prescribed for mood stabilizer and to promote sleep.

R100's Psychosocial Assessments identified 3/28/17: resident has been yelling out/verbally aggressive towards staff and refusing cares since hospitalization. Resident is adjusting to placement back at facility and is struggling with new medical issues.

A care conference summary dated 4/4/17, identified mood and behavior status: irritable, restless, agitated, yells out for needs, increased confusion and anger.

R100's Behavior Monthly Flow sheets dated for the month of 3/17 identified medications Buspirone and Celexa and the following behaviors of code 39 refusing to leave room, code 40 refusing to cooperate with recommended plan of care and code 12 depressed withdrawn were being monitored. The month of 4/17 identified medications Risperdal/Celexa/Buspirone and the same codes were being monitored as for the month of 3/17. No additional target behaviors were identified for the use of the Risperdal.

R100's care plan failed to address use of the Risperdal and target behaviors related to the use of the Risperdal.

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F 280	Continued From page 61 On 4/14/17, at 3:36 p.m., registered nurse (RN)-D verified target behaviors had not been identified for the use of the Risperdal. On 4/14/17, at 4:05 p.m., the director of nursing (DON) stated she would expect target behaviors to be identified and monitoring of the target behaviors to be implemented for the use of the Risperdal. LACKED DEVELOPMENT OF NEW SIGNS AND SYMPTOMS FOR USE OF ANTIDEPRESSANT MEDICATION: R100'S current care plan with print date of 4/17/17, identified administer Celexa for target behavior: refusing to leave room, flat affect, isolating and Buspar for target behavior: refuses to cooperate with recommended plan of care. R100's Psychosocial Assessments identified 3/28/17: resident has been yelling out/verbally aggressive towards staff and refusing cares since hospitalization. Resident is adjusting to placement back at facility and is struggling with new medical issues. A care conference summary dated 4/4/17, identified mood and behavior status: irritable, restless, agitated, yells out for needs, increased confusion and anger. R100's Behavior Monthly Flow sheets dated for the month of 3/17 and 4/17 identified medications Buspirone and Celexa and the following behaviors of code 39 refusing to leave room, code 40 refusing to cooperate with recommended plan of care and code 12 depressed withdrawn	F 280		

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were being monitored.

On 4/13/17, at 3:10 p.m., licensed practical nurse (LPN)-H stated (in regards to R100 mood and behaviors) R100 yells out and when placed on the commode in five seconds is yelling help. R100 does not want to be in her room. Before she was in her room and would sleep in the recliner in her room. Now R100 does not want to sleep in her room. Every time the NA's bring R100 to her room, she does not want to stay there and requests top go back to the dining room.

On 4/13/17, at 3:17 p.m., NA-J stated regarding R100's mood and behaviors, R100 does not want to be in her room anymore and R100 is not wanting to sleep in her room. Before she would sleep in her recliner and watch T.V. NA-J stated the change in R100's behavior started about a month ago.

On 4/14/17, at 3:36 p.m. RN-D stated (in regards to R100's change in behaviors) in conversation with R100's physician I talked in length of R100's fear of being isolated or alone in her room, questioning if related to cardiac issues and the feeling patients have with cardiac issues of feeling suffocated. RN-D stated the physician thought that was reasonable. RN-D verified R100's Behavior Monthly Flow sheets had not been updated to reflect the change in behaviors R100 has had, for monitoring.

On 4/14/17, at 4:05 p.m., the DON stated she would expect any medication to have the appropriate target behaviors identified and monitoring of the target behaviors to be implemented.

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F 280	Continued From page 63 The facility policy Antipsychotic Medication review, dated 3/17/16, indicated Procedure: To ensure that the medical record of any resident who receives antipsychotic medication contains documentation supporting the appropriateness and necessity for the use of the drug. Procedure Details: Review the care plan for the following information: antipsychotic medication, reason (purpose) for the medication, side effects, behaviors and suggested interventions. Review that behaviors are being monitored and documented on the Care Tracker and/or behavior sheet that is easily accessible to staff.	F 280		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 ensure oral care was provided according to the plan of care for 2 of 2 residents (R90 and R195) reviewed for dental status; failed to ensure assistance with grooming of facial hair was provided according to the plan of care for 2 of 3 residents (R40 and R42) reviewed for activities of daily living; and the facility failed to provide activities as care planned for 2 of 3 residents (R56 and R100) reviewed for activities.	F 282	F282 1. R100 and R42 have been discharged from the facility. R90 and R195 had care guides updated and has oral care provided to them as needed. R40 is being assisted with facial grooming as needed. R56 was reassessed for activity needs and care planned accordingly. Staff was inserviced on updated activities care plan.	5/28/17

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Findings Include:

R90's annual Minimum Data Set (MDS) dated 3/10/17, identified required extensive assist of one for personal hygiene.

R90's care plan with a print date of 4/12/17, included, at risk for dental problems related to some or all natural teeth loss. Resident has full upper dentures and his own lower teeth. Interventions instructed staff to provide assistance with oral cares as needed and to provide extensive assistance of one with personal hygiene.

R90 was observed on 4/12/17, at 7:11:29 a.m., during morning cares with nursing assistant (NA)-A had been observed to brush R90's upper dentures in the bathroom and then place the upper dentures in R90's mouth. NA-A stated she was done with R90's morning cares and stated there was nothing else she needed to do for R90 this morning to get him ready for the day. NA-A did not brush R90's lower natural teeth.

During an interview on 4/12/17, at 11:24 p.m., NA-A stated R90 had upper and lower dentures. NA-A confirmed she did not provide oral care for his natural bottom teeth. NA-A stated she had planned to talk to the nurse to see if his lower dentures were missing, since they were not in the denture cup this morning when she provided cares.

During an interview on 4/12/17, at 1:51 p.m., licensed practical nurse (LPN)-A stated she would have expected the nursing assistant to complete oral care for R90's natural teeth at the same time

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2. Residents who require assistance with ADLs, specifically oral care and facial grooming, and residents requiring assistance with activity participation/choices have the potential to be affected by this practice.

3. Care plans and are guides for residents who require assistance with ADLs, specifically oral cares and facial grooming, were reviewed and updated as needed. Care plans and care guides for residence requiring assistance with activity participation/choices and 1:1 activities were reviewed and updated as needed. Nursing staff was inserviced on oral care, shaving and activities. Activities Director and team were inserviced regarding 1:1 activities and care planning. Nursing staff were inserviced on providing oral care, facial hygiene (both male and female residents), and care planned activities per care guides and care plans. Nursing staff and Activity staff will have completed this education by May 28, 2017. PRN nursing staff will complete the education prior to his/her first scheduled shift. Inservices will be ongoing as needed.

4. The Director of Nursing/designee will monitor compliance through observations on daily rounds and random audits of AM/PM cares of residents care guides 3 x weekly for a minimum of 3 months or until compliance is achieved. The Director of Activities/Director of Nursing/designee will monitor compliance through random

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F 282	Continued From page 65 she had cleaned his upper dentures and placed the dentures in his mouth. LPN-A verified care plan directed staff to completed oral cares as needed. LPN-A stated staff did not follow the care plan for oral care when R90's natural teeth were not brushed this morning. During an interview on 4/12/17, at 2:31 p.m., the director of nursing stated the expectation was to provide oral care to dentures and the natural teeth in the oral cavity. The DON verified staff did not provide oral care per R90's care plan. A policy related to activities of daily living and grooming was requested, none was provided. LACK OF FACIAL GROOMING: R40 was observed on 4/10/17, at 11:12 a.m. be sitting in her chair in her room. R40 had several short facial hairs across her chin and two, one-half inch long facial hairs on her chin and cheek. R40 was observed on 4/11/17, at 12:01 p.m., to be sitting in her chair in her room and the facial hairs on her chin and cheek remained. R40's quarterly Minimum Data Set (MDS) dated 2/16/17, identified R20 had limited vision and required limited assist of one for personal hygiene. R40's care plan with a print date of 4/11/17, included, "I have a physical functioning deficit related to: Self care impairment s/t legally blind." Interventions included, "Personal Hygiene assistance of 1." "Impaired Vision related to: Cataract, Macular degeneration, and Blepharitis	F 282	audits of residents to ensure care planned activities are being provided to residents 3 x weekly for a minimum of 3 months or until compliance is achieved. The results of these observations/audits will be brought monthly to QA/PI for review and recommendation.	

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which led to legally blind and eyelid redness. "

R40 was observed during morning cares on 4/12/17, at 8:39 a.m. with nursing assistant (NA)-C. Morning cares were completed without offering to shave R40's facial hairs.

During an interview on 4/12/17, at 12:57 p.m., NA-C stated she provided shaving for facial hair anytime R40 looked like she may need to be shaved. NA-C stated she did not even check to see if R40 had facial hair this morning. NA-C completed an observation of resident on 4/12/17, at 1:01 p.m. verified the facial hair on R40's chin and cheek. NA-C stated R40 did need to be shaved and would complete this task after lunch.

During an interview on 4/12/17, at 1:21 p.m., licensed practical nurse (LPN)-A completed an observation of R40 and stated R40 should have had her facial hair shaved this morning. LPN-A stated she observed one-half inch facial hair underneath R40's chin and on her cheek. LPN-A stated the staff did not follow the care plan for personal hygiene as resident's facial hair was not shaved and stated she expected staff to follow the care plan.

During an interview on 4/12/17, at 2:26 p.m., the director of nursing (DON) stated facial hair should be shaved on bath days and as needed. The DON verified staff did not follow the care plan to provide personal hygiene for facial hair for R40.

During an interview on 4/14/17, at 9:02 a.m. with family member (FM)-B stated it was very important to R40 to have facial hair removed. FM-B stated family completed facial hair removal for R40 and stated the shaver was in her drawer

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and if staff wanted to shave her, they could. FM-B asked, "Is this (meaning facial hair removal) something the facility should be providing to her? Quite honestly I see quite a few women there with facial hair."

LACK OF ACTIVITIES PER CARE PLAN:

R56 was observed on 4/10/17, at 10:53 a.m., sitting in her wheelchair on her side of the room, the television was not on and there was no music playing in the room.

R56 was observed on 4/11/17, at 12:00 p.m. in her wheelchair on her side of the room, the television was not on and there was no music playing in the room.

R56's care plan with a print date of 4/12/17, included, "I have a poor response to others and the environment limited ability to communicate, limited ability to react due to dementia w/ [with] Lewy Bodies. Goal: I will continue to receive visits from family members and hospice, and will attend music programs when I am awake." Interventions included: Call my name or gently touch my arm or hand to help me maintain awareness of the activity going on around me. Encourage me to maintain eye contact with you during 1:1 activities to help keep me focused on what you're doing Please help me participate in my favorite activities at my highest level.

R56's significant change Minimum Data Set (MDS) dated 3/29/17 indicated R56 had severe cognitive impairment, dementia, Parkinson's disease and aphasia. The MDS indicated R56 required total assistance with all activities of daily living. The MDS also included a staff assessment

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of daily and activity preferences, which indicated, R56 liked listening to music, being around animals such as pets and spending time outdoors. The Care Area Assessment (CAA) for psychosocial well-being, printed 4/12/17 included, "CAA triggered due to the resident not participating in her favorite activities over the look back period. CAA triggered due to resident not being able to complete her activities interview and the staff interview having to be conducted. Resident currently has diagnoses of Lewy Body Dementia, and Parkinson's disease. Resident has aphasia and is unable to make her needs known in any way whether verbal or non-verbal. Resident has a decreased level of consciousness and does not open her eyes often throughout the day. Staff will continue to talk to resident with all cares to increase her socialization. Staff will encourage the resident's family to visit with the resident. Resident does not currently participate in activities due to her advanced disease process. Staff will continue to provide resident with individualized activities as needed. Resident's family is active in her plan of care with no questions or concerns about activities at this time. Resident went off hospice on 3/29/17.

R56's recreational; therapy attendance record revealed from 4/1/17 to 4/11/17, R56's activity was coded as television on the day shift eleven times and had a visitor one time.

R56's recreational; therapy attendance record revealed from 3/1/17 to 3/31/17, R56's activity was coded as television thirty times, visitor seven times and independent socialization eight times.

R56's recreational; therapy attendance record revealed from 2/1/17 to 2/28/17, R56's activity

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F 282	Continued From page 69 was coded as television thirty-one times, visitor eight times, independent socialization three times and reminisce one time. R56's recreational; therapy attendance record revealed from 1/1/17 to 1/31/17, R56's activity was coded as television thirty-three times and visitor ten times. During an interview on 4/12/17, at 1:02 p.m., nursing assistant (NA)-C stated R56 did not participate in activities. NA-C stated the activity staff did not do any activities or 1:1 visits with her. NA-C stated she was not aware of any activities to provide to R56 in her room. During an interview on 4/12/17, at 10:53 a.m. activities (A)-A stated family preferred R56 to stay in her room at this point as she was on hospice cares. A-A stated I was told by family member (FM)-A did not want her brought down stairs for any music programs. A-A stated R56 was currently not attending any activities programs at this time and stated staff always have the television on in her room and that seemed to sooth her. A-A also stated the activity department was not providing any activities for R56 in her room. A-A stated R56 had daily visits from her husband and family members visited quite often. A-A verified the activity care plan indicated R56 was receiving 1:1 activities and A-A stated the activity department were no longer providing 1:1 one visits to R56. A-A stated R56 had not received 1:1 visits from the activity department in the last year. A-A stated television on in R56's room and reminisce one time were the only activities provided by the facility for R56 in last three months. A-A verified activity staff were not providing R56 activities per her current care plan.	F 282		

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During an interview on 4/14/17, at 8:33 a.m. family member (FM)-A stated staff members were not providing any activities for R56 that FM-A was aware of. FM-A had not been opposed to activity staff completing 1:1 to one visits with R56 and stated staff could bring R56 downstairs to activities to listen to music programs, as she liked music. FM-A stated staff could provide any activities that they would want to for R56.

A policy and procedure was requested for following the care plan, and none was provided.
LACK OF ORAL HYGIENE:

R195's Admission Record, dated 4/13/17, included diagnosis of dementia without behavioral disturbance.

R195's care plan undated, included mouth care: oral hygiene assist, full upper denture.

On 4/12/17, at 8:47 a.m., nursing assistant (NA)-J entered R195's room to provide a.m. cares. R195 was observed to have upper dentures in place. NA-J assisted R195 with peri-cares and dressing. After dressing R195, NA-J transferred R195 into his wheelchair and assisted R195 to the dining room for breakfast. NA-J had not provided or offered oral cares.

On 4/13/17, at 3:15 p.m., NA- J confirmed she had not brushed or offered to brush R195's dentures on the morning of 4/12/17, when she had provided a.m. cares. NA-J stated the facility protocol was to provide oral cares in the a.m. and at bedtime. NA-J stated R195 typically does not wash up at night or want oral cares, so one of those we do not do on a regular basis. NA-J

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stated I could have offered oral cares, even knowing the fact R195 refuses at times.

On 4/13/17, at 3:33 p.m. the DON stated the facility protocol was to provide oral cares in the a.m. and p.m. whether care planned or not, unless the resident specifies different. The DON stated she would expect the NA to offer oral cares and if the resident declined inform the nurse.

The facility policy Oral Hygiene dated 1/20/16, indicated procedure purpose to cleanse the mouth, teeth and dentures, to prevent infection and irritation, to moisten the mucous membrane and to promote personal hygiene. The policy did not address the facility protocol to provide oral cares with a.m. and p.m. cares.

LACK OF ACTIVITIES PER CARE PLAN:

R100's Admission Record, dated 4/17/17, included diagnosis of dementia without behavioral disturbance.

R100's current care plan included she preferred independent activities or spending time with my family rather than doing things in groups. Offer me activities and supplies for things I can do in my room. I have a history of depression, please include me in activities or at least offer them. Ask my family to bring in pictures and other familiar items from home to have near me for comfort and a sense of belonging. Have my Guardian Angel visit with me every week so I can voice any concerns or needs.

On 4/11/17, at 7:04 p.m., R100 was seated in her wheelchair in the dining room. A man with a guitar was singing and other residents were holding

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songbooks and singing along. R100 was sitting with her eyes closed and was not participating in the activity. At 7:14 p.m., R100 was observed to be sitting in her wheelchair and a visitor was pushing R100 in her wheelchair. The visitor asked R100 if she wanted to go outside and R100 replied yeah, before it gets dark out.

On 4/12/17, at 4:05 a.m., R100 was seated in her wheelchair in the dining room awake and the T.V. was on.

On 4/13/17, at 2:47 p.m., R100 was seated in her wheelchair in the dining room with other residents. A movie was playing. R100 was sleeping.

R100's Recreational Therapy Attendance Records dated from 10/1/16 through 3/31/17, identified the following activities were documented:
Month of 10/2016: T.V. 25 days, outside 6 days, trivia 23 times, therapy one day, entertainment one day, snack one day.
Month of 11/2016: T.V. 30 days, visitor 23 times, outside four times, entertainment two times.
Month of 12/2016: T.V. 30 days, visitor 14 days, gift giving one day, social and snack one day.
Month of 1/2017: T.V. 25 days, visitor four days, movies one day, art one day, social two days, independent socialization five days.
Month of 2/2017: T.V. 27 days, visitor four days, social and snack one day, independent socialization 27 days.
Month of 3/2017: T.V. 28 days, visitor six days, independent socialization 28 days.

The sheets lacked documentation regarding R100 preference of independent activities being

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offered and offering activities and supplies for things to do in room as care planned.

On 4/14/17, at 9:34 a.m., activity director (AD)-A and A-B stated for the activity outside was the family taking R100 outside when the weather was nice for fresh air. Visitor was the family and the family bringing the family dog in to visit. Independent socialization was R100 socializing with staff and family. The last couple of weeks R100 has started coming out for more activities, I think her children are encouraging her to participate more in activities. R100 was always in her room prior to return from last hospitalization (returned 4/2/17) and she mainly watched TV. We have always asked R100 to participate and have not had good results in the past. When queried if they had provided any one on one activities with R100 AD-A and A-B stated we have not been doing any one on ones with R100 for activities. We offer general activities to R100 and she refuses to join. We have not offered any one on one with reading and news. When queried if had provided independent activities in R100 room as music AD-A and A-B were unsure if R100 had a device in her room for music. When queried regarding the lack of documentation of refusals on the Recreational Therapy Attendance Sheets, AD-A and A-B confirmed refusals were not being documented. A-B stated we used to write in red and circle when a resident refused, but our hours were cut back in our department and we do not have time to document refusals anymore.
LACK OF FACIAL GROOMING:

R42's diagnosis found on the diagnosis report dated 11/30/15, indicates major depressive disorder, type 2 diabetes with diabetic neuropathy.

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R42 has a BIMS (brief interview for mental status) score of 12 out of 15 which indicates R42 to have moderate cognitive impairment; last dated 3/6/17.

Care plan with revision date of 4/3/17, indicates R42 to have a self-care deficit related to impaired mobility which requires the assistance of one staff for dressing, grooming and bathing. R42 transfers with a mechanical lift and staff assistance of one; impaired elimination related to incontinence.

Review of weekly skin documentation indicates R42 received a shower every Sunday morning.

Observation and interview on 4/10/17, at 1:38 p.m. with R42. Observation of facial hair on upper lip and lower jaw, resembling a beard. R42 stated staff doesn't help her with shaving and her razor doesn't work very well.

Observation on 4/11/17, at 11:39 a.m. R42 continues to be unshaven. Facial hair present on upper lip and lower jaw, resembling a beard.

Observation of morning cares on 4/12/17, at 6:56 a.m. with nursing assistant (NA)-F. During morning cares, NA-F assisted R42 with cleansing upper and lower body with washcloth and soap, peri-care, dressing, offered the commode, offered oral care and assisted R42 with brushing her hair. Observed NA-F transfer R42 from bed to wheelchair utilizing the mechanical lift. NA-F exited R42's room without offering to assist with facial grooming needs.

Interview on 4/12/17, at 7:35 a.m. with NA-F who verified she did not offer to assist R42 with shaving. NA-F stated she has never noticed

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whiskers on NA-F before. NA-F stated residents should be shaved every day as long as she can find a razor.

Interview on 4/12/17, at 7:39 a.m. with NA-F stated she followed up with R42 and offered shaving assistance. NA-F stated she found R42's razor to not be in working order. NA-F stated R42 would notify her family of razor not working.

Observation and interview on 4/13/17, at 9:15 a.m. with R42, continues to have facial hair present to upper lip and lower jaw, resembling a beard. R42 stated the razor doesn't work, I'll have my family shave it.

Observation on 4/14/17, at 8:24 a.m. R42 continues to have facial hair present to upper lip and lower jaw, resembling a beard.

Interview on 4/14/17, at 8:32 a.m. with NA-E stated residents should be shaved every morning and with baths. NA-E stated if the resident doesn't have a personal shaver then she wasn't sure how she would shave them. NA-E stated there aren't community razors available to use. NA-E verified R42 to have large amount of facial hair present.

Interview on 4/17/17, at 8:40 a.m. with LPN-C stated R42's care plan does not specifically identify shaving but shaving would be included under grooming needs and would include staff offering shaving assistance. LPN-C verified staff were not following the care plan and should have been offering to shave R42.

Requested policy related to following the care plan. No policy was provided.

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F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R42) reviewed for activities of daily living, received assistance with shaving. Findings include: R42's diagnosis found on the diagnosis report dated 11/30/15, indicates major depressive disorder, type 2 diabetes with diabetic neuropathy. R42 has a BIMS (brief interview for mental status) score of 12 out of 15 which indicates R42 to have moderate cognitive impairment; last dated 3/6/17. R42's comprehensive care plan with revision date of 4/3/17, indicates R42 to have a self-care deficit related to impaired mobility which requires the assistance of one staff for dressing, grooming and bathing. R42 transfers with a mechanical lift and staff assistance of one; impaired elimination related to incontinence. Review of weekly skin documentation indicates R42 received a shower every Sunday morning. Observation and interview on 4/10/17, at 1:38 p.m. with R42. Observation of facial hair on upper lip and lower jaw, resembling a beard. R42 stated	F 311	F311 1. R42 no longer resides at the facility. 2. Residents who require assistance with ADLs, specifically facial grooming (shaving) have the potential to be affected by this practice. 3. Care plans and care guides for current residents who require assistance with ADLs, specifically facial grooming, were reviewed by the clinical team. New resident's care plans and guides will be reviewed at his/her 72 hours care conference. Nursing staff was inserviced on providing facial hygiene (both male and female residents). Nursing staff will have completed this education by May 28, 2017. PRN nursing staff will complete the education prior to his/her first scheduled shift. Inservices will be ongoing as needed. 4. The Director of Nursing/designee will monitor compliance through observations on daily rounds and random audits of AM/PM cares of residents care guides 3 x weekly for a minimum of 3 months or until compliance is achieved. The results of	5/28/17

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F 311	Continued From page 77 staff doesn't help her with shaving and her razor doesn't work very well. Observation on 4/11/17, at 11:39 a.m. R42 continues to have facial hair. Facial hair present on upper lip and lower jaw. Observation of morning cares on 4/12/17, at 6:56 a.m. with nursing assistant (NA)-F. During morning cares, NA-F assisted R42 with cleansing upper and lower body with washcloth and soap, peri-care, dressing, offered the commode, offered oral care and assisted R42 with brushing her hair. Observed NA-F transfer R42 from bed to wheelchair utilizing the mechanical lift. NA-F exited R42's room without offering to assist with removal of facial hair. Interview on 4/12/17, at 7:35 a.m. with NA-F verified she did not offer to assist R42 with shaving. NA-F stated she has never noticed facial hair on NA-F before. NA-F stated residents should be shaved every day as long as she can find a razor, that's a problem around here to find razor. Interview on 4/12/17, at 7:39 a.m. with NA-F stated she followed up with R42 and offered shaving assistance. NA-F stated she found R42's razor to not be in working order. NA-F stated R42 would notify her family. Facial hairs not removed. Interview on 4/12/17, at 8:29 a.m. with nurse manager licensed practical nurse (LPN)-C, stated residents should be offered shaving based on personal preference. Expectation is residents are offered that service on bath days or when resident requests.	F 311	these observations/audits will be brought monthly to QA/PI for review and recommendation.	

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Interview on 4/13/17, at 8:34 a.m. with director of nursing (DON) stated shaving should be completed on bath day and as needed. DON stated with women it's not every day but some men have preferences for when to be shaved.

Observation and interview on 4/13/17, at 9:15 a.m. with R42 continues to have facial hair present to upper lip and lower jaw. R42 stated the razor doesn't work, I'll have my family shave it.

Observation on 4/14/17, at 8:24 a.m. R42 continues to have facial hair present to upper lip and lower jaw, resembling a beard.

Interview on 4/14/17, at 8:29 a.m. with LPN-C stated if residents don't have their own razor then a community razor can be utilized. LPN-C stated staff should be reporting broken razors to me so it can be fixed. LPN-C stated he was unaware R42's razor was broken.

Interview on 4/14/17, at 8:32 a.m. with NA-E stated residents should be shaved every morning and with baths. NA-E stated if the resident doesn't have a personal shaver then she wasn't sure how she would shave them. NA-E stated there aren't community razors available to use. NA-E stated broken razors should be reported to nurse first. NA-E verified R42 to have large amount of facial hair present.

Interview on 4/14/17, at 3:51 p.m. with LPN-C stated we are working on getting R42 a new razor, a message was left with her family that a new razor is needed. LPN-C stated he would request to have the beautician on Monday see what could be done. LPN-C clarified there was not a community razor available for use.

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F 311	Continued From page 79 Requested policy related to providing activities of daily living. No policy was provided.	F 311		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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 oral hygiene was provided for 1 of 3 residents (R90) and failed to ensure grooming needs (facial hair removal) was provided for 1 of 2 residents (R40) reviewed who were dependent upon staff assistance with activities of daily living (ADL). Findings Include: R90's annual Minimum Data Set (MDS) dated 3/10/17, identified required extensive assist of one for personal hygiene. R90's care plan with a print date of 4/12/17, included, at risk for dental problems related to some or all natural teeth loss. Resident has full upper dentures and his own lower teeth. Interventions instructed staff to provide assistance with oral cares as needed and to provide extensive assistance of one with personal hygiene. R90 was observed on 4/12/2017, at 7:11 a.m., during morning cares with nursing assistant (NA)-A. NA-A was observed to brush R90's upper	F 312	F312 1. R90 had his/her care guide updated and oral care provided. R40 was assisted with facial grooming. 2. Residents who require assistance with ADLS, specifically oral care and facial grooming have the potential to be affected by this practice. 3. Care plans and care guides for residents who require assistance with ADLS, specifically oral care and facial grooming were reviewed and updated as needed. Nursing staff was inserviced on oral care and shaving. Nursing staff was inserviced on providing oral care, facial hygiene (both male and female residents), and care planned activities per care guides and care plans. Nursing staff and Activity staff will have completed this education by May 28, 2017. PRN nursing staff will complete the education prior to his/her first scheduled shift. Inservices will be ongoing as needed.	5/28/17

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F 312	Continued From page 80 dentures in the bathroom and then place the upper dentures in R90's mouth. NA-A stated she was done with R90's morning cares and stated there was nothing else she needed to do for R90 this morning to get him ready for the day. NA-A did not brush R90's lower natural teeth. During an interview on 4/12/2017, at 11:24 p.m., NA-A stated R90 had upper and lower dentures. NA-A confirmed she did not provide oral care for his natural bottom teeth. NA-A stated she had planned to talk to the nurse to see if his lower dentures were missing, since they were not in the denture cup this morning when she provided cares. During an interview on 4/12/2017, at 1:51 p.m., licensed practical nurse (LPN)-A stated she would have expected the nursing assistant to complete oral care for R90's natural teeth at the same time she had cleaned his upper dentures and placed the dentures in his mouth. During an interview on 4/12/2017, at 2:31 p.m., the director of nursing stated the expectation was we provide oral care to both dentures and the natural teeth in the oral cavity. A policy related to activities of daily living and grooming was requested, none was provided. R40 was observed on 4/10/17, at 11:12 a.m. be sitting in her chair in her room. R40 had several short facial hairs across her chin and two one-half inch long facial hairs on her chin and cheek. R40 was observed on 4/11/2017, at 12:01 p.m., to be sitting in her chair in her room and the facial hairs on her chin and cheek remained.	F 312	4. The Director of Nursing/designee will monitor compliance through observations on daily rounds and random audits of AM/PM cares of residents care guides 3 x weekly for a minimum of 3 months or until compliance is achieved. The results of these observations/audits will be brought monthly to QA/PI for review and recommendations.	

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R40's quarterly Minimum Data Set (MDS) dated 2/16/17, identified R20 had limited vision and required limited assist of one for personal hygiene.

R40's care plan with a print date of 4/11/17, included, "I have a physical functioning deficit related to: Self care impairment s/t legally blind." Interventions included, "Personal Hygiene assistance of 1." "Impaired Vision related to: Cataract, Macular degeneration, and Blepharitis which led to legally blind and eyelid redness. "

R40 was observed during morning cares on 4/12/2017, at 8:39 a.m. with NA-C. Morning cares were completed without offering to shave R40's facial hairs.

During an interview on 4/12/2017, at 12:57 p.m.,NA-C stated she provided shaving for facial hair anytime R40 looked like she may need to be shaved. NA-C stated she did not even check to see if R40 had facial hair this morning. NA-C completed an observation of resident on 4/12/2017, at 1:01:18 p.m. verified the facial hair on R40's chin and cheek. NA-C stated R40 did need to be shaved and would complete this task after lunch.

During an interview on 4/12/2017, at 1:21 p.m.,LPN-A completed an observation of R40 and stated R40 should have had her facial hair shaved this morning. LPN-A stated she observed one-half inch facial hair underneath R40's chin and on her cheek.

During an interview on 4/12/17, at 2:26 p.m., the director of nursing (DON) stated facial hair should

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F 312	Continued From page 82 be shaved on bath days and as needed. During an interview on 4/14/2017, at 9:02 a.m. with family member (FM)-B stated is very important for R40 to have her facial hair removed. FM-B stated family completed facial hair removal for R40 and stated her shaver was in her drawer and if staff wanted to shave her, they could. FM-B asked, "Is this (meaning facial hair removal) something the facility should be providing to her? Quite honestly I see quite a few women there with facial hair."	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide skin care in accordance with physician orders, to promote healing and prevent further pressure ulcers from	F 314	F314 1. R100 has been discharged from the facility. R122 was seen by the Nurse	5/28/17

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developing for 2 of 2 residents (R122 and R100) reviewed for pressure ulcers. As a result of the facility's failure to assess and provide appropriate pressure ulcer care and services, R122 sustained harm when she developed a second pressure ulcer, and later developed a cellulitis infection of the wounds.

Findings include:

R122 was observed in her wheelchair sitting in the hallway outside her room on 4/11/17 at 5:13 p.m. The resident was observed wearing a specialized boot on her lower leg. When asked why she was wearing the boot, R122 said she'd had something rubbing her foot that had caused a sore and now she has a scab on her foot so wears the boot for protection.

During a review R122 records found on physicians orders that the dressing change is completed every other day for a stage 3 left lateral malleolus pressure ulcer dated to start 3/29/17 treatment is to :
1) Cleanse with normal saline.
2) Apply hydrogel to wound edges only.
3) Apply Silvercell AG to wound edges only.
4) Cover with Telfa and wrap with Kerlix. order dated in the physician order 3/28/17 signed on 4/3/17.

On 4/12/17 at 1:31 p.m. R122 was transferred to her bed for staff to complete a dressing change. Registered nurse (RN)-B, the facility's wound care nurse, said the resident's treatment order is to apply hydrogel to both wounds, and that since she had developed the wounds, she had undergone debridement two times. RN-B said that the area around the wound is redder than

Practitioner and new orders received. Wound documentation, treatment, and care plan was updated.

2. Facility residents have the potential to be affected by this practice.

3. Facility residents with wounds have been reassessed. Wound documentation including measurements, orders, treatments, and care plans were updated. Facility nursing staff was inserviced by the Director of Nursing/designee on the process used when a wound or skin condition change is first noted as well as a description of wounds upon readmission from a hospital stay. Licensed nursing staff were inserviced on dressing change basics to include infection control measures and following of physician orders for wound care. Current nursing staff will have completed this education by May 28, 2017. PRN nursing staff will complete the education prior to his/her first scheduled shift. Inservices will be ongoing as needed.

4. The Director of Nursing/designee will monitor compliance through observations on wound/treatment rounds and medical records audits 3 x weekly for a minimum of 3 months or until compliance is achieved. Results of observations/audits will be brought monthly to QA/PI for review and recommendations.

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F 314	Continued From page 84 before. When asked when the treatment had last been completed, RN-B said yesterday. She said when she completed the wound care, the wound areas were always chronic pink all the time. RN-B said the pressure ulcer on R122's heel had been acquired while living at the facility, and her ankle ulcer was hospital acquired. RN-B stated they continue with the dressing changes. RN-B was observed to then scrape with her gloved thumbnail at the soiled dressing and stated, there is a minimum to moderate purulent drainage. RN-B also acknowledged there was an odor. At 1:51 p.m. RN-B continued with the assessment of the wound on R122's ankle and stated it was unstageable, and that the heel ulcer was a stage 3. RN-B shared that R122 would be going to the wound clinic if her sister took her. RN-B said that she would update the provider regarding the drainage and odor of the wounds. In addition, she said the CNP (certified nurse practioner)-A was at the facility. At that time, RN-B asked CNP-A to assess the ulcers. CNP-A stated she thought the wounds looked infected, and would start R122 on antibiotic for cellulitis. CNP-A gave RN-B directions to mark the reddened area in order to monitor the progression. At 2:04 p.m. RN-B was observed drawing around the reddened area; measurements included 0.6 x 0.6 cm on heel, ankle measured 1.8 cm X 1.5 cm X 0.2 cm, she said she could not really tell the depth of the open area but was guessing it would be 0.2 cm, and the red area measured 6.5 cm X 6.2 cm. On 4/12/17 at 2:14 p.m. RN-B tried to get the slough off when cleaning the wounds in a circular motion, RN-B stated pretty much necrotic, not getting much off. CNP-A told RN-B to place hydro gel all over wound perimeter while she was	F 314		

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out of the room, RN-B applied hydro gel with finger to both wounds however, did not use application appliance such as q-tip, follow rest of written order. RN-B stated R112 wears boots 24 hours a day.

R122's Admission Record form identified an admission date of 9/23/16, also diagnosis of heart disease, pressure ulcer, stage II and unspecified staging, diabetes, right leg below the knee amputation and dementia with behavioral disturbance, history of deep vein thrombosis.

The clinical document copy titled Primary Care Internal Med Nursing Home physician visit notes dated 9/27/16, indicated R122 was in the hospital after a fall from a previous nursing home possibly caused by her polypharmacy, and that nursing would not take her back due to her aggressive behaviors. The note indicated R122 realized she could not go home and was aware she could not mobilize herself to go to the bathroom or perform her own activities of daily living (ADL) in light of her comorbidities.

R122's admission Minimum Data Set (MDS) dated 9/30/17, indicated the resident had no pressure ulcers, but was at risk to develop skin break down, including Moisture Associated Skin Damage (MASD). The MDS further indicated R122 required extensive assistance of 2 assist to meet repositioning, locomotion, toileting and dressing; and required supervision with oversite, encouragement, and cueing for eating.

R122's quarterly Minimum Data Set (MDS) assessment dated 3/27/17, indicated R122 required extensive assistance (two persons for physical assist) to complete transfers, bed

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mobility and toileting; and one-person assist for dressing and personal hygiene. In addition, the quarterly MDS indicated R122 had one stage III pressure ulcer and one unstageable pressure ulcer.

A review of R122's care plan indicated a problem with impaired mobility, alteration in skin integrity and diabetes. The goals included for R122 to have good wound healing with no signs and symptoms of infection and to have no further skin break down. Interventions for care included: inspect skin with care, report reddened areas, rashes, bruising or open areas to the charge nurse, conduct weekly skin inspection, heel lift boot on left lower extremity when in bed, pressure reduction mattress to the bed, and pressure reduction to the chair, treatments as ordered, monitor for effectiveness and monitor/document/report any new or non-healing wounds, or signs and symptoms of infection to any open areas, redness, pain, heat, swelling or pus formation.

R122's Nursing Assistant (NA) 3/28/17 care guide/assignment card, (which included specific care plan interventions the NA should implement for R122), indicated R122 required one assist with ADL's, two assist with transfers using a mechanical lift, heel lift boot on the left lower extremity in bed, and (in capital letters) BOOT ON LT (left) FOOT AT ALL TIMES.

Clinical Document Copy notes from attending physician/Certified nurse practitioner dated 10/21/16, indicated the pressure ulcer to R122's left lateral heel had been discovered 10/18/16. The note further indicated that on 10/18/16 the blister was intact, and the provider thought it was

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a pressure related area. The note included, "Tried to protect area and yesterday it ruptured and we now have an open draining lesion. Will have foam boot and will try to keep on her. The ulcer is about a 50 cent piece size. About half of the overlying skin has come off, revealing an erythematous (red) base with some serous drainage. Plan to apply a moisturizing dressing, start on antibiotic for early signs of cellulitis and will arrange wound clinic appointment, foam boot on to protect and take pressure off and facility to make sure she is positioned correctly both in the chair and in bed, especially."

The Clinical Document Copy note dated 10/24/16, indicated the resident's skin was dry and intact, and under system review indicated "skin: heel wound, nurse observing."

Clinical Document Copy notes dated 1/12/17, indicated the resident had a nursing home readmission after a stay in the hospital for an exacerbation of her asthma. Documentation included, "left heel pressure developed in October (2016) last wound clinic 12/6/16 and has not been back since. There remains a small eschar over the ulcer which has been healing. Denies any pain, and no evidence of infection. Measures approximately 3 cm (centimeter) in diameter. Plan for the wound is to arrange to have it debrided to heal faster, either at the wound clinic or have a nurse practitioner who is certified in debridement complete."

Clinical Document Copy notes dated 1/18/17 included: "full thickness wound present that is covered with hard black eschar. After eschar removal, debridement with wound base measurements 2.0 centimeters X 2.2 cm X 0.3.

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Per nursing staff at facility they have been providing daily dressing with 50% iodosorb and 50% hydrogel

Clinical Document Copy notes dated 1/25/17 included: "stage II pressure ulcer, left foot. Dressing changes with iodosorb and curasol covered with telfa. Will re-evaluate in approximately a week."

Clinical Document Copy notes dated 2/3/17 included: "ulcer on left foot measure 1.5 X 1.5 cm wound, healing."

Clinical Document Copy notes dated 2/24/17 included: "left heel ulcer slowly improving. Resident is reluctant to attend the Wound Clinic due to transportation issues. Staff to address the tiny ulcerations on the lateral malleolus. (This is a new finding located on outside of left ankle). Dressing daily with curasol and iodosorb. They do have a special boot that does keep her foot from tipping on to the left, which is likely the cause of those previous ulcerations.

Clinical Document Copy notes dated 3/28/17, included documentation about the right lateral heel ulcer. "They do have a special boot that does keep her foot from tipping on to the left, which is likely the cause of those previous ulcerations."

Consultation/Clinic Referral notes dated 10/25/16, problem of wound care, referral for the vascular center notes derided left lateral heel. Appears superficial.

Care Plan Report Vascular Ulcer/Wound Healing Clinic dated 10/25/16 document included,

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diagnosis ulcer left lateral heel, dressing instructions: 1. Wash hands, 2. Remove old dressing, 3. Gently cleanse ulcer base with normal saline and gauze, 4. Apply iodosorb/curasol (50:50) mixture to ulcer base, 5. Cover with mepilex border, 5. Change dressing once a day. Special instructions use foam boot at all times. Keep pressure off heel at all times, check feet daily for any signs of pressure spots and or new wounds forming follow up appointment in 4 weeks. There is no measurements from this wound clinic visit.

Consultation/clinic referral for the vascular center notes dated 12/6/16, included plan for patient needs to obtain PRAFO boot, ulcer with increased necrotic eschar (dead skin), patient needs physical therapy to maintain large muscle strength, but needs to avoid walking on the left foot, PRAFO to be worn in the wheelchair and in bed. Additional information from this day. Check feet daily for any signs of pressure spots and/or new wounds forming. Follow up appointment in 3 weeks. There is no measurements from the wound clinic.

Nutrition note dated 3/27/17 does not address additional nutrition supplement for wound healing.

Facilities most current Order Summary Report dated 2/23/17 signed by physician 2/24/17 included,
LEFT LATERAL HEEL WOUND DRESSING, change once daily, start 1/11/17. Monitor of wound changes, pain at site, redness or other changes in the skin, status of surrounding tissue, presence of possible complications (redness, swelling, increased drainage). If pain is present, how it was controlled. Document note in PCC

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F 314	Continued From page 90 (point click care) with dressing changes. One time a day. Start 1/19/17. R122's progress notes were reviewed from 10/1/16 to 10/17/16 with no new skin issues noted. On 10/18/16 at 1:41 p.m. the resident had a change in condition, with blister on right outer side of right (R122 has below the knee amputation) ankle, area intact, no drainage 4 cm X 4 cm in diameter, family aware, SBAR -change in condition (form used to update physicians) 10/19/16 at 5:59 p.m. R122 has a blister on the left heel and dressing is intact. 10/21/16 at 1:07 p.m. apply dry gauze and Kerlix to left heel blister. Apply protective heel boot over. Float heel when in bed, done by wound nurse today. Antibiotic for cellulitis. 10/23/16 at 9:08 p.m. resident continues to have open are on left heel from popped blister. Dressing was changed this shift. 10/29/16 at 1:56 p.m. skin around ulcer is dry and peeling. Ulcer is over a 50 cent piece in size. No drainage observed. No complaints of pain during cleaning and dressing the wound. Foam boot reapplied. 10/30/16 at 2:40 p.m. left foot ulcer completed per treatment instructions. Some tenderness when cleansed, wound lightly smaller. 11/2/16 at 3:36 completed by wound nurse. 11/4/16 at 2:19 p.m. changed to left heel area dry and peeling. 11/5/16 at 10:29 a.m. left heel dressing changed this shift area around wound dry and skin peeling off. wound area is red in color. 11/6/16 shower tonight no new skin issues noted. 11/7/16 dressing to left heel changed, skin around the wound is dry and peeling. Wound is pink and one quarter size in area is dark red. Some	F 314		

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F 314	Continued From page 91 tenderness when cream applied. 11/10/16 at 10:53 a.m. left heel dressing changed. Center of wound is dark brown in color and outside area is red. Skin around wound is peeling. Resident stated it is sore while the writer is doing her treatment. 11/12/16 dress changed to left heel tender to touch. Area is dark red/brown in color and approximately 1 ½ x 1/12 inch. Skin around wound is dry and peeling. 11/13/16 wound on left heel is dark in color. No change from yesterday. Wearing foam boot constantly. Shower tonight no new skin issues noted. 11/15/16 wounds bed is dark reddish black in color. 11/16/16 much of dry skin had peeled off around the wound. The wound is dark blackish red, scab-like with out drainage. Slightly tender to touch. 11/20/16 refused 11/21/16 shower no other skin issues noted heel continues to have treatments. 11/22/16 dressing completed by wound nurses. 11/27/16 small area bleeding from callused area falling off. denies pain, wound base is necrotic. 11/30/16 left heel/sole wound is about a 50 cent piece in size, is tender to touch, no drainage, is dark reddish/black in color. Foam boot re-placed on foot. 12/5/16 wound is dark brown in color, no drainage noted, no bleeding, no odor on it. The are around the wound is dry . moderate amount of pain was noted during the dressing change. 12/6/16 done by wound nurse this morning. 12/7/16 left heel/foot ulcer dressing changed, very tender to touch, heel boot was on and reapplied after dressing done. 12/10/16 dressing completed, very tender to	F 314		

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F 314	Continued From page 92 touch, no drainage. 12/11/16 dressing changed slight tenderness to touch, wound is dry. 12/13/16 done by wound nurse. 12/14/16 done by wound nurse this morning. 12/16/16 dressing changed, resident grimaced some during procedure and said it hurt a little foam boot replaced once dressing was done. 12/22/16 dressing change to left heel. 12/23/16 no new skin issues. 12/27/16 done by wound nurse. 12/28/16 dressing changed to Right heel (right below the knee amputation) wound bed is dark in color, some pain during dressing change, brace reapplied. 12/29/16 dressing completed to left heel no changes from yesterday 12/30/16 send to emergency room. 1/4/17 return from hospital, no reassessments completed, left lateral heel wound dressing, done in hospital. 1/8/17 left heel wound is dry and without drainage-does not complain of pain or tenderness when dressing changed. 1/12/17 dressing completed area is dry, dark brown. 1/17/17 done by wound nurse. 1/18/17 left lateral heel wound dressing, soaked wound in acetic acid saturated gauze x 10 minutes, then washed with saline, no dry skin was removed in the process, no drainage, no tenderness or pain. 1/18/17 certified nursing practitioner (CNP) derided today 1/19/17 dressing changed to left heel. 1/24/17 dressing change to left heel, wears brace over dressing. 1/25/17 dressing change to left heel daily, today was completed by wound nurse.	F 314		

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F 314	Continued From page 93 1/26/17 dressing changed to left heel. 1/29/17 shower this shift. Dressing on left heel changed no discharge noted, no swelling, area is dry, dark brown in color. 2/4/17 dressing to left heel done, denies pain, wound is healed over 2/5/17 left heel dressing changed wound area is white-yellow in color, area around the wound is pink. 2/8/17 wound is open about the size of a quarter. Resident did not complain of pain during the soaking or dressing change. 2/11/17 dressing on left heel, area is pink around. White yellow in the mid area. 2/12/17 shower no new skin issues noted open are noted on left heel wears boot at all times. 2/18/17 unable to complete dressing change 2/19/17 left heel dressing completed. 3/8/17 resident has two openings on left foot-one on heel and one on lateral ankle. Dressing change done per treatment instructions. 3/10/17 wound is red/pink. Resident complain of pain for the duration of the dressing change. 3/12/17 dressing completed, resident complained of pain during dressing change and movement of her leg. 3/19/17 heel wound nearly healed but has wound on left lateral, expressed pain during the process. 3/22/17 dressing to left heel changed, two areas appears dry, dark brown in color, no drainage. Skin around wound area red, no increased swelling noted. 3/25/17 treatment completed for ulcers on the left heel and left lateral malleolus. Left heel stage 3 ulcer and lateral malleolus was previously unstageable but was able to remove eschar/necrotic tissue/slough with acetic acid soak today. 4/12/17 a significant change noted in the left	F 314		

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lateral malleolus unstageable ulcer compared to 4/11/17 dressing change. Tissue surrounding is red and warm to touch. Measurements 1.8 cm X 1.5 cm X 0.2 cm, red area 6.5 cm X 6.2 cm. 4/11/17 1.5 cm X 1.5 cm X 0.2 cm, 4/12/17 measurements of left heel 0.6 cm X 0.6 cm 4/11/17 was 0.3 cm X 0.5 cm X 0.1 cm, left lateral malleolus moderate drainage with a foul smell. CNP updated and ordered antibiotic. Both wounds cleansed with normal saline per order. Hydrogel applied to entire wound bed per CNP recommendation, rather that just the wound edges, due to previous dressing being difficult to remove (wound was dry). Aquacel AG (silvercell AG) applied to wound, covered with telfa, and wrapped with Kerlix.
Daily dressing changes and notes were completed on the wounds.

RN-B was interviewed on 4/14/17 at 10:44 a.m., regarding wound tracking for R122. RN-B stated the tracking was in the computer, except for the last week. When asked whether there was documentation available for review, RN-B stated her assessments were all in the computer, and she had no other notes available.

Review of the facility's Treatment administration record for April 2017, revealed R122's physician had prescribed dressing treatments to the left lateral malleolus pressure ulcer once daily. There was no documentation to identify the wound on the left heel or whether or not the treatments had been completed for the heel wound since 3/28/17. There was no documentation on the treatment record, nor in the progress notes that identified dressing changes had been completed on April 6, 8, or 10, 2017. Documentation was also lacking to indicate a dressing change had

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been conducted on April 14, 2017.

During interview with RN-B on 4/17/17 at 9:48 a.m. she stated she completed wound rounds once a week for measurements. RN-B said she expects nurses to place a note in the computer when they do the dressing changes. RN-B said she is aware that is not always completed and is planning to educate staff because they lack understanding. RN-B was asked about the missing documentation. She stated she would expect an initial or some sort of document showing the dressing change had been completed. RN-B verified the missing documentation on the treatment records and confirmed that the wound is now infected. RN-B stated the heel wound had started in October 2016, and the ankle wound in January of 2017. RN-B verified interventions put in place for the heel wound continued to stay in place even after the development of the wound to the ankle and no new interventions were reviewed to help prevent the development of additional wounds. RN-B verified CNP-A had made mention in a past notation that the facility had utilized a boot that may have caused the ulcerations, but that there was no additional follow-up regarding the comment. RN-B verified that the same boot remained in place.

During interview with RN-B on 4/17/17 at 10:38 a.m. RN-B verified there could have been a more comprehensive wound assessment completed for the pressure ulcers.

The facility policy Skin integrity Guideline, included: "Patients/residents will be assessed or observed for the risk of skin breakdown within 24 hours of admission or readmission, quarterly,

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before transfer or discharge to a setting... develops a routine schedule to review wounds on a weekly basis. The interdisciplinary plan of care will address problems, goals and interventions directed toward the prevention of pressure ulcers concerns identified. If there is a decline in skin integrity, pressure redistribution surfaces will be reviewed for appropriateness and implement as indicate by the individualized plan of care. If resident is refusing, review risk, benefits and alternatives. Re-evaluate and attempt other interventions."
R100's significant change Minimum Data Set (MDS) assessment dated 2/3/17, indicated R100 had a stage three pressure ulcer, slough (yellow or white tissue in the wound bed), was receiving pressure ulcer care, application of non-surgical dressing and had pressure relieving devices in chair and bed. R100's Admission Record dated 4/17/17, included diagnoses of diabetes, peripheral vascular disease (PVD), dementia without behavioral disturbance, and acquired absence of right leg below knee.

R100's Braden Assessment (scale for predicting pressure sore risk), dated 4/2/17, indicated score of 11, high risk.

R100's current care plan dated 4/17/17, included focus: actual/potential for alteration in skin integrity related to impaired mobility, PVD, left below knee amputation, pressure ulcers, Foley catheter. Interventions included: 8/29/16 from OT (occupational therapy): use 'G' size tubigrip (compression bandage) and two layer wraps for compression of stump right lower extremity (LE) 23 x 7. Monitor the wraps during the day for good skin integrity. Left LE use the compression sleeve of prosthesis. Monitor skin integrity. Bed mobility

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F 314	Continued From page 97 (resident sleeps in recliner); assist of two reposition every two hours and prn (as needed) as resident will allow. Encourage resident offload frequently. Risk and benefit signed by resident and daughter due to non-compliance with repositioning. Complete Braden Scale per living center policy. Keep skin as clean and dry as able. Monitor positioning of catheter tubing to ensure no pressure areas on skin. Monitor skin wraps and prosthetics for skin breakdown. OT as ordered. ROHO (pressure relieving) cushions in wheelchair and recliner to help avoid pressure. Skin assessment to be completed per living center policy. Treatments as ordered. Monitor for effectiveness. Weekly Wound assessments. R100's nursing assistant (NA) care guide assignment sheets updated 3/28/17, included do not put footrest on bottom of leg rest. ROHO cushion when in recliner and wheelchair, do not cover with anything. Sleeps in recliner. Assist to turn and reposition every two hours and prn. Monitor skin with cares and report changes to nurse. R100's physician orders dated 4/10/17, directed staff to apply Santyl ointment (cleans wounds to clear the way for healthy tissue) 250 unit/GM (gram) topically every day to right lower extremity wound beds after cleansing with normal saline. R100's medication/treatment administration record (MAR/TAR) dated 4/17, included Santyl ointment 250 unit/GM apply to wounds/ulcer topically every day right lower extremity wound beds after cleansing with normal saline. There was no documentation to identify whether or not the treatments had been completed on April 3, 5 or 6, 2017.	F 314		

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On 4/12/17, at 10:06 a.m., RN-B was observed to provide wound treatment to R100's right lower extremity wounds (three total). RN-B cleansed three wound bases with acetic acid 0.25 percent and gauze and then applied a 50:50 mixture of Iodosorb (antimicrobial) and Hydrogel (a gel in which the liquid component is water) to all three wound bases. RN-B failed to follow the current physician orders for treatment of the wounds.

On 4/12/17, at 11:13 a.m., RN-B when queried regarding what the current physician orders were for treatment for R100's right stump wounds, stated R100 had gone to the wound clinic on 3/30/17 and were the orders she had followed (iodosorb and hydrogel). When queried regarding the Hospital Discharge order dated 4/2/17, for Santyl to the wound areas, RN-B stated "oh crap", the hospital orders from 4/2/17 would trump the wound clinic orders. The DON was present at the time and stated to RN-B you need to call the wound clinic and clarify what treatment they want and write a clarification order.

R100's progress notes and wound evaluation flow sheets dated from 11/28/16 to 4/2/17 were reviewed with RN-B on 4/14/17, at 10:53 a.m. At the time, review of the documentation and interview with RN-B identified the following:

RN-B stated the pressure ulcer was first identified on R100's right lower stump on 11/28/17, and the cause of the pressure ulcer was due to pressure from R100's wheelchair footrest. RN-B stated R100's wheel chair was modified (footrests were removed) and R100 was offloaded (pressure to bony areas removed) with a pillow under her legs. RN-B stated R100 currently only had pressure

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ulcers located on her right stump.

Nursing notes dated 11/28/16, indicated 2.8 x 1.5 suspect deep tissue, treatment cover with Allevyn foam dressing, legs wrapped daily, leg propped pillow in wheelchair.
Nursing notes 12/6/16, 2.5 x 1.8, changed to stage two, not deep tissue, right foot peddle removed primary source pressure, educate resident, no signs of symptoms infection.
Nursing notes 12/16/16 3 x 3, patient refusing to remove foot pedals, pillow placed for reduction.
Nursing notes 12/23/16 1.5 x 1.5 will have NP (nurse practitioner) evaluate, further recommendations. Patient continues to be non-adherent to pressure reducing recommendations of floating and no wheelchair peddles.

R100's record lacked documentation of weekly wound assessments after 12/23/16 until January 17, 2017. RN-B confirmed at the time and stated my best guest would be she refused and I did not document. RN-B stated when looking at her progress notes she was refusing many things at the time.

Nursing notes 1/17/17 0.5 x 0.5 x 0.1 eschar scab derided from wound, wound bed visible stage three.
Nursing notes R100 was in the hospital from 1/23 through 1/26.
Nursing notes 1/27/2017 readmit from the hospital. The Hospital Dismissal Summary dated 1/27/17, indicated primary diagnosis sepsis from streptococcus dysgalactiae blood stream infection, likely due to #2 sacral decubitus ulcer stage 2 due to #3 non-st elevation myocardial infarction due to #1. #4 right plantar stump ulcer

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with possible soft tissue infection, less likely contributor to #1. Skin alterations: right foot unstageable, no drainage, color black, scab.

R100's record lacked wound assessment for the right stump upon return from the hospital on 1/27/17 through 2/7/17. RN-B stated I charted regarding R100's left buttock, but nothing about the right stump. RN-B verified wound assessment for R100's right stump upon return from the hospital was first dated 2/8/17.

Nursing notes 2/8/17, right stump 4.5 x 5.2 cm, unstageable pressure continues to be non-compliant cares and requires a lot of encouragement to get dressing done. NP will be referring patient to wound clinic to ensure that they look at this area for possible debridement. Area appears to have eschar covering wound base at this time, making it invisible. Will continue to follow on wound rounds.
Nursing notes 2/20/17, late entry for 2/14/17, 5 x 3 wound has been derided showing healthy epithelial tissue. Will continue to monitor on wound rounds.
Nursing notes 2/22/17, Weekly wound rounds completed today. Patient initially noncompliant with dressing change. After re-approaching and explaining the importance of preventing another infection from arising, patient complied with dressing change. Dressing completed to pressure ulcers on right stump and buttocks. Wounds are stable at this time. Again, re-educated patient on the importance of compliance with repositioning to promote wound healing. Patient verbalized understanding; however, patient is historically noncompliant with this aspect of care; risk and benefits documentation in place. The note lacked measurements and detail of the wound

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F 314	Continued From page 101 appearance. RN-B confirmed. R100 was hospitalized from 2/25/17 through 2/28/17. The Hospital discharge summary dated 3/1/17 indicated primary diagnosis C. Difficile colitis. #5 right stump ulcers, non-infected. Skin alterations: right lower extremity unstageable. Nursing notes 3/1/17, upon return from the hospital lacked measurements and wound appearance for the right stump. RN-B confirmed and stated the first measurements upon return from the hospital was on 3/7/17. Nursing notes 3/7/17, right stump area #2 was 3 x 5 cm unstageable, area #1 with 1 x 1 cm, 50/50 epithelial/granulation. Resident readmitted from the hospital. No signs or symptoms of infection. No complaints of pain. Will continue to follow on rounds. Nursing notes 3/15/17, with a 5 x 11 cm blister has enveloped both necrotic areas with copious amounts of rusty colored drainage exuding from wound. Patient sent to emergency room (ER) for evaluation. Nursing notes 3/15/17, included, seen at emergency department, cellulitis - please follow up with wound care return if fever or spreading redness beyond markings. RN-B stated the cellulitis location was above the wound areas. R100 was hospitalized from 3/16 through 3/23/17. Nursing notes 3/24/17, included upon admission, it was noted R100 had two open blisters just below her right inferior scapula (sustained in hospital due to hot liquid burn spilled coffee). Areas are healing and remain open to air. Wound nurse notified and observed. All other wounds are consistent with those had prior to hospital	F 314		

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transfer. The not lacked measurements and appearance of right stump wounds. RN-B confirmed.

Nursing notes 3/30/17, included a 7 x 4 x 0.5 and 1 x 1 cm, wounds continue to improve slightly, no obvious signs of infection. Will continue to monitor.

R100 was again hospitalized from 3/30/17 through 4/1/17. The Hospital Dismissal Summary dated 4/2/17 indicated primary diagnosis acute on chronic heart failure with preserved ejection fraction. Skin alterations: right lower extremity (LE) as unstageable color tan, right LE unstageable color tan, right LE ulcer color red, right LE color black.
Nursing notes 4/2/17, progress note upon readmission identified Skin: resident has four wounds to right stump. Measurements of wounds to stump from frontal aspect of stump moving in distal direction:
1. 2.6 cm x 4.2 cm (open area with wound bed yellow)
2. 2.8 cm x 1.6 cm (open area with wound bed pink)
3. 3.8 cm x 2.0 cm (Open area with wound bed pink)
4. 1.4 cm x 1.0 cm (intact and eschar tissue)
Left stump is currently intact. Licensed nurse to complete weekly skin checks. Braden skin score is 11.

On 4/14/17, at 11:31 a.m. RN-B stated staff were to be signing off on the treatment administration record (TAR) for treatment of the right stump wounds.

On 4/14/17, at 3:56 p.m., the DON stated she

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F 314	Continued From page 103 would expect weekly wound measurements and documentation. The DON stated the facility policy was to do an assessment of wounds upon readmission from the hospital within 24 hours. The DON stated she would expect treatment orders to be followed, if conflict make a call to the provider. The DON stated she would expect staff to provide the treatment daily and staff to sign for the treatment completed daily. A policy for wound assessments and implementation of physician orders was requested, but not provided.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary	F 315		5/28/17

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F 315	Continued From page 104 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a medical justification for the ongoing use of an indwelling catheter for 1 of 2 residents (R100) reviewed for urinary catheter use and the facility failed to monitor and review interventions for 1 of 3 residents (R103) reviewed for urinary incontinence with an indwelling catheter. Findings include: R100's significant change Minimum Data Set (MDS) assessment dated 2/3/17, indicated R100 had an indwelling catheter and required extensive assist with toileting. R100's Admission Record dated 4/17/17, included diagnoses of diabetes, dementia without behavioral disturbance, and chronic kidney disease stage four. On 4/10/17, at 11:37 a.m., R100 was observed to be seated in her wheelchair in the dining room. A catheter drainage bag, placed inside of a cloth bag, was observed to be hanging underneath	F 315	F315 1. R100 no longer residents at the facility. R103 no longer resides at the facility. 2. Residents with urinary catheters have the potential to be affected by this practice. 3. Record reviews were completed for residents who currently have urinary catheters in place. Continued use of an indwelling catheter justification documentation was updated as needed. Licensed nursing staff was inserviced by the Director of Nursing/designee on the use of urinary catheters, specifically justification of continued use documentation, care planning specific information about the resident's urinary catheter, and interventions in place as a result of the urinary catheter. Current licensed staff will have completed this education by May 28, 2017. PRN licensed	

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F 315	Continued From page 105 R100's wheelchair. R100's current care plan included, alteration in Elimination related to impaired mobility, urinary retention, Foley catheter, bowel incontinence. Interventions included: administer medications as ordered, monitor for effectiveness. Change catheter bag weekly. Change Foley catheter as ordered. Size 16 French with 25 cc (cubic centimeters) balloon. Resident has history of declining catheter changes. Encourage and re-approach resident with declines of catheter changes. Check catheter tubing for proper drainage and positioning. Incontinence care after each incontinent episode. Indwelling catheter care every shift and as needed. Keep drainage bag below bladder level to prevent reflux, maintain a closed drainage system. Labs as ordered. Monitor/document/report s/sx (signs and symptoms) of constipation. Monitor/document/report s/sx of UTI (urinary tract infection); fever, abdominal pain, mental status changes, weakness, functional decline, nausea, vomiting, dark cloudy urine, foul smelling urine, retention (new), blood in urine, pus in urine. Record catheter output Q shift. The nursing assistant care guide assignment sheet, dated 3/28/17, included catheter, record catheter output every shift, keep drainage bag below bladder level and off the floor. R100's Treatment Administration Record, dated 4/17, identified indwelling catheter size 16 French with 25 cc balloon. Change once per month and as needed. Foley catheter emptied every shift. R100's physician orders, dated 4/10/17, lacked to include an order for the indwelling Foley catheter.	F 315	nursing staff will complete this education prior to his/her first scheduled shift. Inservices will be ongoing as needed. 4. The Director of Nursing/designee will monitor for compliance through 3 random audits weekly of residents with urinary catheters for a minimum of 3 months or until compliance is achieved. The results of these audits will be brought monthly to QA/PI for review and recommendations.	

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R100's Hospital discharge summary dated 4/2/17, included urinary management: Indwelling catheter. Indication: chronic indwelling catheter. Records state this is due to incontinence with wound infections. A physician order dated 7/20/16, indicated clarify indwelling Foley catheter diagnosis: urinary retention, chronic kidney disease - stage four.

R100's Clinical Heath Status document dated 4/2/17, indicated urinary incontinence, urine color straw, urine appearance clear, appliances/programs history catheter use last 48 hours, indwelling catheter evaluation yes to having terminal illness, yes to having a stage three or four pressure ulcer in an area affected by incontinence and yes to inability to manage retention with intermittent catheterization. However, R100's current physician order dated 4/10/17, failed to include a terminal illness diagnosis and observation on 4/12/17, at 10:39 a.m., with registered nurse (RN)-B identified R100's skin on buttocks was blanchable and had no area of pressure ulcers (an ulcer in an area affected by incontinence). In addition, R100's record lacked documentation regarding intermittent catheterization had been attempted.

R100's record lacked documented physician justification for the continued use of an indwelling Foley catheter and documentation regarding an attempt to remove the catheter since admission 4/2016.

On 4/13/17, at 3:10 p.m., licensed practical nurse (LPN)-H stated R100 has had the indwelling Foley catheter since first admission here, not sure of the date. R100's Admission Record, dated 4/17/17, identified admission date of 4/1/16.

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On 4/14/17, at 10:01 a.m.., RN-D stated the only documentation by the physician for justification for R100's Foley catheter was the order dated 7/20/16. RN-D stated per discussion at a care conference the nurse practitioner, family and nurse indicated the catheter was permanent. RN-D stated R100 had been admitted with the catheter 4/2016 and the facility had not attempted to remove R100's catheter since admission.

On 4/14/17, at 11:46 a.m., RN-D stated R100 had not been seen by urology in regards to use of the indwelling Foley catheter.

On 4/14/17, at 4:04 p.m. the director of nursing (DON) when queried regarding the lack of physician justification for R100's continued use of a Foley catheter, stated I cannot answer that without doing more research. The DON stated we do have a form to justify use of a urinary catheter.

A policy for physician justification related to catheter use was requested, but not provided.

R103's 60 day Minimum Data Set (MDS) dated 2/27/17, Brief Interview for Mental Status at a 12. Diagnosis of clostridium difficile (C-diff), dementia, diabetes, retention of urine and flaccid neurogenic bladder, needed extensive assistance with toileting, and has an indwelling catheter.

R103's annual Urinary Incontinence and indwelling catheter Care Area Assessment dated 1/12/17 indicated needing extensive assist with toileting and requires an indwelling catheter related to impaired mobility, diabetes, urinary urgency and neurogenic bladder.

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R103's current Bowel and Bladder Assessments dated 1/9/17 and 4/6/17, identified R103 is incontinent of bowels having diarrhea with C-diff, has Foley indwelling catheter and the need to for exact measurements of urine output. There is a hand written note on the bladder assessments that reads, "Pt. is at severe risk of dehydration.

R103's current care plan, directed staff to monitor/document/report signs and symptoms of urinary tract infection (UTI), offer fluids between meals and when rendering care, monitor/document/report signs and symptoms of dehydration.

An untitled nursing assistant sheet, identified staff were to encourage fluids and document Foley catheter output.

Document titled Clinical Document Copy-Primary Care Internal Medicine dated 1/9/17 reads family concerned about weight lost, poor appetite, not eating or drinking with reports of concentrated urine with a concern for dehydration. Decision made to send R103 sent via ambulance, as he requires fluid resuscitation. On 2/8/17 R103 is to receive intravenous hydration in the skilled nursing facility. 3/7/17 reads R103 receiving intravenous fluids once a week to help maintain fluid status.

Facilities treatment administration record monitors Foley output every shift start date 1/30/17 with low outputs. First day output documented on facility Treatment administration record is 850 milliliters (ml), February output documented 14 days less than 1000 ml, March 22 days less than 1000 ml, April 13 days output less than 1000 ml. During an interview with the

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F 315	Continued From page 109 Registered, nurse (RN)-B and RN-A on 4/17/17 at 9:04 a.m. Stated the staff monitor the output on the certified nurse sheets. Surveyor updated RN-B that the outputs were low for someone with a catheter and frequent diarrhea considering the physician documented weekly hydration RN-B verified that R103 had been receiving weekly intravenous hydration. RN-B asked regarding intervention in placed for staff to be able to care for R103, regarding the catheter cares and hydration needs. RN-B and RN-A was updated the facility care plan reads R103 has a catheter and to monitor of UTI, no additional information available for staff working with R103 to know what to do if something to occur. RN-A stated is a nursing practice to know what to do, if we would put every intervention in the care plan than care plans would be many pages, surveyor explained that this particular resident is missing information for your staff to care for them in relation to his catheter and hydration requirement. Review of facility policy titled Catheter Care; Indwelling Catheter dated last reviewed 8-9-16 reads: assessment guidelines; Hydration and fluid balance status and Documentation guidelines; intake and output and evaluation of intake and output per facility procedure.	F 315		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		5/28/17

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F 329	Continued From page 110 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale) assessment after starting an antipsychotic medication; increase an antidepressant without	F 329	F329 1. R100 has been discharged. R165 had their Seroquel order updated with target behaviors defined for monitoring	

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clinical support to justify increase; and lack of titration of an antianxiety medication for 1 of 5 residents (R100). In addition, the facility failed to document non-pharmacological interventions attempted prior to the administration of as needed (PRN) pain and psychotropic medications for 1 of 5 residents (R165) reviewed for medication use.

Findings include:

R100's significant change Minimum Data Set (MDS) assessment dated 2/3/17, indicated R100 displayed verbal behaviors and rejection of care one to three days and had moderate cognitive impairment. R100's Admission Record dated 4/17/17, included diagnosis of dementia without behavioral disturbance, anxiety disorder, insomnia and major depressive disorder.

LACK OF AIMS ASSESSMENT FOR USE OF AN ANTIPSYCHOTIC MEDICATION:

R100's record identified on 3/28/17, Risperdal 0.25 mg was prescribed for mood stabilizer and to promote sleep. R100's medication administration record dated 4/17, identified R100 received the medication as ordered.

A Review of R100's record lacked evidence of an AIMS assessment.

On 4/13/17, at 2:57 p.m., RN-D confirmed R100 was receiving an antipsychotic medication. RN-D stated he had not completed an AIMS assessment for R100.

On 4/14/17, at 4:05 p.m., the DON stated she would expect an AIMS assessment to be

effectiveness. Licensed nurses caring for R165 were educated on documenting non-pharmacological interventions prior to PRN pain medication administration.

2. Residents who receive antipsychotic medications, antidepressant medications, antianxiety medications, and PRN pain medications have the potential to be affected by this practice.

3. Residents who have PRN pain medications, antidepressant, antianxiety, or antipsychotic were reviewed by the Director of Nursing and Consultant Pharmacist for AIMS assessment, last Gradual Dose Reduction (GDR), target behaviors, and non-pharmacological interventions. Licensed nursing staff was inserviced by the Director Nursing/designee on documentation of non-pharmacological interventions prior to administration of PRN pain medications or PRN antianxiety medication. The Clinical Nurse Managers were inserviced by the Director of Nursing on the completion of an AIMS prior to starting an antipsychotic medication, and the GDR process. Current nurses and Clinical Managers will have completed the education by May 28, 2017. PRN licensed nursing staff will complete the education prior to his/her first scheduled shift. Inservicing will be ongoing as needed.

4. The Director of Nursing/designee will monitor compliance through random audits of resident medical records of those who take any antidepressant,

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F 329	Continued From page 112 completed for the use of an antipsychotic medication. LACK OF CLINICAL SIGNS/SYMPTOMS TO JUSTIFY INCREASE IN ANTIDEPRESSANT: On 2/10/17, Celexa (anti-depressant) was decreased from 20 mg to 10 mg due to pharmacy recommendation which indicated her last several PHQ9's have been insignificant. On 4/7/17, an order was written to increase the Celexa to 20 mg., even though R100's record identified PHQ9 (assessment for indicators of depression) scores were as follows: 7/16 score 0, 10/16 score 2, 1/17 score 0 and 4/3/17 score 4. The PHQ9 indicates for scores of 1 to 4 minimal symptoms of depression. R100's record lacked documentation of clinical rationale by the physician for increasing the Celexa to 20 mg on 4/7/17, in regards to whether R100's target symptoms returned or worsened after the most recent attempt at tapering the dose. On 4/14/17, at 4:05 p.m., the DON stated she would expect physician justification to be documented for the use of the Risperdal and Celexa. LACK OF TITRATION REDUCTION OR DOCUMENTED PHYSICIAN JUSTIFICATION FOR THE CONTINUED USE OF AN ANTIANXIETY MEDICATION: R100'S physician orders dated 4/10/17, included an order for Buspirone (antianxiety) 10 mg twice a day for anxiety. R100's Hospital Discharge Summary dated 4/1/16, indicated, upon admission to the facility R100's orders included	F 329	antianxiety, antipsychotic, or PRN pain medication 3 x weekly for a minimum of 3 months or until compliance has been achieved. The results of these audits will be brought monthly to QA/PI for review and recommendations.	

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F 329	Continued From page 113 Buspirone 10 mg two times a day. R100's MAR dated 4/17, identified R100 was receiving the medication s ordered. R100's Behavior Monthly Flowsheets dated from the month of 10/2016 through 4/13/17, identified use of Buspirone and Celexa and indicated occurrences of behaviors were being monitored. Review of R100's records identified the record lacked documentation by the physician for the continued use of the antianxiety medication or clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. On 4/14/17, at 3:36 p.m., RN-D stated R100 had been on the same dose of Buspirone 10 mg twice daily since admission to the facility on 4/1/16 and the dosage of the medication had not been changed since admission. On 4/14/17, at 4:05 p.m., the DON stated she would expect physician justification to be documented for the use of the Buspirone. LACK OF IDENTIFIED TARGET BEHAVIORS FOR USE OF ANTIPSYCHOTIC MEDICATION: R100's record identified on 3/28/17 Risperdal 0.25 mg was prescribed for mood stabilizer and to promote sleep. R100's Psychosocial Assessment dated 3/28/17, indicated: resident has been yelling out/verbally aggressive towards staff and refusing cares since hospitalization. Resident is adjusting to	F 329		

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placement back at facility and is struggling with new medical issues.

A care conference summary dated 4/4/17, identified mood and behavior status: irritable, restless, agitated, yells out for needs, increased confusion and anger.

R100's Behavior Monthly Flowsheets dated for the month of 3/2017 identified medications Buspirone and Celexa and the following behaviors were monitored: refusing to leave room, refusing to cooperate with recommended plan of care and depressed/withdrawn. The month of 4/2017 identified medications Risperdal/Celexa/Buspirone and indicated the same behaviors were being monitored.

On 4/14/17, at 3:36 p.m., RN-D verified target behaviors had not been identified for the use of the Risperdal.

On 4/14/17, at 4:05 p.m., the DON stated she would expect target behaviors to be identified and monitoring of the target behaviors to be implemented for the use of the Risperdal.
LACK OF IDENTIFYING NONPHARMACOLOGICAL INTERVENTIONS PRIOR TO USE OF AN AS NEEDED PAIN AND AS NEEDED ANTI-ANXIETY MEDICATIONS:

R165's facility admission record indicated admission the the facility on 3/1/17. R165 returned to the hospital on 3/18/17, at returned 3/23/17. R165's care plan dated 3/20/17, indicated she received psychotropic medications related to depressive disorder and anxiety disorder along with non-pharmacological interventions to help R165 remain calm.

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Interventions included: approach from the front; if upset; please re-direct the conversation or task; offer things that are soothing to me; avoid things that increase anxiety, give medications to reduce anxiety. The care plan further included non-pharmacological interventions for comfort that included: ice, back rub, food, soft music, repositioning and diversion as able and resident will allow. The care plan directed staff to monitor and document effectiveness.

A review of R165's Medication Administration Record (MAR), dated March 2016 and April 2016, identified the following medication:

Acetaminophen 500 Milligrams (mg), two tablets by mouth every six hours as needed for pain, Quetiapine Fumarate (Seroquel) tablet 25 mg, give half tablet by mouth as needed for insomnia at bedtime and Quetiapine Fumarate tablet 25 mg, give half tablet by mouth as needed for augmentation of her anti-anxiety medications at bedtime for severe claustrophobia.

Review of the March and April 2017 MAR's indicated the following:

R165 received PRN acetaminophen 6 times from 3/1/17 to 4/14/17. The facility failed to document non-pharmacological interventions attempted prior to the PRN acetaminophen being administered 6 of 6 times.

R165 received PRN quetiapine fumarate 14 times from 3/1/17 to 4/14/17. The facility failed to document non-pharmacological interventions attempted prior to the PRN quetiapine fumarate being administered 14 of 15 times.

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F 329	Continued From page 116 During interview on 04/13/2017, at 3:07 p.m. LPN-F, that she would attempt a non-pharmacological intervention should as offering TV or conservation with staff prior to giving as needed medications. "I would chart non-pharmacological intervention tired in a progress note." During interview on 04/14/2017, at 9:15 a.m., LPN-E stated prior to giving a PRN medication, staff attempt non pharmacological interventions such as massage, cold or heat therapy for pain. She stated, prior to administration of PRN anti anxiety medications staff she offered interventions that included talking and offer other distractions. LPN - E stated she would chart non-pharmacological intervention tried in the nurse's progress notes. During interview on 4/14/17 at 9:53 a.m., the director of nursing (DON) stated she expected staff to offer non-pharmacological interventions prior to using PRN medications. The DON further stated that nurses should use their professional judgement for intervention. The DON stated staff should still be documenting the use of non-pharmacological interventions electronic medication record or in the progress notes. Received Policy and procedure for "Administration procedures for all medications" revised August 2014: letter M. indicates, "When administering an "as needed" (PRN) medication, document reason for giving, observe for medication actions/reaction and record [on the prn effectiveness sheet/nurse's notes]."	F 329		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		5/28/17

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(d) Influenza and pneumococcal immunizations

(1) Influenza. The facility must develop policies and procedures to ensure that-

(i) Before offering the influenza immunization, each resident or the resident’s representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident’s representative has the opportunity to refuse immunization; and

(iv) The resident’s medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident’s representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal

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F 334	Continued From page 118 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of education was provided for 2 of 5 residents (R40, R192) prior to receiving the influenza and/or pneumococcal immunization. Findings include: R40's Medication Administration Record dated 10/1/16 through 10/31/16, identified R40's admission date was 9/12/12 and the facility had	F 334	F334 1. R192 has been discharged from the facility. R40's family was given a copy of the most current vaccine information statement for both vaccines and signed a consent for them. 2. Facility residents have the potential to be affected by this practice.	

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F 334	Continued From page 119 administered a PCV13 vaccine on 10/12/16. R40's facility clinical immunization record identified the facility had administered the influenza vaccine on 10/13/16. No other information was provided by the facility. A review of R40's medical record lacked documentation to indicate whether education had been provided prior to receiving the influenza and pneumococcal immunizations. R192's record identified the resident was 77 years old and had been admitted to the facility on 3/21/17. Review of R192's facility clinical immunization record, and the Immunization Summary from the clinic, lacked documentation regarding pneumococcal immunizations for PPSV23 (pneumococcal polysaccharide vaccine) and/or PCV13 (pneumococcal conjugate vaccine). No other information was provided by the facility. R192's record lacked documentation to indicate whether the resident had been provided the vaccinations, any provision of education, or if the vaccine was not provided, the reason why the vaccine was not provided, such as medical contraindications, refusal, unavailability of the vaccine, or vaccine was already given prior to admission for the pneumococcal immunization. On 4/14/17 at 2:37 p.m., the assistant director of nursing stated, "I do not have any more information that I can produce at this time. I gave you what I had." The facility's policy, Influenza/Pneumococcal Immunization Guideline dated 11/2/15, indicated a Guideline Statement: "...will offer and encourage that each resident receive immunization against influenza annually, as well	F 334	3. Licensed nursing staff were inserviced by the Director of Nursing/designee on the policy and procedure for influenza and pneumonia vaccinations, including appropriate education and consent. Current licensed nursing staff will have completed this education by May 28, 2017. PRN licensed nursing staff will complete this education prior to his/her first scheduled shift. Inservicing will be ongoing as needed. 4. The Director of Nursing/designee will monitor compliance through auditing new admissions for appropriate documentation of vaccinations, vaccinations given, and education provided 3 x weekly for a minimum of 3 months or until compliance is achieved. Results of audits will be brought monthly to QA/PI for review and recommendations.	

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F 334	Continued From page 120 as lifetime immunization against pneumococcal disease. This immunization will be administered unless it is medically contraindicated, the resident has already been immunized or the resident and/or responsible party refuses the immunization. Procedure: New Admissions Consent or Decline: 1. Upon admission to the living center the resident and/or responsible party will be given education regarding the risks and benefits of receiving the influenza and pneumococcal immunization vaccine. 3. The resident and/or responsible party will be required to sign the immunization consent or declination form. The resident annual consent or declination form will be signed each year as proof that education of risks/benefits was provided on the influenza vaccine. Verbal consents that are documented will be fine. Refusal of either vaccine will be documented in the immunization portal of the electronic health record. The original copy of the immunization consent or declination form will be maintained on each resident's current medical record. Pneumococcal Immunization-... will offer and encourage that all residents receive the pneumococcal immunization PPSV23 and/or PCV13 unless both were previously received. 1. The consent and/or need for the resident to receive the pneumococcal vaccine will be confirmed per the following: if the resident is admitted and had no history of ever having received either pneumococcal vaccine the vaccine should be offered. This information will be documented in the immunization portal of the electronic health record. If the resident's previous immunization history is unable to be obtained the request should be made that the resident receive the pneumococcal vaccine. If the immunization was refused verify that the immunization consent and declination form was completed and signed."	F 334		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely administration of medications for 2 of 2 residents (R18 and R195), observed to receive medications greater than an hour past the scheduled time of administration. Finding include: R18's Admission Record, dated 4/13/17, included diagnosis of dementia without behavioral disturbance. On 4/10/17, at 11:02 a.m. R18 was observed to be seated in a wheelchair in his room, sleeping with headphones on. Oral medications (eight pills) were observed to be in a plastic medication cup on R18's bedside tray table. No licensed staff were present in R18's room. At 11:04 a.m., registered nurse (RN)-C confirmed eight pills were in a medication cup on R18's bedside tray table. RN-C woke R18 up and directed R18 to take his medications. RN-C stated he had taken	F 425	F425 1. R18 and R195 were assessed regarding receiving medication late. No negative outcomes were identified. The residents' physicians were notified. The nurse involved was educated on medication pass times by the DON. 2.Facility residents have the potential to be affected by this practice. 3. Medication administration times have been reviewed by the facility Medical Director and Director of Nursing and updated as needed. Licensed nursing staff and medication aides were inserviced by the Director of Nursing/designee on medication administration times. Current nurses and medication aides will have completed this education by May 28, 2017. PRN licensed nursing staff will complete the education	5/28/17

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	245184	A. BUILDING ______ B. WING ______	04/18/2017

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F 425	Continued From page 122 the medications into R18's room 10 to 15 minutes ago. RN-C stated the medications were R18's 8:00 a.m. medication dosages including: aspirin, multivitamin, Lasix (diuretic), losartan potassium (angiotensin receptor blocker), Lipitor (statin), protonix (proton pump inhibitor), donepezil (enzyme blocker) and citalopram an antidepressant. R18's physician orders dated 3/30/17, included donepezil 10 mg (milligrams) one time a day, aspirin 81 mg one time a day, citalopram 10 mg one time a day, Lasix 40 mg one time a day, Lipitor 10 mg one time a day, losartan potassium 50 mg one time a day and protonix 40 mg in the morning. R18's medication administration record (MAR) dated 4/17, identified the medications were scheduled to be given at 8:00 a.m. except the protonix was scheduled to be given at 7:00 a.m. The medications were administered over one hour from the scheduled administration time. R195's Admission Record, dated 4/13/17, included diagnosis of dementia without behavioral disturbance. On 4/10/17, at 11:32 a.m. R195 was observed to be laying in bed. Nebulizer equipment with a mask attached was observed to be laying on top of a blanket covering R195. The nebulizer machine was running. R195 stated he did not know when he had last had medication from the nebulizer. No licensed staff were present in R195 room. At 11:37 a.m., RN-C was alerted by the surveyor and as RN-C was walking down the hall towards R195's room, RN-C stated, "Oh it is his neb isn't it." RN-C entered R195's room and turned the nebulizer machine off. RN-C stated he had started the nebulizer medication treatment for R195 around 11:15 a.m. and the medication was R195's 8:00 a.m. scheduled DuoNeb solution	F 425	prior to his/her first scheduled shift. Inservicing will be ongoing as needed. 4. The Director of Nursing/designee will monitor for compliance through random audits 3 x weekly of medication pass times for a minimum of 3 months or until compliance is achieved. The audit results will be brought monthly to QA/PI for review and recommendations.	

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F 425	Continued From page 123 (bronchodilator). Review of R195's MAR at the time showed the DuoNeb scheduled at 8:00 a.m. which was not given until 11:15 a.m., had been documented as having been given at 8:00 a.m. When queried documenting accurate times of administration of medications, RN-C stated he could not change the time on the MAR. R195's physician orders dated 4/10/17, included DuoNeb solution 0.5-2.5 - 3 mg/3 ml (milliliters) 3 ml inhale four times a day. R195's MAR identified DuoNeb solution 0.5-2.5 - 3 mg/3 ml inhale 3 ml four times a day scheduled times of 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. The medication was administered over one hour past the scheduled administration time of 8:00 a.m. On 4/13/17, at 3:26 p.m. the director of nursing (DON) stated R18 and R195's medications being given over one hour past the scheduled administration time were medication errors. The DON stated the expectation for scheduled medications to be given would be no earlier than one hour before the scheduled time and no later than one hour after the scheduled time. The DON stated she had no policy for medication errors.	F 425		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects	F 428		5/28/17

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F 428	Continued From page 124	F 428		

Continued From page 124

brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and

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F 428	Continued From page 125 steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified the lack of a titration or documentation of physician justification for the continued need of an antianxiety medication at the same dose for 1 of 5 residents (R100) reviewed for unnecessary medications. Findings include: R100's significant change Minimum Data Set (MDS) assessment dated 2/3/17, indicated R100 had no moods, behaviors of verbal and rejection of care one to three days and had moderate cognitive impairment. R100's Admission Record dated 4/17/17, included diagnoses of dementia without behavioral disturbance, anxiety disorder, insomnia and major depressive disorder. R100'S physician orders dated 4/10/17, included an order for Buspirone (antianxiety) 10 mg (milligrams) twice a day for anxiety. R100's Hospital Dismissal Summary dated 4/1/16, identified upon admission to the facility R100's orders included Buspirone 10 mg two times a day. R100's MAR dated 4/17, identified R100 was receiving the medication s ordered. R100's Behavior Monthly Flowsheets dated from the month of 10/16 through 4/13/17 identified meds Buspirone and Celexa and the following occurrences of behaviors being monitored:	F 428	F428 1. R100 is no longer a resident at the facility. 2. Facility resident's on antianxiety medication have the potential to be affected by this practice. 3. Residents on antianxiety medications were reviewed by the Consultant Pharmacist and Director of Nursing for possibly Gradual Dose Reduction (GDR) and updated as needed. Clinical Managers and ADON were inserviced by Director of Nursing on the GDR process and the need for physician documentation for justification of the continued need for the medication at the present dose. This education will be completed by May 28. 2017. Inservicing will be ongoing as needed. 4. The Director of Nursing/Consultant Pharmacist/designee will monitor compliance by reviewing resident's on antianxiety medication monthly. The Consultant Pharmacist will make recommendations for GDR when clinically warranted. The Director of Nursing/designee will ensure physician justification for continued need for the medication at the current dose is present in the chart when needed. The Director of	

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F 428	Continued From page 126 10/16: code 39 refusing to leave room - nine times, code 40 refusing to cooperate with recommended plan of care - none. 11/16: no behaviors documented for codes 39 and 40. 12//16: code 39 - two times, code 40 none and code 4 anxiety none 1/17: code 39 none, code 40 one time 2/17: code 39 none, code 40 one time 3/17: code 39 one shift all a.m., code 40 none, code 12 depressed withdrawn none 4/17 Risperdal/Celexa/Buspirone medications. Code 39 none, code 40 none, code 12 none. R100's Psychosocial Assessments identified: 10/19/16 - no mood or behaviors noted during assessment period. 1/12/17: No mood or behavior concerns noted during assessment period. 3/3/17: resident struggles with placement at this facility. 3/28/17: resident has been yelling out/verbally aggressive towards staff and refusing cares since hospitalization. Resident is adjusting to placement back at facility and is struggling with new medical issues. Review of R100's records identified the record lacked to include documentation by the physician for the continued use of the antianxiety medication or clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. R100's consultant pharmacist notes were reviewed from 8/17/16 to 4/12/17. The notes lacked any documented recommendation by the	F 428	Nursing will conduct random audits of medical records of resident's taking antianxiety medication x 3 weekly for a minimum of 3 months or until compliance is achieved, Results of audits will be presented monthly to QA/PI for review and recommendations.	

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F 428	Continued From page 127 consultant pharmacist for a titration or documented physician justification for the decline of a titration for the use of the Buspirone. On 4/14/17, at 3:36 p.m., RN-D stated R100 had been on the same dose of Buspirone 10 mg twice daily since admission to the facility on 4/1/16 and the dosage of the medication had not been changed since admission. On 4/17/17, at 9:50 a.m., the consultant pharmacist (CP)-E stated he had not recommended a titration of the Buspirone due to R100 not doing well. CP-E stated he is more aggressive with Risperdal (started 3/28/17) not appropriate. I made a clinical decision not to make any recommendations for GDR due to not doing well until January (2017) and then I suggested a GDR for the Celexa. I would not know if the physician documented justification for the use of the Buspirone without being able to look in the record at the facility. I do not make note in my notes regarding physician justification. The facility policy Antipsychotic Medication review, dated 3/17/16, indicated Procedure Details: Review to ensure that the pharmacy consultant has reviewed the medication program at least monthly and made recommendations for the dose reductions, as appropriate.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		5/28/17

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F 431	Continued From page 128 law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

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F 431	Continued From page 129 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 Tubersol solution (solution used for injection to check for tuberculosis) was not expired before being administered to 1 of 1 resident (R138) who had been identified to have received the undated solution. Findings include: On 4/13/2017, at 1:14 p.m. the third floor medication room was reviewed with licensed practical nurse (LPN)-A. A single small refrigerator was opened and inspected which identified four boxes of multidose tubersol solution. Two boxes were unopened and inside a plastic bag which was labeled from the pharmacy as being filled on 6/30/2016; another two boxes were opened and sitting on the shelf available for use. The two opened vials were inspected and were undated as to when they had been opened and first used. One vial with Lot number C5036AA and the other vial with Lot number C4864AA. Immediately following the observation, LPN-A reviewed the opened vials with the surveyor and stated there was no date identified as to when they had been opened and first used. LPN-A stated there were approximately six doses	F 431	F431T 1. R138 received a new tubersol injection to ensure accurate test results. The resident suffered no ill effect from the previous injection. Per the manufacturer and CDC - the only potential side effect is a reduction in the effectiveness of the solution. The expired open vials of Tubersol were destroyed. Tubersol solution in house was checked for appropriate expiration dates. 2. Facility residents have the potential to be affected by this practice. 3. Licensed nurses received education by the Director of Nursing/designee regarding labeling medications with appropriate date once they have been opened and checking for expiration dates prior to usage and discarding expired or unlabeled open medications. Current licensed nursing staff will have completed this education by May 28, 2017. PRN licensed nursing staff will complete the education prior to his/her first scheduled shift. Inservicing will be ongoing as needed.	

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F 431	Continued From page 130 remaining of the solution between the vials. LPN-A stated the vials should be dated when opened so they are not used past their expiration date and discarded. Further, LPN-A stated third floor had a recent admission in which the undated solution could have been administered. R138's undated tuberculin skin test flow sheet identified R138 admitted on 3/23/2017, and received two separate doses of tubersol solution; each dose coming from one of the undated vials according to the recorded Lot numbers. When interviewed on 4/14/2017, at 2:30 p.m. director of nursing (DON) stated the staff should mark the day they open the tubersol as it was only good for 30 days after being opened. Further, DON stated expired solution could cause a skewed result. A facility Storage of Medications policy dated August 2014, identified multidose injectable bottles once opened require an expiration date shorter than the manufacturer's expiration date to insure purity and potency. The policy directed the nurse to place a "date opened" sticker on the medication and enter the date opened and the new expiration date on the vial. Further, the policy identified the expiration date of the vial will be 30 days unless the manufacturer recommended another date. A Tubersol package insert dated September 2015, identified a vial of Tubersol which has been entered and in use for 30 days should be discarded.	F 431	4. The Director of Nursing/designee will monitor compliance through random audits of medication storage 3 x weekly for a minimum of 3 months or until compliance has been achieved. Results of the audits will be presented monthly to QA/PI for review and recommendations.	
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		5/28/17

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(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 441	Continued From page 132 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices were implemented when cleaning a multi resident use glucometer for 1 of 6 residents (R100) who had blood sugars checked utilizing the glucometer; failed to ensure proper infection control practices were implemented for peri-cares, emptying a Foley catheter bag and for changing a wound dressing. In addition, the facility failed to ensure surveillance analysis of infections and failed to ensure staff education for infection control. This	F 441	F331 1. R100 has discharged from the facility. R195 was assessed for an infection and suffered no ill effects. R122 was assessed for an infection and has not suffered any ill effect. DON reviewed the infection control program, including line listing, tracking and trending, monitoring and analysis, and updated the program as needed. The DON inserviced the ADON regarding the infection control program.	

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F 441	Continued From page 133	F 441		

had the potential to affect all 95 residents, staff and visitors.

Findings include:

GLUCOMETER:
On 4/11/17, at 5:33 p.m., licensed practical nurse (LPN)-H washed hands, applied gloves and checked R100's blood sugar with a glucometer. LPN-H then placed the glucometer in a box with alcohol wipes and lancets (not used), removed gloves and washed hands. LPN-H then carried the box with the glucometer in it out to the medication cart and set the box on top of the medication cart. LPN-H then proceeded to administer R100's insulin and assist R100 with going to the dining room. LPN-H failed to clean the glucometer after use. At 5:51 p.m., LPN-H verified she had not cleansed the glucometer after use and stated the glucometer was a multi-use glucometer. LPN-H stated when asked what the facility policy was for cleansing a glucometer, honestly, I wipe down the glucometer with an alcohol pad.

On 4/11/17, at 7:07 p.m., registered nurse (RN)-D stated the glucometer was to be cleansed after each use. RN-D verified the glucometer was a multi-use glucometer. At 7:30 a.m., RN-D stated a total of six residents used the glucometer. The glucometer was an EvenCare G3 and provided typed up manufacturer instructions for cleaning the glucometer.

The instructions for cleaning the meter included, 1. Wash hands with soap and water. 2. Put on single use medical protective gloves. 5. To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Wipe all

2. Facility residents have the potential to be affected by these practices.

3. The facility has transitioned to single resident glucometers. Staff was trained on the new glucometers beginning 5/1/17. A representative from the manufacturer completed "train the trainer" training with ADON. Nursing staff was educated by the ADON/designee on proper perineal care, hand hygiene, glove use, dressing change infection control practices, and proper sequence for emptying a catheter bag beginning 4/26/17. Licensed nursing staff was inserviced on current standards of care for infection control, surveillance and analysis of infections. Facility staff was educated on the communicable/contagious disease and Employee policy. Current facility staff will complete this education by May 28, 2017. PRN staff will complete the education prior to his/her first scheduled shift. Inservices will be ongoing as needed.

4. The Director of Nursing/designee will monitor compliance through competency checks, observations on rounds, and auditing infection control documentation/line listing/ and track/trend data 3 x weekly for a minimum of 3 months or until compliance is achieved. Results of audits will be brought monthly to QA/PI for review and recommendations.

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external areas of the meter including both front and back surfaces until visibly wet. Avoid wetting the meter test trip port. Allow the meter to remain wet at room temperature for: at least 30 seconds for Medline Micro-Kill Bleach, At least 1 minute for Dispatch and Clorox Healthcare, At least 2 minutes for Medline Micro-Kill Wipe meter dry or allow to air dry. 6. Remove gloves.

The facility policy Blood Glucose Monitor Decontamination dated 5/5/16, indicated Procedure: 1. After performing the glucose testing, the nurse, wearing gloves, will use a disposable wipe to clean all external parts of the monitor.

PERI CARES:
On 4/12/17, at 6:18 a.m., nursing assistant (NA)-I and NA-J were observed to place R100 onto a commode. At 6:27 a.m., NA-J with gloves on cleansed R100 peri area with a disposable wipe. NA-J then with the same soiled gloves on applied leg rests to R100's wheelchair, positioned a pillow under R100's legs, applied blanket on R100, obtained a micro kill wipe and cleansed the mechanical lift (used to transfer R100) with the micro kill wipe, cleansed R100's commode and then removed the soiled gloves and washed hands.

On 4/12/17, at 8:47 a.m. NA-J was observed to provide peri-cares to R195. NA-J applied gloves, removed an incontinent product soiled with urine and cleansed R915's peri area. With the same soiled gloves on NA-J then picked up and moved a T.V. remote control, put on R195 a clean incontinent product, pants, shoes, gait belt, pulled back the room curtain, moved R195's wheelchair, moved R195's walker, applied nasal cannula

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oxygen tubing to R195 and transferred R195 into a wheelchair. NA-J then removed soiled gloves and washed hands.

On 4/12/17, at 9:11 a.m., NA-J verified gloves had remained on after providing peri cares.

The facility policy Perineal/Incontinence Care dated 8/8/16, indicated Procedure: 4. Perform hand hygiene. 5. Put on gloves. 6. Wash all soiled areas, washing from front to back, rinse and dry well, especially the folds. 11. Remove gloves. 12. Wash hands.

EMPTY FOLEY CATHETER BAG:
On 04/12/17, at 4:58 a.m., NA-G was observed to empty R100's Foley catheter bag. NA-G applied gloves, obtained a urinal from the bathroom, opened the drain spout on the catheter beg and emptied the urine from the bag into the urinal. NA-G then closed the spout of the catheter bag and emptied the urine from the urinal into the toilet after measuring the amount of urine in the urinal. NA-G rinsed out the urinal, removed gloves and washed hands. NA-G failed to wash hands before the procedure and failed to use an alcohol wipe to cleanse the drain spout on the catheter bag prior to emptying the catheter bag and after emptying the catheter bag.

On 4/12/17, at 5:05 a.m., NA-G verified had not washed hands prior to the procedure of emptying R100's catheter bag and had not used an alcohol wipe to cleanse the drain spout before emptying and after emptying the catheter bag.

WOUND DRESSING CARE:
On 4/12/17, at 10:06 a.m., RN-B was observed to

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F 441	Continued From page 136 provide wound dressing treatment for pressure ulcers to R100 with assistance from LPN-E. LPN-E washed hands, applied gloves removed the soiled dressing from R100's right lower leg, removed gloves and washed hands. RN-B was observed to wash hands, apply gloves, and cleansed two separate wound base areas with the same gauze wet with acetic acid 0.25 percent. RN-B failed to use a separate gauze to cleanse each wound area. RN-B then removed gloves (failed to wash hands), applied clean gloves and mixed Iodosorb (antimicrobial) and hydrogel (a gel) together in a plastic medicine cup with her gloved finger. RN-B then applied the medicine to each wound base (three total) using the same gloved finger. RN-B failed to apply the medicine to each wound base with a different applicator separately. RN-B removed glove on right hand and applied a clean glove to right hand. RN-B then applied a clean dressing to R100's wound areas. RN-B then removed gloves, applied clean gloves and applied lotion to R100's leg. RN-B removed gloves and with bare hands applied a stockinet with visible green and yellow drainage on it over the wound dressing (failed to provide a clean stockinet and had bare hands touching visible drainage on the stockinet) on R100's right leg. RN-B then applied an ace wrap to R100's right leg. RN-B was observed to apply gloves, wipe R100's peri area with a wipe and then using the same wipe cleansed R100's excoriated skin on R100's buttocks with the same wipe (failed to use different wipe to clean the excoriated tissue). RN-B stated R100's buttocks was excoriated at the time and blanchable. RN-B removed gloves, applied clean gloves and applied medseptic skin protectant to R100's buttocks. During the application of the skin protectant RN-B used the same gloved hand used to apply the	F 441		

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protectant to R100's excoriated buttocks into the container twice to obtain the cream and apply it (failed to ensure clean glove for removal of skin protectant from container). RN-B removed gloves. RN-B applied gloves, moved R100's garbage can closer and pushed garbage down into R100's garbage can and with the same soiled gloves on proceeded to cleanse stool from R100's buttocks with disposable wipes. RN-B removed gloves. RN-B proceeded to remove the sling from under R100 in the wheelchair, applied gloves, cleansed R100's commode, removed gloves and washed hands. At 11:13 a.m., RN-B verified the above.

SURVEILLANCE AND ANALYSIS OF INFECTIONS:
The facility monthly Line Listing of Resident Infections were obtained from 8/16 through 3/17. The logs identified for tracking the room, unit, name, admission date, type of infection, if UTI (urinary tract infection) catheter present, symptoms/date, cultures: date/site/results, treatment, other actions if needed, does not meet infection criteria, healthcare associated infection or community acquired infection.

The facility monthly Line Listing of Resident Infections included the following:
8/16 - 6 UTI, 1 C-Diff (stool infection), 1 cellulitis, ongoing non healing wound scrotum
9/16 - 3 UTI, 1 pneumonia
10/16 - 2 pneumonia, 1 respiratory, 1 sepsis due to obstructed left uretal stent
11/16 - 1 C-Diff, 2 pneumonia, 1 cellulitis, 1 admit from hospital with septic shock, 3 skin, 1 viral nausea, 1 blood stream infection, 1 UTI
12/16 - 1 UTI, 1 skin, 1 septic ureteral stone, 3 UTI, 2 respiratory, 4 pneumonia, 1 septic

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pneumonia community acquired, 1 Hepatitis C, 1 viral respiratory
1/17 - 5 UTI, 2 skin, 2 respiratory
2/17 - 8 UTI, 1 skin, 1 viral skin, 1 pneumonia
3/17 - 4 respiratory, 1 possible aspiration pneumonia, 1 C-Diff, 1 skin, 3 UTI

The facility Line Listing of Staff Infections was provided for the month of 12/2016 only and identified vomiting, diarrhea, fever, body aches, nausea as symptoms and a total of 10 employees listed with the varying symptoms identified.
No other information was provided regarding surveillance of staff, visitors and volunteers infections.
Analysis of infections was provided for the following months:
-2/3/17, identified reviewed resident and staff tracking for 1/2017. No trends identified after we analyzed the data. We reviewed the logs and found no correlation between staff and residents.
-3/4/17, identified reviewed the resident tracking for 2/2017. After analyzing the information, we did not find any trends linked to the same pathogen. We did notice there was an increase in UTI's on the third floor, however pathogens were different. The ADON did some peri audits, and did not find any breaks in infection control.
No other information was provided regarding analysis of infections.

On 4/14/17, at 2:433 p.m., when queried regarding A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for staff, volunteers and visitors, the assistant director of nursing (ADON) stated what can I tell you, any staff member that does not show up for work I get a call in sheet. When queried if aware of regulation

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effective regarding having a system in place for the above, the ADON stated what date was the regulation effective. The ADON verified the logs provided to the surveyor were resident logs and contained no other information for staff, volunteers and visitors. The ADON stated the rest of the analysis are in the Quality Assurance Performance Improvement notes with former owner and we do not have access to them anymore.

STAFF EDUCATION:
On 4/10/17 staff education for infection control content and attendance records were requested from the director of nursing (DON).

On 4/13/17, at 12:35 p.m. the ADON stated some information for content of infection control was in a binder he had provided. The content of the infection control education provided was influenza, tuberculosis, bloodborne pathogens, hazard communication and infection prevention content dated 10/11/16. No documented information was provided regarding documented staff attendance for infection control.

On 4/13/17, at 3:14 p.m., the ADON stated I am still waiting for the corporation to send staff education for infection control from the previous owners.

On 4/14/17, at 2:40 p.m., the ADON verified he had not provided attendance of employees for infection control.

The facility policy Infection Preventionist, dated revised 8/2012, included 1. The infection Preventionist or designee shall coordinate the development and monitoring of our facility's

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F 441	Continued From page 140 established policies and practices. 2. The Infection Preventionist shall report information related to compliance with our facility's established infection control policies and practices to the administrator and quality assurance and assessment committee. 3. The infection Preventionist shall keep abreast of changes in infection control guidelines and regulation to ensure our facility protocols remain current and aid in preventing and controlling the spread of infections. 4. Upon approval from the administrator the infection Preventionist may designate other employees to assist him/her in the performance of these duties. 5. The infection Preventionist will collect, analyze and provide infection data and trends to nursing staff and health care practitioners , consult on infection risk assessment and prevention control strategies; provide education and training; and implement evidenced based infection control practices. On 4/14/17, at 3:05 p.m. the ADON stated he would expect staff to follow current standards of practice for wound treatment, emptying a Foley catheter bag, peri-cares and cleansing a glucometer. On 4/14/17, at 4:12 p.m., the director of nursing (DON) stated she would expect immediately after peri cares gloves to be removed and hands washed. The DON stated she would expect each wound to be cleansed separate with a different gauze and an separate applicator be used to apply medication to each wound. The Don stated she would expect a clean wipe be used to cleanse the buttocks of excoriated skin and not the wipe used to cleanse the peri area first. The DON stated for wound treatment infection control technique be followed. For emptying the Foley	F 441		

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F 441	Continued From page 141 catheter bag she would expect an alcohol wipe be used to cleanse the spout. A glucometer should be cleansed after use, using the designated wipe and an alcohol pad was not sufficient for cleansing a glucometer. R122 had been observed on 4/12/17 at 8:38 a.m., to be lying in bed and noticed eyes to be mattered and closed, R122 stated they are crusty and gross. NA-I observed using a dry Kleenex to wipe away matter from R122 eyes with no gloves and did not wash hands after using the same Kleenex on both eyes. At 8:45 a.m. NA-I wet a Kleenex in the bathroom and attempted again to wipe away the mattered on R122 eyes without using gloves or washing hands after procedure. During interview with NA-I on 4/12/17 at 8:52 a.m. NA-I verified she had not used gloves nor washed her hands after wiping drainage on both eyes. NA-I then said that she normally washes her hands before leaving but did not this time.	F 441		
F 496 SS=F	483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING d)(4) Registry verification Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency	F 496		5/28/17

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F 496	Continued From page 142 evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. (d)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (d)(6) Required retraining If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 78 nursing assistants (NA) was on the registry. This had the potential to effect all 95 residents in the facility. Findings include: Nursing assistance (NA) certification verification conducted 4/14/17 at 10:30 a.m., NA-H certification found to have expired on 10/22/16. Review of the staffing schedules from the 1/14/17 through 4/13/17, indicated NA-H had worked on the floor in the facility.	F 496	F496 1. NA-H was suspended on 4/13/17 pending recertification. NA-H was recertified on 5/4/17. An audit of all facility aides was conducted, showing no additional aides to be out of compliance. 2. Facility residents have the potential to be affected by this practice. 3. Facility nursing staff were inserviced by the Director of Nursing/designee on the policy requiring staff to notify the facility as to change of status of licensure or	

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F 496	Continued From page 143 Interview on 4/14/17 at 2:08 p.m. with administrator and director of nursing verified that NA-H was still employed and had been at work during the survey (was sent home by administrator after expired certification was identified by surveyor.) Interview with administrator on 4/17/17 at 3:24 p.m. stated the nursing assistants rotate assignments and could work with any resident in the facility. Staffing policy and nurse assistant certification verification policy and procedure requested was not provided by the facility.	F 496	certification required to perform duties. Human Resources specialist audited licensed nursing staff and certified nurse aides for compliance. Inservices, audits and education will be completed by May 28, 2017. 4. The Director of Nursing/HR Specialist/designee will monitor compliance through random employee records x 3 weekly for a minimum of 3 months or until compliance is achieved. Results of the audits will be brought monthly to QA/PI for review and recommendations.	
F 497 SS=F	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to ensure every 12 month performance reviews were completed for 5 of 5 nursing assistants (NA-M, N, L, D & K) who were employed for more than one year. This had the potential for affect all residents in the facility. Findings include On 4/17/17, reviewed five nursing assistant	F 497	F497 1. Facility nurse aides have received performance reviews. Those employees on leave will receive performance evaluations within 30 days of when they return to work. 2. Facility residents have the potential to be affected.	5/28/17

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F 497	Continued From page 144 (NA)-M, (NA)-N, (NA)-L, (NA)-D, (NA)-K) personnel files. NA-M was hired on 10/20/1988. Review of personnel file did not include any performance reviews. NA-N was hired on 8/22/1996. Review of personnel file did not include any performance reviews. NA-L was hired on 1/13/2012. Review of personnel file did not include any performance reviews. NA-D was hired on 4/16/2014. Review of personnel file did not include any performance reviews. NA-K was hired on 12/29/2015. Review of personnel file did not include any performance reviews. Interview on 4/17/17, at 11:38 a.m. with the administrator who stated no formal performance reviews were completed for any staff in the facility. Administrator stated there is nothing in writing. Administrator stated Golden Living was transitioning and switching to a different system. Administrator could not identify when performance reviews were last completed, stated nothing has been completed in over a year. Policy titled, "Employee Performance Evaluation" dated 3/2/16, indicates "the information in this policy was based on an HR policy that is obsolete and has been archived. A new policy is currently being development through HR. When it becomes available, future updates may include	F 497	3. Facility has updated policy on performance reviews. Going forward, employees will have reviews on an annual basis during employee's anniversary month. Administrator/designee inserviced the interdisciplinary team on employee performance evaluations. Facility employee inservices and evaluations will be completed by May 28, 2017. Inservices will be ongoing as needed. 4. The Director of Nursing/HR Specialist/designee will monitor compliance through random audit of employee records 3 x weekly for a minimum of 3 months or until compliance has been achieved. Results of the audits will be brought monthly to QA/PI for review and recommendations.	

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F 497	Continued From page 145 any appropriate instructions or details that might be specific to the Business Office process."	F 497		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this	F 520		5/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 520	Continued From page 146 section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality committee met as required, to identify quality concerns, and failed to ensure the committe participated in development and oversite of implementation of facility policies and systems to ensure quality of life and quality of care were maintained for 95 of 95 residents residing in the facility. Findings include: Refer to F225 as the facility failed to adequately investigate allegations of abuse for 1 of 1 residents (R42), and failed to ensure adequate protections were put in place for R42 and other residents during an investigation. Refer to F226 as the facility failed to operationalize the Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy and enforce a resident environment that was free from abuse for 1 of 1 residents (R42). Refer to F314 as the facility failed to provide new interventions, and failed to follow physician orders and treatments, for 1 of 1 resident (R122) reviewed for pressure ulcers. R122 experienced actual harm due to development of two stage III pressure ulcers (Full thickness skin loss involving damage or dead tissue) to the heel and an	F 520	F520 1. Printed copies of QA/PI minutes and attendance list will be kept on file by the Administrator for 12 months. Survey results were reviewed at the May QA/PI meeting. 2. Residents have the potential to be affected by this practice. 3. ED, DON, Medical Director and IDT have reviewed the Quality Assurance Performance Improvement (QA/PI) policy. This was completed by May 28, 2017. The QA/PI program will include review of resident care concerns and plans, quality indicators, care trend concerns, pharmacy reports, infection control tracking, grievances, OHFC self-reports, policies and procedures, and employee concerns and needs. Ongoing discussions of the QA/PI format and content will be reviewed by ED, DON, Medical Director, and IDT as needed. 4. The Executive Director will monitor compliance through audits of QA/PI minutes to ensure required areas are covered and plans are in place to address areas not meeting standards. Audits will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 520	Continued From page 147 infection of the ankle pressure wound identified as unstageable (full thickness tissue loss where the ulcer is completely covered with extensive destruction or damage to the muscle, bones). On 4/17/17, at 3:24 p.m. The administrator was interviewed about quality assurance (QA). The administrator stated their QA (refered to as QAPI (quality assurance performance improvement) committee met monthly, and identified who attended as well as how they would identify issues in the facility. The administrator provided QAPI attendance records for a meeting dated 3/15/17. The attendance record indicated neither the director of nursing nor the administrator had attended the meeting. A request for additional verification of meetings/attendance form prior to 3/17 was not provided. The administrator stated their QAPI meeting minutes and attendance were documented on the previous facility owner's hard drive and could not be located. There was no evidence of additional meetings held prior to 3/15/17, which would have identified potential quality deficiencies where the facility would have developed and implemented plans of action to correct those quality deficiencies, which would have included monitoring the effect of implemented changes and making needed revisions to the action plans.	F 520	occur monthly for a minimum of 3 months or until compliance is achieved. These audits will be reviewed in QA/PI for further recommendations	

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

F5184026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Facility name) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 Existing Health Care. (Golden Living Center) is a 3-story building with a full basement. The building was constructed in 1968 and was determined to be of Type II (222) construction. The building has a fully sprinkler system The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 116 beds and had a census of 85 at the time of the survey.	K 000		

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

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