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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IKP4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00144

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245187**
2.STATE VENDOR OR MEDICAID NO.
(L2) **276542000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TEXAS TERRACE CARE CENTER**
(L4) **7900 WEST 28TH STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/10/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(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 :
Gloria Derfus, Supervisor 08/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/28/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1978
(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.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/20/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5187

August 28, 2014

Mr. Reid Hewitt, Administrator
Texas Terrace Care Center
7900 West 28th Street
Saint Louis Park, Minnesota 55426

Dear Mr. Hewitt:

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 August 19, 2014, the above facility is certified for:

118 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 118 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 28, 2014

Mr. Reid Hewitt, Administrator
Texas Terrace Care Center
7900 West 28th Street
Saint Louis Park, Minnesota 55426

RE: Project Number S5187023

Dear Mr. Hewitt:

On July 25, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 21, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 19, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 10, 2014, effective August 19, 2014 and therefore remedies outlined in our letter to you dated July 25, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245187	A. Building B. Wing	8/28/2014

Name of Facility	Street Address, City, State, Zip Code
TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0174** Reg. # **483.10(k),(l)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **08/19/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **08/19/2014**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **08/19/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/19/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **08/19/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	08/28/2014	18623	08/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245187	A. Building B. Wing	8/28/2014

Name of Facility	Street Address, City, State, Zip Code
TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/19/2014**
ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/19/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	08/28/2014	18623	08/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/10/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245187	01 - MAIN BUILDING 01	8/21/2014

Name of Facility	Street Address, City, State, Zip Code
TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0069	07/25/2014	ID Prefix Reg. # NFPA 101 LSC K0072	08/19/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	08/28/2014	28120	08/21/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/10/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IKP4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00144

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245187**
2.STATE VENDOR OR MEDICAID NO.
(L2) **276542000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TEXAS TERRACE CARE CENTER**
(L4) **7900 WEST 28TH STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/10/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 08/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1978
(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.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5279

July 25, 2014

Mr. Reid Hewitt, Administrator
Texas Terrace Care Center
7900 West 28th Street
Saint Louis Park, MN 55426

RE: Project Number S5187023 and Complaint Number H5187062

Dear Mr. Hewitt:

On July 10, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 10, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5187062.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 10, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5187062 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 19, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 19, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC 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,

- Include signature of provider and date.

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

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

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

Failure to submit an acceptable PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 10, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697
Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ B. WING _____	C 07/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an 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. In addition, complaint H5187062 was investigated and the complaint was substantiated at F246.	F 0(	Texas Terrace Care Center submits this plan of correction because it is required by State and Federal Regulation and is not a legal admission that this statement of deficiencies is correctly cited, and is not to be construed as an admission against the interest by the Center, the Administrator or any employees, agents or other individuals who draft or may be discussed in the response and plan of correction. Texas Terrace Care Center respectfully submits this plan of correction and our allegation of compliance as of August 19th, 2014.	
F 174 SS=D	Census 85 483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate missing personal clothing items for 1 of 3 residents (R7) reviewed for personal property.	F 174	All POC date are 8/19/2014 1. Resident #7 has had missing items investigated. 2. All residents with missing items have been reviewed and investigated. 3. All staff have been re-educated regarding missing items and investigations. 4. SSD/Designee will audit up to 4 missing items reports/week. Audit results will be reviewed at QPI.	

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

CNHA | 8/11/14

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

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F 174	Continued From page 1 Findings include: On 7/8/14, at 10:25 a.m. during interview when R7 was asked if he had any personal items missing R7 stated, "I had a TV [television] remote for the DVD [digital video disc] this was when I moved here. When I moved here I bought shirts and underwear and all went missing so I went and bought them and gave him [licensed social worker -LSW] the receipt he reimbursed me. Then after that I made sure they were all labeled then all went missing except one and when I told him he told me to tell my family to buy more and would not reimburse. I have also had an IPOD and MP3 [both are electronic music devices] player missing they told me they were looking but never was found so I bought another one. To this date he has never responded to me. My family has no money and even if they buy them they will be misplaced again by laundry I know I sent them and they never were returned." After the interview the LSW walked past the dining room (DR) and R7 pointed at LSW and stated "That's him he never addresses anything. He reimbursed for the t-shirts the first time and then he tells me my family had to, yet laundry does the laundry." The Cognitive Assessment/Plan of Care dated 6/13, indicated R7 was alert and oriented to person, place and time. The Cognitive loss Care Area Assessment (CAA) dated 12/23/13, identified R7 was alert and oriented and was able to communicate his needs and direct his care. Further document review revealed Progress Notes dated 12/31/13, through 7/9/14, lacked documentation on the missing item investigation. The April 2014 Concern Log (provided by LSW)	F 174		

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F 174	Continued From page 2	F 174		

identified at the bottom of the log R7 had reported "Missing t-shirts and pants," but the concern was undated. The resolution section of the log was marked "Unknown." R7's concern was neither documented as addressed, nor assigned to follow up.

R7's quarterly Minimum Data Set (MDS) dated 5/8/14, indicated R7 Brief Interview For Mental Status (BIMS-tool used to measure cognition) was 15 which indicated intact cognition.

When interviewed on 7/9/14, at 10:10 a.m. LSW stated when a resident reported anything was missing, a report for missing property would be filled out and then with the resident permission, the room or roommate belongings/closet would be searched. LSW stated the laundry and staff would let the resident know they were looking for the missing item. LSW further stated the admission agreement and the missing policy would address what the facility would and would not reimburse.

On 7/9/14, at 2:47 p.m. when asked how the facility handled reported missing items, the interim administrator stated "as indicated in the policy, the facility was not responsible for reimbursing personal items."

On 7/10/14, at 11:02 a.m. LSW stated R7 had reported to somebody he was missing a number of t-shirts, but was not able to state when and where. LSW further stated, "I came to know about it when he walked up to me and started yelling and walked away. I followed him to his room and asked him to search, but [R7] stated he had looked and then reported to house-keeping/laundry and I had told him maybe

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F 174	Continued From page 3 the t-shirts had been sent out with linen and would keep waiting to see if we would get them back." In addition, LSW verified the April 2014 Concern Log was void of documentation on who had addressed the concern, and the date completed. On 7/10/14, at 3:01 when asked if there was documentation completed on the R7's missing shirts, LSW stated he had looked for the Missing Item Form and was unable to locate it and all the documentation would have been on the report. When asked if the missing clothing and the search should have been documented in the medical record LSW stated, "I documented that on the form." Admission Agreement Minnesota revised March 2011, indicated, "The Center shall only be responsible for the loss of money or loss or damage to jewelry, documents or other personal property retained in the Resident's possession if such loss is caused by the negligence of the Center, its employees or agents acting within the scope of the employment or agency or unless as otherwise required under state or federal law." The Personal Items - Care of Procedure revised April 2013, directed staff to assist residents with identification of lost, and/or stolen personal items and to initiate the "Concerns-Resident/Family" procedure located in the Operations Administrative manual if a personal article was missing.	F 174		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by	F 176		

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F 176	Continued From page 4 §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R24, R72) were assessed to safely self-administer their medications. Findings include: R24 was not assessed to be able to safely self-administer their medications and was observed self-administering medications on 7/7/14. On 7/7/14, at 7:25 p.m. registered nurse (RN)-D was observed to prepare R24's medications at the medication cart on West Hall, 2nd floor. Three medications were taken out from the facility supply bottles: Tylenol (pain medication), Aspirin (a medication for pain, inflammation, and could also help prevent stroke or heart attack) and Senna (laxative). Two medications identified as Seroquel (anti-psychotic) and Singulair (a medication to prevent asthma attacks) were taken out from the bubble packages; one medication, Klonopin (an anti-seizure) was taken from the locked narcotic medication box. RN-D put all of the medications in a medication cup and took it to R24's room and handed the cup of pills to R24. R24 was observed to pour the medicines on the bedside table lined with a brown paper towel. RN-D started to move towards door to leave, but R24 stopped RN-D from leaving the room and stated, "You cannot leave the door until I am sure I have all my pills." R24 was observed from the doorway counting her medicines before	F 176	1. Residents #24 & #72 have been assessed for self administration of medications. 2. All residents who self administer medications have been appropriately assessed. 3. Licensed staff have been re-educated regarding self administration of medications. 4. DON/Designee will audit 5 residents per week for self administration assessments. Audit results will be reviewed at QPI.	

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F 176	Continued From page 5 taking the medications. RN-D then left the room before R24 had taken the medications and went down the hallway out of sight of R24. When asked at the time of the observation if it was all right to leave the medications in the room for R24 to take alone, RN-D stated it "was the usual practice" because R24 "would get upset if nurses stayed in the room to watch her take medications." On 7/9/14, at 2:04 p.m. licensed practical nurse (LPN)-B stated R24 took medicines whole with ice water after breakfast. LPN-B stated R24 wanted pills after breakfast, arranged in specific manner and would like to take medications herself, otherwise if nurses stayed/stood in room longer, R24 would get mad. On 7/9/14, at 2:08 p.m. R24's medical record lacked evidence an assessment for self-administration of medications was completed for R24. There was no care plan in the chart that would indicate R24 could self-administer medications. There was no current written doctor's order to indicate R24 could self-administer medications. On 7/9/14, at 2:19 p.m. RN-E verified there was neither an assessment completed nor a plan of care for medication self-administration for R24. RN-E agreed an assessment to determine appropriateness for medication self-administration must be done before leaving the medications for R24 to take by herself. On 7/10/14, at 3:00 p.m. RN-E submitted a Self Medication Data and Assessment (SMDA) form dated 7/10/14, which indicated R24 refused to self-administer medications.	F 176		

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F 176	Continued From page 6	F 176		

R72 was not assessed to be safe to self administer medications and was observed self-administering a nebulizer on 7/10/14.

On 7/10/14, at 10:21 a.m. during the medication observation on the 2nd floor South hallway, the medication cart was observed to be parked on the South hallway against the wall outside R72's room. LPN-B was observed preparing R73's (another resident) medications at the medication cart. R73 waited in their wheelchair near the medication cart.
- At 10:24 a.m. while LPN-B and R73 were talking, surveyor heard the sound of a nebulizer start and then kept going in R72's room. The door was open and R72 was observed to be administering a nebulization treatment independently. R72 stated she was on schedule to have "neb treatment four times a day" and would do the nebulization treatment by herself when the "nurses leave it" for her to do. When asked who left the medicine, R72 stated, "It was there" and was unclear which nurse left the medication. R72 indicated since the medication was left at the bedside, she completed the nebulizer treatment.
- At 10:25 a.m. when surveyor asked LPN-B if it was all right for R72 to do nebulization treatment by herself, LPN-B stated the nebulizer medicine "must have been left" sometime before the morning shift, LPN-B stated she did not give R72's morning medications yet. LPN-B denied giving any nebulizer medication to R72. LPN-B further stated they were not aware if R72 could self-administer medications.

The current June 2014 Physician's Orders noted

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F 176	Continued From page 7 R72 to have received Duoneb (breathing medication adminsitered per nebulizer) four times a day. There were no orders to self-administer the Duoneb. R72's clinical record lacked evidence an assessment for safe self-medication administration of nebulizer medication was completed; there was no care plan developed to identify R72 could self-administer medications; and there was no physician's order to indicate R72 could safely self-administer any medications. On 7/10/14, at 10:28 a.m. registered nurse (RN)-E verified R72 was not assessed for safe self-administration of medications. The facility's policy with regard to medication self-administration dated 4/2006, instructed the interdisciplinary team to do assessments "to determine the resident's ability to self-medicate." The policy directed that determination of ability to self-administer medications should include marking "able" in all questions asked in the SMDA form before a resident can safely self-administer medications.	F 176		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225		

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F 225	Continued From page 8 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 interview and document review, the facility failed to ensure alleged violations involving abuse, resident to resident altercations and financial exploitation were immediately reported to the administrator, the State Agency (SA) and thoroughly investigated for 5 of 9 residents (R62, R20, R174, R113, R53). Findings include:	F 225	1. Resident allegations from residents #62, #20, #174, #113, & #53 have been reported and investigated as appropriate. 2. All resident allegations are being reported immediately to the NHA, DON, and SA. All allegations are being thoroughly investigated. 3. All staff have been re-educated regarding reporting and investigating allegations of abuse, neglect, misappropriation of property, mistreatment, resident to resident altercations, and injuries of unknown origin. 4. NHA/Designee will audit up to 2 allegations/week for notification and investigation. Results of audits will be reviewed at QPI.	

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F 225	Continued From page 9 R62's current plan of care dated 9/13/13, identified R62 had a history of false allegations involving aides and daily cares, history of alleging sexual assault at a previous nursing home (9/10/13). The care plan directed staff to observe for signs and symptoms of abuse, report to supervisor and to investigate and report all allegations. R62 reported verbal abuse from R20 to staff who failed to immediately report to the administrator and SA. R62's Care Area Assessment (CAA) dated 9/30/13, indicated R62 had mild cognitive impairment, possible moderate-severe depression and continued to benefit from Wellbutrin (medication for depression). R62 had a diagnoses of psychosis, personality disorder, depression and adult sexual abuse listed on the Diagnosis Listing by resident dated 4/1/14. The quarterly Minimum Data Set (MDS) dated 5/8/14, indicated R62 was cognitively intact. Resident Concern Report from R62 was submitted 1/30/14, regarding alleged incident of physical abuse on 1/29/14, at midnight from NA-G. Administrator notified 1/31/14. NA-G was considered to be in suspension until completed investigation. The claim was un-substantiated. The facility failed to immediately report the incident to the administrator and SA. R20's current plan of care dated 11/13/13, identified R20 had verbal aggression, swearing at others, and extreme mood changes. R20 had a CAA dated 11/15/13, identified R20 has a history of schizophrenia/ schizoaffective disorder, was disorganized, impulsive and disruptive requiring	F 225		

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F 225	Continued From page 10 staff supervision for safety and compliance. R20 had diagnoses of bipolar, psychosis and depression listed on the diagnosis listing by resident dated 11/19/13. The quarterly MDS dated 4/30/14, indicated R20 was cognitively intact. R174 had a diagnoses that included anxiety and depression listed on the diagnosis listing by resident dated 5/13/14. The admission MDS dated 5/15/14, indicated R174 was cognitively intact. There was no associated mood or behavioral CAA. R174's current plan of care dated 5/14, indicated R174 had alteration in thought related to depression, anxiety and alcohol abuse. A resident concern report filled out by R62 dated 6/29/14, indicated concerns of "[R20] wants to kill me when she get any kind of chance, she try [sic] to get everybody who was on her side to be very nasty to me and says that the place belongs to her." On 6/30/14 staff met with R62 who stated she was feeling "scared" because R20 has been "threatening" and that she was not sleeping at night due to R20's behavior. An incident report dated 7/1/14, indicated R174 stated R20 "swears at me every time I pass by her. She is very rude and hateful not only to me, but I have seen the same behavior from her toward other residents. I feel verbally abused every time it happens and to the point afraid she might do something harmful to me or another resident." Another resident, [R62], voiced a similar concern stating, "She tries to get everybody who was on her side to be very nasty	F 225		

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F 225	Continued From page 11 to me and she says that the place belongs to her." [R62] reports that [R20] has been verbally abusive toward her and has made threats to her. During an interview on 7/9/14, at 10:43 a.m. the interim administrator (IA) stated R62 started writing the resident concern report on 6/28/14 and "we don't know when she gave it to someone except it is signed by the previous administrator on the 30th." IA states, "we gave her a room change on 6/30/14, thought that the intervention was enough and successful, but then we got a second complaint, felt this was a trend and requested a psychology evaluation and [R20] was hospitalized. We then felt it was reportable." During an interview on 7/10/14, at 1:34 p.m. the director of nursing (DON) verified she was notified by way of phone on 6/29/14, at 8:23 p.m. and the administrator was notified on 6/30/14. During an interview on 7/10/14, at 3:00 p.m. IA verified the incident should have been reported immediately. Although the facility was aware of the resident to resident verbal abuse between R62 and R20, they did not notify the administrator or the SA immediately. R113 reported an IPAD (tablet computer) missing and the incident was not reported to the administrator or SA immediately. R113's current plan of care dated 9/13/13, indicated R113 had history of auditory hallucinations but was currently stable. A CAA dated 9/16/13, indicated R113 was alert, oriented,	F 225		

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	245187	A. BUILDING _____ B. WING _____	C 07/10/2014

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F 225	Continued From page 12	F 225		

pleasant, spends much of his time in his room and is visited by psychiatry on a regular basis. R113 had diagnoses that included manic depression and schizophrenia listed on the quarterly MDS dated 5/16/14. The quarterly MDS dated 5/16/14, indicated R113 was cognitively intact.

A resident concern report filled out by R113 dated 5/6/14, indicated R113 reported that he is missing his IPAD. R113 reported it was charging in his room below his stereo. On 5/7/14, the report indicated two rooms were checked and R113's brother was called who stated he had not recalled seeing the IPAD during his last visit, but often does not see it when he visits. On 5/14/14, the administrator received an email from the brother indicating Apple (maker of IPAD) had contacted him regarding someone trying to access the IPAD. At this time police and the SA were notified.

An incident report dated 5/14/14, indicated on 5/6/14, R113 had stated he was not able to find his IPAD prior to a room change that occurred on 5/5/14. Both rooms were searched, a missing item report was completed per policy, but no further report was filed at that time.

During an interview on 7/10/14, at 1:34 p.m. the DON stated "I don't recall if I notified the administrator or not, we thought it went missing during the move, I know the administrator was notified on 5/14/14 when it was reported."

During an interview on 7/10/14, at 3:00 p.m. the interim administrator stated, "I have no idea, I wasn't here."

Although the facility was aware of a report of

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F 225	Continued From page 13 possible stolen property, they did not notify the administrator or state agency immediately. R53 alleged mistreatment and the facility failed to immediately report to the administrator and SA. R53's roommate produced a copy of the report he filed on behalf of his roommate, dated 3/16/14. The roommate said he gave the report to the nurse who gave it to the social worker. The nursing progress notes for R53 were reviewed and lacked any documentation of the event. There were no nursing progress notes recorded for the month of March, 2014. A review of the incident report read, "After listening to the aide and [resident name] yelling at each other (which is what woke me up) [resident name] asked for the supervisor another person came in and they all were yelling!" A review of social services notes lacked evidence the incident had been acknowledged. There was a social services note dated 3/4/14, (prior to the incident) and the next note was dated 5/5/14. The 5/5/14, note indicated the interdisciplinary team met to review current status. The note did not indicate an incident had been reported. The note did indicate R53 had a history of irritability with other residents and staff at times. The CAA for urinary incontinence dated 6/16/14, read, "Resident is alert and oriented, able to call for assistance with toileting, uses urinal and uses toilet. Resident is on a diuretic, CHF [congestive heart failure], HTN [hypertension], COPD [chronic obstructive pulmonary disease]. Resident is continent. Goal is to maintain comfort, avoid further inc [incontinent] episodes."	F 225		

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F 225	Continued From page 14 The copy of the incident was shown to the DON, the administrator, and licensed social worker (LSW)-B on 7/10/14, at 4:00 p.m. They verified it was a legitimate facility report form. They explained the social worker at the time of the incident was no longer employed by the facility and left employment the end of March, 2014. The DON said she was covering for the social worker at that time, but had not seen the report. The administrator explained he was not working in the facility at the time of the incident. The administrator looked for the report, but was unable to locate it. LSW-B also did not recall discussing the incident and stated, "It appears that it was not brought to the attention of the staff." SW-B said he had received other concerns from R53's Roommate that had been investigated. The facility "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" policy dated October 1999, indicated "report the incident immediately to the Administrator and DON/designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property to applicable state and other agencies" and indicates misappropriation of resident property includes, but is not limited to, deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 15 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prevention policy to immediately notify the administrator, immediately notify the State agency (SA) and thoroughly investigate potential allegations of verbal abuse, resident to resident altercations and misappropriation of resident property for 5 of 9 residents (R62, R20, R174, R113, R53). Findings include: The facility's "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" policy dated October 1999, indicated "report the incident immediately to the Administrator and DON/designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property to applicable state and other agencies." R62 reported verbal abuse from R20 to staff who failed to immediately report the allegation to the administrator and SA according to facility policy. R62 had diagnoses to include psychosis, personality disorder, depression and adult sexual abuse listed on the diagnosis listing by resident	F 226	1. The facility has implemented its abuse prevention policy including immediate notification to the administrator and SA as well as completing a thorough investigation of potential allegations. 2. All staff have been re-educated regarding policy implementation. 3. NHA/Designee will audit up to 2 allegations/week for implementation and investigation per policy. Audit results will be reviewed at QPI.	

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F 226	Continued From page 16 dated 4/1/14. The quarterly Minimum Data Set (MDS) dated 5/8/14, indicated R62 was cognitively intact. A Care Area Assessment (CAA) dated 9/30/13, indicated R62 had mild cognitive impairment, possible moderate-severe depression and continued to benefit from wellbutrin (medication for depression). R62's current plan of care dated 9/13/13, identified R62 had a history of false allegations involving aides and daily cares, history of alleging sexual assault at previous nursing home (9/10/13) and that staff will observe for signs and symptoms of abuse, report to supervisor and will investigate and report all allegations. R62 also reported physical abuse from NA-G to staff who failed to immediately report to the administrator and SA. Resident Concern Report from R62 was submitted 1/30/14, regarding alleged incident of physical abuse on 1/29/14, at midnight from NA-G. Administrator notified 1/31/14. NA-G was considered to be in suspension until completed investigation. R20 had diagnoses of bipolar, psychosis and depression listed on the diagnosis listing by resident dated 11/19/13. The quarterly MDS dated 4/30/14, indicated R20 was cognitively intact. A CAA dated 11/15/13, identified R20 has a history of schizophrenia/schizoaffective disorder, was disorganized, impulsive and disruptive requiring staff supervision for safety and compliance. R20's current plan of care dated 11/13/13,	F 226		

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F 226	Continued From page 17 identified R20 had verbal aggression, swearing at others, and extreme mood changes. R174 had a diagnosis that included anxiety and depression listed on the diagnosis listing by resident dated 5/13/14. The admission MDS dated 5/15/14, indicated R174 was cognitively intact. There were no associated mood or behavioral CAA. R174's current plan of care dated 5/14 indicated R174 had alteration in thought related to depression, anxiety and alcohol abuse. A resident concern report filled out by R62 dated 6/29/14, indicated concerns of "[R20] wants to kill me when she get any kind of chance, she try [sic] to get everybody who was on her side to be very nasty to me and says that the place belongs to her." On 6/30/14 staff met with R62 who stated she was feeling "scared" because R20 has been "threatening" and that she was not sleeping at night due to R20's behavior. An incident report dated 7/1/14, indicated R174 stated R20 "swears at me every time I pass by her. She is very rude and hateful not only to me, but I have seen the same behavior from her toward other residents. I feel verbally abused everytime it happens and to the point afraid she might do something harmful to me or another resident." Another resident, [R62], voiced a similar concern stating, "she tries to get everybody who was on her side to be very nasty to me and she says that the place belongs to her." [R62] reports that [R20] has been verbally abusive toward her and has made threats to her.	F 226		

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F 226	Continued From page 18 During an interview on 7/9/14, at 10:43 a.m. the interim administrator stated R62 started writing the resident concern report on 6/28/14 and "we don't know when she gave it to someone except it is signed by the previous administrator on the 30th."The interim administrator stated, "we gave her a room change on 6/30/14, thought that the intervention was enough and successful, but then we got a second complaint, felt this was a trend and requested a psychology evaluation and [R20] was hospitalized. We then felt it was reportable." During an interview on 7/10/14, at 1:34 p.m. the director of nursing (DON) verified she was notified by way of phone on 1/29/14 at 8:23 p.m. and the administrator was notified on 6/30/14. During an interview on 7/10/14, at 3:00 p.m. interim administrator verified the incident should have been reported immediately. Although the facility was aware of the resident to resident verbal abuse between R62 and R20, they did not notify the administrator or the SA immediately as directed by the facility policy. R113 reported an IPAD (tablet computer) missing and the incident was not reported to the administrator or SA immediately according to facility policy. R113's CAA dated 9/16/13, indicated R113 was alert, oriented, pleasant, spends much of his time in his room and is visited by psychiatry on a regular basis. R113's current plan of care dated 9/13/13, indicated R113 had history of auditory hallucinations but was currently stable.	F 226		

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F 226	Continued From page 19 R113 had diagnoses that included manic depression and schizophrenia listed on the quarterly MDS dated 5/16/14. The quarterly MDS dated 5/16/14, indicated R113 was cognitively intact. A resident concern report filled out by R113 dated 5/6/14, indicated R113 reported that he is missing his IPAD. R113 reported it was charging in his room below his stereo. On 5/7/14, the report indicated two rooms were checked and R113's brother was called who stated he had not recalled seeing the IPAD during his last visit, but often does not see it when he visits. On 5/14/14, the administrator received an email from the brother indicating Apple (maker of IPAD) had contacted him regarding someone trying to access the IPAD. At this time police and the state agency were notified. An incident report dated 5/14/14, indicated on 5/6/14 R113 had stated that he was not able to find his IPAD prior to a room change that occurred on 5/5/14. Both rooms were searched, a missing item report was completed per policy, but no further report was filed at that time. During an interview on 7/10/14, at 1:34 p.m. the DON stated "I don't recall if I notified the administrator or not, we thought it went missing during the move, I know the administrator was notified on 5/14/14 when it was reported." During an interview on 7/10/14, at 3:00 p.m. the interim administrator stated "I have no idea, I wasn't here." Although the facility was aware of a report of possible stolen property, the facility did not notify	F 226		

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F 226	Continued From page 20 the administrator or State agency immediately as directed by the facility policy. R53 alleged mistreatment and the facility failed to immediately report to the administrator and SA. R53's roommate produced a copy of the report he filed on behalf of his roommate, dated 3/16/14. The roommate said he gave the report to the nurse who gave it to the social worker. The nursing progress notes for R53 were reviewed and lacked any documentation of the event. There were no nursing progress notes recorded for the month of March, 2014. A review of social services notes lacked evidence that the incident had been acknowledged. There was a social services note dated 3/4/14, (prior to the incident) and the next note was dated 5/5/14. The 5/5/14, note indicated the interdisciplinary team met to review current status. The note did not indicate that an incident had been reported. The note did indicate that R53 had a history of irritability with other residents and staff at times. A review of the incident report read, "After listening to the aide and [resident name] yelling at each other (which is what woke me up) [resident name] asked for the supervisor another person came in and they all were yelling!" The copy of the incident was shown to the DON, the interim administrator, and licensed social worker (LSW)-B on 7/10/14, at 4:00 p.m. They verified it was a legitimate facility report form. They explained that the social worker at the time of the incident was no longer employed by the facility and left employment the end of March, 2014. The DON said she was covering for the	F 226		

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F 226	Continued From page 21 social worker at that time, but had not seen the report. The Interim administrator explained that he was not working in the facility at the time of the incident. The interim administrator looked for the report, but was unable to locate it. LSW-B also did not recall discussing the incident and stated, "it appears that it was not brought to the attention of the staff." LSW-B said he had received other concerns from R53's Roommate that have been investigated.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure individual dignity was maintain for 3 of 4 residents (R50, R48, R55) reviewed for dignity in the areas of grooming and bowel and bladder continence. Findings include: R50 on 7/7/14, at 5:00 p.m. and consecutive days of the survey 7/8/14, 7/9/14, and 7/10/14, was observed to have multiple white facial hairs on her lower chin approximately a quarter (1/4) inch long. R50 was not provided care in a manner that promoted dignity. On 7/9/14, at 11:48 a.m. R50 requested to speak with surveyor during the interview R50 stated "I	F 241	1. Resident #50, #48, and #55 are being treated and provided services to promote dignity as relates to grooming and bowel & bladder continence. 2. All residents are being provided care in a manner and environment that maintains their dignity. 3. All staff have been re-educated regarding providing care in a manner that promotes dignity. 4. DON/Designee will audit 5 residents/week to ensure that care is provided in a manner that promotes dignity. Audit results will be reviewed at QPI.	

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F 241	Continued From page 22 came here 2 years ago and I got good care and good nurses upstairs in the TCU [Transitional Care Unit] and when I told them I was going to stay at the facility I was moved down here and it's been a problem to answer my call light and it would take thirty minutes to one hour. I was a nursing assistant [NA] for many years and I was very good to my resident's. The staff are sometimes rough to both residents and even other staff. There is one blonde one who bosses everyone. I feel that all the staff don't do good pericare. They do pericare from back to front and I think I have gotten infections I think from that. I now have become incontinent because I have to wait and every time I have told them something is not right it takes them too long before they can do anything. I have reported incidents of things to registered nurse [RN-A] and she doesn't do anything. I came here a happy person and now am totally depressed. Last Thursday I told a male nurse my heel was hurting and he told me "When I have time I will." When asked about the multiple white facial hairs on her lower chin approximately a quarter (1/4) inch long, R50 stated "They do it once in a great while and it's only some of them as I used to prefer doing it but with the pain I have told them am not able to do it anymore. A lot of residents need a lot of help and it seems like some residents such as [R8] get favors and staff spend a lot of time with her and this is not fair." During the entire conversation tears were rolling down her cheeks and was shaking as she cried. R50's quarterly Minimum Data Set (MDS) dated 6/6/14, Brief Interview For Mental Status (BIMS-tool used to measure cognition) was 15 which indicated intact cognition. In addition the MDS indicated R50 required extensive physical assist of one for toilet use, personal hygiene, had	F 241		

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F 241	Continued From page 23 verbal behavioral symptoms directed towards others and did not exhibit rejection of care. Activities of daily living (ADL) Care Area Assessment dated 3/27/14, identified R50's diagnoses included diabetes mellitus, congestive heart failure (CHF), obesity, peripheral neuropathy, depression and Chronic obstructive pulmonary disease (COPD). CAA indicated R50 needed assist of one to two staff for bed mobility, transfers, and assist of one staff for toileting, hygiene and bathing. In addition, CAA indicated R50 was resistive to assistance at times and was non-compliant at times with treatment. Review of Progress Notes dated 6/4/14, through 7/10/14, revealed refusal for cares/removal of facial hair had not been documented. During review of June 2014 through July 2014, Treatment Administration Record (TAR's) it was revealed weekly skin check on bath day was blank and had been completed once on 7/6/14, respectively for both months. The medical record lacked evidence of the refusal to remove the facial hair. When interviewed on 7/10/14, at 2:35 p.m. licensed practical nurse (LPN)-C stated after verifying R50 had several facial hairs she expected the NAs to offer to remove the facial hair even though R50 preferred to remove it and if she refused to let the nurse know to document as female facial hair can be a dignity concern. R48 on 7/7/14, 3:54 p.m. was questioned if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R48 stated "About	F 241		

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TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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F 241	Continued From page 24 three weeks ago I had to call for help and the aide came in and I told them I needed my bandages changes because they were soiled and the aide told me the nurse was outside but would not come in and I started begging the aide to them off as I don't want them to be infected and the aide told me "NO" the nurse had to do them." R48 further stated NA-I was working "This was from 11:00 p.m. to 1:30 a.m. I prefer a female nurse and aide but they have told me they don't guarantee that and I have no problem with a male staff giving me my medications but its only for wound care and changing my soiled pad I just would prefer a female staff. Sometimes I feel they think I refuse cares or staff." R48 was crying the whole time when explaining to surveyor with tears rolling down her checks. R48 stated she had talked to her family and was told there was no good nursing home out there and just had to settle with what was going on and compliment the staff when they did good. R48 was not provided care in a manner that promoted dignity. R48's admission 14 day MDS dated 6/10/14, indicated cognition was intact and required extensive physical assistance of two staff with toileting, transferring, bed mobility, dressing, personal hygiene and used a wheelchair for mobility. In addition, the MDS indicated R48 had delusions and exhibited rejection of care but did not have any behavioral symptoms. R55 on 7/7/14, at 4:43 p.m. was asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R55 stated "They are short, they complain among themselves....I will	F 241		

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F 241	Continued From page 25 put the light about 6 p.m. and they came between 9:00 and 9:30 p.m., it happens every now or then it's not every day. I understand the problem they have, the girls really are overworked with their workload. I don't want to make a big deal about it....It has happened, can't tell you when it happened. I messed my pants up and it took them a couple hours to get here...they got here as fast as they could sometimes they are really slow responding to the call light." R55 was not provided care in a manner that promoted dignity. R55's quarterly MDS dated 6/6/14, indicated cognition was intact and required extensive physical assistance of one to two staff with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. Additionally, the MDS indicated R55 neither had behavior symptoms nor rejected care. When interviewed on 7/10/14, at 7:11 a.m. LPN-A stated all the shifts vary but with regarding night shift the lifting can be hard especially when working on Garden Terrace as one of the NA's went to the 2nd floor to assist with rounds and LPN-A had to sometimes "I just prioritize what to do first for example if I had a resident asking to go to the bathroom and another asking for a pill, I have to attend to the pain concern and have the other resident wait and I feel really bad and have to apologize for having them wait."	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and	F 246		

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F 246	Continued From page 26 preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R8, R7) reviewed for environmental concerns, had their call lights kept in reach. Findings include: R8's call light was not at reach. On 7/8/14, at 12:07 p.m. R8's call light was observed clipped to top of cord hanging behind bed as R8 sat on her electric wheelchair parked on the space between the two bed in her room facing the head of bed. When asked if she was able to reach the call light at the current position, R8 stated, "I cannot reach the call light and the pain is killing me" -At 12:12 p.m. nursing assistant (NA)-H verified placement of call light, then reached over behind the bed grabbed the call light and clipped it to the bedding where R8 was able to reach it then asked R8 "Is that all you need [R8]?" and left. R8's Fall/Injury Assessment: Prevention And Management Plan of Care dated 5/14, identified R8 was at risk for falls related to pain, poor weight bearing, weakness, bowel and bladder incontinence. Goal "Will be free of a serious injury if fall would occur." Care plan directed "Keep frequently used items within reach, (call light...)"	F 246	1.Resident #7 & #8 have their call lights within reach. 2. All residents have call lights within reach/available. 3.Staff have been re-educated regarding call light placement. 4.DON/Designee will audit 5 residents/week to ensure appropriate call light placement. Results of audits will be reviewed at QPI.	

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F 246	Continued From page 27 R8's Minimum Data Set (MDS) dated 6/5/14, indicated R8's Brief Interview For Mental Status (BIMS-tool used to measure cognition) was 15 which indicated intact cognition. R7's call light was not accessible. On 7/7/14, at 3:30 p.m. R7's call light was observed on the floor behind the bed not in reach during room observation. During consecutive survey days on the following dates and times R7's call light was observed still behind the bed on the floor and not accessible: - On 7/8/14, from 8:00 a.m. until approximately 4:00 p.m., - On 7/9/14, from 7:15 a.m. until 3:30 p.m.; and - On 7/10/14, at 6:35 a.m. R7 was observed lying on his bed with call light still on the floor behind the bed. R7's MDS dated 5/8/14, indicated R7's BIMS was 15 which indicated intact cognition. The Care Area Assessment (CAA) for Falls dated 12/26/14, identified R7 was, "At risk for falls related to impaired balance during transitions, seizure disorder, pain, and [R7] used walker for ambulation ..." The Fall/Injury Assessment: Prevention and Management Plan of Care dated 12/13, identified R7 was at risk for fall/injury related to history of falls, exhaustion, weakness only at times secondary to post dialysis, and pain. The Goal directed, "Will be free of a serious injury if a fall would occur." The care plan directed staff to "Keep frequently used items within reach (Call	F 246		

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F 246	Continued From page 28 light.)" On 7/10/14, at approximately 12:37 p.m. during the tour when asked if call lights needed to be at reach for residents that were able to use them, the regional director of operations stated "Yes, the call light should be within reach." When interviewed on 7/10/14, at 3:10 p.m. the director of nursing stated her expectation was all resident call lights were supposed to be at reach at all times. Physical Environment policy revised July 2013, directed "Assure an applicable working system is in place and within reach for the resident to summon assistance, including, but not limited to: Typical call light with cord."	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure housekeeping and maintenance services necessary to maintain an odor free, orderly and sanitary environment were provide for 9 of 85 residents, (R115, R88, R121, R145, R66, R62, R21, R8) reviewed for environmental concerns. Findings include:	F 253		

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F 253	Continued From page 29 On 7/10/14, at 12:37 p.m. an environmental tour was conducted with the administrator, house-keeping manager (HKM), regional director of operations (RDOP) and maintenance assistant (MA). The following concerns were identified: Odors R115's and R88's shared bathroom was not kept free of pervasive odors. On 7/7/14, at 3:11 p.m. during room observation the toilet bowl was noted to be dirty with brownish matter on top and the inside of bowl and the bathroom had a very strong malodorous smell. R115's quarterly Minimum Data Set (MDS) dated 4/13/14, indicated R115 was occasionally incontinent of bladder; was continent of bowel and his cognition was severely impaired. R88's quarterly MDS dated 6/1/14, indicated R88 was frequently incontinent of bowel and bladder and cognition had not been assessed. During tour RDOP stated "It's down dirty" and the verified the smell. R121's bathroom was kept in ill repair and not free of pervasive odors. On 7/7/14, at 5:26 p.m. during room observation brown stains/substance was noted around the base of the toilet, cracked tile was observed on the right of the toilet and the bathroom had a malodorous smell. R121's quarterly MDS dated 5/23/14, indicated R121 was continent of bowel; occasionally	F 253	1.Housekeeping & Maintenance services have been provided to resident #115, #88, #121, #145, #66, #62, #21, and #8. 2.All residents areas are receiving housekeeping and maintenance services to ensure an odor free, orderly and sanitary environment. 3.All staff have been re-educated regarding environment and procedure to address any concerns noted. 4.NHA/Designee will audit 5 rooms/week to ensure an odor free, orderly and sanitary environment. Results of audits will be reviewed at QPI.	

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F 253	Continued From page 30 incontinent of urine and had intact cognition. During the tour RDOP verified the smell in the bathroom, stated it was the corking peeling off and verified the cracked tile to the right of the toilet. R145's toilet bowel was kept in ill repair. On 7/7/14, at 5:47 p.m. during room observation the tile at the base of the toilet was noted to be brown, wet and appeared to be dirty. During the tour HKM verified the caulk was coming off causing the brownish color. R145's quarterly MDS dated 4/22/14, indicated R145 was continent of bowel and bladder and was cognitively intact. R66's bathroom and room walls were kept in ill repair. On 7/8/14, at 9:43 a.m. during room observation the wall behind R66's bed was noted to have a large white patch which appeared unpainted, the bottom of the bathroom archway door was observed to be heavily scraped up. During the tour the RDOP verified the archway and the wall was "Buckled;" RDOP indicated a bariatric wheelchair had went through the door. R66's quarterly MDS dated 4/1/14, indicated R66 had moderately impaired cognition, required extensive physical assistance of two staff with toileting, personal hygiene, locomotion in the unit,	F 253		

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F 253	Continued From page 31 transfers and bed mobility. In addition the MDS indicated R66 used a wheelchair for mobility. R62's bathroom was kept in ill repair. On 7/8/14, at 2:35 p.m. during room observation R62's bathroom sink caulking next to the wall was observed to be peeling off, creating a hole; behind the toilet a hole was observed approximately 2.5 centimeters (cm) by 2.0 cm through the sheetrock. During the tour RDOP verified the findings stated the caulking was coming off the sink. And behind the toilet indicated it was the sheetrock that was exposed and needed to be fixed. R62's MDS dated 5/8/14, indicated R62 had intact cognition, required extensive assistance of two staff with activities of daily living (ADL's) and used both the wheelchair and walker for mobility. R21's bathroom, room entrance and closet doors were kept in ill repair. On 7/8/14, 10:23 a.m. during room observation the archway to bathroom was observed scraped with chipped paint, the inside of entrance room door was scraped across the middle and the first closet door to the left was observed to have jagged edges at calf length. During the tour the MA verified the findings including the jagged edges of the closet door. HKM stated he though the scrape on the door was caused by R21's electric wheelchair. When asked if there was a preventative maintenance	F 253		

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F 253	Continued From page 32 program to address the doors, MA stated "Yes." Copies were requested, but not provided. R21's annual MDS dated 6/12/14, indicated both long and short term memory were "OK", R21 required extensive assistance with toileting and personal hygiene and used a wheelchair for mobility. Garden Terrace Tub room/Toilet Shared toilet/Tub room was not kept free of odors. When asked if the building was clean R8 stated "The big shower down here, the floor was atrocious, you can see a band aid used from a resident lying on the floor." and, "There has been mold in it in the corners, told activities about it at resident council meetings." All facility staff present during the tour verified the pervasive odor and stated the malodorous smell was urine. HKM stated the bathroom was cleaned daily and provided a work order dated 5/14/14, when the Tub room/Toilet had last been cleaned. R8's MDS dated 6/5/14, indicated R8 had intact cognition. Physical Environment policy revised July 2013, directed weekly rounds to be conducted with housekeeping manger to include resident's rooms. The policy additionally directed findings to be documented, results to be tracked and trended from the tours, reviewed at the Quality Performance Improvement monthly meetings with the team to establish the root cause and subsequent plan of correction.	F 253		

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F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R191) reviewed for environmental concerns had the room maintained in a comfortable temperature. Findings include: On 7/7/14, at 2:45 p.m. during interview when asked if anything affected his comfort R191 stated, "I wish I had control of the temperature in the room. Am definitely cold in here. I understand am still not strong enough but I am not usually this cold for a long time and all the time at times." Room felt cool at the time of interview and R191 was observed seated on his wheelchair watching television wearing a woolen sweater and had a blanket wrapped around his legs. R191 stated, "I have reported to several staff but nothing has been done yet." R191's recent hospital information from HCMC dated 6/15/14 and 6/22/14, noted R171 had a hemoglobin (HGB) of 8.1 grams/deciliter (gms/dl) on 6/15/14 and 9.4 on 6/22/14. (Normal Men's HGB after middle age: 12.4 to 14.9 gm/dL). The Discharge Orders and Information sheet dated 6/25/14, from Hennepin County Medical	F 257	1.Room in which resident #191 is residing in is within 71 to 81 degree temperature range at all times. 2.All resident rooms will be within 71 to 81 degrees at all times. 3.All staff have been re-educated regarding reporting resident concerns of room temperatures. 4.NHA/Designee will audit 5 rooms/week to ensure all rooms are within the scope of temps. Results will be reviewed at QPI.	

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F 257	Continued From page 34 Center (HCMC) noted R191 had received a new diagnosis of hypothermia (a condition in which the body's core temperature drops below that required for normal metabolism and body functions) on 5/19/14, and R191 was admitted with pneumonia along with hypothyroidism (thyroid hormones help regulate your body metabolism). R191's diagnoses included diabetes mellitus type II, cerebrovascular accident (CVA) and muscle weakness obtained from discharge Minimum Data Set (MDS) dated 6/20/14. In addition, the MDS indicated R191's Brief Interview For Mental Status (BIMS-tool used to measure cognition) was 13 which indicated intact cognition. Psychosocial Well-Being Care Area Assessment (CAA) dated 6/25/14, identified R191 was alert and oriented and was able to communicate his needs and directed his care. R191's Associated Clinic of Psychology Progress Notes dated 6/26/14, revealed a comment under Treatment Plan: "It will be important to work with client on room temperature to increase client's sense of trust of the facility and his sense that his needs can be met." R191's Progress Notes revealed an Interdisciplinary Team (IDT) re-admission review to the facility from the hospital note dated 6/26/14. The note was signed by several staff including the licensed social worker (LSW)-A, LSW-B, director of nursing (DON) among others at the bottom. The note indicated R191 had made a complaint about being "Cold..." and the documented intervention was "Hot chocolate and	F 257		

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F 257	Continued From page 35 warm pack to (L) [left] hand @ HS [at bedtime] which is coldest..." During further review of the Progress Notes it was revealed the complaint of being cold was never followed up on or addressed in the care plan to ensure R191 was comfortable in his room. Cognitive Assessment/Plan Of Care dated 6/14, identified R191 as being alert and oriented to person, place and time, and had intact cognition or mild impairment. On 7/10/14, at 12:10 p.m. during the tour the door to R191's room was observed to be wide open and when the temperature was checked the reading was 72 degrees Fahrenheit (°F), but when asked by corporate regional director of operations (RDOP) about the temperature comfort, R191 stated, "It is freezing especially at night and last night the guy that came in to straight cath [catheterize] me, he even said it was chilly in here. I will really appreciate if it's fixed." RDOP stated, "We will make sure it's taken care of." According to www.webmd.com the symptoms of hypothyroidism are coarse and thinning hair, dry skin, brittle nails, a yellowish tint to the skin, slow body movements, cold skin, inability to tolerate cold, feeling tired, sluggish, or weak, memory problems, depression, or problems concentrating, and constipation.	F 257		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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F 272	Continued From page 36 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the nutritional status for 1 of 3 residents	F 272	1.Resident #118 has had comprehensive nutritional assessment noting her self limiting diet. The MD has reviewed her hgb which is at baseline and trending upward. 2.Dietician has been re-educated regarding comprehensive assessments for residents with self limiting diet and intake. All staff have been re-educated regarding documentation of intake, appropriate utilization of tray cards, and appropriate communication of self limiting diet behaviors. 3.Dietician/Designee to audit 5 residents per week to ensure a comprehensive assessment, that residents' meal offerings include receiving diet per their meal card, MD orders, and plan of care, and to ensure that meal intake is accurately recorded.	

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F 272	Continued From page 37 (R118). Findings include: R118 was observed at lunch on 7/9/14, from 12:15 p.m. until 1:45 p.m. She received a meal of two slices of white bread, a scoop of mashed potatoes, a 4 ounce (oz) yogurt, 8 oz glass of milk and a 6 oz glass of apple juice. R118 proceeded to cut the crust off the bread and spread the remaining bread with margarine. She then put a small piece of bread in her mouth, took a drink of milk, held her napkin to her mouth and held the milk and bread in her mouth for a while and then chewed a bit and swallowed. She repeated this procedure with each bite of bread. She pushed the yogurt container away. After finishing the bread she ate the potatoes, taking a sip of juice after each bite. She appeared physically tired with some heavy breathing, sighs and quivering of lips. By 1:45 p.m. she had finished the bread, potatoes and beverages, but not the yogurt. R118 was interviewed on 7/10/14, at 9:00 a.m. R118 was asked if her mouth hurt. She did not answer but showed her tube of Polident. R118 was wearing an upper denture and had no bottom teeth. R118 was asked if she had pain. R118 replied, "I'm very sick, pain all over here and here and here" as she pointed to her mouth shoulders and body. When asked about eating vegetables, R118 said, "can't eat, only bread. " R118 then demonstrated how she would take a drink of milk and hold in mouth to make bread soft. She was served two pieces of white bread, a boiled egg, milk and juice for the breakfast meal. The annual nutritional review dated 9/12/13, indicated R118 continued to tolerate her altered	F 272		

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F 272	Continued From page 38 texture diet and nutritional supplements to maintain weights, and that meal and supplement intake was adequate to meet established needs as evidenced by a stable weight. Sores in the mouth were noted to be improving via reference to a nurse practitioner note dated 5/19/13. The analysis of finding for the annual Minimum Data Set (MDS) and Care Area Assessment CAA) for nutrition, dated 9/16/13, read, "Increased nutrition risk secondary to anemia, CVD [coronary vascular disease], pain r/t [related to] pemphigus [a skin disorder], chewing difficulty and hx [history] of weight loss." The assessment lacked any indication R118 might be at nutritional risk due to a self-limited diet that excluded basic food groups. A quarterly Nutrition Note dated 2/10/14, indicated a hemoglobin level (a measure of iron in the blood) of 10.9 g/dl (grams per deciliter) and was indicated to be below normal levels. A medical visit note dated 6/3/14, indicated R118 had hemoglobin of 9.2 g/dl. The medical note did not specifically address the low hemoglobin. A Nutrition Note dated 6/25/14, indicated, "[R118] Eats 88/89% avg. of meals/ snacks over past 30 days-adequate." The most recent quarterly nutritional assessment dated 5/20/14, read, "Resident tolerating current diet well per nsg [nursing]." The note went on to explain food intake for R118 was 73% of meals and 50-100% of mighty shakes (a nutritional supplement). Intake was assessed to be 1754 calories and 73 grams of protein "more than optimal to meet needs. " Copies of the meal tickets for R118 were obtained	F 272		

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F 272	Continued From page 39 from the facility on 7/10/14, at 3:30 p.m. and reviewed. The tickets listed breakfast: hot tea with three sugar, milk, juice and bread times two, with special instructions to offer a boiled egg, yogurt and cottage cheese; lunch: hot tea with three sugar, milk, juice, two slices of bread, butter and yogurt; dinner: hot tea with three sugars, milk, juice, two slices of bread with butter. Registered Dietitian (RD)-I was interviewed on 7/10/14, at 1:00 p.m. The weekly meal intake records were reviewed. R118 was listed as consuming an average of 90% of meals for the week. RD-I stated she would assume if 90% of the meal was recorded for an intake, it would be 90% of the entire regular meal for the day as listed on the menu. She verified the assessed protein and calorie intake (per nutrition assessment dated 5/20/14) appeared to be incorrect for an intake of only bread and a few other items. Dietary employee (DTY)-A was interviewed on 7/10/14, at 1:30 p.m. He stated R118 had been eating the same meal of two pieces of bread "for years." DTY-A stated she "never" ate the yogurt and showed how he had just thrown it away from the lunch meal. DTY-A explained R118 was served according to her meal ticket. At 2:00 p.m. nursing assistant (NA)-H stated she was aware R118 was eating only bread, milk and juice for as long as she had been employed, which was one year. A facility policy titled Admission Nutrition Assessment, Intervention, Evaluation and Ongoing Nutrition Monitoring Documentation, and dated April 2012, was reviewed. The policy read, "A complete comprehensive assessment will be	F 272		

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F 272	Continued From page 40 used defining nutritional status using medical diagnosis; nutrition; medication histories; clinical observations; anthropometric measurements; and laboratory data. This data will be used to determine nutrition related problems, causal factors, and significance along with nutrition interventions. Progress will be monitored periodically and at least quarterly to measure and evaluate desired outcomes and need for changes in the nutrition interventions."	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 280	1. Resident #62 care plan has been updated with restorative recommendations after being reviewed by therapy to identify current restorative needs. 2. All residents with restorative plans have had care plan reviews and updated as needed. 3. Appropriate nursing staff re-educated regarding care planning and revisions of restorative programs. 4. ETD/Designee to audit 5 residents per week to ensure appropriate care plans for restorative programs. Audit results will be reviewed at QPI.	

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F 280	Continued From page 41 review, the facility failed to revise the care plan for 1 of 1 resident (R62) reviewed for restorative nursing. Findings include: On 7/8/14, at 2:38 p.m. R62 stated to surveyor, "There sits a lady, she lives down the hall, she has a big strong power chair, when my chair stops it almost automatically goes backwards, I fell asleep a little bit, and she hit me in the back with her chair twice in my injury, and she yelled at me and said 'I don't care where your injuries are, you better move out of the way.' I move, she moves, I move, she moves and yesterday and the day before, she threatened me again saying 'If I stay in the middle of the room she will hit me again, she is very, very mean." R62 stated, "I cannot move out of the way." On 7/9/14, at 10:12 a.m. R62 was observed being pushed in her wheelchair by staff to the large dining room from the small dining room. On 7/9/14, at 2:10 p.m. R62 was observed sitting in her wheelchair (w/c) alone in the small dining room with her feet barely touching the floor and slouched down in w/c. R62's w/c was observed to have no side wheels for the hands to move w/c. During interview on 7/9/14, at 1:41 p.m. R62 stated, "I just wait for staff to come in the dining room or I shout their name and ask to get some help from them." R62 stated, "I feel like a cripple when I have to just sit in the dining room and wait for someone to happen to come and find me in here. I get worried" and "it's too hard to move my chair with my feet because of my right hip. I get	F 280		

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F 280	Continued From page 42 tired a little bit, I have been sitting in here since 12:20 p.m., I lay down after lunch. I go backwards in my chair, I can't go forwards. I turn and watch for staff to walk by in the hall and yell at them for help and I still sit here. I already told them I want a different w/c, but they said, try it out, try it out. When I came to this facility I walked without help, they put me in a w/c right away, was more independent before coming here, been here almost a year." On 7/10/14, at 9:30 a.m. R62 was observed seated in her w/c alone in the small dining room, left foot on floor and half of right foot on the floor. -At 9:55 a.m. R62 was observed sitting in w/c in small dining room alone feet touching floor. Care plan dated 9/20/13, listed diagnoses of lumbar back pain, depression and fibromyalgia. The care plan also indicated R62 was easily fatigued and had generalized weakness. R62's care plan dated 9/20/13, indicated R62 mobility deficit and the care plan indicated interventions were "integrated with restorative nursing." However, the integration of the R62's restorative therapy recommendations were not care planned after occupational therapy (OT) was completed on 5/14/14. The quarterly MDS dated 5/8/14, indicated R62 had intact cognition with a score of 14 on the BIMS, indicating R62 was cognitively intact. Therapy Recommendations dated 5/14/14, under Mobility/Positioning, Reposition to upright sit and encourage using feet to propel forward. Wheelchair adaptation checklist dated 5/15/14, indicated R62's w/c Reclining Back should be	F 280		

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F 280	Continued From page 43 70-80degrees Preferred Resting Angle and 90 degrees Preferred Dining Angle for R62 when in w/c. Multi-Disciplinary Therapy Screening Tool dated 5/27/14, read for R62 OT seen 4/11/14 through 5/16/14. Restorative nursing program (RNP) established to maintain lower extremity strength, promote self-propulsion in w/c, and ensured adequate positioning in w/c. During interview on 7/10/14, at 7:56 a.m. with Restorative Nurse registered nurse (RN)-F stated on 5/14/14, therapy gave her recommendations for R62 after discharged from therapy services and to be picked up by the restorative program. RN-F stated she talked with the unit manager regarding therapy recommendations for R62 when discharged from therapy. RN-F stated R62 had already had two to three restorative programs for the nursing assistants to attend to with R62 and therefore had not added therapy's recommendations for R62 to the restorative program to the lower extremities. RN-F stated R62 used to tip or fall out of her old w/c and the chair R62 now had been the safest chair so far. RN-F stated R62 knew what to do, but cannot quite do it, R62's brain to feet is slow, cognitively long to process to be able to use feet." RN-F also stated she was not aware of R62's feet observed not touching the floor while sitting in present w/c. RN-F stated she could retrain staff regarding therapies recommendations for R62 and add R62 to the restorative program regarding that. During interview on 7/9/14, at 10:30 a.m. with Occupational Therapist/Director of Rehabilitation she stated no staff had asked her to reassess R62's positioning and/or wheelchair (w/c). OT	F 280		

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F 280	Continued From page 44 stated in therapy in May, R62 could move her w/c and at times it was hard for R62 to initiate movement based on her diagnoses. She also stated the facility had submitted to a local vendor regarding a different w/c for R62 and there was no money for R62 to purchase a new w/c. - At 1:15 p.m. nursing assistant (NA)-J stated R62 mostly asks staff to push her w/c as R62 had a hard time moving her w/c with one sore arm. NA-J was unaware of R62's w/c ability to be adjusted to tilt back or forward or ability to lower resident's feet to touch the floor. NA-J stated she had never seen any NA adjust or tilt R62's w/c. - At 1:30 p.m. LPN-C stated R62 used to lean and slide out of her previous w/c. - At 2:01 p.m. NA-C stated R62 needs two staff assist to walk, guide her, and R62 used to walk way more and way better. NA-C stated R62 complains pain in her right arm, and also stated a male resident who was no longer here would go fast last month and bump into her and other residents. NA-C stated she would quickly move residents out of his way. On 7/10/14, at 9:01 a.m. unit manager RN-A stated "I asked for an inservice, to retrain how to utilize the chair [R62's w/c] until we find something different." It will be done today with occupational therapy, and maybe more pain could be the root cause for R62 unable to move her w/c. The w/c R62 had now was meant to help by tilting with off-loading, and kind of help with positioning. - At 2:10 p.m. Occupational Therapist stated therapy had worked with R62 on sit to stand, gait pattern and had tried different chairs with R62 in the past and four times since last September worked with R62 with w/c positioning and mobility. The occupational therapist stated after	F 280		

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F 280	Continued From page 45 discharged R62 from therapy occupational therapy had worked with restorative nursing and gave recommendations. Occupational Therapist also stated therapy had completed staff training with nursing staff regarding R62's positioning while in w/c, and staff being able to tilt and adjust R62's w/c so R62's feet are on the floor, and for staff to encourage R62 to propel forward in her w/c with her feet only as there are no hand wheels on R62's w/c for R62 to utilize with her hands to help move w/c.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 resident (R7) for dialysis dressing removal, monitoring intakes and listening and palpitating the access site. In addition failed to provide facial hair removal for 1 of 3 residents (R50) observed for activities of daily living (ADLs). Findings include: R7 was not provided grooming according to the care plan. On 7/9/14, at 6:57 a.m. R7 was observed seated	F 282	1. Resident #7 and #50 are receiving services per their plan of care. 2. All residents are receiving services per their plan of care. 3. All staff re-educated to follow care delivery guides and plan of care for all residents. 4. DON/designee to audit dialysis MARs and TARS 1 time per week and audit 5 residents per week to ensure residents are receiving care per their plan of care. Audit results will be reviewed at QPI.	

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F 282	Continued From page 46 on his wheelchair all dressed, propelling around the dining room (DR) and nursing station with headphones on. R7 was observed to also read a novel. R7's spot in the DR was observed to have a food tray. -At 7:09 a.m. licensed practical nurse (LPN)-D stated after going through R7 breakfast tray he had consumed 85% of the meal and approximately 400 milliliters (ml) of cranberry, milk and water for his intake. On 7/10/14, at 7:45 a.m. R7 was observed propelling his wheelchair out of his room dressed in a short sleeved checked blue shirt which exposed a small portion of what appeared to be dressing covering the right upper forearm. R7 came down towards LPN-C who was standing at the medication cart parked right outside the nursing station and indicated he had pain to his right knee. R7 requested to have some Bengay (an analgesic heat rub used to relieve muscle and joint pain). On 7/10/14, at 2:35 p.m. R7 was observed to have gauze secured with paper tape on his right forearm access site. When interviewed on 7/9/14, at 7:05 a.m. about how dialysis was going. R7 stated dialysis was going well except for the pain he was experiencing to his left shoulder/arm area, but was getting pain medications and Lidocaine cream (a topical anesthetic) and at times ice "which helped." When asked if the staff removed his dressing after dialysis, R7 stated the staff would remove it before going to bed at times and when he showered they would change it for him. Regarding if staff checked for the bruit/thrill, R7 stated he was not sure. In addition when asked	F 282		

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F 282	Continued From page 47 about if he was familiar with his fluid restriction R7 stated he was aware of his diet and fluid restrictions and thought the fluid restriction was "One Liter." The Hemodialysis Plan of Care dated 12/13, identified R7 had access device on his right forearm, and another wall access site on left upper wall. Plan of care indicated R7 had alteration in renal function evidenced by edema to hands... Goal "Will have patent dialysis access site as evidenced by bruit and thrill." Plan of care directed staff to remove band aid from access site the evening of dialysis, monitor for bruit and thrill daily and record on treatment administration record (TAR). In addition, R7's Nutrition Risk Care Plan dated 12/20/13, indicated R7 was on a 1,500 ml fluid restriction and directed staff to monitor fluid intake on Medication Administration Record (MAR). Nutritional Status Care Area Assessment dated 12/23/13, indicated R7 was at increased nutritional risk secondary to ESRD (end stage renal disease), with HD (hemodialysis). R7's Physician's Order dated and signed 7/9/14, indicated R7 was on a 1500 ml fluid restriction. Review of the July 2014, Medication Administration Record (MAR) revealed R7 had two different instructions written on two flow sheets on the fluid intakes and both were being filled out by the nurses. Both flowsheets indicated nurses were not consistently recording R7's intakes. In addition, one of the MAR's had an order for Nepro (therapeutic nutrition specifically designed to help meet the nutritional needs of patients on dialysis) 240 ml daily every evening (a nutritional supplement) which had only been	F 282		

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F 282	Continued From page 48 recorded twice since the beginning of the month. Review of the July 2014, treatment Administration Record (TAR) and MAR lacked documentation on monitoring of the bruit and thrill. On 7/10/14, at 2:01 p.m. RN-A verified R7's intake was not being consistently recorded and had a lot of missing data with two different sheets in the MAR used to record the intakes with different directions on the amount to offer each period of day. RN-A stated the nurses were supposed to record everything including even "Jell-O and popsicles" as R7 was on a fluid restriction and was going to clarify the fluid amount discrepancy. -At 2:07 p.m. RN-A was overheard asking LPN-C where she recorded R7's intakes and LPN-C replied, "I actually have been recording on both sheets." When interviewed via phone on 7/10/14, at 2:15 p.m. dialysis registered nurse (DRN) stated R7's runs were pretty good, coordination with the facility and communication was good and there was constant back and forth exchange of information. When asked what the dialysis center expected of the home in respect to recording fluid intake, fluid restrictions, monitoring for the bruit and thrill and removal of the dressing after dialysis, DRN stated, "We want the patient to receive less than 1.5 liters, but know he doesn't gain a lot. Also when he returns from dialysis the dressing should be removed four hours after and the nurses are supposed to check the brult and thrill on days he doesn't come for dialysis as we check it when he comes for dialysis." When asked what would happen if the dressing was not removed DRN stated it when the dressing was left in place they can cause the site to clot or	F 282		

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F 282	Continued From page 49 cause an infection to the fistula. On 7/10/14, at 2:36 p.m. RN-A unit manager stated checking bruit/thrill was supposed to be in the TAR for nurses to monitor and listen to and stated the dressing should have been removed as directed by dialysis. RN-A further stated she was going to make sure the documentation was added to the TAR. On 7/10/14, at 2:39 p.m. registered nurse (RN)-B verified R7's dressing was still on from the previous day 7/9/14, when he had dialysis stated the dressing was supposed to have been removed the previous day after dialysis. R7 stated "I was at the facility last evening and no one removed them." RN-B then removed the dressing area noted to be intact with no signs and symptoms of infection and a small amount of dried blood noted on the gauze. After removing the gauze with tape a drop of blood was noted and RN-B applied two regular band aids to area and no further bleeding. On 7/10/14, at 2:44 p.m. RN-B verified the TAR lacked documentation for checking the thrill and bruit, stated it was supposed to be checked daily and was going to add it. On 7/10/14, at 3:09 p.m. the director of nursing (DON) stated her expectation was to follow dialysis instructions, care plan and physicians order for R7's dialysis needs/care. R50 was not provided grooming according to the care plan.	F 282		

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	245187	A. BUILDING _____ B. WING _____	C 07/10/2014

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F 282	Continued From page 50 On 7/7/14, at 5:00 p.m. and consecutive days of the survey 7/8/14, 7/9/14, and 7/10/14, R50 was observed with multiple white facial hairs on her lower chin approximately a quarter (1/4) inch long. On 7/9/14, at 11:48 a.m. R50 requested to speak with surveyor during the interview R50 stated "I came here 2 years ago and I got good care and good nurses upstairs in the [Transitional Care Unit] TCU and when I told them I was going to stay at the facility I was moved down here and it's been a problem to answer my call light and it would take thirty minutes to one hour. I was a nursing assistant for many years and I was very good to my resident's. The staff are sometimes rough to both residents and even other staff. There is one blonde one who bosses everyone. I feel that all the staff don't do good pericare. They do pericare from back to front and I think I have gotten infections I think from that. I now have become incontinent because I have to wait and every time I have told them something is not right it takes them too long before they can do anything. I have reported incidents of things to registered nurse [RN-A] and she doesn't do anything. I came here a happy person and now am totally depressed. Last Thursday I told a male nurse my heel was hurting and he told me "When I have time I will." When asked about the multiple white facial hairs on her lower chin approximately a quarter (1/4) inch long, R50 stated "They do it once in a great while and it's only some of them as I used to prefer doing it but with the pain I have told them am not able to do it anymore. A lot of residents need a lot of help and it seems like some residents such as [R8] get favors and staff spend a lot of time with her and this is not fair." During the entire conversation tears were rolling	F 282		

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F 282	Continued From page 51 down her cheeks and was shaking as she cried. R50's quarterly Minimum Data Set (MDS) dated 6/6/14, Brief Interview For Mental Status (BIMS-tool used to measure cognition) was 15 which indicated intact cognition. In addition MDS indicated R50 required extensive physical assist of one for toilet use and personal hygiene. R50's diagnoses included diabetes mellitus, congestive heart failure (CHF), obesity, peripheral neuropathy, depression and Chronic obstructive pulmonary disease (COPD). ADL/Mobility Care Plan with readmit date 3/12/14, identified R50 had the potential or actual ADL/mobility deficit related to arthritis, polyarthritis, backache, and senile osteoporosis. Care plan goal "Will be neat, clean and well groomed daily." Although the care plan indicated R50 had long facial hair which she shaved when she decided and preferred to manage the facial hair; the ADL Care Area Assessment (CAA) dated 3/27/14, had indicated she needed assist of one to two staff for bed mobility, transfers, and assist of one staff for toileting, hygiene and bathing. In addition, the CAA indicated R50 was resistive to assistance at times and was non-compliant at times with treatment but, review of Progress Notes dated 6/4/14, through 7/10/14, revealed refusal for cares/removal of facial hair had not been documented. During review of June 2014 through July 2014, Treatment Administration Record (TAR's) it was revealed weekly skin check on bath day was blank and had been completed once on 7/6/14, respectively for both months and the medical record lacked refusal to remove the facial hair.	F 282		

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F 282	Continued From page 52 When interviewed on 7/10/14, at 2:35 p.m. licensed practical nurse (LPN)-C stated after verifying R50 had several facial hairs she expected the nursing assistant (NAs) to offer to remove the facial hair even though R50 preferred to remove it and if she refused to let the nurse know to document as female facial hair can be a dignity concern.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 resident (R7) for dialysis dressing removal, monitoring intakes, listening and palpitating the access site. Findings include: R7 was observed seated on his wheelchair on 7/9/14, at 6:57 a.m. all dressed propelling around the dining room (DR) and nursing station with headphones on as he was read a novel. R7's spot in the DR was observed with a food tray. - At 7:05 a.m. R7 stated dialysis was going well except for the pain he was experiencing to his left	F 309	1. Resident #7 is receiving services per the plan of care. 2. All dialysis residents will be receiving services per their plan of care. 3. Residents with dialysis will have MARS and TARS reviewed 1X per week. 4. All licensed nursing staff re-educated regarding dialysis care planning. 5. DON/designee to audit dialysis MARS and TARS to ensure appropriate care is being provided. Results of audit will be shared at QPI.	

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F 309	Continued From page 53 shoulder/arm area but was getting pain medications and Lidocaine cream (a topical anesthetic) and at time ice which helped. When asked if the staff removed his dressing after dialysis R7 stated the staff would remove it before going to bed at times and when he showered they would change it for him. Regarding if staff checked for the bruit/thrill, R7 stated he was not sure. In addition when asked about if he was familiar with his fluid restriction R7 stated he was aware of his diet and fluid restrictions and thought the fluid one was "One Liter." -At 7:09 a.m. licensed practical nurse (LPN)-D stated after going through R7 breakfast tray he had consumed 85% of the meal and approximately 400 milliliters (ml) of cranberry, milk & water for his intake. On 7/10/14, at 7:45 a.m. R7 was observed propelling his wheelchair out of his room dressed in a short sleeved checked blue shirt which exposed a small portion of what appeared to be dressing covering the right upper forearm. R7 came down towards LPN-C who was standing at the medication cart parked right outside the nursing station and indicated he had pain to his right knee and requested to have some Bengay (an analgesic heat rub used to relieve muscle and joint pain). - At 2:35 p.m. R7 was observed to have gauze secured with paper tape on his right forearm access site. R7's Nutritional Status Care Area Assessment dated 12/23/13, indicated R7 was at increased nutritional risk secondary to end stage renal disease (ESRD) and was on hemodialysis (HD). Hemodialysis Plan of Care dated 12/13, identified R7 had access device on his right forearm, and	F 309		

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F 309	Continued From page 54 another wall access site on left upper wall. Plan of care indicated R7 had alteration in renal function evidenced by edema to hands... Goal "Will have patent dialysis access site as evidenced by bruit and thrill." Plan of care directed staff to remove band aid from access site the evening of dialysis, monitor for bruit and thrill daily and record on treatment administration record (TAR). In addition, R7's Nutrition Risk Care Plan dated 12/20/13, indicated R7 was on a 1,500 ml fluid restriction and directed staff to monitor fluid intake on Medication Administration Record (MAR). Nutritional Status Care Area Assessment dated 12/23/13, indicated R7 was at increased nutritional risk secondary to ESRD, with HD R7's quarterly Minimum Data Set (MDS) dated 5/8/14, indicated diagnoses included chronic kidney disease stage IV, ESRD, uremic encephalopathy, epilepsy and psychosis. In addition the MDS indicated R7's Brief Interview For Mental Status (BIMS-tool used to measure cognition) score was 15 which indicated intact cognition. R7's Physician's Order dated and signed 7/9/14, indicated R7 was on a 1500 ml fluid restriction. Review of July 2014, MAR revealed R7 had two different instructions written on two flow sheets on the fluid intakes and both were being filled out by the nurses but were not consistently recording R7's intakes. In addition one of the MAR's had an order for Nepro 240 ml daily every evening (a nutritional supplement) which had only been recorded twice since the beginning of the month. Review of the July 2014, TAR and MAR lacked documentation on monitoring of the bruit and	F 309		

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F 309	Continued From page 55 thrill. On 7/10/14, at 2:01 p.m. registered nurse (RN)-A verified R7's intake was not being consistently recorded and had a lot of missing data with two different sheets in the MAR used to record the intakes with different directions on the amount to offer each period of day. RN-A stated the nurses were supposed to record everything including even "Jell-O and popsicles" as R7 was on a fluid restriction and was going to clarify the fluid amount discrepancy. -At 2:07 p.m. RN-A was overheard asking LPN-C where she recorded R7's intakes and LPN-C indicated "I actually have been recording on both sheets." When interviewed via phone on 7/10/14, at 2:15 p.m. dialysis registered nurse (DRN) stated R7's runs were pretty good, coordination with the facility and communication was good and there was constant back and forth exchange of information. When asked what the dialysis center expected of the home in respect to recording fluid intake, fluid restrictions, monitoring for the bruit and thrill and removal of the dressing after dialysis, DRN stated "We want the patient to receive less than 1.5 liters but know he doesn't gain a lot. Also when he returns from dialysis the dressing should be removed four hours after and the nurses are supposed to check the bruit and thrill on days he doesn't come for dialysis as we check it when he comes for dialysis." When asked what would happen if the dressing was not removed DRN stated it when the dressing was left in place they can cause the site to clot or cause an infection to the fistula. On 7/10/14, at 2:36 p.m. RN-A unit manager	F 309		

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F 309	Continued From page 56 stated checking bruit/thrill was supposed to be in the TAR for nurses to monitor and listen to and the dressing should have been removed as directed by dialysis. RN further stated she was going to make sure the documentation was added to the TAR. On 7/10/14, at 2:39 p.m. RN-B verified R7's dressing was still on from the previous day 7/9/14, when he had dialysis stated the dressing was supposed to have been removed the previous day after dialysis. R7 stated "I was at the facility last evening and no one removed them." RN-B then removed the dressing area noted to be intact with no signs and symptoms of infection and a small amount of dried blood noted on the gauze. After removing the gauze with tape a drop of blood was noted and RN-B applied two regular band aids to area and no further bleeding. On 7/10/14, at 2:44 p.m. RN-B verified the TAR lacked documentation for checking the thrill and bruit and stated it was supposed to be checked daily and was going to add it. On 7/10/14, at 3:09 p.m. the director of nursing (DON) stated her expectation was to follow dialysis instructions, care plan and physicians order for R7's dialysis needs/care. The dialysis policy was requested on 7/10/14, at 12:31 p.m. but was not provided. Nutritional Status Procedure revised October 2012, directed staff to monitor resident's intake to determine if it was adequate but lack specific directions on recording consistently fluid intake for dialysis residents as ordered and lacked information on who was responsible in	F 309		

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F 309	Continued From page 57 overseeing that intakes for residents on fluid restrictions such as R7 were being consistently recorded ad ordered.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide facial hair removal for 1 of 3 residents (R50) observed for activities of daily living (ADLs). Findings include: R50 was not provided grooming. On 7/7/14, at 5:00 p.m. and consecutive days of the survey 7/8/14, 7/9/14, and 7/10/14, R50 was observed with multiple white facial hairs on her lower chin approximately a quarter (1/4) inch long. On 7/9/14, at 11:48 a.m. R50 requested to speak with surveyor during the interview R50 stated "I came here 2 years ago and I got good care and good nurses upstairs in the [Transitional Care Unit] TCU and when I told them I was going to stay at the facility I was moved down here and it's been a problem to answer my call light and it would take thirty minutes to one hour. I was a	F 312	1. Resident #50 is receiving necessary services to maintain grooming. 2. All residents are receiving grooming per their plan of care. 3. All staff have been re-educated regarding delivery of care for grooming. 4. DON/designee to audit 5 residents per week to ensure appropriate grooming is being completed. Results of audit will be shared at QPI.	

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F 312	Continued From page 58 nursing assistant for many years and I was very good to my resident's. The staff are sometimes rough to both residents and even other staff. There is one blonde one who bosses everyone. I feel that all the staff don't do good pericare. They do pericare from back to front and I think I have gotten infections I think from that. I now have become incontinent because I have to wait and every time I have told them something is not right it takes them too long before they can do anything. I have reported incidents of things to registered nurse [RN-A] and she doesn't do anything. I came here a happy person and now am totally depressed. Last Thursday I told a male nurse my heel was hurting and he told me "When I have time I will." When asked about the multiple white facial hairs on her lower chin approximately a quarter (1/4) inch long, R50 stated "They do it once in a great while and it's only some of them as I used to prefer doing it but with the pain I have told them am not able to do it anymore. A lot of residents need a lot of help and it seems like some residents such as [R8] get favors and staff spend a lot of time with her and this is not fair." During the entire conversation tears were rolling down her cheeks and was shaking as she cried. R50's quarterly Minimum Data Set (MDS) dated 6/6/14, Brief Interview For Mental Status (BIMS-tool used to measure cognition) was 15 which indicated intact cognition. In addition the MDS indicated R50 required extensive physical assist of one for toilet use, personal hygiene, had verbal behavioral symptoms directed towards others and did not exhibit rejection of care. R50's diagnoses included diabetes mellitus, congestive heart failure (CHF), obesity, peripheral neuropathy, depression and Chronic obstructive pulmonary disease (COPD).	F 312		

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F 312	Continued From page 59 ADL/Mobility Care Plan with readmit date 3/12/14, identified R50 had the potential or actual ADL/mobility deficit related to arthritis, polyarthritis, backache, and senile osteoporosis. Care plan goal "Will be neat, clean and well groomed daily." Although the care plan indicated R50 had long facial hair which she shaved when she decided and preferred to manage the facial hair; the ADL Care Area Assessment (CAA) dated 3/27/14, had indicated she needed assist of one to two staff for bed mobility, transfers, and assist of one staff for toileting, hygiene and bathing. In addition, the CAA indicated R50 was resistive to assistance at times and was non-compliant at times with treatment but, review of Progress Notes dated 6/4/14, through 7/10/14, revealed refusal for cares/removal of facial hair had not been documented. During review of June 2014 through July 2014, Treatment Administration Record (TAR's) it was revealed weekly skin check on bath day was blank and had been completed once on 7/6/14, respectively for both months and the medical record lacked refusal to remove the facial hair. When interviewed on 7/10/14, at 2:35 p.m. licensed practical nurse (LPN)-C stated after verifying R50 had several facial hairs she expected the nursing assistant (NAs) to offer to remove the facial hair even though R50 preferred to remove it and if she refused to let the nurse know to document as female facial hair can be a dignity concern.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		

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F 318	Continued From page 60 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide lower extremity restorative nursing program according to the assessed need for 1 of 1 resident (R62) in the sample. Findings include: On 7/8/14, at 2:38 p.m. R62 stated to surveyor, "There sits a lady, she lives down the hall, she has a big strong power chair, when my chair stops it almost automatically goes backwards, I fell asleep a little bit, and she hit me in the back with her chair twice in my injury, and she yelled at me and said 'I don't care where your injuries are, you better move out of the way.' I move, she moves, I move, she moves and yesterday and the day before, she threatened me again saying 'If I stay in the middle of the room she will hit me again, she is very, very mean." R62 stated, "I cannot move out of the way." On 7/9/14, at 10:12 a.m. R62 was observed being pushed in her wheelchair by staff to the large dining room from the small dining room. On 7/9/14, at 2:10 p.m. R62 was observed sitting in her wheelchair (w/c) alone in the small dining	F 318	1. Resident #62 is receiving restorative programing per therapy recommendations. 2. All residents with an assessed need are being provided with restorative programing. 3. All Nursing staff have been re-educated regarding restorative programing. 4. DON/designee will audit 5 restorative programs per week. Audit results will be shared at QPI.	

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F 318	Continued From page 61 room with her feet barely touching the floor and slouched down in w/c. R62's w/c was observed to have no side wheels for the hands to move w/c. During interview on 7/9/14, at 1:41 p.m. R62 stated, "I just wait for staff to come in the dining room or I shout their name and ask to get some help from them." R62 stated, "I feel like a cripple when I have to just sit in the dining room and wait for someone to happen to come and find me in here. I get worried" and "it's too hard to move my chair with my feet because of my right hip. I get tired a little bit, I have been sitting in here since 12:20 p.m., I lay down after lunch. I go backwards in my chair, I can't go forwards. I turn and watch for staff to walk by in the hall and yell at them for help and I still sit here. I already told them I want a different w/c, but they said, try it out, try it out. When I came to this facility I walked without help, they put me in a w/c right away, was more independent before coming here, been here almost a year." On 7/10/14, at 9:30 a.m. R62 was observed seated in her w/c alone in the small dining room, left foot on floor and half of right foot on the floor. -At 9:55 a.m. R62 was observed sitting in w/c in small dining room alone feet touching floor. Care plan dated 9/20/13, listed diagnoses of lumbar back pain, depression and fibromyalgia. The care plan also indicated R62 was easily fatigued and had generalized weakness. R62's restorative therapy recommendations were not instituted after occupational therapy (OT) was completed on 5/14/14. The quarterly MDS dated 5/8/14, indicated R62 had intact cognition with a score of 14 on the	F 318		

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F 318	Continued From page 62 BIMS, indicating R62 was cognitively intact. Therapy Recommendations dated 5/14/14, under Mobility/Positioning, Reposition to upright sit and encourage using feet to propel forward. Wheelchair adaptation checklist dated 5/15/14, indicated R62's w/c Reclining Back should be 70-80 degrees Preferred Resting Angle and 90 degrees Preferred Dining Angle for R62 when in w/c. Multi-Disciplinary Therapy Screening Tool dated 5/27/14, read for R62 OT seen 4/11/14 through 5/16/14. Restorative nursing program (RNP) established to maintain lower extremity strength, promote self-propulsion in w/c, and ensured adequate positioning in w/c. After surveyor intervention the facility obtained a Physician's Order on 7/9/14, for R62 which read OT to evaluate and treat wheel chair position/cushion. In-Service Training Record dated 7/10/14, indicated staff training was completed with two objectives listed: "1. Resident's feet need to touch the floor at all times while up in her wheelchair to allow the resident to move independently as needed. 2. Staff understand how to use the tilt function on w/c." During interview on 7/10/14, at 7:56 a.m. with Restorative Nurse registered nurse (RN)-F stated on 5/14/14, therapy gave her recommendations for R62 after discharged from therapy services and to be picked up by the restorative program. RN-F stated she talked with the unit manager regarding therapy recommendations for R62	F 318		

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F 318	Continued From page 63 when discharged from therapy. RN-F stated R62 had already had two to three restorative programs for the nursing assistants to attend to with R62 and therefore had not added therapy's recommendations for R62 to the restorative program to the lower extremities. RN-F stated R62 used to tip or fall out of her old w/c and the chair R62 now had been the safest chair so far. RN-F stated R62 knew what to do, but cannot quite do it, R62's brain to feet is slow, cognitively long to process to be able to use feet." RN-F also stated she was not aware of R62's feet observed not touching the floor while sitting in present w/c. RN-F stated she could retrain staff regarding therapies recommendations for R62 and add R62 to the restorative program regarding that. During interview on 7/9/14, at 10:30 a.m. with Occupational Therapist/Director of Rehabilitation she stated no staff had asked her to reassess R62's positioning and/or wheelchair (w/c). OT stated in therapy in May, R62 could move her w/c and at times it was hard for R62 to initiate movement based on her diagnoses. She also stated the facility had submitted to a local vendor regarding a different w/c for R62 and there was no money for R62 to purchase a new w/c. - At 1:15 p.m. nursing assistant (NA)-J stated R62 mostly asks staff to push her w/c as R62 had a hard time moving her w/c with one sore arm. NA-J was unaware of R62's w/c ability to be adjusted to tilt back or forward or ability to lower resident's feet to touch the floor. NA-J stated she had never seen any NA adjust or tilt R62's w/c. - At 1:30 p.m. LPN-C stated R62 used to lean and slide out of her previous w/c. - At 2:01 p.m. NA-C stated R62 needs two staff assist to walk, guide her, and R62 used to walk way more and way better. NA-C stated R62	F 318		

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F 318	Continued From page 64 complains pain in her right arm, and also stated a male resident who is no longer here would go fast last month and bump into her and other residents. NA-C stated she would quickly move residents out of his way. On 7/10/14, at 9:01 a.m. unit manager RN-A stated "I asked for an inservice, to retrain how to utilize the chair [R62's w/c] until we find something different." It will be done today with occupational therapy, and maybe more pain could be the root cause for R62 unable to move her w/c. The w/c R62 had now was meant to help by tilting with off-loading, and kind of help with positioning. - At 2:10 p.m. Occupational Therapist stated therapy had worked with R62 on sit to stand, gait pattern and had tried different chairs with R62 in the past and four times since last September worked with R62 with w/c positioning and mobility. The occupational therapist stated after discharged R62 from therapy occupational therapy had worked with restorative nursing and gave recommendations. Occupational Therapist also stated therapy had completed staff training with nursing staff regarding R62's positioning while in w/c, and staff being able to tilt and adjust R62's w/c so R62's feet are on the floor, and for staff to encourage R62 to propel forward in her w/c with her feet only as there are no hand wheels on R62's w/c for R62 to utilize with her hands to help move w/c.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325		

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F 325	Continued From page 65 (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to promote highest nutritional status for 1 of 3 residents (R118) reviewed for nutrition. Findings Include: On 7/9/14, from 12:15 p.m. until 1:45 p.m. R118 was observed at lunch. She received a meal of two slices of white bread, a scoop of mashed potatoes, a 4 ounce (oz) yogurt, 8 oz glass of milk and a 6 oz glass of apple juice. She proceeded to cut the crust off the bread and spread the remaining bread with margarine. She then put a small piece of bread in her mouth, took a drink of milk, held her napkin to her mouth and held the milk and bread in her mouth for a while and then chewed a bit and swallowed. She repeated this procedure with each bite of bread. She pushed the yogurt container away. After finishing the bread she ate the potatoes, taking a sip of juice after each bite. She appeared physically tired with some heavy breathing, sighs and quivering of lips. By 1:45 p.m. she had finished the bread, potatoes and beverages, but not the yogurt. R118 was interviewed on 7/10/14, at 9:00 a.m.	F 325	1. Resident #118 has a comprehensive nutritional assessment and is being served a therapeutic diet. 2. All staff have been re-educated regarding therapeutic diets, preferences, and providing diets based on comprehensive assessment, care plan, MD orders, and preferences of the individual resident. 3. Dietician/Designee to audit 5 residents per week to ensure resident receives diet per their meal card, care plan, MD orders and nutritional assessment.	

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F 325	Continued From page 66 R118 was asked if her mouth hurt. She did not answer but showed her tube of Polident. R118 was wearing an upper denture and had no bottom teeth. R118 was asked if she had pain. R118 replied, "I'm very sick, pain all over here and here and here" as she pointed to her mouth shoulders and body. When asked about eating vegetables, R118 said, "can't eat, only bread." R118 then demonstrated how she would take a drink of milk and hold in mouth to make bread soft. She was served two pieces of white bread, a boiled egg, milk and juice for the breakfast meal. Dietary employee (DTY)-A was interviewed on 7/10/14, at 1:30 p.m. He stated R118 had been eating the same meal of two pieces of bread "for years." He said she "never" ate the yogurt and showed how he had just thrown it away from the lunch meal. DTY-A explained R118 was served according to her meal ticket. At 2:00 p.m. nursing assistant (NA)-H stated she was aware R118 was eating only bread and milk and juice for as long as she had been employed, which was one year. Copies of the meal tickets for R118 were obtained from the facility on 7/10/14, at 3:30 p.m. and reviewed. The tickets listed breakfast: hot tea with three sugars, milk, juice and bread x 2, with special instructions to offer a boiled egg, yogurt and cottage cheese; lunch: hot tea with three sugars, milk, juice, two slices of bread, butter and yogurt; dinner: hot tea with three sugars, milk, juice, two slices of bread with butter. A nutrition note dated 6/25/14, indicated, "[R118] Eats 88/89% avg. of meals/ snacks over past 30 days-adequate." The most recent quarterly nutritional assessment dated 5/20/14, read, "Resident tolerating current diet well per nsg	F 325		

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F 325	Continued From page 67 [nursing]." The note went on to explain that food intake for R118 was 73% of meals and 50-100% of mighty shakes (a nutritional supplement). Intake was assessed to be 1754 calories and 73 grams of protein "more than optimal to meet needs". The analysis of finding for the annual minimum data set (MDS) care are assessment (CAA) for nutrition, dated 9/16/13, read,"Increased nutrition risk secondary to anemia, CVD [coronary vascular disease], pain r/t [related to] pemphigus [a skin disorder], chewing difficulty and hx [history] of weight loss". The assessment lacked any indication R118 might be at nutritional risk due to a self-limited diet which excluded basic food groups. The annual nutritional review dated 9/12/13, indicated R118 continued to tolerate her altered texture diet and nutritional supplements to maintain weights; meal and supplement intake was adequate to meet established needs as evidenced by a stable weight. Sores in the mouth were noted to be improving via reference to a nurse practitioner note dated 5/19/13. A food preference record, dated 4/15/12, idicated R118 liked vegetables and soups. A quarterly nutrition note dated 2/10/14, indicated a hemoglobin level (a measure of iron in the blood) of 10.9 g/dl (grams per deciliter) and was indicated to be below normal levels. A medical visit note dated 6/3/14, indicated that R118 had a hemoglobin of 9.2 g/dl. The medical note did not specifically address the low hemoglobin. A review of nursing notes revealed there were a total of seven nursing notes from 11/21/13 until	F 325		

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F 325	Continued From page 68 4/15/14, which was the last note recorded in the progress notes. The documentation lacked any indication that R118 was eating a limited diet. The nutritional risk plan of care for R118 identified nutritional risk related to cardiac disease, chewing difficulty and need for an altered texture diet, refusal to eat at times, abnormal lab values for hemoglobin and hematocrit, a history of weight loss and a history of weight gain, swallowing difficulties, constipation, at risk for skin breakdown, skin impairment, anemia, schizo-effective disorder, history of pneumonia and history of urinary tract infection. The plan did not identify a self limited diet. The goal was for R118 to eat at least 75% of meals and supplements, for weight to remain stable, no dehydration, have normal bowel movements and be free of skin breakdown. Interventions were listed as providing a dysphagia 3 diet (a texture altered diet), honor food preferences of yogurt with meals, monitor intake of meals and offer alternates, vitamin supplement, nutritional supplements, monitor weights and monitor for signs of dehydration. The record for R118 lacked evidence of interventions to try to improve the variety of R118's diet. Registered Dietitian (RD) was interviewed on 7/10/14, at 1:00 p.m. The weekly meal intake records were reviewed. R118 was listed as consuming an average of 90% of meals for the week. The RD stated that she would assume that if 90% of meal was recorded for an intake, it would be 90% of the entire regular meal for the day as listed on the menu.The RD verified that the assessed protein and calorie intake, per nutrition assessment 5/20/14, appeared to be incorrect for an intake of only bread and a few	F 325		

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F 325	Continued From page 69 other items. Registered Nurse (RN)-E was interviewed on 7/10/14, at 2:45 p.m. She was not aware of R118's specific food intake choices. She did state that R118's weights were stable. RN-F was interviewed on 7/10/14, at 3:00 p.m. RN-F provided training to nursing staff on how to record meal intakes. She explained that staff are to record the percentage of the meal eaten according to what they received. She explained that if a resident ate all the food they received, no matter what it was, it would be recorded at 100%. If a resident had a consistent trend of poor intake, then staff were to let a nurse or others know so that it could be addressed. In the case of R118, if she received and consumed 100% of two pieces of bread, mashed potatoes and beverages, the staff were to document 100% meal intake. The procedure was in contradiction to what the RD stated, on 7/10/14, at 1:00 p.m. she would consider 100% of the meal to represent when using meal intakes to assess nutritional status. A facility policy titled Admission Nutrition Assessment, Intervention, Evaluation and Ongoing Nutrition Monitoring Documentation, and dated April 2012, was reviewed. The policy read, "A complete comprehensive assessment will be used defining nutritional status using medical diagnosis; nutrition; medication histories; clinical observations; anthropometric measurements; and laboratory data. This data will be used to determine nutrition related problems, causal factors, and significance along with nutrition interventions. Progress will be monitored periodically and at least quarterly to measure and evaluate desired outcomes and need for changes	F 325		

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F 325	Continued From page 70 in the nutrition interventions."	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R191) had specific target behaviors identified for using an anti-anxiety medication and for 1 of 5 residents (R174) who was not monitored for adverse side effects with use of antipsychotic	F 329	1. Resident #191 and #174 have had target behaviors put in place, the DISCUS has been completed, and the provider has reviewed the pharmacist recommendations. The residents have been provided information regarding their psychotropic medications. 2. All residents requiring target behaviors/DISCUS have been reviewed. Pharmacist recommendations have been reviewed and addressed as appropriate. All residents on psychotropic medications are being provided with information regarding their psychotropic medications.	

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F 329	Continued From page 71 medications and whose target behaviors were not identified. Findings include: R191 lacked target behavior monitoring for the use of diazepam (Valium, an anti-anxiety medication). Review of R191's Prescription Slip and Discharge Orders dated 6/16/14, and 6/25/14, respectively revealed R191 had an order for Valium 5 milligram (mg) one tablet by mouth at bedtime as needed for anxiety. During review of R191's Medication Administration Record (MAR's), Treatment Administration Record (TAR's) and Target Behavior Program Summary Reports dated 6/16/14 through 7/9/14, all lacked evidence of documentation for monitoring R191's specific target behaviors for using Valium. Psychotropic Drug Use Mood & Behavior Symptom Assessment Care Plan dated 6/17/14, identified R191 had the potential for side effects related to psychotropic drug use "Valium" for anxiety and the behavioral symptoms drug was intended to treat anxiety. Goal "No negative outcomes resulting from use of psychotropic medications." The care plan identified the side effects but lacked to identify R191's specific target behaviors for the use of Valium. R191's discharge Minimum Data Set (MDS) dated 6/20/14, indicated R19's diagnoses included anxiety, depression, diabetes mellitus type II, cerebrovascular accident (CVA) and muscle weakness. In addition, the MDS indicated	F 329	3. Social Services have been re-educated about target behaviors. Nurse Manages have been re-educated about DISCUS being completed per policy and follow up with MD on pharmacy recommendations. 4. DON/designee to audit 5 charts per week for appropriate target behaviors and completed DISCUS. DON/Designee will audit 5 pharmacy recommendations per month to ensure timely response to recommendations. Audit results will be reviewed at QPI.	

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F 329	Continued From page 72 R191 did not have any behaviors. Psychotropic Medication Care Area Assessment (CAA) dated 6/27/14, indicated R191 was presently on Remeron, Zoloft and Trazodone (Anti-depressants) however lacked to address R191 was also on Valium. During review of R191's June 2014, MAR it was revealed R191 had received Valium on 6/25/14, at 10:00 p.m. however, review of the Progress Notes on the same day lacked behavior documentation. Psychopharmacological Medication Information Sheet dated 7/8/14, indicated R191 had on order for Valium for anxiety at bedtime as needed. When interviewed on 7/9/14, at 2:53 p.m. the consultant pharmacist (CP) stated the facility should have identified R19's specific target behaviors for using the Valium and should have been monitoring his behaviors. When interviewed on 7/9/14, at 3:07 p.m. licensed social worker (LSW)-A stated, "I was told when a resident was on anti-anxiety as needed order, they did not need to have target behaviors, but I will have to ask my boss and get back to you." -At 3:16 p.m. LSW-A returned stated she had found out all residents who took hypnotic, anti-anxiety, anti-depressants and anti-psychotropic had to have target behaviors monitoring. During the conversation LSW-A stated she needed to look through R191's initial admitting physician orders to verify if R191 had been admitted with order for Valium. After looking through LSW-A verified R191 had order from when he had been admitted on 6/16/14, and after	F 329		

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F 329	Continued From page 73 R191 returned from short hospital stay to the facility on 6/25/14, LSW-A stated, "It got missed and I will add it to Care Tracker now." When interviewed on 7/10/14, at 3:09 p.m. the director of nursing (DON) stated "The facility policy is we should have target behaviors for anti-anxiety medications." Psychoactive Medication policy revised October 2008, indicated Extendicare Health Services, Inc. required a review of residents prescribed psychoactive medication upon admission, annually, quarterly and with a significant change of condition. The policy lacked information on who was responsible to ensure specific resident target behaviors had been identified and were being monitored for residents who used anti-anxiety medications for as needed basis. R174: On 7/10/14, at 1:20 p.m. R174 stated not having been educated about the side effects of psychotropic medications he was taking. Further, R174 stated he had been on the psychotropic medications like Seroquel "for a long time" and was not aware of any dose changes of the psychotropic medications he had been taking since admission. R174's plan of care for mood and behavior symptoms dated 5/10/14, directed staff to monitor for side effects for the use of Ativan, Seroquel, Trazodone, Remeron and Celexa. There was no evidence that a dyskinesia identification system: condensed user scale (DISCUS- a tool to determine extra pyramidal side effects) was completed.	F 329		

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F 329	Continued From page 74 The doctor's admission orders for R174 dated 5/12/14, included the following medications: Trazodone for depression; Seroquel for mood disorder with depression; Remeron for depression and Celexa for depression. The hospital record sent to the facility included Ativan for anxiety as needed but was not ordered during admission. There were no specific target behaviors identified to be monitored on R174 for the use of psychotropic medications. R174's admission MDS dated 5/15/14, indicated R174 had the following diagnoses: cancer; anemia; hypertension; gastro esophageal reflux disease (GERD); benign prostatic hyperplasia (BPH); renal failure/insufficiency; diabetes mellitus (DM); anxiety disorder; and depressive disorder. The admission MDS indicated R174 had a brief interview for mental status (BIMS) score of 15, which indicated R174 had no cognitive impairment; and the mood symptom severity score was 3, which indicated R174 had minimal depression. R174's CAAs dated 5/16/14, triggered for psychotropic drug use for the antipsychotic, antianxiety and antidepressants. The CAAs identified adverse consequences of these drugs to include urinary incontinence; risk of pressure ulcer development; risk for falls; depression; and disturbances of balance, gait and positioning ability. Ativan 1mg by mouth twice a day/ Ativan 0.5mg daily at noon: On 5/22/14, R174 had a doctor's order for "1 mg Ativan po BID [twice a day] prn [as needed]	F 329		

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F 329	Continued From page 75 Ativan will beck [sic]. The diagnosis listed for the order of Ativan was "anxious [sic]." The order did not specify R174's specific symptoms of anxiety to be identified and monitored. The medication administration records revealed that aside from the Ativan 1 mg by mouth (PO) twice daily which was started on 5/22/14, R174 recieved the "as needed" dose of Ativan 0.5 mg daily from 5/10/14 to 5/30/14, and 7/1/14 to 7/9/14. The Ativan 0.5mg dose was always given "per request" as entered in the notes at the back of the MARs dated 5/10, 5/12, 5/15, 5/17, 5/26, 5/28, 7/8 and 7/9/14. On the other days that R174 was given Ativan 0.5mg, there were no rationales given for the use. There were no specific signs of anxiety identified on R174 before giving the Ativan 0.5mg. There was no evidence that non-pharmacological intervention was used by staff before giving the Ativan. A doctor's order for R174 dated 7/9/14, indicated the Ativan 0.5mg will no longer be an "as needed" dose but to give Ativan 0.5mg by mouth daily at noon and to continue with the old order of Ativan 1mg by mouth twice daily. There were no entries in the R174's Group Behavior Chart dated 6/10/14 to 7/9/14, about specific signs of anxiety being monitored. Seroquel 100mg by mouth every night: The medication administration records further revealed on 5/9/14, R174 was on Seroquel 100mg by mouth every night; on 5/19/14, the dose was increased to Seroquel 125mg by mouth every night; on 5/29/14, the medication was reduced to the current dose of Seroquel 100mg by mouth every night. There were no entries in R174's group behavior charts for 5/14 and 6/14,	F 329		

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F 329	Continued From page 76 to indicate any behavior manifestation to justify changes in doses of medications. In addition, there were no entries in nurses' progress notes from 5/9/14 to 6/27/14, to indicate monitoring of specific target behaviors. Remeron 15mg by mouth (PO) at bedtime/Trazodone HCL 100mg PO at bedtime/ Citalopram HBR 20mg PO (all are anti-depressants) daily: The medication administration records dated 5/9/14, indicated R174 was on Remeron 15mg by mouth at bedtime; Trazodone HCL 100mg by mouth at bedtime; and Citalopram HBR 20mg by mouth daily. A Consultation Report by Omnicare of Minnesota (CROM) dated 6/4/14, indicated the CP made a comment regarding R174 taking two medications "which when taken together may increase the risk for serotonin syndrome. Mirtazapine, Trazodone HCL, Citalopram Hydrombromide." The drug interaction (serotonin syndrome) was further explained as "presents with mental, autonomic and neuromuscular changes including, but not limited to, confusion, myoclonus, tremor, agitation, ataxia, restlessness, diarrhea, nausea, diaphoresis and tachycardia." There were no entries in the nurses' progress notes to indicate monitoring of side effects. In the Recommendation section of the CROM dated 6/4/14, the CP recommended that the prescriber document an assessment of risk versus benefits to indicate that dual therapy was a valid therapeutic intervention for R174 and the interdisciplinary team to ensure ongoing monitoring for effectiveness and potential adverse consequences. The recommendation was not	F 329		

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F 329	Continued From page 77 acted upon by the physician as there was no note made in the Physician's Response section of the CROM. There was no physician's order entered from 6/5/14 to 7/9/14, to indicate CP's recommendation had been addressed. On 7/9/14, another CROM was made by the CP with a recommendation for the re-evaluation of the three antidepressants: Remeron, Trazodone HCL, and Citalopram HBR. That recommendation was not acted upon as of 7/10/14. On 7/9/14, at 3:19 p.m. during interview, the CP stated baseline assessment for specific target behaviors and side effects of psychotropic medications should have been established; and monitoring thereafter was expected, because they were the bases of whether or not there was a need for a gradual dose reduction (GDR), or to increase or to maintain the medication dosage. On 7/10/14, at 7:57 a.m. licensed practical nurse (LPN)-C stated R174 never manifested any negative behaviors. LPN-C further stated R174 was "a very really nice guy who walks and comes to us when he needs something." LPN-C verified there was no specific target behavior or symptom being monitored on R174 for the use of the psychotropic medications. - at 1:05 p.m. registered nurse (RN)-A verified there was no DISCUS form found in R174's chart. RN-A stated DISCUS for R174 was not done. - At 2:30 p.m. RN-A provided to surveyor a "baseline" DISCUS form for R174 dated 7/10/14. - At 2:35 p.m. the DON verified there was no DISCUS done on R174. DON added DISCUS should have been done "within 72 hours from admission." DON stated she expected it to have been accomplished during the initial assessment	F 329		

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F 329	Continued From page 78 on admission. The facility's policy for the use of psychotropic medications dated 10/2008, directed staff to: use psychoactive medications for identified target behavior; document behavioral symptoms the medication was prescribed to decrease; use behavioral/non-drug interventions in conjunction with medication; complete DISCUS as required by state regulation; monitor regularly for side effects; and review the psychopharmacologic information sheet with the resident when a psychoactive medication was prescribed.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	Resident #50, #99, #174, #48, #126, #55, #53, #106, #7, #21, #118, #8, #62, #35 and #49 are all getting their needs met timely. All residents are receiving care in a timely manner. All staff re-educated regarding providing care in a manner that fits with the resident's plan of care. DON/designee to interview 5 residents per week regarding timeliness of needs being met. Results of audits will be reviewed at QPI.	

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F 353	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review with residents and staff the facility failed to ensure sufficient qualified nursing staff were available to meet the needs of 15 of 85 residents (R50, R99, R174, R48, R126, R55, R53, R106, R7, R21, R118, R8, R62, R49, R35) residents and staff voiced concerns regarding lack of staff to assure resident needs were met. Findings include: R50 was not provided grooming. On 7/7/14, at 5:00 p.m. and consecutive days of the survey 7/8/14, 7/9/14, and 7/10/14, R50 was observed with multiple white facial hairs on her lower chin approximately a quarter (1/4) inch long. On 7/9/14, at 11:48 a.m. R50 requested to speak with surveyor during the interview R50 stated "I came here 2 years ago and I got good care and good nurses upstairs in the [Transitional Care Unit] TCU and when I told them I was going to stay at the facility I was moved down here and it's been a problem to answer my call light and it would take thirty minutes to one hour. I was a nursing assistant for many years and I was very good to my resident's. The staff are sometimes rough to both residents and even other staff. There is one blonde one who bosses everyone. I feel that all the staff don't do good pericare. They do pericare from back to front and I think I have gotten infections I think from that. I now have become incontinent because I have to wait and every time I have told them something is not right	F 353		

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F 353	Continued From page 80 it takes them too long before they can do anything. I have reported incidents of things to registered nurse [RN-A] and she doesn't do anything. I came here a happy person and now am totally depressed. Last Thursday I told a male nurse my heel was hurting and he told me "When I have time I will." When asked about the multiple white facial hairs on her lower chin approximately a quarter (1/4) inch long, R50 stated "They do it once in a great while and it's only some of them as I used to prefer doing it but with the pain I have told them am not able to do it anymore. A lot of residents need a lot of help and it seems like some residents such as [R8] get favors and staff spend a lot of time with her and this is not fair." During the entire conversation tears were rolling down her cheeks and was shaking as she cried. R50's quarterly Minimum Data Set (MDS) dated 6/6/14, Brief Interview For Mental Status (BIMS-tool used to measure cognition) was 15 which indicated intact cognition. In addition MDS indicated R50 required extensive physical assist of one for toilet use and personal hygiene. R50's diagnoses included diabetes mellitus, congestive heart failure (CHF), obesity, peripheral neuropathy, depression and Chronic obstructive pulmonary disease (COPD). ADL/Mobility Care Plan with readmit date 3/12/14, identified R50 had the potential or actual ADL/mobility deficit related to arthritis, polyarthritis, backache, and senile osteoporosis. Care plan goal "Will be neat, clean and well groomed daily." Although the care plan indicated R50 had long facial hair which she shaved when she decided and preferred to manage the facial hair; the ADL Care Area Assessment (CAA) dated 3/27/14, had indicated she needed assist of one	F 353		

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F 353	Continued From page 81 to two staff for bed mobility, transfers, and assist of one staff for toileting, hygiene and bathing. In addition, the CAA indicated R50 was resistive to assistance at times and was non-compliant at times with treatment but, review of Progress Notes dated 6/4/14, through 7/10/14, revealed refusal for cares/removal of facial hair had not been documented. During review of June 2014 through July 2014, Treatment Administration Record (TAR's) it was revealed weekly skin check on bath day was blank and had been completed once on 7/6/14, respectively for both months and the medical record lacked refusal to remove the facial hair. When interviewed on 7/10/14, at 2:35 p.m. licensed practical nurse (LPN)-C stated after verifying R50 had several facial hairs she expected the nursing assistant (NAs) to offer to remove the facial hair even though R50 preferred to remove it and if she refused to let the nurse know to document as female facial hair can be a dignity concern. Stage 1 Resident Interviews: R99's quarterly MDS dated 523/14, indicated cognition was intact and required extensive physical assistance of one staff with dressing and personal hygiene and used a wheelchair for mobility. On 7/7/14, at 3:16 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R99 stated about two weeks ago, 5:00 a.m. she had put call light on and had asked NA to wash under	F 353		

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F 353	Continued From page 82 stomach and NA-G told her she had to wait for the nurse or next shift because she was the only NA on. R99 stated again about 6:00 a.m. asked [LPN-F] to wash her and she said "No, I don't have time." R99 further stated she had witnessed her roommate put her call light on at 6:00 a.m. and heard staff tell roommate to put her light back on at 6:30 a.m. because they do not have time and when roommate puts the call light between 7:00 a.m. and 7:15 a.m. NA's tell roommate they are busy or the lift was being used and roommate continuously had to wait to go to bathroom on day, evening and night shifts. R174's admission 30 day MDS dated 6/5/14, indicated cognition was intact, required extensive physical assistance of one with toileting and needed supervision oversight with transferring, bed mobility, dressing and personal hygiene. On 7/7/14, at 3:51 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R174 stated end of June 2014, when he had diarrhea he pulled the call light in the bathroom NA came stated would tell the nurse but had to wait for twenty to twenty five minutes. R174 further stated anytime he had to wait after putting his call light for assistance for a while like morning of interview he had waited for forty minutes after putting his call light on to get help with Thrombo Embolic Deterrent (TED stockings- anti-embolism stockings for the legs that help prevent blood clots. R48's admission 14 day MDS dated 6/10/14,	F 353		

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F 353	Continued From page 83 Indicated cognition was intact and required extensive physical assistance of two staff with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. On 7/7/14, 3:54 p.m. when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R48 stated "About three weeks ago I had to call for help and the aide came in and I told them I needed my bandages changes because they were soiled and the aide told me the nurse was outside but would not come in and I started begging the aide to them off as I don't want them to be infected and the aide told me "NO" the nurse had to do them." R48 further stated NA-I was working "This was from 11:00 p.m. to 1:30 a.m." R48 was crying the whole time when explaining to surveyor with tears rolling down her checks. R48 stated she had talked to her family and was told there was no good nursing home out there and just had to settle with what was going on and compliment the staff when they did good. R126's quarterly MDS dated 4/11/14, indicated cognition was intact, was independent with ADL's and used a walker for mobility. On 7/7/14, at 4:28 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R126 stated he had fallen several times, waited in hall about half hour after falling about a month ago around 10:45 p.m. and did not get help until 11:15 p.m., yelled out, another resident came out to see	F 353		

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F 353	Continued From page 84 what was going on and went and told staff. R126 further stated he had fallen in bathroom about month ago, lay for twenty to twenty five minutes, and then decided to pull emergency string. R55's quarterly MDS dated 6/6/14, indicated cognition was intact and required extensive physical assistance of one to two staff with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. On 7/7/14, at 4:43 p.m. when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R55 stated "They are short, they complain among themselves....I will put the light about 6 p.m. and they came between 9:00 and 9:30 p.m., it happens every now or then it's not every day. I understand the problem they have, the girls really are overworked with their workload. I don't want to make a big deal about it....it has happened, can't tell you when it happened. I messed my pants up and it took them a couple hours to get here...they got here as fast as they could sometimes they are really slow responding to the call light." R53's annual MDS dated 6/6/14, indicated cognition was intact and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. On 7/7/14, at 4:53 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you	F 353		

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F 353	Continued From page 85 need without having to wait a long time R53 stated "I have to wait long time for help to get to bed, wait an hour, have told manager ..." R106's quarterly MDS dated 6/9/14, indicated cognition was intact and required extensive assistance of two staff with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. On 7/7/14, at 5:48 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R106 stated "Sometimes I have to wait for an hour or two to go to the bathroom. It's terrible. I have had accidents from waiting." R7's MDS dated 5/8/14, indicated R7's BIMS was 15 which indicated intact cognition. On 7/8/14, at 10:32 a.m. when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R7 stated "Sometimes the call light can stay on for a couple hours and when I fell I had to stay on the floor and my roommate had to help me." R21's annual MDS dated 6/12/14, indicated both long and short term memory were "OK", R21 required extensive assistance with toileting and personal hygiene and used a wheelchair for mobility. On 7/8/14, at 10:44 a.m. during interview when	F 353		

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F 353	Continued From page 86 asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R21 stated "I have had to wait two hours, I need assistance with urination and have had to wait half hour for it and it can get pretty bad when you have to go, when you need assistance and can't get it" R21 further stated "Staff will say they are busy, and that they are helping people needing two staff assist and you will just have to wait which happens all shifts quite often ..." R118's quarterly MDS dated 5/15/14, indicated cognition was intact and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair and walker for mobility. On 7/8/14 11:05 a.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R118 stated "Sometimes when I push the button they don't come it can take a long time, sometimes immediately and sometimes not at all...for example I need to go to the bathroom and they don't come I hold it and have not had an accident and it happens more often after 10 a.m. R8's quarterly MDS dated 6/5/14, indicated R8 had intact cognition. On 7/8/14, at 12:17 p.m. when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R8 stated "Nope tried to get staff to help a resident who had waited for	F 353		

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F 353	Continued From page 87 at least an hour to get staff assistance." R62's MDS dated 5/8/14, indicated R62 had intact cognition, required extensive assistance of two staff with activities of daily living (ADLs) and used both the wheelchair and walker for mobility. On 7/8/14, 2:12 p.m. during interview when asked if he felt there is enough staff available to make sure you get the care and assistance you need without having to wait a long time R62 stated "I wear diapers and have had to go in my diapers from waiting so long for staff assist." It makes me feel bad when I came in here, I could walk and do everything for myself and now I can hardly do anything" I want to go home but I am homeless. I want to leave here as soon as I can walk." R62 further stated licensed social worker (LSW)-B was looking for another place but had not found one yet but she asked LSW-B stated "I can only do so much". Random resident requested interviews: R49's quarterly MDS dated 5/6/14, indicated cognition was intact and required extensive assistance of with toileting, transferring, bed mobility, dressing and personal hygiene On 7/10/14 9:42 a.m. R49 requested to speak to surveyor during conversation R49 stated "When a pt. [patient] needs help and pushes the red button it takes an hour and a half for staff to help them they say they will be back in two minutes and it will be a couple of hours, two minutes to them is two hours, right now they have extra people here, after you guys leave it will be back to less staff, residents screaming, shouting, they like to put	F 353		

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F 353	Continued From page 88 psycho mental people here, it's all about the money to them. I don't trust them at all." R35's quarterly MDS dated 4/30/14, indicated cognition was intact and required extensive assistance of two staff with toileting, transferring, bed mobility, dressing and personal hygiene. On 7/10/14, at 12:29 p.m. R35 requested to speak to surveyor. During conversation R35 indicated "Half of the problem there is not enough aides, nights last night 9 p.m. had three aides, as two were sent home, that happens a lot and night before we had to go to bed 8:30 p.m. and I prefer to go to bed at 10 p.m. nursing assistant [NA-C] is one of the good aides, sometimes offered choice to go to bed later." Staff Interviews: When interviewed on 7/9/14, at 6:47 a.m. RN-C stated currently there was no staffing concerns but usually it was hard to replace staff with call-ins and they are forced to work short which can be challenging. On 7/9/14, at 6: 50 a.m. RN-G stated overall staffing was good, had no issues, but indicated she could get cares done "It's busy, but we try to do it" RN-G would not elaborate. On 7/9/14, at 1:48 p.m. NA-A stated she does not have a problem personally with staffing because she started the day early and left when it was time for her to go. NA-A further stated she heard complaints from other NA's about being understaffed and most complaints came from morning NA's.	F 353		

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F 353	Continued From page 89 On 7/9/14, at 2:03 p.m. NA-C stated she worked both day and evening and there was three NA's scheduled for day and evening shifts and there was never changes made to staff when residents census had increased. NA-C further stated "Some days mornings really hard, still getting residents up when food comes, dietary gets mad at us that we can't serve food when the food comes, everybody helping to serve food like now does not happen. We let residents lay down when they want to, so when nights come they expect all residents to be in bed, nights get upset if residents are still up when nights come in, evenings work more as a team, mornings don't work together so much, just do their own, overnights do not get any residents up." On 7/10/14, at 5:59 a.m. NA-D stated "On Garden one and a half nursing assistants work nights with one nurse because the second NAR goes to 2nd floor to help with their first rounds for three hours." NA-D also stated on Garden Terrace on the night shift when NA's came in they typically would put three to six residents to bed because the population was younger and they like to stay up later and the floor had a lot of residents who required two staff to assist. In addition, NA-D stated after turning one of the resident between 1:00 a.m. to 1:30 a.m. the NA went to 2nd Floor and while gone upstairs, the floor nurse helped the NA with any residents that needed two person assist, lights, charting to do and transfers involving mechanical devices. NA-D further stated, "there was no time to get up residents, the last half hour was for leftover charting, lights and they had to be independent or else they would not get their work done."	F 353		

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F 353	Continued From page 90 When interviewed on 7/10/14, at 7:00 a.m. NA-B stated staffing at the facility depended on what the census was and sometimes "When the census is low one NA is cut and one of the NA's from [Garden Terrace] GT has to go to the second floor to help with rounds and at times it takes a long time before the GT NA gets upstairs for rounds and it than takes a long time before we are able to turn and reposition some of the residents." On 7/10/14, at 7:02 a.m. director of nursing (DON) indicated Garden Terrace getting up times was resident driven, varied, sometimes residents get up earlier, sometimes later, and depended on time factor if a resident needed two staff assistance NA's needed to plan a little better." When interviewed on 7/10/14, at 7:11 a.m. LPN-A stated all the shifts vary but with regarding night shift the lifting can be hard especially when working on Garden Terrace as one of the NA's went to the 2nd floor to assist with rounds and LPN-A had to sometimes "I just prioritize what to do first for example if I had a resident asking to go to the bathroom and another asking for a pill, I have to attend to the pain concern and have the other resident wait and I feel really bad and have to apologize for having them wait." On 7/10/14, at 9:00 a.m. an interview was conducted with staffing coordinator (SC) and DON. When asked how the facility determined the staffing patterns for the facility units DON stated "We look at the census in each unit and we look at the acuity of the residents." When asked about the staffing patterns for each unit, SC indicated was as follows:	F 353		

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F 353	Continued From page 91 Garden Terrace (GT): Day and PM two nurses Day and PM- basically three to four NA's depending on the census Nights one nurse Nights - two NA's 1st Floor: Day and one to two nurses normal depending on the census. Days and two's Nights one NA Night one RN Supervisor. 2nd Floor: Day & PM two nurses Day & PM five to six NA's Nights one nurse Night two to three NA's When asked who did the staffing when SC was not at the facility, SC stated DON would or on off hours the nurse on 1st floor did and would replace the call-in. When asked what happed when the census was low and if the facility flexed down, the DON stated "We usually do, Yes." When asked if staffing was tracked and trended with incidents such as falls etc. and if she had identified any patterns DON stated, "I have not identified a pattern there." When asked if facility had any employee injuries in the last three months, DON stated "We just had one employee and did not require medical care but was repositioning a resident and heard a pull on her shoulder." When asked how many open positions SC stated "I do have open positions on top of my head five NA's all shifts part time and two full times." In addition, DON	F 353		

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F 353	Continued From page 92 stated there was one nurse part time evening opening and another at the end of the month when a nurse retired. When asked if staffing concerns had been discussed at the monthly quality assurance meetings DON stated she was not sure but would be checking and let surveyor know later. Call light logs and audits were requested and DON stated the facility did not have logs and would provide some of the audits. When DON was asked was staff had brought her concerns about the workloads, DON stated "We have heard specific concerns to some units have juggled the workload, Team assignments" on 2nd Floor and "We occasionally have heard concerns about the call lights and have filled out resident concern forms and investigated." DON further stated she had found out that one of the residents who had reported sitting on the toilet for one and a half hours but after investigating she found out that resident had been on the toilet for fifteen minutes only after resident had been left on the toilet by therapy and removed by a nursing assistant. Review of the Call Light Audit forms dated 2/3/14 through 7/7/14, provided by the DON revealed the facility was using four different kinds of forms for auditing which did not contain consistent information and did not consistently provide follow up. Only one of five of the audits indicated resident needs had been fulfilled and the rest of the audits needs were never addressed. The facility lacked a consistent call light audit system. Review of the random schedules dated 1/1/4, going forward revealed the following: On 1/1/14: - AM Shift one LPN from GT was	F 353		

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F 353	Continued From page 93 moved to 2nd Floor, one LPN was moved from 1st Floor to GT with a note to side of name "Help out 1st FL [floor] & Breaks" and 1st Floor had a nurse name written on the manager slot. In addition, one NA was moved to GT from 1st Floor and two NA's were "Cut." -PM Shift one LPN was split between GT and indicated to nurses name "Help out 1st FL & Breaks." -Nights Shift one NA was moved from 1st Floor to 2nd Floor and 1 NA was "Cut." Unable to determine the census in the units for all the shifts. On 2/9/14: - AM Shift two NA's were moved to 2nd Floor from 1st Floor and one NA was replaced for a half (1/2) hour and one NA had a "[Request] req cut" to name. -PM shift one NA and one LPN were moved from 2nd Floor to GT. -Night Shift two NA's were moved from 2nd Floor to GT of which one of the NA was changed to a trained medication assistant (TMA) slot to fill an open nurse spot. Unable to determine the census in the units for all the shifts. On 3/12/14: - AM Shift one NA was moved from 2nd Floor to GT and oneNA had a split shift indicated for GT and 2nd Floor. -PM Shift two LPN's scheduled on 2nd Floor were moved to 1st Floor and GT and one LPN who had worked Day shift stayed for PM Shift until 8:00 p.m. and 2nd Floor night LPN came at 8:00 p.m. -Night shift one NA on 1st Floor was "Cut." Unable to determine the census in the units for all the shifts. On 4/18/14: - AM Shift one LPN was moved to	F 353		

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F 353	Continued From page 94 GT from 1st Floor -PM Shift two RN's from 1st Floor to 2nd Floor and replaced by one RN and one NA from GT to 1st Floor. -Night Shift two NA's were moved from 1st Floor and 2nd Floor to GT. Unable to determine the census in the units for all the shifts. On 5/3/14: - AM Shift one NA was moved from 1st Floor to GT. -PM Shift one NA spot on GT was not filled; TMA on GT was moved to 1st Floor and RN sent from 1st Floor GT. -Night Shift one NA from 1st Floor and 2nd Floor each was moved to GT. Unable to determine the census in the units for all the shifts. On 6/16/14: - AM shift one RN from GT was moved to 2nd Floor and one NA scheduled NA shift on the 1st Floor was changed to TMA instead. -PM Shift one NA was moved from 2nd Floor to GT. -Night Shift one NA was moved from 2nd Floor to GT. Unable to determine the census in the units for all the shifts. Review of the random daily schedules revealed the facility shifted staff from floor to floor frequently without regard to the duties that needed to be replaced such as filling a nurse slot with a TMA on 2/9/14, night shift. DON was asked if sufficient nursing concerns were brought to monthly quality meetings and no information was provided either verbally or in written form. Review of the Accident/Incident (A&I) Report Summary's provided by the DON revealed the facility fall rates were as follows with factors	F 353		

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F 353	Continued From page 95 involved being unable to determine: -January 2014, 48.9% -February 2014, 59.5% -March 2014, 52.8% -April 2014, 51.4% -May 2014, 44.4% -June 2014, 27.9% The information provided the facility had an increased rate of falls from January 2014, to May 2014.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness. This had the potential to affect 83 of 85 residents who were served food out of the kitchen. Findings include: During tour on 7/7/14, at 11:45 a.m. the following equipment sanitation problems were observed:	F 371	1. Coolers, freezers, stovetop, and stove have been cleaned to maintain sanitary conditions. 2. Cleaning schedules have been provided to kitchen staff to maintain sanitary conditions. 3. Re-education provided to dietary staff regarding cleaning schedules. 4. NHA/designee to audit cleanliness 1X per week to ensure sanitary conditions. Results of audits will be reviewed at QPI.	

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F 371	Continued From page 96 - A four burner stove/oven with attached grill was observed to have a buildup of greasy brown food splatter behind the backsplash covered with dust buildup and greasy brown food splatter on the left side of the stove covering approximately the two foot wide by three foot long area next to the food preparation table. Both ends of the stove handle had a buildup of a greasy dark substance surrounding the handle. Below the oven the uncovered electrical and piping unit had a buildup of a greasy dark substance with heavy dust buildup which was open to the kitchen and food preparation area. - The three door reach in freezer measuring approximately eight feet high and ten feet wide had heavy condensation around the door rubber seals. There was a black buildup of fuzzy type substance around the door handles, down the length of the unit between each door and across the entire length of the bottom of the unit. There was dirt, food and paper debris with water buildup on the floor directly in front of the entire length of the unit. When interviewed on 7/7/14, at 11:45 a.m. cook-(A) verified the stove unit was dirty and needed cleaning. Cook-A stated "it should be cleaned daily; I don't know who would do the deep cleaning." Cook-A stated "the kitchen staff cleans the inside of the freezer unit, I don't know who cleans the outside, but it is dirty." When interviewed on 7/7/14, at 11:49 a.m. maintenance assistant (MA) verified the black buildup and debris was unclean, "it's terrible and needs to be cleaned." MA later verified maintenance was responsible for the freezer	F 371		

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F 371	Continued From page 97 parts, such as the coils but "not for cleaning the inside or outside of the freezer." When interviewed on 7/10/14, at 10:26 a.m. cook-(B) stated "we clean as we work, there is no deep cleaning schedule for the stove." Cook-B further stated, "I clean the freezer, it isn't on any cleaning schedule." A review of the facility oven policy dated November 2000 indicated the "ovens would be maintained in a clean and sanitary condition....thorough cleaning will occur once per week." The policy lacked direction for cleaning the outside of the stove/oven unit and surrounding area. A review of the facility refrigerators, coolers, and freezers policy dated November 2000 indicated "refrigerators, coolers and freezers will be maintained in a clan and sanitary condition...will be kept clean on a daily basis...will be thoroughly cleaned every two weeks or more often as needed." The procedure section, number eight outlined to "wash shelves, plastic strip doors, walls, ceilings, and the exterior of the unit with warm detergent water."	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and	F 412		

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F 412	Continued From page 98 must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine dental services for 2 of 3 residents (R55, R62) whose dentures did not fit in the sample reviewed for dental status and services. Findings include: R55 was interviewed on 7/7/14, at 5:00 p.m. it was observed that R55 did not have teeth and was not wearing dentures. R55 stated, "My dentures slide out, they don't stay in, they said they are going to get me a dentist I could work with." R55's admission Minimum Data Set (MDS) dated 10/3/13, identified R55 had intact cognition and had no broken or loosely fitting full or partial dentures, no discomfort or difficulty with chewing. The nutritional status Care Area Assessment (CAA) dated 10/7/13, indicated R55 had no loose dentures and no dental CAA. Review of R55's nutrition risk plan of care dated 10/1/13, activities of daily living (ADL)/mobility plan of care dated 9/26/13, and the comprehensive care plan review summary dated 6/17/14, were all void of R55's dental status. The Hospice Certification and Plan of Treatment dated 5/19/14, revealed R55 had a section tiltled Disease burden. The noted R55 to have "poor appetite weight loss of over 50 pounds in past	F 412	1. Resident #55 and #62 will be seen by dental services on August 4th, 2014. 2. All residents will be seen by the dentist per their yearly assessments and recommendations. 3. Internal system review completed by SS, Med Records, Nursing, NHA, and dental provider to ensure that services are provided per recommendations. 4. DSS/designee will audit 5 charts per week to ensure compliance with dental recommendations and services. Results of audits will be reviewed at QPI.	

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	245187	A. BUILDING _____ B. WING _____	C 07/10/2014

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F 412	Continued From page 99 month." Review of Apple Tree Dental MDS Oral/Dental assessment form dated 6/6/14, outlined R55's oral/dental status as loosely fitting lower dentures and no natural teeth or tooth fragment(s) and outlined a treatment plan "needs lower denture relined/adjusted." During an interview on 7/10/14, at 7:53 a.m. licensed social worker (LSW)-B stated "I'm not sure if it has been addressed, the household unit coordinator (HUC) would take care of that." During an interview on 7/10/14, at 7:55 a.m. registered nurse (RN)-E stated that medical records would coordinate his appointments, "I bring him his breakfast and he has never complained to me." During an interview on 7/10/14, at 1:45 p.m. HUC stated "I was not aware that he needed follow up, I didn't know they were here and don't know who should have done it." During an interview on 7/10/14, at 2:18 p.m. SW-B stated that "the dentistry people put it in the chart, I wasn't aware of it". SW-B stated Appletree dental needs a consent form, they did not have consent and "I didn't know they were in the room, Appletree dental just put the assessment in the chart." RN-E stated she also was not aware Appletree dental was in to see R55. During an interview on 7/10/14, at 4:02 p.m. the director of nursing (DON) stated the dental provider would need consent for treatment and typically it would be given to the nurse manager.	F 412		

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F 412	Continued From page 100 During an interview on 7/10/14, at 4:06 p.m. LSW-C stated she did not know anything about the dental assessment. R62's care plan dated 9/20/13, listed diagnoses of lumbar back pain, depression and fibromyalgia. Care plan also stated was easily fatigued and had generalized weakness. The Quarterly MDS dated 5/8/14, indicated R62 had intact cognition with a score of 14 on the BIMS. Physician orders dated 5/27/14, indicate R62's diet to be controlled carbohydrate. During interview on 7/8/14, at 2:25 p.m. R62 stated her dentures hurt for her to wear them and she had been told she had to wait three years to get her dentures realigned. R62 also stated she could not eat some foods like meat, steak because she could not wear the bottom dentures because they hurt so bad to wear. R62 was observed with only top dentures in her mouth. On 7/9/14, at 10:42 a.m. RN-A stated she knew nothing about R62's dentures and staff had not said anything about R62 unable to wear her bottom dentures. - At 10:44 a.m. licensed practical nurse (LPN)-D stated resident had not gone out to a dentist but did not know if R62 had seen dentist in facility. LPN-D stated about R62 "she never wears the bottoms", her bottom dentures were put in the drawer in the nursing cart to keep them safe and "the bottom dentures have been in the drawer for a long time for months." - At 10:59 a.m. Health Unit Coordinator stated she talked to the dental office and the dental	F 412		

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F 412	Continued From page 101 office had no notes regarding R62 and R62 had not been seen at the dentist. - At 11:07 a.m. unit manager RN-A verified dental visits/services was not checked off in the current care plan. Current care plan states set up for provide oral care daily and prn. On 7/10/14, at 7:02 a.m. DON stated if a resident complained of dentures not fitting properly she would expect staff to notify nurse manager, assess the resident and call dental. On 7/10/14, at 9:15 a.m. LPN-C asked HUC to put R62 on the list to be seen by in-house dentist for ill-fitting dentures. Review of the facility Dental Services procedure policy dated April 2000, indicated Extendicare Health Services, Inc. (incorporated) (EHS) centers will assist residents in obtaining routine and 24-hour emergency dental care, would attempt to arrange for dental services to be provided and determine and schedule the dates for the contracted dental services to be available at the center and to identify those residents who need routine services that include "fitting dentures."	F 412		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 102 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 2 Treatments Carts that stored prescription ointments, creams, and sharp instruments, located at the long term care unit 2nd Floor was secured (locked). This had the potential to affect 10 of 51 residents who were alert and oriented and 41 of 51 residents who were cognitively impaired who resided in the unit per facility staff.	F 431	1. Treatment carts will remain locked at all times in the facility. 2. The identified nurse has completed one on one education. 3. All nurses have been re-educated regarding locking treatment carts. 4. DON/designee to audit treatment carts for locked drawers 3X per week. Results of audits will be reviewed at QPI.	

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F 431	Continued From page 103 Findings include: On 7/10/14, at 7:05 a.m. on the South hallway on 2nd floor, a treatment cart was observed to be unlocked. The treatment cart was parked in the hallway, close to the dining room where residents, visitors, and staff members had easy access. The treatment cart was observed to have been left unlocked for about five minutes before registered nurse (RN)-E walked towards the cart, and verified it was unlocked and stated, "I had just locked this earlier." RN-E locked the treatment cart and left. At 10:20 a.m. licensed practical nurse (LPN)-B stated the treatment cart contained prescription ointments, creams, scissors, and other dressing supplies. At 10:30 a.m. RN-E verified the treatment cart which was left open at 7:05 a.m. contained dressing supplies, prescription ointments and creams. At 2:00 p.m. RN-E approached surveyor stated the treatment cart was left unopened "again" even after the surveyor and RN-E discovered the unlocked treatment cart in the morning and showed surveyor a paper which LPN-B had signed a form indicating she was responsible and had been educated about securing the treatment cart. At 2:35 p.m. The director of nursing (DON) stated treatment carts should be locked at all times. The facility's policy # 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles dated 5/2010, provided under	F 431		

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F 431	Continued From page 104 Procedure, number 3. General Storage Procedure: 3.3. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that was inaccessible by residents and visitors.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1. Staff will follow appropriate infection control guidelines for catheter care. 2. Identified NAR has completed one on one education regarding catheter care infection control. 3. Re-Education given to all nursing staff regarding catheter care infection control. 4. ETD/designee to audit proper catheter care infection control 3X per week.	

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F 441	Continued From page 105 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gloves were applied during cares for 1 of 3 residents (R55) reviewed for catheter cares. Findings include: On 7/9/14, at 11:23 a.m. nursing assistant (NA)-A was observed to don gloves after washing her hands in the bathroom upon entering R55's room. -At 11:25 a.m. NA-A explained what she was going to do for resident and reassured R55 then went to the bathroom wet two blue wash towels grabbed a plastic bag, graduate cylinder wrapped in a clear plastic bag and a dry towel and brought supplies to the bedside. -At 11:27 a.m. NA-A cued R55 before starting to wipe the peri-area around the penis as she folded inward wash towel with each wipe. Resident cued NA-A to dab area rather than wipe as the area was easily irritated. -At 11:29 a.m. NA-A was observed to dispose the wash towels in a plastic bag and then was observed to wash her hands for approximately 10 seconds. NA-A then came back to R55's bed side, donned another pair of gloves, opened the alcohol wipe wrap and started cleaning the resident's catheter with the alcohol wipe. NA-A cleansed away from the penal area, disposed the	F 441		

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F 441	Continued From page 106 wipe off, took another wipe, un-wrapped it, and wiped in a twisting motion the catheter tube part. NA-A was observed to open the catheter bag, pinch the catheter tube, used the clean alcohol wipe to clean the ends of both tubes and then reconnect them. -At 11:31 a.m. NA-A then unwrapped another alcohol wipe, cleaned the end of the catheter tube area before draining the urine into the graduate cylinder, wiped it with the same wipe, hung the catheter bag at the base of bed, gathered all the supplies and went to the bathroom to dump the urine. NA-A cleansed the graduate cylinder and then washed their hands. NA-A then came back to R55's bedside, was observed to pick up the yellow part of the catheter tube going into R55's penis with bare hands and secure it to the leg strap. NA-A then adjusted R55's linen, bedside pull table and coffee cups without washing her hands then went to the bathroom washed her hands for approximately 10 seconds and came out of R55's room carrying a plastic bag with soiled linen to the soiled room. On 7/9/14, at 11:35 a.m. when asked if she usually used her bare hands to adjust the catheter tubing to secure it to strap NA-A stated "I know I missed that part I should have gone to get gloves." When interviewed on 7/10/14, at 9:45 a.m. the infection control registered nurse (RN)-F stated "I know she was nervous she should have worn gloves" when asked if the NA-A needed to wear her gloves when handling the catheter. Infection Control Manual revised November 2011, directed, "Wear appropriate gloves when it can be reasonably anticipated that there will be	F 441		

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

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F 441	Continued From page 107 contact with blood, other potentially infectious materials, when performing vascular access procedures, and when handling or touching contaminated items or surfaces."	F 441		

F5187023

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITIES POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Texas Terrace Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok JR 8-4-14 RECEIVED AUG - 1 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DD: 8-19-14
EXIT: 7-10-14

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

[signature] | LNHA | 8/1/14

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

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K 000	Continued From page 1 Marlan.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Texas Terrace Care Center is 3-story building with no basement. The original building was constructed in 1972 and was determined to be of TYPE I(332) Construction. In 1995 an addition was constructed to the west and it was determined to be of TYPE I(332) Construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.The facility has a capacity of 118 beds. At the time of the survey the census was 85. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069		

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K 069	Continued From page 2 Based on record review and interview, the facility's kitchen cooking equipment has not been maintained in accordance with Sec. 9.2.3 and NFPA 10. This deficient practice could affect some residents if near the kitchen. Findings include: On facility tour between 9:30 AM and 11:15 AM on 07/10/2014, record review revealed that the last semi-annual kitchen hood suppression system inspection was on 12/03/2013. This deficient practice was verified by the administrator at the time of the inspection.	K 069	1. Nardini Fire Equipment Co. has serviced the kitchen hood suppression system. 2. Nardini Fire Equipment Co. was scheduled and completed their inspection of the hood suppression system on July 25th, 2014. 3. The facility Director of Maintenance will continue to monitor and schedule semi-annual hood suppression system inspections.	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation. Findings include: On facility tour between 9:30 AM and 11:15 AM on 07/10/2014, observation revealed that there is	K 072	1. The facility will obtain a categorical waiver to allow wheeled storage in the facility hallways. 2. The facility will obtain a categorical waiver prior to August 19th, 2014. 3. NHA to monitor and prevent re-occurrences of LSC violations.	

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TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(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 072	Continued From page 3 wheeled storage in the corridors throughout the facility. The facility does not have a categorical waiver for this type of storage. This deficient practice was verified by the administrator at the time of the inspection.	K 072		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5279

July 25, 2014

Mr. Reid Hewitt, Administrator
Texas Terrace Care Center
7900 West 28th Street
Saint Louis Park, MN 55426

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5187023 and Complaint Number H5187062

Dear Mr. Hewitt:

The above facility was surveyed on July 7, 2014 through July 10, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5187062 that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF

MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File