Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 23, 2019

Ms. Linda Atkinson, Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

Re: Lake Winona Manor - Independent Informal Dispute Resolution
CMS Certification Number (CCN) 245240
Project # S5240030

Dear Ms. Atkinson:

In a request dated February 8, 2019, Lake Winona Manor requested removal of a deficiency cited at F686 as a result of a survey completed on November 2, 2018 by the Licensing and Certification program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated April 10, 2019.

The revised CMS 2567 is enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Becky Wong

Becky Wong

CC: Office of Ombudsman for Long-Term Care
Mary Absolon, Program Manager
Pam Kerssen, Assistant Program Manager
Maria King, Assistant Program Manager
Brenda Fischer, Assistant Program Manager
Lindsey Krueger, OHFC Director
Licensing and Certification File

IIDR - Revised 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING ______ B. WING ______	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

(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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on October 29, 30, 31, November 1 & 2, 2018, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan included a method for sharing information the facility had determined appropriate, with clients and their families or representatives. This had the potential to affect all 89 residents currently residing in the facility and their families/representatives. Findings include: On 10/31/18, at 1:38 p.m. the facility emergency policies and procedures were reviewed with the registered nurse (RN)-G. RN-G stated the facility had not shared any information with clients and	E 035	E-035 Standard work for family notification of facility emergency plans will be created on 12/4/2018. The Lake Winona Manor Emergency Prep Policy will be updated to include notification of plan to residents and responsible parties by 12/4/2018. LWM staff will be educated on updates to standard work and policy by 12/11/18. A social worker or designee will audit perform a monthly audit x 4 months to monitor compliance. Results will be brought to the QA/QI for further recommendations.	12/11/18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/30/2018

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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E 035	Continued From page 1 their families or representatives.	E 035		
F 000	INITIAL COMMENTS On October 29, 30, 31, November 1 & 2, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and 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 observation, interview, and record	F 557	F557 Respect/Dignity	12/11/18

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F 557	Continued From page 2 review, the facility failed to ensure 1 of 1 resident (R42) was treated in a dignified manner while being provided assistance with personal cares. Findings include: R42's Face Sheet dated 11/1/18, identified an admit date of 5/18/17, a diagnoses of multiple sclerosis (MS), depression and anxiety. R42's quarterly Minimum Data Set MDS an assessment, dated 8/30/18, identified to have intact cognition, required 1 person extensive assist with dressing and personal hygiene, 2 person extensive assist with bed mobility and transfers. R42's care plan updated 10/19/18, identified a problem: I need assistance with my activities of daily living (ADL's) because I have MS. Approach: personal history-as evening approaches I am more tired and may not cope with deviation from my routine. I have a history of sexual assault and at times incidents can make me feel vulnerable. Please explain all cares as they are being provided. I am ok with male and female care givers to complete all parts of my care. Problem: I can be demanding and controlling of others. I may have verbal outbursts as this is how I cope with my MS. Approach: taking time to listen to what I have to say, allowing me to vent is helpful and calming. Behavior record charting dated 10/17/18 at 10:47 p.m., indicated, Resident was rude to the male staff member telling other staff she didn't want him in there or even want him to be in there to do cares with her while aide was in the room. Stated to the male nurse, "I can't wait for you to go on	F 557	Resident 42□s care plan was updated on 10/18/2018 and reviewed for accuracy on 11/29/2018. Employee involved in situation received coaching on 10/19/2018. The VA Policy and standard work were reviewed and updated on 11/27/2018. All LWM staff will be trained on VA Policy by 12/11/2018. Random Audits of 5 staff will occur weekly x 5 weeks by the Social Worker or Designee to monitor compliance. Results will be brought to the QA/QI for further recommendations.	

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vacation because you bother everyone around here." And he left with his partner and she was the last to go to bed.

Behavior record charting dated 10/18/18, at 12:07 a.m. indicated, resident was upset about her p.m. cares, stating the aides "weren't being friendly towards her. Aide was pulling on my shirt and it felt like I was being raped. If I needed help with my shirt, I would ask for help, I can do it myself." Night aide allowed resident to let out feelings. A few minutes later, resident asked for some hard alcohol, stated to resident if you need anything to put on the call light.

Behavior charting dated 10/18/18, at 8:17 a.m. indicated, due to comment of 'felt like being raped' this writer and charge RN (registered nurse) came to talk with resident. Asked resident if she felt threatened by male caregiver. Resident responded, "No I am not threatened by him ...he just grabs and starts doing things and I am not ready. "Writer asked resident what she meant by doing these things and resident replied that he just starts grabbing on my shirt or starts getting washcloths ready and I don't want that yet ...he goes so fast and I have no time to process things ..." Writer paraphrase this reply back stating "So what you are saying is that he starts his cares without seeing what you need done first or he does not tell you what he is doing step by step so you know what is coming? Resident said, yes that is what he does, you know he and me, we just do not mesh well. Writer then did question the resident say "you reported to my aides that you felt he was grabbing at you and you felt you were being rape? Resident reply saying "well what I meant was I know he was not going to rape me, but the way he grab me ...reminded me

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of a situation in my past where I was raped and the person grab me similar to this." Writer then suggested that due to past and situation would she be ok with female only care giver. Care Plan updated, resident is a female only care giver except in case of emergency a male care giver can be used to help assist resident.

During interview on 10/30/18, at 9:21 a.m. R42 stated, nursing assistant (NA)-N was disrespectful towards me about a week ago around 6:30 p.m. I had a bad day, my nephew had given me some bad news and I had just found out one of my good friends with a cancer diagnosis may not make it through the night. So what happened was NA-N and NA-M came into my room to help me get ready for bed. I was in the process of taking off my shirt and NA-N stated, No, I will get it When he went to pull my top on it hit me all wrong. I told him I would ask for help if I needed it, and he said, ok, ok! It seems like he is always in a big hurry, so I proceeded to tell him, as he was trying to tug at my shirt, this is the way guy's rape women, and I should know it has happened to me twice. He then backed off and told me, "You will not show me disrespect!" He then snapped his fingers and pointed towards the door and went out the door and [NA-M] followed him. They didn't come back in till 9:45 p.m. that night. Then my nurse, [licensed practical nurse (LPN)-F] comes in my room and said very sternly to me, "[NA-N] will be getting you ready for bed whether you like it or not, so I don't want to hear anymore that you are being disrespectful to him." [LPN-F] had made her mind up, she was siding with [NA-N] and "It made me feel like I was reprimanded like a child." She had been in here earlier that night and we were laughing and joking about my flamingo

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clock. I was not expecting her to come in and talk to me like that, I feel like I was disrespected by both of them. Well they both came back and NA-N helped me into bed and then NA-M finished helping me. I am not worried right now about NA-N, he is on vacation, so I haven't had to deal with him. You learn around here that it is their way or no way. They acted like I was screaming at him, I was just having a bad day and I wasn't in the mood to have my shirt pulled like that. The next morning [social services (SS-B] came in and talked with me, when I told him what happened he told me they were wrong in doing that. I think NA-N blew it way out of proportion, I think he was telling them that I said he tried to rape me and that was not at all what I said. Then [administrator (A)-B] came and asked me what happened and I told her it was a PTSD (post traumatic stress disorder) thing with [NA-N] when he grabbed my shirt. She then told me they would get me someone to talk to for that. No one else ever came in and talked to me about it, that was it. R42 stated, "I do not feel like [NA-N] abused me, I just want to be treated with respect and dignity, I feel like no one here is supporting me."

During phone interview on 11/01/18, at 12:39 p.m. nursing assistant (NA)-M stated, some people find R42 difficult, but when she complains her points are valid, sometimes she just has a hard time getting her point across. About 2 weeks ago one of my co-workers [NA-N] and I were working on R42's wing. I think she was kind of mad at him because he was late with her stretches the night before, and when she gets mad she can hold grudges. Anyway's, he had her shirt half on and R42 yelled at him, get the hell out of here and go to Mexico! (She knew he was going there for vacation.) I personally thought that was

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inappropriate. Then [NA-N] said to [R42], you will not disrespect me like that, you will not treat me this way, in a very stern voice and left her shirt half on. Then he said to me, come on we are leaving. I thought it was wrong, he should have let me finish putting her shirt all the way on, I suppose [R42] tried to make us look bad, going through the common area with her shirt half on and off, she has an electric wheelchair and went to the trans care unit (TCU), telling people, they put my shirt half way on then left me. NA-M stated, I did go back in there a while later and asked if she was ready for bed, and we helped her to bed. [R42] was still very upset with [NA-N] and told me she was not going to talk to him. NA-M verified no other staff came and talked to her about this specific incident. The next day we told [registered nurse (RN)-F] and she told us to make sure we chart this as a behavior, so we did. I do think it was disrespectful that [NA-N] left her shirt half on and half off and demanded me to walk out with him, when I could have finished helping her.

During interview on 11/01/18, at 2:22 p.m. RN-F verified the incident happened on 10/17/18, during the evening shift and that she was notified the following morning. RN-F verified she did know NA-M and NA-N were involved in the incident and did not interview them. RN-F stated, I would say leaving [R42's] shirt half on and half off was disrespectful, that should not have been done.

During interview on 11/01/18, at 2:39 p.m. SS-B stated he was not aware of the whole situation concerning R42. SS-B stated, I feel the situation was not handled well, it is their job to care for the resident, her shirt never should have been left

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half on, and cares come first. "It does go back to dignity, you can't just leave someone with their shirt half on."

During interview on 11/01/18, at 3:14 p.m. A-B verified she went and talked with R42 the morning she was notified of the incident and stated, I will have to interview the staff members before I could say if this resident was treated disrespectfully. A-B further stated, R42 did mention she left the room with her shirt half off, because she wanted to show them.

During interview on 11/01/18, at 4:39 p.m. director of nursing DON stated, I was notified right away about this incident, the administrator followed up on that and closed the loop on that. I want all my residents to be treated with dignity and respect. They (the staff) struggle with the right tools for her behaviors and we are working at that. "She is a vulnerable adult and we have to care for her and treat her with respect and dignity and it is obvious we have some work to do."

Policy requested regarding dignity, however none provided.

F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		12/26/18

§483.10(j) Grievances.
§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other

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F 585	Continued From page 8 residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,	F 585		

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F 585	Continued From page 9 receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and	F 585		

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F 585	Continued From page 10 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to communicate and implement a grievance process for 9 of 9 residents (R8, R17, R82, R3, R41, R43, R49, R25 and R50) reviewed during resident council. Findings include: During a resident council meeting without staff present with R8, R17, R82, R3, R41, R43, R49, R25 and R50, on 10/31/18, at 10:30 a.m. when asked if anyone knew how to file a grievance or who their grievance official was 8 of 9 residents in attendance stated they did not know how to file a grievance or who the grievance official was, with the exception of R18. R18 stated there are paper forms on the doors of the social workers and that you fill out the form and the social worker will get back to you. R82 stated, "I have been here for 7 years and I never heard of being able to file a grievance." When asked if the facility follows up on grievances all residents were in disagreement with stating, "No." and shaking their heads. A few had confused looks on their faces, R43 stated, they do not respond to our concerns, that's why half the time we don't repeat it. Several residents were nodding their heads in agreement as R43 said this. At 10:40 a.m. R41 stated, no, they do not always act promptly to our complaints/grievances, sometimes you have to repeat it to the head of one of the committees (department heads) whoever you are having the problem with and sometimes you can't discuss	F 585	F 585 Grievances A policy and form for LWM Grievances was created on 11/30/2018. ALL LWM staff will be trained on new standard work by 12/11/2018. Updated Standard Work for resident grievance education created by 12/4/2018. All residents and responsible parties will be trained on grievance process by 12/26/2018. Audits of resident care conferences will be done x 8 weeks by a Social Worker or Designee to determine level of understanding. Results will be brought to the QA/QI Committee for further recommendations.	

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certain things in front of everybody.

During interview on 10/31/18, at 12:14 p.m. health unit coordinator (HUC) stated, resident grievances are entered into ECS (electronic medical record), was not sure if there was a paper form.

During interview on 10/31/18, at 12:16 p.m. when asked about how a resident would file a grievance, licensed practical nursed (LPN)-C stated, we do not have paper grievance forms, if a res had a complaint they would tell the aide, the aide would tell me and I would document in ECS, "I think they have a grievance file there." LPN-C was unsure and directed this surveyor to the director of nursing.

During interview on 10/31/18, at 2:50 p.m. registered nurse (RN)-A stated resident grievances are filed under logic manager (program in electronic health record). This is used more for family grievance process. If a resident has a complaint we chart it in quality assurance (QA) (another program in electronic health record) under ECS. I think our grievance official is, I guess it depends on what the concern is. We do not have 1 specific grievance official. If a resident has a concern I guess the nursing assistant has no way to help the resident to fill out a grievance form because they do not have access to the quality assurance in ECS. The nursing assistant or resident would have to report it to the nurse so she could put it in quality Assurance in ECS for investigation. The resident grievance will not get a letter like the family grievance would. I am not sure why there are two different systems for this.

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F 585	Continued From page 12	F 585		

During interview on 11/01/18, at 9:13 a.m. nursing assistant (NA)-L stated, I don't think there is any grievance form for the residents to use and I have been here since June.

During interview on 11/01/18, at 12:58 p.m. nursing assistant (NA)-M stated, If I ever heard a resident who had a complaint, I would tell my trained medication aide (TMA) and then hopefully they would report it to the charge nurse which would be down on the TCU (trans care unit) for the evening shift. I am not sure how they get followed up on.

During interview on 11/01/18, at 1:40 p.m. licensed practical nurse (LPN)-E stated in response to residents filing a grievance, "If an aide came to me and told me a resident wanted to file a grievance or complaint, I am not sure, I would ask the charge nurse, maybe there is a form." LPN-E was unable to answer how the grievance system works and had to ask her charge nurse.

During interview on 11/01/18, at 1:51 p.m. registered nurse (RN)-F stated, as far as a resident complaint/grievance the process is the resident would have to come to licensed staff and they would put it in QA/incident in ECS. I am not sure how a TMA would file it, I would have to ask. If it is a complaint for another department other than nursing we would document that in logic manager. This is the one where they would receive a letter in response to the complaint. With nursing concerns we follow up verbally, it is not documented.

During interview on 11/1/18, at 3:44 p.m. director of nursing (DON) stated, I have worked here

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F 585	Continued From page 13 since 2013, when asked what the policy or process of how a resident files a grievance, and who the designated grievance official is and what action is taken to resolve the grievance, the DON verified the policy does not have a clear process for grievances. Facility policy, Patient/Resident Grievance and /or complaint Winona Health policy, revised 4/18, indicated the purpose: requires prompt reporting of all negative feedback for timely investigation and to initiate corrective actions as appropriate. Patients will be informed of any follow up actions. In the event a feedback is a grievance, the final resolution of the grievance must be given to the person in writing. Policy: negative feedback should be addressed at the level and at the time it originates. When negative feedback is received, it is entered into the electronic reporting system (Logic Manager) as soon as possible. The department director, manager or supervisor will 0. (No further plan identified).	F 585		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		12/11/18

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F 607	Continued From page 14 by: Based on interview and document review, the facility failed to ensure their abuse prohibition policy and procedures identified a definition of resident-to-resident abuse and reporting procedures for resident-to-resident abuse. This has the potential to effect all 89 residents in the building. Findings include: Review of The Vulnerable Adult Abuse Prevention Plan with a revision date of 3/18, revealed the policy did not include a definition of resident-to resident abuse. The Facility flow sheet for Resident-To-Resident Altercations dated 7/2014, included, "Did the resident act willfully in the altercation?" and included the definition of "willful" as the individual intended the action itself that he/she knew or should have known could cause physical harm, pain or mental anguish. Even though a resident may have cognitive impairment, he/she could still commit a willful act. The flow chart directed staff that if the willful act did not result in physical harm, pain, or mental anguish, the act was not reportable. During an interview on 10/31/18, at 2:50 p.m. social services (SS)-A verified by reviewing the Vulnerable Adult Abuse Prevention Plan, it did not include a definition of resident-to resident abuse. SS-A stated, "I guess I am not seeing it either (referring to definition of resident-to resident abuse)." SS-A stated at the nurse stations there was a flow sheet for resident-to-resident altercations for staff to follow. SS-A stated the flow sheet directed staff if there was no intent to	F 607	F607 Develop and Implement Abuse/Neglect Policies The LWM VA policy was updated with current definition of resident-to-resident abuse on 11/27/2018. All LWM staff will be trained on VA Policy by 12/11/2018. 5 Random audits of behavior documentation will occur weekly x 8 to monitor for compliance to reporting requirements by a Social Worker or designee. Results will be brought to the QA/QI Committee for further recommendations.	

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F 607	Continued From page 15 not report. The State Operations Manual (SOM) Appendix PP dated 11/22/17, defined the definition of willful as used in this definition of abuse, "means the individual mush have acted deliberately, not the individual must have intended to inflict injury or harm."	F 607		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		12/11/18

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F 676	Continued From page 16 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cares were provided for oral hygiene and bathing for 1 of 5 residents (R34), reviewed for activities of daily living (ADLs). Findings include: R34's admission Minimum Data Set (MDS), dated 9/4/18, indicated R34 had moderate cognitive impairment, required one assist with personal hygiene and bathing and activity of bathing did not occur during entire period. R34's care plan, dated 9/21/18, included I need assistance with my ADLs and approaches included oral hygiene set up assist and for bathing I would like to try a whirlpool bath to see if it helps my back. R34's nursing assistant care sheet included bathing: dependent with one person physical assist, resident request tub bath one time a week on the p.m. shift. Oral care: upper full set, four natural teeth on the bottom. Grooming: independent with set up. During interview on 10/29/18, at 3:03 p.m., R34	F 676	F676 ADLS-Care plans and NA task lists were reviewed and updated for R34 on 11/29/2018. R78 no longer resides at this facility. Standard work for oral care and the Resident□s Personal Appearance and Hygiene Policy were reviewed and updated on 11/29/2018. All nursing staff will be trained on new standard work by 12/11/2018. 5 random audits of both oral care and bathing records will be performed weekly x 5 by the Nurse Manager or Designee. Results will be brought to the QA/QI Committee for further recommendations	

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F 676	Continued From page 17	F 676		

stated they do not offer me a bath or shower anymore. I am washed up in the bathroom in my room. I only get a scrub down. I do not know what the scoop is. I have had my hair washed one time and that was in the shower that I had once.

During interview on 10/29/18, at 3:22 p.m. R34 stated I do not always get help with brushing my teeth. I do not know if that is my fault or not. I do not ask. They offer once in a blue moon. The last time I had my teeth brushed was a couple months ago.

During observation on 10/31/18, at 8:26 a.m., R34 laid in bed dressed eating breakfast. R34 stated my upper denture plate was cleaned last night. When asked if her four natural teeth in her mouth had been brushed this morning with cares, R34 stated no, I should have had them brushed at the time I was dressed. Everything is in such a rush when they come in to help you get dressed.

R34's record identified the following information was documented for bathing by the nursing assistants: 9/10/18 tub bath given, 9/17/18 bed bath given and 10/8/18 hair shampooed and shower given.

During interview on 10/31/18, at 9:19 a.m., nursing assistant (NA)-B stated she had assisted R34 with a.m. cares. When asked if she had offered or brushed R34's four bottom natural teeth when providing morning cares, NA-B stated I gave R34 her upper denture, but I did not offer or brush R34's natural teeth.

During interview on 10/31/18, at 3:30 p.m., the director of nursing (DON) confirmed R34's care plan as above. DON stated the facility protocol for

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F 676	Continued From page 18 oral hygiene was to be completed with morning and evening cares, anytime needed and at request. DON stated she would expect oral hygiene to be completed every a.m. or offered. During interview on 11/01/18, at 7:53 a.m., NA-C stated R34 received a bath on Monday evenings and the nursing assistant's document completion of the bath under the nursing assistant charting in the computer system. During interview on 11/01/18, at 10:09 a.m., the DON reviewed R34's record and confirmed the above three times of bathing having been documented. DON stated there was no other documentation of any other times bathing had been completed for R34. DON stated staff may have missed charting a bath for R34, but she would not expect to see that many gaps of documentation not being completed for bathing. DON stated if the resident had refused, she would expect staff to document the refusal. The facility policy Care Plans and Care Conferences, dated 4/16, indicated a multidisciplinary approach is used to individualize each resident's care plan to achieve and maintain the resident's optimal physical, communicative, psychosocial, functional, spiritual and emotional status.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		12/11/18

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F 677	Continued From page 19 by: Based on observation, interview, and document review the facility failed to ensure timely toileting assistance for 1 of 5 residents (R78) reviewed for activities of daily living. Findings include R78's Diagnoses List dated 11/1/18, included diagnoses of malignant neoplasm of bladder, constipation, and chronic renal disease stage 4. R78's annual Minimum Data Set (MDS) dated 10/11/18, indicated R78 cognitive skills for daily decision making were severely impaired. The MDS further indicated R78 required extensive of assistance from two staff for transfer and extensive assistance from one staff for toileting. The MDS also indicated R78 was frequently incontinent of bladder and bowel and was not on a toileting program. R78's urinary incontinence Care Area Assessment (CAA) that was printed on 11/1/18, did not include a date of completion. The CAA indicated R78 required assistance with toileting, was taking diuretic medication that caused urge incontinence and anticholinergic's that made lead to overflow incontinence. The further indicated R78 had diabetes, bladder cancer, and had stress incontinence with urgency. The CAA also indicated, "revise current care plan." R78's self-care deficit care plan for toileting care plan dated 10/3/18, directed staff to use 1-2 staff assist depending on R78's mood and to assist every two hours and as needed. The care plan further directed staff if R78 was resistive to toileting return later and attempt again. R78's skin	F 677	F677 R78s is no longer a resident at the facility. Toileting standard work was created on 11/30/2018. All nursing staff will be trained on the toileting standard work by 12/11/2018. 5 Random audits weekly of toileting completion will occur x 6 weeks by the Nurse Manager or designee. Results will be brought to the QA/QI Committee for further recommendations.	

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F 677	Continued From page 20	F 677		

care plan dated 10/4/18, indicated R78 was at risk for impaired skin integrity related to incontinence and directed staff to keep skin clean and dry and to apply barrier cream after any incontinent episode.

R78's progress note dated 10/16/18, included: Resident is totally dependent on staff for all toileting needs. He is incontinent of both, but he will have bowel movements in the toilet if staff gets him there in time. He doesn't tell staff when he needs to use the toilet, but becomes increasingly anxious when needs to have a bowel movement and that is a cue for the staff.

During an observation on 10/31/18, at 7:38 a.m. R78 laid in bed with his eyes closed. Nursing assistant (NA)-E indicated sometimes R78 was a one assist or two assist depending on what his mood was in the morning. NA-E attempted gently to wake R78 up and folded down the top sheet and blankets. The top sheet, mattress protector pad and fitted bottom sheet were noted to be saturated with urine. R78's incontinent brief and gown were also saturated. At 7:47 a.m. NA-F entered the room to assist NA-E. R78 became resistive to get out of bed. While NA-F changed R78's gown and replaced the urine saturated top sheet with a fresh clean sheet, NA-E put new socks on R78's feet. During the observation neither NAs offered to take R78 to the bathroom nor did the attempt to offer or change the soiled brief or linen.

During an interview on 10/31/18, at 8:52 a.m. NA-E stated she attempted to get R78 up again, however, he was not ready to get up. NA-E she had not provided any cares, however, the nurse checked his blood sugar.

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F 677	Continued From page 21	F 677		

During an observation on 10/31/18, at 10:01 a.m. NA-E knocked on R78's room and entered. R78 laid in bed with his eyes closed and snoring. NA-E stated R78 could sleep all day. NA-E asked R78 if he wanted to get up and get ready, R78 did not respond. NA-E then left R78's room without checking R78's linen or offering to take R78 to the restroom.

During an observation on 10/31/18, at 11:34 a.m. registered nurse (RN)-C and NA-F entered R78's room. R78 was agreeable to get up out of bed and allowed NA-F and NA-G to assist with morning cares. R78's brief, mattress protector pad, and fitted bottom sheet were saturated with urine.

During an interview on 10/31/18, at 11:43 a.m. NA-F stated she had thought the other NA had offered and/or checked and changed R78's brief and linen as she had been in there prior to her arriving in the room that morning. NA-F stated if she would have known that was not completed during the first attempt to get him out of bed, she would have asked and/or changed the soiled linen. NA-F stated the linen should been attempted to be changed and R78 should have been offered toileting and/or checked and changed.

During an interview on 11/1/18, at 8:31 a.m. registered nurse (RN)-A stated R78 was supposed to be toileted every two hours and if he was in bed he was supposed to be checked and changed every two hours. RN-A indicated sometimes R78 displayed aggressive behaviors and approach was key, if R78 had behaviors the expectation was for staff to leave and

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F 677	Continued From page 22 re-approach until cooperative. RN-A stated R78 could not tell staff when he needed to use the bathroom. RN-A stated it was expected staff change and/or offer toileting and if R78 refused multiple times then the nurse or clinical manager should have been made aware. During an interview on 11/1/18, at 11:20 a.m. director of nursing (DON) stated staff should have offered toileting or checked and changed R78 as per the care plan. DON further indicated if R78 was incontinent staff should not have waited another hour to re-approach to remove the soiled garments and linen and should have reported the refusals of care to the nurse in order to come up with another intervention. Policy relating to incontinence/toileting was requested and not received.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide ongoing assessment/monitoring or care for edema (fluid retention) for 3 of 3 residents (R78, R7 & R73) reviewed with cardiac and respiratory	F 684	F684 Care plans for R7 and R73 were reviewed and updated to include edema monitoring instructions by 11/30/18 . R78 is no longer a resident at the facility. New standard	12/11/18

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F 684 Continued From page 23

complications. Also the facility failed to ensure a dressing change was implemented as written per the physician orders for 1 of 1 resident (R1) and failed to ensure a follow-up physician visit was completed for 1 of 1 resident (R34) following a visit to the emergency room.

Findings include:

EDEMA MONITORING:

R78's Diagnosis List dated 11/1/18, included diagnosis of congestive heart failure, hyperkalemia (high potassium), chronic kidney disease stage 4, and vascular dementia.

R78's annual Minimum Data Set (MDS) an assessment, dated 10/11/18, indicated R78's cognitive skills for daily decision making was severely impaired, identified the diagnosis of congestive heart failure (CHF), and received diuretic medications during all days of the assessment period.

R78's physician orders dated 11/1/18, included:
-Furosemide (diuretic medication) 40 milligrams (mg) twice per day (start date 7/17/18).
-Tubular bandage/Ted hose (compression stockings) to both lower extremities on during the day and off at night (start date 10/4/18)

R78's care plan dated 11/1/18, did not identify diagnosis of CHF nor goals for treatment and management. The skin integrity care plan dated 9/15/18, directed staff to observe skin with cares for any redness signs and symptoms of skin breakdown and update nurse to evaluate as needed, Ted stockings on in the morning and off at bed time, encourage resident to elevate legs

F 684

work was developed on Edema monitoring and Aseptic Dressing Changes on 11/30/18. All residents screened for necessity of edema monitoring and care plans updated accordingly. All licensed staff will be trained on new standard work and policy updates by 12/11/2018. Weekly audits of 5 residents appropriate for edema checks will be performed by the Nurse Manager or designee x 6 weeks. Results will be brought to the QA/QI Committee for further recommendations.
Provider Notification standard work was updated on 11/30/2018 to include actions related to discharge provider visit recommendations. All Licensed Nursing staff and Health Unit Coordinators will be educated on standard work by 12/11/2018. 2 Random audits of standard work will be performed by a Health Unit Coordinator or designee weekly x 6 weeks. Results will be brought to the QA/QI Committee for further recommendations.

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during the as tolerated.

R78's record was reviewed from 8/6/18 through 11/1/18; the record lacked evidence of ongoing edema monitoring. The only edema assessment in the record during that period included the following:
-R78's ANNUAL/SCSA Assessment: 10/10/18, EDEMA indicated, no edema was present, had peripheral pulses, and has diagnosis of CHF and received Lasix. Weights stable.

During an observation on 10/29/18, at 2:34 p.m. R78 sat in wheelchair with his eyes closed; R78 legs had Tubular bandages on. R78's legs were edematous; right leg was more swollen than the left when compared.

During an observation on 10/31/18, at 7:38 a.m. R78 laid in bed, had gripper socks on. Nursing assistant (NA)-E removed the gripper socks; the skin above the ankle where the top of the gripper sock had been was indented. NA-E then put clean socks on.

During an interview on 10/29/18, at 2:48 p.m. family member (FM)-A stated R78 had more swelling in both his legs than he has had before. FM-A was not sure if R78 received a diuretic medication however, stated he used the "tubi grips" to help with the swelling. FM-A stated R78 had a weight gain since last care conference of at least 3-4 pounds.

On 11/1/18, at 9:25 a.m. registered nurse (RN)-A reviewed R78's record and verified there was not documentation of edema and/or not consistent. RN-A indicated the overall documentation of monitoring and assessment of edema was

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lacking. RN-A stated edema should routinely be monitored and documentation should include location, extent, and determination if interventions were effective.

During an interview/observation on 11/1/18, at 9:34 a.m. R78 sat in his wheelchair in his room with tubular bandages to both legs. RN-A removed the bandages, stated the left leg had trace edema was not pitting. RN-A then stated R78's right leg had 3+ edema from foot to mid-calf.

During an interview on 11/1/18, at 11:20 a.m. director of nursing (DON) stated, monitoring of edema should be done daily; documentation should include location and extent of edema. DON then stated weekly more comprehensive assessments should be done.
R7 had been interviewed on 10/29/18, 3:56 p.m. at this time R7 was noted to have significant swelling of both lower legs and noted there were compression wraps in place. When asked about the edema, R7 said he thought he was on some medication for the swelling, but could not remember. When asked if the facility was monitoring his edema he was unable to say. When asked if the staff encouraged him to lay down or to put if feet up, R7 demonstrated how he could tilt his feet up while sitting in his wheelchair. He then lowered his feet back down.

R7 was observed on 10/30/18, 9:00 a.m. and 12:45 p.m. and legs were not elevated.
On 10/31/18, when observed at 7:17 a.m., 9:30 a.m., 10:50 a.m. and 12:00 p.m. R7 was not noted to have his feet elevated at any time.

A review of R7's progress notes failed to indicate

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any regular monitoring of edema.

According to an interview on 11/01/18, 9:37 a.m. RN-F confirmed that R7 did not have regular edema monitoring/assessments. RN-F was unable to state how much edema R7 currently had, but did know he came to the facility with "Ready Wraps" (to control swelling) which, according to R7's care plan, are to be applied by the nursing assistants daily. When asked about when a nurse would assess R7's edema, RN-F said that "he has been pretty stable" so would only assess if he had a change in condition because "this is his home." RN-F said a general assessment is done on all resident quarterly, but nurses would rely on nursing assistants to report on a change in condition.

During an interview on 11/01/18, 1:20 p.m. the director of nursing (DON) said that the decision to monitor edema would be made according to the chronicity and acuteness of a resident's condition and that "quarterly is not frequent enough." When asked about R7, given an extensive history of cardiac and respiratory issues including a past history of hospitalization for fluid overload, DON stated R7 should have edema monitoring on a regular basis and no less than weekly.

R7's current physician orders included an order for Bumex (bumetanide), a diuretic medication to reduce fluid retention.

R7's care plan states that R7 is at risk for fluid volume deficit related to his ordered diuretic. Also includes nursing assistants to assist R7 with dressing, including application of the "Ready Wraps." however, the care plan lacked monitoring/assessments and at what frequency

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and to watch/report any signs symptoms of fluid overload.
R73's change of condition Minimum Data Set (MDS) an assessment dated 10/4/18, identified R73 had diagnoses including Dementia, other fracture and hypertension. The MDS also identified R73 had short term memory problems, moderately impaired decision making skills for daily living and was administered diuretic medications.

R73's physician orders dated 10/12/18, included: Furosemide (diuretic medication) 80 milligrams (mg) daily in the morning for congestive heart failure.

R73's nutritional care plan dated 10/26/18, indicated R73 on 9-28-18 had significant weight gain in 30/180 days caused by edema. 10/2/18, Decreased intake, Fall with elbow fracture 9-30-18. 10-26-18 significant planned weight loss with decrease in edema. Approach: Offer ensure at meals if not eating 50%.

R73's fluid volume deficit care plan dated 10/1/18, included Potential for fluid volume deficit, related to daily use of Lasix. Goal: Electrolytes within normal limits, will have no indicators of dehydration. Approach: Nurses---observe for s/s (signs and symptoms) dehydration, encourage fluids between meals. Update NP/MD (nurse practitioner/medical doctor) as needed with concerns. Nurse Aides---update with changes in weight, encourage fluids between meals, update nurse with any signs or symptoms of dehydration (constipation, fever, dry oral membranes, increased confusion, low BP (blood pressure), increased pulse etc.) The care plan did not address edema monitoring and/or management.

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On 10/30/18, at 9:41 a.m. during an observation and interview with registered nurse (RN)-A at the time. RN-A
stated R73 had 3 plus pitting edema up to her mid calves. RN-A stated R73 used to have pitting all the way to her knees and hard edema extend all the way to her mid thighs, had some sacral edema. RN-A stated R73's edema was much improved. RN-A stated R73 was also not eating well, some was weight loss and some was fluid loss. RN-A stated the nurses completed pathway charting for the edema daily as R73 had congestive heart failure. RN-A encouraged R73 to elevate her legs. R73 allowed RN-A to put her feet on the tray table base.

R73's physician progress note dated 8/31/18 included, Assessment and Plan: 1. CHF (congestive heart failure) Probable diagnoses especially given sacral edema in addition to lower extremity edema. Her weight is up pretty considerably. I doubt it is from increased oral intake. The pressure is also up significantly. I would anticipate this is diastolic dysfunction although we do not have any previous echocardiograms. I do not think it would be overall beneficial to obtain a cardiogram at this time. While she does have congestive heart failure exacerbation, treatment would be furosemide whether or not it is systolic or diastolic dysfunction. Given her advanced age she would be a poor candidate for ischemic workup. She does have known vascular calcifications and so therefore, there is a high likelihood that she also has cardiovascular calcifications. We will start her on furosemide 20 mg daily. May need to be increased to 40 mg daily. She will likely need this medication long term.

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R73's certified nurse practitioner visit note dated 10/30/18 included, CHF the patient has lost approximately 26 pounds since the initiation of furosemide at the end of August. She is also on potassium supplement 10 mEq (milliequivalents per liter) daily. Her lower extremity edema is about 2+ from feet to below the knees. Lings clear and no SOB (shortness of breath) complaints. Blood pressures have been under good control. She has been on 80 mg of furosemide daily since 10/12/18. Continue this dosing. Patient is resistant to compression stocking or elevating her feet. She does become a bit more complaint when her daughter is visiting.

R73's progress notes were reviewed for September and October 2018. For the month of September one progress noted was found that included a comprehensive assessment of R73's edema that included a description of edema and degree of pitting. In October two progress notes were found that included a comprehensive assessment of R73's edema that included a description of the edema and degree of pitting.

On 11/01/18, at 1:56 p.m. registered nurse (RN)-C was asked what should be charted for edema monitoring. RN-C stated should chart the edema and stated the degree of pitting should be in the notes to help determine whether or not it's the edema getting worse. RN-C stated for example whether or not it is one plus or two plus pitting edema. RN-C stated would also look at other factors such as weights or other symptoms of shortness of breath, all pieces that fit together in the puzzle. RN-C stated need to assess all the component of edema and really need to use your

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assessment skills when assessing the patient.

On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of edema. At 4:15 p.m. RN-A pulled up progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema.

A policy and procedure on edema monitoring was requested and not provided.
DRESSING CHANGE:
R1's Diagnosis List, dated 11/1/18, included diagnosis of localized edema (dependent bilateral lower extremity edema).

R1's current physician treatment orders identified an order dated 10/30/18, Treatment: to left lower extremity (LLE): 1. Cleanse with normal saline or wound cleanser 2. Pat dry with gauze (gentle) 3. Apply no-sting barrier to intact and macerated skin 4. Apply adaptic to small anterior open area and ABD (abdominal pad) 5. Secure with kling and tape, tubigrip and ace 6. Change once daily. Treatment: to right lower extremity (RLE): 1. Cleanse with normal saline or wound cleanser 2. Pat dry with gauze (gentle) 3. Apply no-sting barrier to intact and macerated skin 4. Cover weeping areas with maxorb (calcium alginate) and ABD 5. Secure with kling and tape, ace

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wraps 6. Change twice daily, once drainage is under control change once daily.

During observation on 10/31/18, at 10:31 a.m., registered nurse (RN)-D provide a dressing change treatment to R1's lower legs. RN-D removed the old dressings from R1's lower legs and cleansed both lower legs with SAF-Clens AF Dermal Wound Cleanser and 4 x 4 gauze pad. RN-D placed a 4 x 4 Vaseline gauze pad on the skin of the shin area of the right and left leg and placed an 8 x 10 abdominal pad over the top of the Vaseline gauze. RN-D stated she applied the Vaseline gauze to keep the dressing from sticking to R1's legs. RN-D lifted up the abdominal pads and placed a 4 x 4 gauze pad underneath the abdominal pads on each leg, wrapped both legs with Kerlix (cling wrap) and secured the Kerlix in place with tape. RN-D applied a tubigrip (compression) over each lower leg. R1 refused to have ace wraps applied to each lower leg.

During interview on 11/01/18, at 10:04 a.m., the director of nursing stated she would expect staff to follow R1's physician orders for treatment of the lower legs.

FOLLOW UP PHYSICIAN VISIT:
R34's Diagnosis List, dated 11/1/18, included diagnoses of chest pain unspecified and chronic obstructive pulmonary disease.

R34's resident progress note, dated 10/13/18, identified resident complains of neck pain. Rates it as 8 out of 10. Resident took scheduled pain medication. She elected to go to the ER (emergency room) due to concerns of possible cardiac issues. Resident felt that she was having a stroke. BP (blood pressure) elevated, skin

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clammy, and complaints of neck pain, which she has a history of. Resident had three strokes in the past and that could lead to a heart attack. I just want to get it checked out. Resident told me that she was feeling hot but not clammy. She complained of neck pain and shortness of breath. Resident denied having any chest pain. Resident voiced concerns that she thought she was having a heart attack. I took residents vitals at 21:45 (9:45 p.m.) and got temperature of 98.1, O2 (oxygen) saturation 90% on one liter, BP 212/81, pulse 85, respirations 22. BP 197/74 at 22:00 (10:00 p.m.). Resident decided he wanted to go to the ER.

R34's emergency department (ED) note dated 10/13/18, included Impression and Plan: follow up with physician within one to two weeks.

R34's record lacked documentation R34's primary physician was informed R34 was seen in the ED and lacked documentation of a physician follow up within one to two weeks as recommended per the ED note.

During interview on 11/01/18, at 10:19 a.m., RN-F stated R34 had not been seen by the physician after the ED visit and R34's record had no documentation R34's primary physician was informed R34 was seen in the ED on 10/13/18.

During interview on 11/01/18, at 10:27 a.m., the DON stated if an order to be seen by the physician in 1 to 2 weeks was not written on the order sheet upon return form the emergency department (ED), then there was no order. DON stated staff can look at the ED progress note, but the plan to follow up with primary physician in one to two weeks was not an order.

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Citation Text for Tag 0686, Regulation FF11 Carey, Lisa Based on observation, interview and document review, the facility failed to provide services and treatments as assessed/ordered to promote healing and prevent new pressure ulcers from developing for 1 of 2 residents (R46) who had a stage 4 pressure ulcer to the sacrum. Findings include: The facility's policy Skin Care dated 3/2018, included the definitions of pressure ulcer stages: Stage 1- Non-blanchable erythema of intact skin. Intact skin with localized area of non-blanchable erythema (redness). The presence of blanchable erythema or changes in sensation, temperature or firmness may precede visual changes.	F 686	F686 R46□s Care Plan was reviewed and updated to include specific offloading cares on 11/30/2018. Updated standard work for Chair Positioning as well as the Skin Care policy to define offloading and techniques was updated on 11/30/2018. All residents screened for necessity to update care plan with offloading techniques. All nursing staff will be trained on offloading standard work by 12/11/2018. 8 Random weekly audits will be performed by the Nurse Manager or Designee x 8 weeks. Results will be brought to the QA/QI Committee for further recommendations.	12/11/18

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Stage 2-Partial-Thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. The stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns abrasions).

Stage 3-Full-thickness skin loss. Full-thickness skin loss of skin in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical locations: areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Facia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer.

Stage 4-Full-thickness and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole, undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer.

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R46's Diagnosis List located on admission form dated 11/1/18, included dementia without behavioral disturbance, and pressure ulcer of sacral region.

A physician visit note dated 8/8/18, indicated R46 had been admitted in June 2018, and was 99 years of age.

R46's quarterly Minimum Data Set (MDS) assessment dated 9/6/18, indicated R46's cognitive skills for daily decision making were severely impaired, and indicated R46 had rejected care during 1 to 3 days of the assessment period. The MDS also indicated R46 was not ambulatory, required extensive assistance of one staff member for bed mobility, transfers, dressing, and personal hygiene, and required extensive assistance of two staff for toileting. The MDS further indicated R46 was frequently incontinent of urine and occasionally incontinent of bowel. In addition, the MDS indicated R46 was at risk for pressure ulcers, had a stage 4 pressure ulcer and an unstageable pressure ulcer. The interventions included: pressure reducing device for chair and bed, nutrition interventions, pressure ulcer care, and application of nonsurgical dressings.

R46's current physician orders included:
-Ultram (pain medication) 50 milligrams twice per day (start date 10/31/18)
-Regular diet with Ensure (dietary supplement) with all meals (start dated 10/4/18)
-Left hip treatment (area of eschar) observe area daily, right hip pad with Mepilex (white foam) and observe daily and change foam every three days (start date 9/5/18)
-Left hip treatment: keep area dry, apply maxorb

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over eschar and cover with Mepilex AG form or Kerracel. Secure with paper tape or Medipore tape if needed. Observe daily, you may use the same dressing, though and change dressing every three days. If area opens please notify registered nurse (RN)/wound care nurse. (start date 9/29/18)
-Sacral wound: 1) cleanse wound with wound cleanser, pat dry. 2) apply ¼ normal Dakin's Solution damp to dry using kerlix, pack lightly. 3) cover with 4 x 4 ABD. 4) secure with tape. 5) change three times a day (start date 9/7/18).

R46's undated pressure ulcer Care Area Assessment (CAA) indicated R46 was newly admitted with an unstageable sacrum pressure ulcer that was infected. The CAA indicated R46 was at risk for pressure ulcers related to incontinence, poor nutrition, required staff assistance to move sufficiently to relieve pressure over any one site, and required pressure reducing mattress or seat cushion. Under the heading "Care Plan" included, "Revise current plan".

R46's care plan dated 10/11/18, indicated R46 was resistive to cares at times and directed staff to leave resident alone for short period of time and re-approach; if continued to be resistive have another staff approach. R46's skin impairment care plan dated 10/11/18, indicated R46 had a stage 4 sacral decubitus ulcer and black eschar to left hip, did not identify the lower sacral wound that was identified on 9/11/18, and further indicated R46 had impaired skin integrity related impaired cognition, impaired mobility, incontinence, and was resistive to cares.
Interventions included:
-Staff to assist resident with repositioning every one hour and as needed and when in bed attempt

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to avoid having her lay on her back repositioning from side to side if she will tolerate.
-Nursing to monitor and chart weekly on all skin concerns, consult with wound nurse as needed.
-Nursing to update MD/NP (medical doctor/nurse practitioner) as needed with changes or concerns to skin status.
-encourage fluids, offer lotion to skin
-nursing staff to follow wound care orders updating wound care nurse from clinic or MD/NP as needed with concerns
-Offer snacks between meals, Ensure and Prostat
-assist resident with bathroom needs every two hours and as needed with goal to keep skin clean and dry; staff to update nurse if dressing to sacral wound noted to be soiled to change as needed
-observe skin for redness, bruising, or signs and symptoms of breakdown and update nurse to evaluate, update nurse with any verbalizations up pain to evaluate as needed
-pressure reducing pad to wheelchair when up
-2 staff with lift sheet, to move resident up in bed as needed
-assure foam padding intact to left hip.

R46's Nursing Assistant Care Plan dated 10/11/18, included: REPOSITIONING: I need 1-2 staff assist for repositioning every hour due to my continued risk for further skin breakdown.

R46's Skin Alterations notes included the following documented measurements:
-9/5/18, note included: Sacral stage IV (4) 2.2 centimeters (cm) x 1.0 cm x 2.5 cm, 6 o'clock tunnel 4 cm. Continue with Dakin's damp to dry changing as directed. Area does appear to be slough today. Drainage was thick and straw colored, no odor noted. Continue to provide

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F 686	Continued From page 38 repositioning. -9/11/18, note included: Sacral wound dressing change completed this evening. Upon assessment a small red open area about an inch below sacral wound was noted. Assessment did not include measurements of the sacral wound nor the new open area. -9/12/18, note included: Wound on sacrum appears unchanged from yesterday, drainage pinkish brown in color. New open area size of pencil point just below the initial ulcer is noted with care this morning. Resident verbalizes a lot of pain and fear with care to wounds and repositioning in bed. -9/14/18, note included: The original sacral wound is 2 x 1 x 4 cm, with tunneling and communication to a second opening that is 0.5 cm x 0.5 cm, measuring 3.5 cm from one wound to the other. There is undermining circumferentially, measuring 4 cm in some areas. Pt (patient) has pressure relieving cushion and continues to be repositioned by staff. Continue with dressings, at this point there is not another dressing that will be better for infection control. -9/20/18, note included: Ulcer on buttocks measures 2.5 cm length x 1.5 cm width x 2.5 cm deep, serous drainage with no odor. Tiny hole underneath where ulcer tunnels through 0.7-0.8 cm x 0.3-4 cm. -9/25/18, note included: Stage 4 sacral ulcer 2.3 cm x 1.5 cm 2.5 cm. Circumferential undermining at 12 o'clock: 2 cm, wound communication to second opening along gluteal cleft: second opening measures 0.2 cm x 0.1 cm and the length between the superior open area and communicate is 3.5 cm. The note further indicated the wound is chronic and may deteriorate depending on patients nutrient intake and other factors. At this time she prefers to sit	F 686		

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F 686	Continued From page 39 up in her chair. Wounds like this do not typically heal when sitting up on it and patients usually are on bed rest with side to side positioning. Patient does have two areas on her hips that are problem caused by both pressure and hardware migration, so side to side repositioning would be difficult unless she has a different support surface. Since patient is up in chair and likes to participate in activities, will keep treatment unless staff report any concerns. -9/26/18, Sacral ulcer stage IV, 2.8 cm x 1.8 cm x 2.8 cm, tunneling at 6 o'clock 3.3 cm and 2.0 cm at 12 o'clock, unable to visualize tunneling. -10/4/18, note indicated sacral wound treatment was done; moderate amount of bloody yellow drainage. Just below wound bed a pen tip hole noted. -10/8/18, note indicated stage 4 sacral wound measured 1.5 cm x 2.5 cm x 2.8 cm, tunneling at 6 and 12 o'clock positions. Second open area below the larger sacral ulcer measuring less than 0.5 cm in diameter. (did not include a depth). -10/10/18, note indicated sacral region had two openings: lowest one measured 1.4 cm x 1 cm and upper opening is 2 cm by 1.2 cm wound tunnels from 6 o'clock 4.2 cm. From 6 o'clock to 11 o'clock is undermined about 1.2 cm. -10/17/18, note indicated sacral ulcer less than 2 cm length, less than 1 cm width, depth 6 o'clock and 12 o'clock but filling in with tissue less than 1.5 cm. Smaller one below tunneling 1 cm x 0.5 cm with 2 cm depth. -10/23/18, note included: sacral ulcer 2 cm x 1.5 cm with 1.75 cm depth but filling in with tissue. Smaller hole underneath 0.75 cm x 1.2 cm with 2.5 cm depth. Applied dressings as ordered. R46's record lacks evidence of documentation of refusals to reposition/offload.	F 686		

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F 686	Continued From page 40 R46's last physician visit dated 10/8/18, indicated primary physician had treated R46's wound empirically with antibiotics related to question of infection and new on-set of tunneling in the wound. The note indicated since that time the sacral ulcer had improved and was stable. The note referenced areas of impaired skin which included the left hip and Stage 4 sacral ulcer that measured 2.8 cm by 1.8 cm with a depth of 2.8 cm. The physician visit note did not reflect the development of the new wound that measured less than 0.5 cm in diameter the same day as visit. During an observation on 10/31/18, at 7:15 a.m. R46 was transferred from bed to bedside commode. R46's sacral dressing was dry and intact. R46 cried out "ohhhh" during the transfer. Licensed practical nurse (LPN)-C stated she had pain medication already that morning and had completed the dressing change to sacral wound. LPN-C indicated R46 had a pea sized open area with tunneling to a wound right below. After morning cares were provided by trained medication assistant (TMA)-A and nursing assistant (NA)-H, R46 was transferred to her wheelchair via full body lift at 7:40 a.m. -At 7:53 a.m., R46 was wheeled out of her room to the dining room for breakfast. -At 8:07 a.m. R46's meal tray was placed in front of her and was assisted by staff to eat her meal until 8:41 a.m. -At 8:42 a.m. R46 was wheeled to an adjacent table in the dining room by NA-I. -At 8:48 a.m. TMA-A and NA-E removed R46 from the dining room and wheeled her back to her room, offered toileting, and repositioned her to a straight sitting position. NA-E stated, R46 did	F 686		

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not have to use the restroom, and verified R46's bottom was shifted from the left to the right because she had been leaning more to the left. NA- confirmed the repositioning was not offloading (the removing of pressure to pressure points to prevent tissue damage) of pressure to the sacral region.
-At 9:15 a.m. R46 was wheeled into her room and offered toileting by TMA-A. TMA-A and NA-I transferred R46 via full body mechanical lift to the commode; the sacral dressing was observed to be soiled by watery loose stool.
-At 9:37 a.m. LPN-C entered the room. NA's transferred R46 into her bed. LPN-C washed hands, donned gloves and removed soiled dressing which revealed 2 sacral wounds that were both soiled with watery loose stool. LPN-C removed gloves, sanitized hands, donned new gloves, cleansed wound, and repeated hand hygiene to apply ordered treatment. LPN-C stated the lower wound is newer and are conjoined at the bottom of the wound. LPN-C stated the lower wound was not packed with anything and the upper wound packing could be visualized at the bottom of the lower wound.
-At 10:15 a.m. R46 wanted to get out of bed.
-At 10:45 a.m. R46 was observed in the activity room sitting up in her chair.
-At 10:50 a.m. R46 was wheeled to another activity that was located down the hallway.
-At 11:18 a.m. R46 continued to be in the activity sitting in wheelchair.
-At 12:01 p.m. TMA-A stated she and NA-J had pulled R46 aside and shifted her bottom from the left to the right. However, had not removed pressure for any length of time to the buttock area.

During an interview on 10/31/18, at 4:22 p.m.

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TMA-D indicated repositioning had to do with making sure the resident was positioned correctly in their chair; making sure they were not leaning and/or back far enough. TMA-D then stated offloading was used to keep pressure off of the area. TMA-D stated offloading to reduce pressure should be done for about five minutes.

During an interview on 10/31/18, at 4:26 p.m. nursing assistant (NA)-K used the terms repositioning and offloading interchangeably. NA-K then stated if someone had a pressure ulcer on their bottom then you would have to get them off the area of pressure to relieve pressure. NA-K indicated unawareness of how long offloading should occur for tissue re-perfusion.

During an interview on 10/31/18, at 4:33 p.m. LPN-C stated residents should be repositioned/offloaded for at least 2 minutes for tissue re-perfusion. LPN-C indicated ideally the resident should be laid down in bed. LPN-C indicated R46 was supposed to be repositioned/offloaded every hour. LPN-C indicated R46 did not like to lay in bed, and used a standing lift which was harder on her arms, and that would be worse.

During an interview on 11/1/18, at 9:01 a.m. registered nurse (RN)-A reviewed wound assessment notes and verified not all wound assessments were complete. RN-A indicated residents should be repositioned/offloaded off of pressure areas for at least 1-2 minutes for tissue re-perfusion. RN-A indicated staff should have attempted and/or offered R46 repositioning/offloading; and shifting of her bottom while in the chair would not adequately relieve pressure to the sacral area because of the

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location. RN-A further stated if R46 refused, staff should have re-approached her, reported to the nurse, and document refusals.

During an interview on 11/1/18, at 11:04 a.m. the director of nursing (DON) indicated each wound should be comprehensively assessed individually and at a minimum of weekly. DON was informed the NA's moved the resident from side to side while in the wheel chair and called it off loading. The DON said that the NA's could have done a better job with repositioning/offloading to shift pressure off the wound. DON stated residents should be repositioned/offloaded off the area of pressure for 1-2 minutes in order for tissue re-perfusion.

Facility Skin Care policy dated 3/2018, also indicated purpose to: provide care and services to prevent pressure ulcer development, promote the healing of pressure ulcers/wounds that are present and to prevent the development of additional pressure ulcers/wounds.
III. Nursing personnel will utilize results of the physical exam and the skin assessment tools to determine an individualized skin care plan for each resident. This may include interventions: A) protect skin against the effects of pressure, friction, shearing, moisture, or bruising interventions B) encourage optimal nutrition and hydration. Update dietary staff to review for appropriate protein supplement C) educate staff, residents, and families on risk factors and preventative measures D) Institute an immediate prevention plan when potential areas are identified E) update care plan, MAR/TAR with specific interventions and treatment.
IV. When a skin ulcer or other wound is identified, an assessment of that specific wound will be

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F 686	Continued From page 44 completed and documented in the electronic medical record by the nurse. The assessment will include: A) measure pressure ulcer, other wound or bruising, noting condition of wound bed, condition of surrounding tissue, and any other signs of infection. Weekly skin assessments of the area should be added to the MAR/TAR. B) Treatment of the wound or pressure ulcer being implemented. C) A review of the resident's care plan and medical status-any other possible risk factors to be identified. D) Identify type of skin ulcer. E. Update the wound care nurse as needed to consult. F. If the wound has not improved, contact the MD/NP/Wound specialist for change in treatment. V. any resident education will be documented. VI. Nursing staff who will be providing care for receive ulcer education annually. They will also be instructed on interventions specific for each resident. Facility protocol Standard Work Chair Repositioning dated 6/12/14, indicated the purpose to help prevent skin breakdown for residents unable to reposition themselves. Major steps included: 1) residents should be repositioned every two hours if they are unable to do so themselves. 2) Resident can be repositioned in chair by moving a pillow to one side or the other to shift the weight or by reclining the resident. 3) Document the change of position and the time.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		12/11/18

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F 689	Continued From page 45 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for root cause analysis related to falls and implement interventions to minimize the risk for injury for 2 of 3 residents (R73 & R78) reviewed for accidents. Findings include: R73's change of condition Minimum Data Set (MDS) an assessment dated 10/4/18, identified R73 had diagnoses including Dementia, other fracture and hypertension. The MDS also identified R73 had short term memory problems, moderately impaired decision making skills for daily living and required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. R73's care plan included, Problem: fall risk traumas Related to: impaired mobility, pain recent fx (fracture) of left elbow, cognitive impairment. Goal: Will have no major injury as a result of a fall. Approaches: Assist with ambulating transfers, toileting. Check comfort level every two hours. Bed in lower, locked position. Encourage to ask for assistance. Keep control to alter position of recliner out of view. Offer reminders to call staff for any assist needed. (per family ok) call light to be hooked to bed at all times and bell on tray table d/t (due to) call light on chair causing resident increased agitation and she will unhook	F 689	F689 R73□s Care Plan was reviewed and updated by 11/28/2018. R78 No longer resides at the facility. The Quality Assurance Reports/Grievances policy was updated to include required root cause analysis. All licensed nursing staff will be educated by 12/11/18. Random Audits of post fall assessments will occur weekly x 5 by a nurse manager or designee. Results will be brought to the QA/QI Committee for further recommendations.	

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and throw on the floor. Assure non-skid pad in resident's personal chair, and increased 1-hour checks during night when sleeping in personal chair no bed, (No alarms per daughters request).

R73 was observed on 10/29/18, 4:12 p.m. to be sitting in her recliner in her room watching television; call light was attached to her recliner.

R73 was observed on 10/31/18, at 6:57 a.m. sitting in her recliner in her room, with the tray table in front of her, using a pen and is scribbling on the paper. The bell was on the tray table; the soft call light was next to her attached to the recliner and she was wearing gripper socks.

R73 was observed on 10/31/18, at 8:04 a.m. sitting in her recliner, feet propped on base of tray table, with a spoon in her coffee mug stirring it, watching television, call light in reach attached to her recliner, bell on tray table.

R72 was observed on 10/31/18, at 9:54 a.m. in her recliner, footrest was elevated at this time; call light attached to recliner, bell on tray table and was sleeping.

R72 was observed at 11/01/18, at 7:46 a.m. in her room asleep in the recliner, pillows placed for positioning, bell on tray table, feet were positioned on the floor, dressed for the day, and call light was clipped to her recliner.

R73's incident report dated 9/30/28, included, resident was found seated beside the bed, legs straight out in front of her back and head leaning against the side of the bed. Moderate amount of fresh blood noted on the floor, bleeding and scalp. Quarter size hematoma with a small

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F 689	Continued From page 47 laceration noted, bleeding had stooped spontaneously. BP (blood pressure) 117/64, P (pulse) 68 Resident assisted to feet with three staff and gait belt and walker. Further assessment reveals area reddened mid back and reluctance to use left arm, pain with rising arm appears to be in the shoulder area. Follow up BP (blood pressure) 87/58, P (pulse) 64. Pupils unequal but reactive to light, initial responses sluggish. Unable to follow directive in part to hearing deficit. Was fall observed: No. Did fall result in injury: Yes. Hematoma and laceration on scalp, left shoulder pain. Indicate degree of harm: moderate harm event. Why do you think you fell: unable to respond. Footwear: slippers and gripper socks. Physical status at time of the fall: unsteady gait, impaired mobility/transfers. Mental status at time of the fall: Disorientated unable to follow directions. Resident activity: unknown. Call button within reach: Yes. Call light on at time of fall: No. Immediate intervention: personal alarm. Has the resident had a fall in the last 30 days: Yes 8-14-18. Care plan updated: No. Date of Fall: 9/30/18. Time of fall 7:45 a.m. R73's post fall investigation dated 9/30/18 at 8:51 p.m. Date of incident: 9/30/18. Time of incident: 7:45 a.m. Day of week Sunday. Did fall result in injury? Yes, laceration to back of head and left arm pain which was later dx (diagnosed) in urgent care as a fx (fracture) of the left elbow and resident was placed in long-term hard splint and returned with sling to help bearing of weight. Risk Factors: On assessment, this is a 90 year old female resident with noted dx (diagnosis) congestive heart failure, venous stasis dermatitis, osteoarthritis, mild cognitive impairment, noted lung nodules, and hx (history) of anemia. Her vision is very poor in which she reports she can	F 689		

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only see shadows and you have to be very close to her as her hearing is significantly impaired. Her ability to always recognize her needs and limitations is significantly impaired and often she does not ask for assistance and does not like her call light in which she has hx (history) of un-hooking call light and throwing it across the room in which she was given a bell to use and has been more cooperative at times. She has hx (history) of getting up independently and not always using her walker has in the past been noted to come out in hall using her bedside table as support but is almost always cooperative with redirection and staff assistance when they have seen her walking independently. She has had no recent complaints of being dizzy although has had recent increase in Lasix secondary to significant lower extremity edema, which extended to upper thigh region and was offering increased complaints of lower back and leg pain. Medication status: Lasix, ultram. New medication in the past week: Lasix increased on 9/23/18. Was care plan updated at time of the fall: Yes- reviewed by RN personal alarm has been implemented at this time d/t (due to) her significant impaired mobility with inability to use left arm. Resident fall risk score: Score prior to fall: 6. Score following fall: 10. Resident is at high risk for falls: yes.

R73's ED(emergency department)/urgent care provider note dated 9/30/18, included chief complaint: Resident is here after falling around 0800 this morning. Patient has laceration to back of her head and sore left elbow. History of Present Illness-Provider: R73 is 90-year-old female presents today with her daughter after falling at Lake Winona Manor. Patient does not recall falling and does have a history of dementia.

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Patient reports a great deal of left arm pain. It is reported by the nurse from Lake Winona Manor that is nauseous consciousness. It is reported that this occurred at 8 AM. She has laceration to the back of the head on the left side as well as pain in the elbow. Patient is reporting mostly pain in the left elbow. She does not recall why she is here. She denies any other systemic systems or concerns. Patient is incredibly hard of hearing.

On 10/31/18, at 3:11 p.m. trained medication aide (TMA)-A stated R73 would always get agitated by her call light cord if it was hooked to her chair and stated she does have a bell on her tray table that she can ring if she needs us. At 3:16 p.m. during an observation, R73's call light was observed to be clipped to her recliner. TMA-A stated it was care planned to not be attached to her recliner and was observed to remove the call light from the recliner attach the call light to her bed.

On 11/01/18, at 1:07 p.m. registered nurse (RN)-A stated R73 had a history of getting up on her own; she fell out of bed and fractured her elbow. RN-A stated when R73 was asked what happened she was unable to respond. RN-A stated the activity at time of fall was unknown. RN-A stated R73 had cognitive impairment. RN-A verified the fall documentation was not a complete investigation of the incident, as it did not include a root cause analysis of the fall, did not include staff interviews regarding the fall and did not include if the care plan was being followed. RN-A stated self-transferring was the reason for the fall, but we do not know why she was trying to self-transfer. RN-A verified the intervention put into place at the time of the fall was a personal alarm, but stated was no longer being used per daughters request. RN-A verified without

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F 689	Continued From page 50 completing a root cause analysis of the fall the facility would be unable to determine what interventions would be appropriate to be implemented to minimize the risk of further falls. RN-A verified the care plan for R73 included to not clip the call light to the recliner as when she first came in, she would unclip the call light and throw it off. RN-A stated she expected staff to follow the care plan to not have it clipped to her recliner. On 11/01/18, at 1:18 p.m. RN-A verified through observation call light was clipped to the recliner and stated would reassess. R78's Diagnosis List dated 11/1/18, included diagnoses of history of falls, congestive heart failure, hypertension, diabetes type II, and chronic renal disease stage 4. R78's annual Minimum Data Set (MDS) dated 10/11/18 indicated R78's cognitive skills for daily decision making was severely impaired. The MDS also indicated R78 required extensive assistance from two staff for transfers and bed mobility, and required extensive assist from one staff for ambulation, dressing, and toileting. The MDS further indicated had one fall without injury since admission or the last assessment period. R78's care plan dated 10/4/18, included; Problem: fall risk goal of will not have major injury as a result of a fall. The interventions dated 10/14/18, included the following: assist with ambulating, transferring, and toileting. Check comfort levels every 2 hours. Bed in lower, locked position. Encourage to ask for assistance. Resident is to be wear his shoes or have gripper socks on at all times. Personal alarm on wheelchair and bed. Check at 9:00 p.m. to ensure R78 was not attempting to self-transfer. Frequent checks to ensure that personal alarm was in	F 689		

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place and functioning. Dycem no-skid pad in wheelchair/recliner when up. R78 was to be assisted to bed by 8:30-9:30 p.m. per family request otherwise they ask that he be out by staff and not left in his room on night shift.

During an observation on 10/29/18, at 2:30 p.m. R78 sat in his wheelchair in his room next to family member (FM)-A. R78 had his eyes closed, underneath his right eye was a fading bruise and just above his eyebrow was a fading scar approximately 2-3 inches long. R78 had a personal safety alarm on his wheelchair.

During an observation on 11/1/18, at 9:32 a.m. R78 sat in his wheelchair in his room with no staff present. R78 had personal safety alarm on his wheelchair. At 9:33 a.m. an unidentified NA walked into the room.

R78's progress note dated 10/13/18, at 10:51 p.m. indicated R78 was transferred to the emergency department related to fall with significant contusion with laceration above his left eye.

R78's incident report dated 10/14/18, indicated the date of fall was 10/13/18, at 10:32 p.m. and the writer of the report was down another hallway when a loud bang was heard. R78 was found in the hallway lying on the floor face down, slightly on his side, about 10 feet from his door. The report further indicated R78's personal alarm was activated, did not have an incontinent brief on at the time, and there was a pool of blood on the floor. The report also indicated R78 had contusion the size of an egg with a deep laceration above his right eye. The report then indicated the fall was not witnessed, a cold

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F 689	Continued From page 52 compress was applied, and the degree of harm was minor harm event. In response to the report question, Why do you think the you fell: resident unable able to respond secondary to significant cognitive deficits. Immediate interventions: resident assisted off the floor with the full body lift and into his wheelchair. New interventions: assist into bed at 10:00 p.m. rounds. R78's emergency department visit note dated 10/13/18, at 10:57 p.m. indicated R78 had fallen out of his chair and described as a fall from ground level. The note indicated R78 had struck his head and resulted in a hematoma and a large laceration around his right eye. The note further indicated the laceration was 6 centimeters in length with a superficial depth that required six sutures. R78 was then discharged back to the facility. R78's Post Fall Risk Assessment dated 10/14/18, at 2:16 a.m. indicated R78 had a history of falls, was at high risk for falls, has diagnosis of dementia with behavioral disturbance, has incontinence. The assessment indicated R78 indicated the hallway where R78 had fallen was dimmed due to the time of night. R78's Post Fall Investigation dated 10/14/18, at 3:20 p.m. identified the recompilation of the incident report documentation and as a result of the fall R78 required 6 sutures to the laceration above his right eye. The investigation report indicated protective/safety devices that were in place during the fall were personal alarm which charting indicated that the alarm was going off but staff were not able to get to him before he fell. Risk Factors: On assessment this resident is a 86 year old male with noted diagnoses of mixed	F 689		

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Alzheimer's with vascular dementia with behavioral disturbance, seizure disorder, and poorly controlled diabetes. This resident's cognition is significantly impaired and his ability to ask for assistance or recognize his needs is significantly impaired in which staff need to anticipate all his needs and very seldom used call light even with reminders. His mobility has remained unchanged and is able to ambulate with staff assist and walker although this as well depends on his mood/behaviors and is noted at times to become agitated and can become physically aggressive and will hit out. Last evening prior to the fall resident had been noted to be very agitated at times attempting to self-transfer followed by episodes of sleeping in his wheelchair in which this most likely why staff assisted to personal chair for comfort although he did then attempt to self -transfer which resulted in the fall. Resident's overall status has remained unchanged he has had not noted changes in respiratory status no urinary concerns, and up till this recent fall he had not been offering any reports of pain and had not appeared to be in any discomfort. Secondary to noted increased agitation prior to fall during the shift care plan has been revised for resident to be assisted to be not in chair and per family request resident to be assisted to bed by 8:30-9:00 p.m. otherwise they ask that he be out by staff and not left in his room. The investigation report further indicated, no recent changes in status, had had two falls in the last 90 days, and pattern of falls identified as both occurred during his personal chair however, no pattern to time of the falls.

R78's fall incident report dated 10/19/18, indicated R78 had an unwitnessed fall without injury at 6:25 p.m. in the dining room. The report

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included: writer was coming off the elevator heard alarm going off. Went into the dining room to find resident on his left side on the floor. When asked what he was doing resident stated that he was trying to go home, can you please take me home. The report indicated R78 was wearing slippers, floor was slippery (report did not indicate why the floor was slippery), vital signs, and notifications to appropriate parties.

The incident report did not identify immediate and/or ongoing fall interventions.

R78's Post Fall Investigation dated 10/21/18, included the recompilation of the fall incident report and included; Risk Factors: cognitive loss and unsteady gait. General Health: baseline stable overall with progressing dementia, impaired mobility. The investigation indicated there was not a need for re-education for staff/resident/or family, and the care plan was reviewed by the registered nurse at the time of the fall. The investigation report further identified R78 as being high risk for falls, had 3 falls in the last three months and the relationship or pattern of the falls was indicated as "self-transfers".

The Investigation report lacked a comprehensive analysis and/or root cause of R78's fall on 10/19/18, and further lacked evidence of identification and/or evidence of implementation of interventions related to that fall occurrence.

During an interview on 10/29/18, at 2:30 p.m. family member (FM)-A stated R78 has had several falls and has had less falls since the facility initiated the low bed. FM-A stated R78 fell three weeks ago that resulted in an emergency room visit and sutures over his right eye. FM-A

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indicated R78 had been sitting in his recliner with an alarm on, and then he got up and walked out into the hallway without his walker. FM-A stated family requested the staff provide him with more supervision at night because he moved quickly, and didn't think staff were always in near proximity.

During an interview on 10/31/18, at 11:34 a.m. nursing assistant (NA)-F stated R78 was at risk for falls. NA-F indicated staff try to keep R78 out of his room and within view of staff, NA-F stated when R78 became agitated and attempted self-transfers they try to ambulate him and/or provide distractions.

During an interview on 11/1/18, at 8:37 a.m. registered nurse (RN)-A indicated after a fall occurred the nurse was supposed to complete fall charting and complete a fall risk assessment. RN-A then indicated the registered nurse would do the fall follow-up investigation which included talking with the team to determine what happened in order to evaluate and implement interventions. RN-A stated, after the fall with injury on 10/20/18, we discussed with family and determined the immediate intervention was to keep R78 out of his room and lay him down in bed at the requested times. RN-A reviewed the fall incident report and the fall investigation report and confirmed based on the documentation it could not be determined what potentially caused R78's agitation prior to the fall because there was not a behavior analysis. RN-A further indicated even though R78 was found in the hallway without incontinent brief on, a bowel and bladder assessment or diary had not been completed. RN-A then reviewed the fall incident report and post fall investigation from the fall that occurred

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F 689	Continued From page 56 on 10/19/18, and indicated the both the fall incident report and the fall investigation were incomplete. RN-A indicated the fall incident report lacked identification of immediate interventions and the post fall investigation lacked a comprehensive assessment of the fall, risk factors, did not include a root cause, and lacked identification of interventions. RN-A indicated the team did utilize a focus board to determine triggers for agitation, and when the team noticed thing it was talked about. RN-A further stated fall investigations were constant and ongoing and could not be completed all at once. During an interview on 11/1/18, at 11:20 a.m. director of nursing (DON) reviewed the incident and investigation reports for R78's falls that occurred on 10/13/18 and on 10/19/18. The DON stated the expectation of completed post fall analysis and documentation of a root cause analysis of why the fall could have occurred. The DON indicated the documentation should include details of everything they looked at in the investigation and what they did for interventions and details of the team discussion in what they did. Facility policy Cumulative Fall record dated 1/2017, included the purpose: A cumulative fall record is kept in each resident's electronic medical record to facilitate identification of patterns of causative factors that may have contributed to the fall. The policy indicated/directed the following: A) Resident is not moved unless in jeopardy until a licensed nurse examines the resident and records the blood pressure and pulse. B) directed staff to notify family/significant other and chart in the electronic medical record.	F 689		

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F 689	Continued From page 57 C) chart fall in ECS, reporting vital signs, neuro checks if applicable and chart follow-up assessment x 24 hours. D) Provider will be notified of all falls immediately for significant injury or change in resident status. Leaving a message/fax during clinic office hours if no significant injury. E) Care plan will be reviewed and updated if necessary after each fall. F) Falls discussed with interdisciplinary team, including therapy to determine appropriate interventions. G) Follow-up recommendations will be discussed at that time. H) Overall falls recorded will be reviewed quarterly by Quality Assurance team if specific patters noted.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		12/11/18

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F 692	Continued From page 58 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete comprehensive hydration/nutritional assessment and monitoring, prior to and/after discontinuation of tube feeding, in order to prevent dehydration for 1 of 1 resident (R56) reviewed for hospitalization. The facility's failures caused harm for R56 who becaming severely dehydrated and sustained acute renal failure. Findings include R56's Diagnosis List dated 11/1/18, included diagnosis of traumatic brain injury, dysphagia, chronic kidney disease, cardiomyopathy, mild cognitive impairment, diabetes type 2. Diagnoses added 9/17/18, included left kidney stone, hydronephrosis (a swelling of kidney due to urine build-up) and constipation. On 9/18/18, a diagnosis of urinary tract infection was added. R56's quarterly Minimum Data Set (MDS) assessment dated 6/21/18, indicated R56 had severe cognitive impairment, and required supervision with eating. The MDS indicated during the assessment period, R56 had complaints of difficulty or pain with swallowing, weighed 184 pounds, had no weight loss, had a physician prescribed diet for weight gain, had a feeding tube and also had orders for a mechanically altered diet. The MDS also indicated R56 received 51% of total calories and averaged 501 cubic centimeters (cc) or more of fluid via the feeding tube.	F 692	F692 R56s Care Plan and nutritional monitoring were updated 11/29/2018. The Hydration Management and Nutritional Risk Protocol policies will be updated by 12/4/2018. All tube fed residents were audited for hydration risk. Licensed nursing staff and Nutritional Specialists will be updated on new policy by 12/11/2018. 1 Random audit of the nutritional assessments will occur weekly x 5 by a Care Coordinator or designee. Results will be brought to the QA/QI Committee for further recommendations.	

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R56's annual MDS dated 9/19/18, indicated R56's cognitive skills for daily decision making were severely impaired and R56 required supervision for eating. The MDS also indicated the resident had no difficulty with chewing or swallowing, a weight of 179 pounds, was not on a physician prescribed diet for weight gain, did not receive tube feeding, and received a mechanically altered and therapeutic diet.

R56's nutritional care plan dated 9/21/18, identified R56 had been hospitalized on 9/7/18, related to dehydration and urinary tract infection, and had swallowing difficulty. The care plan goals included: weight will remain above 170 pounds (lbs) and would consume adequate intake to meet his needs. The care plan further included directives for staff to ensure adequate fluid intake, not use straws, and to give strawberry Ensure at 10:00 a.m. and chocolate Ensure at 2:00 p.m. (8 ounces) for additional calories. The care plan did not include any goal for fluid intake.

R56's hospital discharge summary dated 9/17/18, indicated R56 was admitted to the hospital on 9/13/18. The hospital note included: R56 had long-standing history of traumatic brain injury, who just recently had his percutaneous endoscopic gastrostomy (PEG) tube removed on 8/24/18. He was admitted with obvious dehydration, hypernatremia (high sodium) and acute kidney injury. The discharge summary also indicated during the hospital course R56 was diagnosed with urinary tract infection and was started on a course of antibiotics.

R56's nutritional assessment dated 6/29/18, indicated R56 had been working with speech

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F 692	Continued From page 60 therapy to progress to eating by mouth and that at time the diet was mechanical soft textures. The assessment further indicated R56's oral intake had increased however, R56 continued to refuse breakfast on most days and may improve with further tube feeding reduction. Tube feeding was decreased on 6/18/18, to promote increased intake at meals. The note indicated another decrease in amount of tube feeding would begin. The Osmolite 1.5 would be decreased to three hours per day to run at 130 cc (cubic centimeters)/hr (hour) from 9:00 p.m. to 11:00 p.m., with continued 400 cc water flushes four times a day because oral intake remained inadequate. The assessment indicated R56 required 2590 cc's of fluid daily. The note also indicated a calorie count would be started for 5 days. R56's nutritional assessment dated 7/5/18, indicated fluid intake at meal times was inadequate as well as between meals, and therefore R56 continued to receive water flushes between meals to prevent dehydration. The note also indicated the Osmolite 1.5 feeding would be held for one week to see if he continued to eat well and to determine if he could maintain weight between 185-190 lbs.; current weight was 189 lbs. and because fluid intake was inadequate water flushes would continue to be provided and fluid intake would be re-evaluated in one week. The assessment further indicated staff would monitor his fluid intake on a daily basis. The goal was to wean R56 from the tube feeding and need for fluids and medications via the tube. R56's next nutritional assessment was dated 7/23/18, and indicated R56 was recently upgraded to a regular diet with ground or cut up	F 692		

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meats, whereas he had previously also had a tube feeding. The assessment indicated he had been doing well with food intakes from 50-100% for lunch and dinner with some refusals for breakfast, because he liked to sleep in late. The assessment also indicated R56 received Ensure when he get up in the morning and his current weight was 197 lbs, however also indicated: "Oral intake of fluids remains inadequate."

R56's August 2018, Medication Administration Record (MAR) included the following physician orders: Tube feeding-120 ml (milliliters) manual flush daily at 4:00 p.m. to keep tube patent with a start date of 7/30/18, and end date of 8/24/18. The MAR further indicated the previous order that started on 6/29/18, which included Osmolite 1.5, 130 cc's an hour times three hours was discontinued on 8/5/18.

R56's progress note dated 8/13/18, included: no longer receives tube feeding; does receive 120 ml flush daily before supper. A subsequent progress note dated 8/13/18, indicated the nurse practitioner was updated on constipation since diet change and a new orders were obtained.

R56's record lacked assessment to determine fluid intakes were sufficient according to assessed needs.

R56's subsequent nutritional assessment was dated 8/14/18, and included: weight has decreased 8 lbs. in 30 days, on 7/25/18, the Mighty Shake supplement was changed to give only at dinner. Current weight 186 lbs. The note indicated a decrease in minimum weight; 180-190 lbs. The note further included; Resident is consuming 100% of breakfast in the last 3 days,

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refused x 2 days, consumes 75-100% at lunch, 50-100% at dinner, no problems with swallowing and current textures provided, no edema. Will review weight weekly. The assessment did not include evaluation of fluid intake.

R56's progress note dated 8/14/18, indicated R56 continued to be eating and drinking well at meals and did not have indicators of dehydration.

R56's next nutritional assessment was dated 8/17/18. The assessment indicated the purpose of the note was due to the resident's weight fluctuating. The additional comments section of the note included: "resident is on a regular diet, is eating at a supervised table and uses a divided plate, gripper mat, gets his meats chopped or ground up. His fluids continually improves. He receives Might Shake at dinner daily. His goal weight is 190-195 lbs. Staff continues to encourage intake of food and fluids. He will be followed monthly."

R56's next nutritional note was dated 8/21/18, indicated a weight of 183.2 lbs., decrease of 2.8 lbs. in one week, continue to monitor weight weekly.

R56's daily fluid record from 8/20-8/24/18 reflected the following:
8/20/18: breakfast= 370 cc, lunch=zero (resident refused lunch), dinner=290 cc, daily flush 120 cc. (Total 780 cc)
8/21/18: breakfast= 370 cc, lunch=180 cc, dinner=480 cc, daily flush 120 cc (Total 970 cc)
8/22/18: breakfast= zero (resident does not want breakfast), lunch 180 cc, dinner=510 cc. (Total 810 cc)
8/23/18: morning=180 cc, lunch=370 cc,

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dinner=300, daily flush 120 cc (Total 970 cc)
8/24/18: breakfast=180 cc, lunch=160 cc, dinner 120 cc. (Total 580 cc)

R56's surgery note dated 8/24/18, indicated reason for visit is to have PEG removed. The note indicated R56 had been able to eat a general diet, and had been thoroughly evaluated by a speech pathologist. The note also indicated the PEG tube had not been used for at least three months. The note further indicated R56's blood pressure was low and that findings had been communicated to the nurse at Lake Winona Manor to do more frequent checks to make sure it was stable.

R56's progress note dated 8/24/18, indicated R56 was incontinent twice with dark concentrated urine with hematuria (blood in urine) and staff would encourage fluids between meals. No further hematuria was indicated in progress notes until 8/28/18.

R56's record reflected the following daily fluid intake totals after PEG removal; the record continued to lack evidence of comprehensive evaluation of daily fluid intake, and failed to identify current hydration needs after removal of the PEG.
8/25/18: breakfast=180 cc, lunch=zero, dinner=340 cc. (Total 520 cc)
8/26/18: breakfast=zero resident does not want, lunch resident does not want, dinner 370 cc's. (Total 370 cc)
8/27/18: breakfast= 360 cc, lunch=zero, dinner=280 cc. (Total 640 cc)
8/28/18: breakfast=360 cc, lunch=not recorded, dinner=360 cc (total 720 cc)

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R56's progress note on 8/28/18, indicated R56 was incontinent twice with urine that was dark orange in color.

8/29/18: breakfast=150 cc's, lunch=zero resident does not want, nothing recorded for dinner (Total 150 cc)
8/30/18: breakfast=zero resident does not want, lunch resident does not want, dinner=360 cc. (Total 360 cc)

R56's progress note dated 8/30/18, indicated R56 was not feeling well but demonstrated no outward symptoms. A progress note later that day at 3:35 p.m. indicated no further concerns with hematuria or concentrated urine, continued to drink fluids well, and had no indicators of dehydration.

8/31/18: breakfast=zero refused, lunch=160 cc, dinner=330. (Total 490 cc)
9/1/18: breakfast=zero refused, lunch=zero refused, nothing recorded for dinner. (Total zero cc)
9/2/18: breakfast=420 cc, lunch=zero refused, dinner=zero refused. (Total 420 cc)
9/3/18: breakfast=360 cc, lunch=180 cc, nothing recorded for dinner. (Total 540 cc)
9/4/18: breakfast=420 cc, lunch=zero refused, dinner 300 cc. (Total 720 cc)

R56's next nutritional note dated 9/4/18, lacked an evaluation of the daily fluid deficit, however, indicated a weight loss over the prior two weeks; 8/27/18, weight was 181 lbs., 9/4/18, weight was 175.4 lbs., The note indicated R56 agreed to drink Ensure supplement at all meals.

R56's record from 9/5 through 9/7/18, continued to reflect fluid deficits even with the addition of

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Ensure supplement.
9/5/18: breakfast=610 cc, lunch=190 cc, dinner=420 cc. (Total of 1220 cc)
9/7/18: breakfast=420 cc, lunch zero resident refused, dinner 460 cc. (Total 880 cc)

R56's progress note dated 9/7/18, indicated R56 had cloudy urine with no burning and to push fluids.

R56's record revealed no nutritional assessment was conducted immediately after the PEG tube was removed (8/24/18) until 9/7/18. The 9/7/18, assessment indicated R56's daily fluid requirements was reduced from 2590 cc per day to 2390 cc, indicating R56 consumed 1500-2000 cc/day, and was at "LOW RISK" for dehydration even though, the daily fluid intake monitoring between 8/24 through 9/7/18, reflected a daily average liquid consumption of only 495 cc per day. The assessment further indicated R56's weight was 175.4 lbs. with an ideal body weight of 128-161 lbs. Nutritional needs required: KCAL 1450-2190, protein 58-73 grams, and was given nutritional supplement with meals. The note further indicated R56 was refusing dinner and lunch often however, was drinking 100% of Ensure, was walking more, and was not snacking as much. The assessment further indicated R56 was a high nutrition risk-class 4, and weight was reviewed weekly.

R56's intake record from 9/8 through 9/11/18, continued to reflect fluid deficits following the nutritional assessment on 9/7/18. The total daily assessed fluid intake needs identified 9/7/18 =2390 cc.
On 9/8/18 the resident's fluid intake included: breakfast other=250 cc, lunch 420 cc, dinner 180

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cc. (Total 850 cc)

R56's progress note dated 9/8/18, indicated R56 was having difficulty swallowing his pills earlier in day; R56 told staff that he had been having a hard time swallowing recently. A subsequent progress note indicated later that evening R56 again had a hard time swallowing pills, however, eventually was able to get them down.

R56's intake 9/9/18 included: breakfast=zero refused, lunch=zero refused, dinner=300 cc. (Total 300 cc)

R56's progress notes from 9/9/18, indicated R56 did not eat breakfast or lunch, and did not each much for supper. A progress note indicated he took his medication slowly like he was remembering how to swallow.

R56's intake 9/10/18 included: breakfast=240 cc, lunch=190 cc, dinner=200 cc. (Total 630 cc)

R56's progress notes from 9/10/18, indicated he did not eat well for breakfast or lunch and was slow to swallow water and medications. The progress notes indicated at 4:05 p.m. on 9/10/18, the nurse practitioner (NP) was updated related to occasional periods of holding medications in mouth, as well as not wanting as many snacks as in past. In addition the NP was informed that although R56 was eating his meals, he had noted weight loss.

R56's intake 9/11/18 included: breakfast 120 cc, lunch=zero resident did not want, dinner 20 cc. (Total 140 cc)

R56's progress notes dated 9/11/18, from a

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Provider Visit included: "past two days had been verbalizing sore throat and had increased difficulty swallowing at times." A progress note at 4:00 p.m. indicated a discussion with R56's power of attorney and included: "although is still drinking and eating well for meals, past three days has verbalized sore throat at times although upon assessment no noted redness."

R56's nutritional assessment note from 9/11/18, did not include a comprehensive evaluation of fluid intake. The assessment indicated R56's weight on 9/10/18, was 173.4 lbs., down two pounds in one week. The note indicated Ensure had been started with meals, but R56 had some swallowing problems noted so would be evaluated by speech therapist.

R56's intake 9/12/18 included: breakfast=zero refused, lunch=zero refused, dinner=zero refused. (Total zero cc)

R56's progress note dated 9/12/18, indicated R12 had not had a bowel movement in five days, had been complaining of abdominal discomfort, a suppository was given and R56 expelled an extra large amount of sticky stool that required digital assistance. Progress note at 4:09 p.m. indicated R56 was seen by MD (medical doctor) related to weight loss, periods of refusing to eat, and recent concerns of constipation: MD ordered labs.

R56's physician visit note from 9/12/18, included: "He had a feeding tube for many months but his oral intake was much better and the tube was discontinued. Recently he has not been eating as well and has been complaining of abdominal discomfort. Nursing felt that this was related to constipation. He is much more sedated than he

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has been in the past." The physical exam indicated no qualifying data for vital signs and measurements, less alert than he previously has been, and had active bowel sounds. The assessment and plan included: "it is apparent that his status is changed considerably since last seen and labs will be ordered to see if there is anything reversible here."

R56's intake 9/13/18 included: breakfast=360 cc, lunch=zero refused, dinner= resident was not there.

R56's progress note dated 9/13/18, at 1:24 p.m. indicated his physician had called with orders to transfer R56 to the emergency room for intravenous fluids because his lab work reflected "severe dehydration."

R56's emergency department visit dated 9/13/18, indicated nursing staff had reported decreased intakes over the past week, labs had been ordered related to weakness, and R56 had been sent to the emergency department for further evaluation. The diagnosis that was given was "dehydration." The notes included: dehydration/acute kidney injury: patient was sent from Lake Winona Manor for further evaluation. Patient had PEG tube removed on 8/24/18, likely unable to keep up fluid needs. The note indicated the patient presented with blood pressures between 99/61 and after intravenous fluids given blood pressure improved to 115/71. The note further indicated the patient reported constipation and had a distended abdomen with no complaints of pain; imaging study would be decided after hospital admission. Physical exam indicated ears, nose, mouth, and throat had dry mucous membranes. Labs on 9/13/18, at 11:05 a.m.

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included: sodium of 149 mEq/L (high), BUN 77 mg/dl (high), and Creatinine 2.42 mg/dl (high).

During an observation on 10/31/18, at 7:55 a.m. R56 laid in bed with his eyes closed. Nursing assistant (NA)-G stated she had already provided morning cares however, R56 refused to get out of bed. NA-G stated somebody would take him in a nutritional supplement and offer him that for breakfast.

During an observation on 11/1/18, at 7:50 a.m. R56 sat in his wheelchair at the dining room table. R56 stated ever since they took out the PEG tube he had been struggling with constipation.

During an interview on 10/31/18, at 4:46 p.m. registered nurse (RN)-J stated R56 was eating and drinking ok. RN-J stated the nursing assistants documented the amount of fluid intake after each meal. RN-J indicated an unawareness if total daily fluid intake was assessed and was not aware of who was assessing the total amount of fluid intake in order to ascertain deficits that could lead to dehydration. RN-J stated if R56 had a decrease in fluid intake, or was not drinking, RN-J would encourage fluids. RN-J further stated the documentation should indicate a deficit and interventions attempted or used to replace the fluid deficit. RN-J was asked about R56's change in urine integrity; RN-J stated usually they would not call the doctor unless there were three symptoms of urinary tract infection. However, RN-J also stated it would also be dependent on nursing judgement.

During an interview on 11/1/18, at 7:57 a.m. RN-A stated R56 had been admitted to the facility with

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the PEG tube; the reason for PEG tube was not certain. RN-A stated R56 had worked with speech and R56 worked really hard to eat so the PEG could be removed. RN-A stated R56's intakes were monitored by dietary and he was weaned off the formula when his intakes were sufficient to sustain daily recommended nutritional needs. RN-A stated the Osmolite formula started being held on 7/30/18, with 400 cc's flushes three times a day until 7/30/18, then the flushes were decreased to 150 cc's once per day. RN-A reviewed R56's nutritional assessments and verified the record lacked evidence of a nutritional assessment prior to or immediately following the PEG tube removal to identify daily fluid intake requirements. RN-A also confirmed R56's record lacked evidence of daily fluid intake totals and evaluations to determine fluid deficits even after the 9/7/18, nutritional assessment that that identified R56 required daily fluid amount of 2390 cc. RN-A stated prior to R56's hospitalization, R56 had seemed to drink and eat less than he had been. RN-A stated R56 did not have an order for strict intake and output monitoring prior to the hospitalization; so the amounts entered probably weren't accurate. RN-A reviewed the documentation related to R56's change in urine integrity and indicated although there was hematuria documented, the symptoms resolved after a couple of days with no other symptoms, so it may have been appropriate not to call the physician and just push fluids.

During an interview on 11/1/18, at 10:23 a.m. nutrition specialist (NS) reviewed the record and confirmed neither the registered dietian, nor dietary supervisor had completed a comprehensive assessment of R56's daily fluid intake requirements prior to, or immediately after,

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the removal of the PEG. The NS said the assessment dated 9/7/18 did not reflect fluid intakes as documented. The NS also verified nutrition progress notes prior to, and after removal of the PEG tube, lacked evaluation of daily fluid requirements and deficits. The NS also stated she was unsure whether nursing was evaluating daily fluid intakes.

During an interview on 11/1/18, at 11:42 p.m. director of nursing (DON) stated the expectation that nutritional assessment should have been completed prior to, and/or immediately following the PEG removal, to identify daily fluid requirements. The DON further stated R56's fluid intakes should have been monitored and evaluated daily.

The facility's Hydration Management policy dated 6/2017, indicated the purpose was: To ensure risk factors for dehydration are identified and steps are taken to determine that a resident has sufficient fluid intake to maintain proper hydration and health status. The policy included the following risk factors for dehydration: weight loss, tube feedings, resident dependent on staff for intake, diuretic use, cardiovascular agents, renal disease, history of refusing fluids, limited fluid intake, resident lacking sensation of thirst.
-Nursing assessment: A) Residents' dehydration risk is assessed on admission, quarterly, and as needed thereafter. B) Nursing should update provider if dehydration is suspected so resident may be evaluated further. C) Some common symptoms include: thirst, dark urine, headache, tenting of skin. -Care Plans: risk factors for dehydration should be identified by nursing assessment, appropriate care plan and interventions should be documented.

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F 692	Continued From page 72 The facility's Nutrition Risk Protocol dated 5/6/17, identified nutritional risk categories, and included and/or identified categories of risk specific for dehydration.	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 725	F725	12/11/18

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F 725	Continued From page 73 failed to ensure sufficient staffing was available for the evening shift, in order to provide timely assistance with personal cares according to the resident's assessed need for 8 of 8 residents (R8, R17, R3, R50, R82, R1, R49 & R43) assessed to need staff assistance with activities of daily living (ADL). Findings include: R8's quarterly, Minimum Data Set (MDS) and assessment dated 8/2/18, indicated intact cognition and needed extensive assist with activities of daily living (ADL). R17's annual, MDS, dated 8/9/18, indicated intact cognition and needed extensive assist with ADL. R3's quarterly,MDS, dated 8/2/18, indicated intact cognition. R50's quarterly, MDS, dated 9/13/18, indicated intact cognition and needed extensive to total assist with ADL. R82's quarterly, MDS, dated 10/11/18, indicated intact cognition and needed extensive assist with ADL's. R41's quarterly, MDS, dated 8/30/18, indicated intact cognition. R49's quarterly, MDS, dated 9/13/18, indicated intact cognition and needed supervision with toileting. R43's quarterly, MDS, dated 8/30/18, indicated intact cognition and needed extensive assist with ADL's.	F 725	The staffing guidelines in the facility assessment and staff schedule were revisited and updated by 11/30/2018 for residents on LVC. All licensed nursing staff and scheduling staff will be instructed on staffing recommendations by 12/11/2018. Random audits of 5 residents weekly will be done by a Social Worker or designee to determine feedback on staff response. All results will be brought to the QA/QI Committee for further recommendations.	

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RESIDENT INTERVIEWS:

R8 attended the resident council meeting on 10/31/18, at 10:59 a.m. R8 stated, sometimes they forget to put your call light on you and then you have to yell for help, then they (the staff) get mad at you for yelling for help. R8, R17, R3, R50, R82, and R41 said that they have been unable to reach their call light because staff forgot to give it to them. R41 stated, "What good will it do if you can't reach your call light?" R82 stated, I fell one time because they did not answer my call light, I waited 20 min, I had to go to the bathroom, I couldn't wait anymore, I know I need help, but I didn't want to go in my pants, so I tried to go myself and I fell. This was during the day about 6 months ago. I didn't get hurt bad, but I was sure sore for a few days. At 11:05 a.m. R43 stated, a lot of people won't complain because it doesn't do any good anyways. We have been talking about them turning off our call lights for a long time now in these meetings and it was never fixed, so why bother complaining?, it doesn't change. At 11:06 a.m. R17 stated, I have been yelled at by the staff and asked, why are you turning on your light? Several residents nod their heads in agreement. At 11:07 a.m. 6 of 9 residents stated they have waited over an hour for call light assistance. When asked what is the longest you have had to wait for a response to the call light, they responded with: R43, R8, R17, R82, R3 all stated over an hour. R50 stated, wait time was 1 hour and 45 minutes. At 11:10 p.m. when asked if anyone had ever soiled their pants from waiting so long, R8, R17, R3, R50, and R82 all said they had. R82 stated, "I felt deserted when I felt no one answering my call light when I had to go to the bathroom so bad." The worst staffing is

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during the evening shift, several residents nodded their heads in agreement. R8, R17, R3, R50, R82, R41, R49, and R43 said that staffing is worse on the evening shift. At 11:13 a.m. R82 stated, "We need more help, we are too short staffed." At 11:16 a.m. R8 stated, another concern is when they put you on the toilet, it seems like you sit there for an hour, and when you need to get help to get off the toilet your butt can get pretty sore. R82 stated, "Yes your butt does get awful sore!" R17, and R50 all nodded yes in agreement.

STAFF INTERVIEWS:

During interview on 11/01/18, at 9:13 a.m. nursing assistant (NA)-L stated I mainly work day shift, I work every fourth weekend and they always ask me to stay late on the weekend. Sometimes when we are short staffed and R42 will get changed a half hour late. I always work lake view court (LVC), we have group 1 and group 2, and we have 2 aides scheduled for each group for day and evening shift. Sometimes an aide will call-in or won't be scheduled and we only have 3 aides to work. This is when we are short. This doesn't happen as often on day shift, mostly on evening shift. I think our being short on staff is more of a scheduling issue not a calling in issue, it happens more on evening shift.

During interview on 11/01/18, at 9:35 a.m. NA-O stated I have worked here 2 years, I work mostly day shift. Staffing is not good on the evening shift, especially once the college kids go back to school in the fall. I have heard there was issues with call lights during the evening.

During phone interview on 11/01/18, at 1:08 p.m.

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NA- M stated, I work evening shift and almost every weekend I work I get asked to stay late. We are usually really short staffed on the weekends. As far as staffing goes, it gets bad on evenings after supper, we will have like 8 call lights on at the same time and they all want to go to the bathroom and then to bed. What would be ideal is to have an extra float person on from supper until we get everybody to bed, this would help with our call light problems. I know residents have wet their pants waiting, I try my best to get to them. I bust my butt and I try to get to everybody, especially the people I know can't hold it for very long. I know we do turn off the call lights and we mean to get back to the resident right away, but it isn't always possible and I feel bad, I am doing the best I can. The scheduling is a problem, sometimes an aide is not scheduled, sometimes they call in, and sometimes they are late. So we end up working an aide is short most weekends for sure and sometimes during the week too. If we wanted to get those call lights answered timely we should have two aides for group 1 and group 2, with a float to help with call lights after supper time until we get everyone to bed.

During interview on 11/01/18, at 1:40 p.m. licensed practical nurse (LPN)-E stated, I work strictly day shift, we have no concerns with staffing during the day. On evening shift they have 1 registered nurse (RN) that floats, then trained medication aides and NA's. I have heard from other staff that there have been issues with call lights being answered during the evening, they have been brought up at resident council, and this was maybe a couple months ago. I think the call light wait time is the biggest concern, no concerns with staffing on the day shift, just the

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F 725	Continued From page 77 call lights. During interview on 11/1/18, at 12:50 p.m. maintenance (M)-A stated, I checked with persons on electrical crew and at this time we have no way to run reports on the call lights (such as when they go on and when they are turned off). During interview on 11/01/18, at 4:39 p.m. the director of nursing (DON) was informed of the issue with call lights being answered without care being provided to the residents in need, residents wetting their pants because call lights are not answered timely, long call light wait times, a fall because resident did not get call light answered timely and tried to take herself to the bathroom knowing she needed assistance, and residents voicing complaints about being left on the toilet. THe DON stated, I want all my residents to be treated with dignity and respect. The facility's Nurse Staffing Guidelines revised 3/18, indicated the purpose was to assure there are sufficient qualified nursing staff members to meet the nursing care needs of residents throughout the facility. The policy further indicated the nurse staff coordinator or charge nurse (during non business hours) will ensure there is a qualified number of staff to handle acuity/workload.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726		12/26/18

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resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure staff have the knowledge, competencies and skill sets to provide care, and respond to each resident's individualized assessed needs safely in a manner that promotes each person centered care, basic nursing skills, infection control and identification of changes in condition, mental and psychosocial well-being. This practice was evident for 2 of 2 registered nurses (RN-D and RN-E).

F726
Standard work for Aseptic Dressing Changes was developed on 11/30/2018 for licensed nursing staff. All licensed staff will undergo competency testing of compliance by 12/26/2018. 2 Random audits of wound or dressing care will be performed weekly by a Nurse Manager or designee. All results will be brought to the QA/QI Committee for further recommendations.

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F 726	Continued From page 79 Finding include: Refer to 880: RN-E hand not preformed hand hygiene after glove removal, had not removed contaminated gloves and soiled gloves touched other areas had not worn a gown for protection and had not cleaned scissors during wound cares dressing changes. RN-D had not preformed hand hygiene after glove removal and had not cleansed scissors for wound care dressing changes. Competencies were provided for RN-E, however the competencies did not include pressure ulcer wound care. No competencies were provided for RN-D. During interview on 11/01/18, at 3:25 p.m., the director of nursing confirmed RN-D and RN-E had no competencies as noted above.	F 726		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure annual performance reviews were conducted for 5 of 5 employees (E-1, E-2, E-3, E-4, and E-5) reviewed who had been employed over 1 year. This had the potential to affect all residents in the facility who had the potential to have interaction with these staff.	F 730	F730 An Annual performance review process for nurse aides was developed and implemented 11/30/2018. All nurse aides will receive an annual review during mandatory competency labs during the calendar year. All nurse aids and	12/11/18

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F 730	Continued From page 80 Findings include: An undated Employee Roster Report identified employee (E-1) was hired 12/6/05, and employee record lacked any evidence an annual performance review having been completed for greater than 10 years. E2 was hired 8/22/16, and employee record lacked any evidence an annual performance review had been completed since E2 was hired over two years ago. E3 was hired 5/31/17, and employee record lacked any evidence an annual performance review had been completed since E3 was hired over a year ago. E4 was hired 5/10/10, and employee record lacked any evidence an annual performance review had been completed since E4 was hired eight years ago. E5 was hired 9/11/17, and employee record lacked any evidence an annual performance review had been completed since the employee was hired. During interview on 11/01/18, at 5:08 p.m. when the director of nursing (DON) was asked, "if you don't do performance evaluations on your staff, how do you know what training to provide them if you don't know their areas of weakness?" The DON stated, we do not do formalized performance reviews currently, "it is a work in progress." The DON verfied staff receive verbal follow up as corrections are necessary. The DON also reported the facility conducts leader rounding monthly for staff, which is a way to do	F 730	management staff will be trained on annual review process by 12/11/2018. The Staff Development Coordinator or Designee will audit review compliance biannually following the competency labs. All results will be brought to the QA/QI Committee for further recommendations.	

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F 730	Continued From page 81 formal rounding for all employees to verify employee progress, but don't maintain formal documentation. A Performance Review Policy was requested, however was not received.	F 730		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) 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 properly secure	F 761	F761 Standard work for Medication	12/11/18

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F 761	Continued From page 82 medications for 2 of 5 medication carts observed, and failed to ensure that expired medications were removed from medication storage and destroyed in a timely manner for 5 of 5 carts observed and 2 of 3 overflow medication storage units. Findings include: On 10/31/18, 8:11 a.m. LPN-C was observed to leave a Humalog insulin pen unsecured on top of a medication cart and walk across the hall to give medications to another resident. Following this, LPN-C walked further down the hall to check on a resident to see if she was done with breakfast. At 8:37 a.m. LPN-C returned to the medication cart and prepared the insulin pen for administration. During an interview on 10/31/18, at 11:55 a.m. LPN-C stated that she leaves the insulin pen on top of the cart as a reminder so she "doesn't forget it." LPN-C stated "I thought it was okay because it doesn't have a needle when it's sitting there." According to the director of nursing (DON) who was interviewed on 11/01/18, 1:37 p.m. it was expected that all persons responsible for administering medications would keep pharmaceuticals in a secure locked area when not being used. On 10/29/18, at 5:10 p.m. while observing LPN-D and the Lakeview Court (LC) North medication cart a vial of Refresh Tears (a moisturizing eye drop) was found with an expiration date of September/2019 was found but the label had September 11 written on it. LPN-D was unsure as	F 761	Administration and Medication Expiration Dates were reviewed on 11/29/18. All licensed staff and Trained Medication Assistants will be re-educated on these by 12/11/2018. On 10/28/18 a review of medication storage areas, including medication carts, was completed and expired medications removed. A random audit by the pharmacy consultant or designee will occur monthly on each unit x 3 months for expired meds. 5 observations per week x 5 of medication administrations will be done by the Nurse Manager or designee to monitor compliance of Expired Medication and Med Administration standard work. The Nurse Manager or designee will complete full review of medication expirations for each unit monthly starting in 12/2018. All results will be brought to the QA/QI Committee for further recommendations.	

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to whether that was the date when the bottle was open or of when the eye drop should be disposed. LPN-D then went to the medication overflow storage to get a different bottle. The bottle LPN-D returned with was marked as having been opened September 12, 2018.

According to a document listing expiration dates for various medications used in the facility, all eye drops are considered expired 28 days after being opened. This document is available on all medication carts according to a note written of the page provided.

On 10/30/2018, 11:30 a.m. LPN-B was observed at the second floor medication cart for the south hall. Another eye drop, Lumigan 0/01% (eye drops to treat elevated pressure in the eye) was noted as being in the cart without documentation of the date it was open. LPN-B stated, "it should be okay for six months after opening."
Manufacturer instruction state that the medication should be disposed of 4 weeks after opening.
Also, found in the same medication cart:
-Artificial tears (lubricating eye drops) marked as having been opened 11/9/17 and expired 3/24/18
-Artificial tears with an expiration date of 8/10/18 and no date opened
-Ear drops 6.5% (generic ear drops to soften ear wax) with no date opened but delivered from the pharmacy 4/15/18.
-Lantus insulin (a long acting insulin) pen with no open date but marked as having been delivered to the facility on 9/28/18. LPN-B stated, "it is only good for 28 to 30 days after opening." LPN-B removed the pen from the cart.
-Milk of Magnesia (mineral suspension given for gastric upset or constipation) marked as having been opened 2/25/2012 and with a pharmacy

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expiration date of 2/25/2018.
-Theragesic (a topical arthritis rub) with an expiration date of 8/15/15
-Nystop 100,000 units (an anti-fungal powder for the skin) with an expiration date of 10/27/18

On the same floor but the north cart, when observing TMA-B, a container of Artificial tears was found that was marked as having been opened 2/28/18. When asked if it could still be used, TMA-B stated, "I think they are good for 6 months. "At end of day, TMA-B found the surveyors and indicated that the eye drops had been disposed of because, "they were expired."

Medication storage for over flow medication on the LC unit was examined with RN-F for expired medication on 11/01/18, 7:53 a.m. and the following were discovered:
-Metoclopramide (a medication to treat heartburn) expired 8/3/18
-Sumatriptan succinate (a migraine medication)-two bottles, expired 5/11/18 and 10/12/13
-Spironolactone (a diuretic to treat high blood-pressure) expired 10/29/18
-Senexon (a bowel stimulant) expired 10/23/18
-Levothyroxine (a thyroid medication) expired 9/1/18
-Omeprazole (stomach acid reducer) expired 9/15/18
-Losartan (for high blood pressure) expired 8/14/18
-Triamcinolone (steroid cream) expired 8/18/18
-Hydrophor 42% (moisturizing ointment) expired 9/14/18
-Refresh Liquidgel 1% (moisturizing eye drops)opened 9/12/2018
-Citalopram (an antidepressant) expired 2/2/18

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F 761	Continued From page 85	F 761		

-Acidophilus (probiotics for gastric problems) expired 10/18

Following the finding of the above expired medications, RN-F, nurse manager for the LC unit was asked to explain the facility process that assures expired medications are removed. RN-said she thought the PM shift TMAs were supposed to be doing this but any nurse who would notice expiration dates during medication administration should "pull the medications".

The LC south medication cart was examined for expired medications on 11/01/18, 9:18 a.m. with LPN-C. The following were discovered:
-Triamcinolone 0.15 expired 8/14/18 and triamcinolone 0.1% expired 8/10/18 and triamcinolone 0.1% expired 8/19/18
-Bisac-evac (bowel stimulant suppository) expired 7/2018
-Ventolin HFA AER (an inhaler to treat spasms in the airways) expired 7/13/18
-hydrocortisone (a steroid) expired 8/8/18

The Bluffview Transitional Care Unit (TCU) medication cart was examined for expired medications on 11/01/18, 11:11 a.m. with RN-G. The following were discovered:
-Atorvastatin (a lipid reducer) expired 8/12/18
-Omeprazole 20 mg expired 6/17/18
-Warfarin (an anticoagulant) expired 6/16/18
-Systane balance (moisturizing eye drops) expired 7/2018
-Econazole 1% (antifungal cream) expired 5/2018
-Miconazole 2% (antifungal cream) expired 8/27/18

The medication over flow store room for the TCU was examined with RN-G as well, and the

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F 761	Continued From page 86 following were discovered: -Ipratropium Bromid & Albuterol (an aerosol solution to treat bronchospasms) expired 9/13/18 - Biotene Dry Mouth Oral (mouth rinse) expired 10/16/18 According to an interview with the DON on 11/01/18, 1:37 p.m. she stated an expectation for all person administering medications to be checking expiration dates. DON said, "We should be looking before administration, I would say they are not." A facility provided document titled Standard Work: Medication Expiration Checks and last updated 6/3/2016 includes the following information: before administering medication check expiration date. Multi-dose inhalers, insulin pens, nitro, vaccinations must be dated when opened. Put date expires and initial. Refer to medication protocols in book on carts for exact amount (i.e. 30 days, 60 days.). A facility provided document titled Standard Work: Eye Drop Admin. And last updated 6/13/2016 includes the following information: Gather eye drops and be mindful of the expiration date. If a new bottle then it needs to be dated and initialed (bottles expire between 30-60 days depending on medication. A facility provided policy titled Storage-General and dated as having been reviewed 6/12 was provided and includes the following information: Medications and devices shall be stored to ensure their integrity, stability, and effectiveness. Medications and biologicals will be stored so that only authorized personnel have access ...All drugs and biologicals must be secure. The policy does not include information on who should monitor storage areas for expired medications.	F 761		

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all items on room trays for the supper meal were covered for 5 of 5 room trays delivered on the second floor observed during the dining observation. Findings include: On 10/29/18, at 5:09 p.m. nursing assistant (NA)-D started to deliver room trays on the second floor. Five room trays were served to residents in rooms 246, 248, 250, 252 and 243. There were no covers on the beverages, which included water, coffee and hot chocolate. There were no covers on the small dishes of mandarin oranges on any of the room trays.	F 812	F812 The Lake Winona Manor meal service policy was updated to include standard tray practices. All LWM Dietary and Nursing staff will be educated on the new policy by 12/11/2018. The Dietary Manager or designee will audit 15 room trays weekly x 5 weeks to monitor for compliance. All results will be brought to the QA/QI Committee for further recommendations.	12/11/18

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F 812	Continued From page 88 On 10/29/18, at 5:14 p.m. NA-D verified none of the beverages or the small dishes of mandarin oranges had covers on them, when he delivered the room trays to the residents on the second floor. NA-D verified these items should have had covers. On 11/01/18, at 8:53 a.m. the certified dietary manager (CDM) stated all items on the room trays are to be covered. The CDM stated I know on Monday night there were instances that items were not covered. The CDM stated the next day we had brief meeting with all of the staff and talked about the expectation that everything that leaves the dining room must be covered. At 9:35 a.m., the CDM verified staff did not follow the policy to ensure all items were covered on the room trays. The LWM Meal Service Policy dated 11/1/16 included, "Resident's choosing to eat in their rooms are able to fill out a menu for that meal and have the tray delivered to them by a nursing staff member ...b. All items that leave the dining room on a tray must be covered including beverages, desserts, fruit, etc.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		12/11/18

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct

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F 880	Continued From page 90 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene during a wound dressing change for 2 of 3 residents (R33 and R1) and failed to ensure nebulizer equipment was cleaned after use for 1 of 1 residents (R37) and failed to establish an on-going infection control program, which included comprehensive surveillance of resident infections that did not require an antibiotic and analysis of infections to reduce the risk of spread within the facility. This practice had potential to affect all 89 residents residing in the facility. Also failed to ensure hand hygiene was practiced following medication passes for 3 of 7 resident (R67, R63 & R30) and for sanitizing a glucometer. Findings include: HAND HYGIENE:	F 880	F880 Glucometer standard work updated 11/29/2018. Medication Administration Standard Work updated 11/29/2018. Nebulizer standard work reviewed and updated on 11/29/2018. Wound Care standard work created 11/30/2018. All licensed nursing staff and Trained Medication Aides will be trained on the new standard work by 12/11/2018. 2 Random audits of wound or dressing care will be performed weekly by the LWM Infection Control Nurse or designee. 5 observations per week x 5 of medication administration will be done by the LWM Infection Control Nurse or designee to monitor compliance of equipment cleaning and hand hygiene. All results will be brought to the QA/QI Committee for further recommendations.	

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R33 was observed on 10/31/18, at 8:29 a.m. to receive a pressure ulcer wound dressing change by registered nurse (RN)-E. RN- E washed hands, applied gloves, assisted R33 to roll over in bed (R33 laid on an cloth incontinent pad, which had a visible large amount of secretions from the sacral wound on the pad), removed old dressing from a sacral wound (saturated with secretions) and left gluteal fold pressure wounds, measured the sacral wound and removed gloves. RN-E applied clean gloves, cleansed the sacral wound and removed gloves. RN-E applied clean gloves, measured the left gluteal fold wound and removed gloves. RN-E applied gloves, applied four strips of carousel AG to the sacral wound bed, cut the strips of carousel AG (while in the wound bed) with scissors (unclean prior to use) to the right length, covered the wound with Kara foam dressing and removed gloves. RN-E applied gloves, placed dressing over the left gluteal wound, applied barrier cream to skin on R33's buttocks and removed gloves. RN-E applied gloves and changed the incontinent pad (soaked with a large amount of secretions). RN-E with the same soiled gloves on handed R33 two Kleenexes, applied lotion to R33's arms, legs and removed gloves. RN-E applied gloves, applied tubigrip on R33's left leg and removed gloves. RN-H placed the soiled scissors on top of R33's tray table, with no barrier underneath the scissors. RN-E removed the soiled scissors from the tray table and placed the scissors into a dressing box on R33's counter. RN-E walked out of R33's room and washed hands in the dirty utility room.

During interview on 10/31/18, at 8:29 a.m., RN-E stated she had not cleansed the scissors prior to use or after use. RN-E confirmed she had

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washed hands at the start of the wound care and after leaving R33's room. RN-E confirmed she had not washed hands between glove changes during the wound care.

R34's current care plan included problem, dated 10/29/18, Infection sacral wound related to osteomyelitis, MRSA (Methicillin-resistant Staphylococcus aureus) and cellulitis.

During observations of the wound care gloves were the only personal protective equipment (PPE) worn. No gown was worn by RN-E to protect clothing from wound secretions during the wound care procedure.

The Centers for Disease Control (CDC) at https://www.cdc.gov/mrsa/healthcare/clinicians/precautions.html read Gowning Wear a gown that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

During interview on 10/31/18, at 11:18 a.m., RN-G confirmed R33 had MRSA infection in sacral wound. When asked what PPE staff should wear during the wound dressing change for R33's sacral wound, RN-G stated unless the drainage is not contained, standard precautions should be followed. If there is excessive drainage, staff should gown.

R1 was observed on 10/31/18, at 10:31 a.m., to receive dressing changes to both lower extremities by RN-D. RN-D washed hands, applied gloves, removed old dressings from both lower extremities (LE) (left LE dressing had

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moderate amount of green drainage), cleansed both LE with wound cleanser and removed gloves. RN-D applied gloves, applied 4 x 4 Vaseline gauze pads (cut the Vaseline gauze with scissors pulled out of uniform pocket) to both LE, and applied 4 x 4 gauze pad and abdominal pad over the Vaseline gauze, wrapped both LE with Kerlix (cling wrap) and removed gloves. RN-D applied tubigrip to both LE. RN-D picked up scissors, washed the scissor in soapy water in R1's bathroom, dried the scissors and placed the scissors back into uniform pocket. RN-D washed hands.

During interview on 10/31/18, at 10:59 a.m., RN-D verified had not washed hands in between glove changes during the dressing change for both LE. RN-D verified she had not sanitized the scissors prior to use and had cleansed with soap and water after use.

During interview on 10/31/18, at 3:34 p.m., the director of nursing (DON) stated she would expect handwashing in between glove changes.

NEBULIZER:
R37 stated on 10/29/18, at 4:19 p.m., he has had a respiratory problem for a couple months now with a cough that will not go away. R37 stated facility staff started using that thing over there (pointing to nebulizer machine sitting on his bed). The nebulizer equipment set on the bed, was fully connected and had moisture in the medication cup.

During observation of R37's room on 10/31/18, at 7:18 a.m., nebulizer equipment set on a stand by R37's T.V. The medication cup had visible moisture inside. At 9:27 a.m., the nebulizer

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equipment remained the same.

During observation on 10/31/18, at 9:31 a.m., RN-H confirmed the nebulizer equipment was together with moisture in the medication cup. RN-H stated we had respiratory therapy training as part of nursing skills station and we were trained the equipment does not have to be rinsed after each use, we replace all of the equipment once a week. RN-H stated I think the training was in July.

During interview on 10/31/18, at 3:35 p.m., DON stated facility standard was to rinse the nebulizer equipment after each use. DON stated the training was washing the machine once a week, but staff should still be rinsing out the equipment after each use. That was what staff were trained on.

The facility Standard Work sheet, last updated 8/9/18, directed wash mask/medication cup with soap and water or vinegar, let air dry, 1 X/week (one time per week) on Wednesdays.

SURVEILLANCE:
During interview on 10/31/18, at 10:23 a.m., nursing assistant (NA)-A stated we had scabies up here on the south hall (second floor). NA-A stated she started itching like crazy and had open sores on her leg from the scabies. NA-A stated she was not aware the residents had scabies, as her and another co-worker had to find out why they were itching so badly. NA-A stated the scabies occurred mid-September. NA-A stated we found out residents had scabies after staff members went to urgent care.

The facility Monthly Infection Reports dated from

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months of 5/18 through 9/18 and Antibiotic Use sheets for 10/18 indicated the following:
5/18:1 pneumonia, 2 urinary tract infection (UTI) without catheter
6/18: 1 UTI with catheter, 1 conjunctivitis, 2 wound
7/18: 1 pneumonia, 2 UTI with catheter, 1 UTI without catheter
8/18: 1 upper respiratory, 2 UTI with catheter, 2 UTI without catheter, 1 wound
9/18: 1 pneumonia, 1 UTI with catheter, 1 wound
10/18: 2 UTI without catheter, 2 cellulitis, 1 presumed bronchitis

There was no documentation from the sheets regarding scabies.

During interview on 11/01/18, at 12:59 p.m., RN-I stated I do not document analysis of infections, I gather data for infections. RN-A stated I do not document as needed education provided for employees about communication for infections when occur on how to prevent the spread of infections. RN-I stated I do not track viruses. RN-I stated the facility had scabies in house last month. RN-I stated she had no documented information regarding surveillance of the scabies, action taken and outcome. RN-I provided information that indicated 15 residents in the facility had been treated with Permethrin topical (works by disrupting the function of the neurons of lice and scabies mites) for scabies. RN-I stated the medical director was informed and the staff were offered treatment.

The facility policy Hand Hygiene, dated 7/18, indicated VI. Indications for hand hygiene: Always perform hand hygiene in the following situations. B. Before and after performing invasive

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procedures. Although gloves are worn for certain procedures, hand hygiene before donning gloves and after removal is necessary because of the possibility of tears or holes in the gloves. D. Between care activities on the same patient involving different body sites (care of Foley/IV/wound/trach). E. After contact with blood, body fluids or excretions, or wound dressings. F. Before exiting the patient's care area after touching the patient or the patient's immediate environment.

The facility policy Standard Precautions, dated 1/17, indicated II. Personal Protective Equipment (PPE): PPE is worn when there is potential for contact with blood or body fluids. B. Gowns 1. Wear an impervious gown to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretion or excretions is anticipated.

The facility policy Infection Management Plan, undated, indicated Surveillance, prevention and control program: 1. Surveillance is the process of case finding and analysis used to report and assess infection concerns and to identify risks. 2. Prevention is the comprehensive process of identifying potential risk and utilizing appropriate actions prevent untoward events. 3. Control is the process, which establishes for actions necessary to respond to outbreaks, clusters, or individual cases of infection requiring isolation precautions. Reporting: 1. The infection Control Coordinator will analyze and present the surveillance data to infection control committee and nursing leaders.

R67 received medications during a medication pass on 10/31/18, 8:13 a.m. when licensed

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practical nurse (LPN)-C was observed returning to a medication cart after administering medications. LPN-C was wearing gloves and removed them, but failed to do hand hygiene upon removal. LPN-C then proceeded to set up medications for R67, touching the medication cart, computer for documentation, resident medication containers, and medication cups. LPN-C then applied gloves and went to R67's room and administered medications. Following this, LPN-C again returned to the medication cart, removed gloves and failed to perform hand hygiene. LPN-C then documented the administration on the computer.

R63 received medications on 10/31/18, 8:37 a.m. when LPN-C was observed returning to the medication cart after administering medications down the halls and ready to prepare an insulin injection for R63. LPN-C failed to perform hand hygiene upon return to the cart and before preparing the insulin pen for injection. LPN-C cleaned the insulin pen with alcohol and attached a needle to the pen. Following this, LPN-C went to R63's room where hand hygiene was performed and gloves applied. The insulin was administered and LPN-C then returned to the medication cart, removed the contaminated needle, returned the pen to the cart and removed gloves. LPN-C then failed to perform hand hygiene.

R63 had a blood sugar check done on 10/31/18, 11:33 a.m. when LPN-C was observed performing a blood sugar check on R63. During the observation, LPN-C was noted to take the glucometer (a machine to check blood sugar) to R63's room where nurse performed handwashing and applied gloves, cleansed R63's finger with

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING ______ B. WING ______	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	**865 MANKATO AVENUE WINONA, MN 55987**

(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 880	Continued From page 98	F 880		

alcohol and collected a blood sample from R63's finger with the glucometer. Then LPN-C carried the soiled glucometer from the room, returned to the medication cart and set it down without any barrier between the soiled equipment and the cart. Following this, LPN-C removed gloves but did not perform hand hygiene. LPN-C stated the proper cleaning wipes were not available and cleansing would have to wait. The soiled glucometer remained on top of the medication cart where medications are prepared for administration.

R30 received medications on 10/31/18, 11:36 a.m. when LPN-C was observed to prepare R30's medications and enter resident's room without having performed hand hygiene. LPN-C applied gloves and administered medications and flush R30's gastric tube without hand hygiene. Following these tasks, LPN-C removed gloves and left the room to return to the medication cart where hand hygiene was done.

During an interview on 10/31/18, 11:49 a.m. LPN-C was asked when it was appropriate to do hand hygiene when administering medications. LPN-C said hand hygiene should be done before administering medications and if called to a different room, to "do it again." When asked about appropriate hand hygiene related to hand hygiene, LPN-C said, "I should be doing it when I remove gloves." LPN-C also stated that the facility provided frequent education related to hand washing and she had received education.

During the same interview, LPN-C stated she would clean the glucometer by wiping it thoroughly three times with a disinfecting wipe and then let it sit for two minutes to dry. Shortly

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING ______ B. WING ______	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

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F 880		F 880		

Continued From page 99

after, LPN-C picked up the glucometer and went down the hall with it and set it on a counter near the nurses' station without providing a barrier between the counter and the soiled glucometer while she got the appropriate disinfecting wipes. LPN-C did not apply gloves, but wiped the glucometer off and returned it to the cart. The counter and surface of the medication cart were not cleansed with the disinfecting wipes.

During an interview on 11/01/18, 1:27 p.m. the director of nursing (DON) stated she would expect general principles for infection control to be followed by placing a barrier to protect a clean surface from contamination. DON said that glucometers should be cleaned between uses.

At 11/01/18, 1:30 p.m. the DON was asked about expectations related to hand hygiene during medication administration. The DON said that hand hygiene should be done before and after medication administration and "in-between as needed, between dirty to clean" tasks.

A policy for handwashing and glove use during medication administration was requested and none provided.

A policy for glucometer cleaning was requested and a document titled Standard Work-Chemstrips and dated 4/6/2017 was supplied. This document instructs licensed practical nurses and trained medication aides to wash hands and apply gloves prior to testing. Furthermore, after testing it directs the user to immediately dispose of the test strip and to clean the entire meter with "Super Sani-Cloth/purple top wipes" then remove gloves and wash hands. An additional document was supplied by the facility titled, Winona Health

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

(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 880	Continued From page 100 NOVA StatStrip Blood Glucose Meter Direct Observation [COMPETENCY]. The first two steps to perform stated: "follow proper Standard Precautions Policy Guidelines" and "wash hands with soap and water and put on gloves." Then the meter should be readied. The competency indicates gloves should be changed for patient testing. After testing, the competency directs that the meter should be cleaned with "correct wipes (Sani-clothe Plus. Wipes wet not dripping)" and then the meter to be stored. Both documents fail to provide the process for correctly cleaning the glucometer with the exception of which wipes to use. The documents do not address maintaining a clean environment in response to soiled equipment. The Centers for Disease Control recommend health professionals practice hand hygiene before and after direct contact with a patient's skin, after contact with blood or body fluids, after contact with the patient's environment and after glove removal.	F 880		

REVISED

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: IQ2C
Facility ID: 00701

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245240**
2. STATE VENDOR OR MEDICAID NO. (L2) **020945700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE WINONA MANOR**
(L4) **865 MANKATO AVENUE**
(L5) **WINONA, MN** (L6) **55987**

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 **12/27/2018** (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) **04/30**

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

12.Total Facility Beds **110** (L18)
13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(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 :
Maria King, Assistant Program Manager 2/6/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 2/6/2019 (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 **02/01/1982** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

CMS Certification Number (CCN): 245240

February 7, 2019

Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

Dear Administrator:

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 December 26, 2018 the above facility is certified for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: IQ2C
Facility ID: 00701

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245240**

2. STATE VENDOR OR MEDICAID NO.
(L2) **020945700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE WINONA MANOR**
(L4) **865 MANKATO AVENUE**
(L5) **WINONA, MN** (L6) **55987**

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 **11/02/2018** (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)
04/30

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From (a) :
To (b) :

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10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(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 :
Lisa Carey, HFE NE II 12/14/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/28/2018 (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)

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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
02/01/1982
(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
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INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

November 21, 2018

Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

RE: Project Number S5240030

Dear Administrator:

On November 2, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this department has recommended and CMS has authorized us to notify you this Department is imposing the following remedy:

- State Monitoring effective November 26, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy(ies) and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 21, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 21, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 21, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 21, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lake Winona Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 21, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, if your ePoC for their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 May 2, 2019 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING ______ B. WING ______	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

(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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on October 29, 30, 31, November 1 & 2, 2018, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan included a method for sharing information the facility had determined appropriate, with clients and their families or representatives. This had the potential to affect all 89 residents currently residing in the facility and their families/representatives. Findings include: On 10/31/18, at 1:38 p.m. the facility emergency policies and procedures were reviewed with the registered nurse (RN)-G. RN-G stated the facility had not shared any information with clients and	E 035	E-035 Standard work for family notification of facility emergency plans will be created on 12/4/2018. The Lake Winona Manor Emergency Prep Policy will be updated to include notification of plan to residents and responsible parties by 12/4/2018. LWM staff will be educated on updates to standard work and policy by 12/11/18. A social worker or designee will audit perform a monthly audit x 4 months to monitor compliance. Results will be brought to the QA/QI for further recommendations.	12/11/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 11/30/2018

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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	245240	A. BUILDING ______ B. WING ______	11/02/2018

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E 035	Continued From page 1 their families or representatives.	E 035		
F 000	INITIAL COMMENTS On October 29, 30, 31, November 1 & 2, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and 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 observation, interview, and record	F 557	F557 Respect/Dignity	12/11/18

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F 557	Continued From page 2 review, the facility failed to ensure 1 of 1 resident (R42) was treated in a dignified manner while being provided assistance with personal cares. Findings include: R42's Face Sheet dated 11/1/18, identified an admit date of 5/18/17, a diagnoses of multiple sclerosis (MS), depression and anxiety. R42's quarterly Minimum Data Set MDS an assessment, dated 8/30/18, identified to have intact cognition, required 1 person extensive assist with dressing and personal hygiene, 2 person extensive assist with bed mobility and transfers. R42's care plan updated 10/19/18, identified a problem: I need assistance with my activities of daily living (ADL's) because I have MS. Approach: personal history-as evening approaches I am more tired and may not cope with deviation from my routine. I have a history of sexual assault and at times incidents can make me feel vulnerable. Please explain all cares as they are being provided. I am ok with male and female care givers to complete all parts of my care. Problem: I can be demanding and controlling of others. I may have verbal outbursts as this is how I cope with my MS. Approach: taking time to listen to what I have to say, allowing me to vent is helpful and calming. Behavior record charting dated 10/17/18 at 10:47 p.m., indicated, Resident was rude to the male staff member telling other staff she didn't want him in there or even want him to be in there to do cares with her while aide was in the room. Stated to the male nurse, "I can't wait for you to go on	F 557	Resident 42□s care plan was updated on 10/18/2018 and reviewed for accuracy on 11/29/2018. Employee involved in situation received coaching on 10/19/2018. The VA Policy and standard work were reviewed and updated on 11/27/2018. All LWM staff will be trained on VA Policy by 12/11/2018. Random Audits of 5 staff will occur weekly x 5 weeks by the Social Worker or Designee to monitor compliance. Results will be brought to the QA/QI for further recommendations.	

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F 557	Continued From page 3	F 557		

vacation because you bother everyone around here." And he left with his partner and she was the last to go to bed.

Behavior record charting dated 10/18/18, at 12:07 a.m. indicated, resident was upset about her p.m. cares, stating the aides "weren't being friendly towards her. Aide was pulling on my shirt and it felt like I was being raped. If I needed help with my shirt, I would ask for help, I can do it myself." Night aide allowed resident to let out feelings. A few minutes later, resident asked for some hard alcohol, stated to resident if you need anything to put on the call light.

Behavior charting dated 10/18/18, at 8:17 a.m. indicated, due to comment of 'felt like being raped' this writer and charge RN (registered nurse) came to talk with resident. Asked resident if she felt threatened by male caregiver. Resident responded, "No I am not threatened by him ...he just grabs and starts doing things and I am not ready. "Writer asked resident what she meant by doing these things and resident replied that he just starts grabbing on my shirt or starts getting washcloths ready and I don't want that yet ...he goes so fast and I have no time to process things ..." Writer paraphrase this reply back stating "So what you are saying is that he starts his cares without seeing what you need done first or he does not tell you what he is doing step by step so you know what is coming? Resident said, yes that is what he does, you know he and me, we just do not mesh well. Writer then did question the resident say "you reported to my aides that you felt he was grabbing at you and you felt you were being rape? Resident reply saying "well what I meant was I know he was not going to rape me, but the way he grab me ...reminded me

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of a situation in my past where I was raped and the person grab me similar to this." Writer then suggested that due to past and situation would she be ok with female only care giver. Care Plan updated, resident is a female only care giver except in case of emergency a male care giver can be used to help assist resident.

During interview on 10/30/18, at 9:21 a.m. R42 stated, nursing assistant (NA)-N was disrespectful towards me about a week ago around 6:30 p.m. I had a bad day, my nephew had given me some bad news and I had just found out one of my good friends with a cancer diagnosis may not make it through the night. So what happened was NA-N and NA-M came into my room to help me get ready for bed. I was in the process of taking off my shirt and NA-N stated, No, I will get it When he went to pull my top on it hit me all wrong. I told him I would ask for help if I needed it, and he said, ok, ok! It seems like he is always in a big hurry, so I proceeded to tell him, as he was trying to tug at my shirt, this is the way guy's rape women, and I should know it has happened to me twice. He then backed off and told me, "You will not show me disrespect!" He then snapped his fingers and pointed towards the door and went out the door and [NA-M] followed him. They didn't come back in till 9:45 p.m. that night. Then my nurse, [licensed practical nurse (LPN)-F] comes in my room and said very sternly to me, "[NA-N] will be getting you ready for bed whether you like it or not, so I don't want to hear anymore that you are being disrespectful to him." [LPN-F] had made her mind up, she was siding with [NA-N] and "It made me feel like I was reprimanded like a child." She had been in here earlier that night and we were laughing and joking about my flamingo

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clock. I was not expecting her to come in and talk to me like that, I feel like I was disrespected by both of them. Well they both came back and NA-N helped me into bed and then NA-M finished helping me. I am not worried right now about NA-N, he is on vacation, so I haven't had to deal with him. You learn around here that it is their way or no way. They acted like I was screaming at him, I was just having a bad day and I wasn't in the mood to have my shirt pulled like that. The next morning [social services (SS-B] came in and talked with me, when I told him what happened he told me they were wrong in doing that. I think NA-N blew it way out of proportion, I think he was telling them that I said he tried to rape me and that was not at all what I said. Then [administrator (A)-B] came and asked me what happened and I told her it was a PTSD (post traumatic stress disorder) thing with [NA-N] when he grabbed my shirt. She then told me they would get me someone to talk to for that. No one else ever came in and talked to me about it, that was it. R42 stated, "I do not feel like [NA-N] abused me, I just want to be treated with respect and dignity, I feel like no one here is supporting me."

During phone interview on 11/01/18, at 12:39 p.m. nursing assistant (NA)-M stated, some people find R42 difficult, but when she complains her points are valid, sometimes she just has a hard time getting her point across. About 2 weeks ago one of my co-workers [NA-N] and I were working on R42's wing. I think she was kind of mad at him because he was late with her stretches the night before, and when she gets mad she can hold grudges. Anyway's, he had her shirt half on and R42 yelled at him, get the hell out of here and go to Mexico! (She knew he was going there for vacation.) I personally thought that was

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inappropriate. Then [NA-N] said to [R42], you will not disrespect me like that, you will not treat me this way, in a very stern voice and left her shirt half on. Then he said to me, come on we are leaving. I thought it was wrong, he should have let me finish putting her shirt all the way on, I suppose [R42] tried to make us look bad, going through the common area with her shirt half on and off, she has an electric wheelchair and went to the trans care unit (TCU), telling people, they put my shirt half way on then left me. NA-M stated, I did go back in there a while later and asked if she was ready for bed, and we helped her to bed. [R42] was still very upset with [NA-N] and told me she was not going to talk to him. NA-M verified no other staff came and talked to her about this specific incident. The next day we told [registered nurse (RN)-F] and she told us to make sure we chart this as a behavior, so we did. I do think it was disrespectful that [NA-N] left her shirt half on and half off and demanded me to walk out with him, when I could have finished helping her.

During interview on 11/01/18, at 2:22 p.m. RN-F verified the incident happened on 10/17/18, during the evening shift and that she was notified the following morning. RN-F verified she did know NA-M and NA-N were involved in the incident and did not interview them. RN-F stated, I would say leaving [R42's] shirt half on and half off was disrespectful, that should not have been done.

During interview on 11/01/18, at 2:39 p.m. SS-B stated he was not aware of the whole situation concerning R42. SS-B stated, I feel the situation was not handled well, it is their job to care for the resident, her shirt never should have been left

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F 557	Continued From page 7 half on, and cares come first. "It does go back to dignity, you can't just leave someone with their shirt half on." During interview on 11/01/18, at 3:14 p.m. A-B verified she went and talked with R42 the morning she was notified of the incident and stated, I will have to interview the staff members before I could say if this resident was treated disrespectfully. A-B further stated, R42 did mention she left the room with her shirt half off, because she wanted to show them. During interview on 11/01/18, at 4:39 p.m. director of nursing DON stated, I was notified right away about this incident, the administrator followed up on that and closed the loop on that. I want all my residents to be treated with dignity and respect. They (the staff) struggle with the right tools for her behaviors and we are working at that. "She is a vulnerable adult and we have to care for her and treat her with respect and dignity and it is obvious we have some work to do." Policy requested regarding dignity, however none provided.	F 557		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other	F 585		12/26/18

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F 585	Continued From page 8 residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,	F 585		

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F 585	Continued From page 9 receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and	F 585		

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F 585	Continued From page 10 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to communicate and implement a grievance process for 9 of 9 residents (R8, R17, R82, R3, R41, R43, R49, R25 and R50) reviewed during resident council. Findings include: During a resident council meeting without staff present with R8, R17, R82, R3, R41, R43, R49, R25 and R50, on 10/31/18, at 10:30 a.m. when asked if anyone knew how to file a grievance or who their grievance official was 8 of 9 residents in attendance stated they did not know how to file a grievance or who the grievance official was, with the exception of R18. R18 stated there are paper forms on the doors of the social workers and that you fill out the form and the social worker will get back to you. R82 stated, "I have been here for 7 years and I never heard of being able to file a grievance." When asked if the facility follows up on grievances all residents were in disagreement with stating, "No." and shaking their heads. A few had confused looks on their faces, R43 stated, they do not respond to our concerns, that's why half the time we don't repeat it. Several residents were nodding their heads in agreement as R43 said this. At 10:40 a.m. R41 stated, no, they do not always act promptly to our complaints/grievances, sometimes you have to repeat it to the head of one of the committees (department heads) whoever you are having the problem with and sometimes you can't discuss	F 585	F 585 Grievances A policy and form for LWM Grievances was created on 11/30/2018. ALL LWM staff will be trained on new standard work by 12/11/2018. Updated Standard Work for resident grievance education created by 12/4/2018. All residents and responsible parties will be trained on grievance process by 12/26/2018. Audits of resident care conferences will be done x 8 weeks by a Social Worker or Designee to determine level of understanding. Results will be brought to the QA/QI Committee for further recommendations.	

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certain things in front of everybody.

During interview on 10/31/18, at 12:14 p.m. health unit coordinator (HUC) stated, resident grievances are entered into ECS (electronic medical record), was not sure if there was a paper form.

During interview on 10/31/18, at 12:16 p.m. when asked about how a resident would file a grievance, licensed practical nursed (LPN)-C stated, we do not have paper grievance forms, if a res had a complaint they would tell the aide, the aide would tell me and I would document in ECS, "I think they have a grievance file there." LPN-C was unsure and directed this surveyor to the director of nursing.

During interview on 10/31/18, at 2:50 p.m. registered nurse (RN)-A stated resident grievances are filed under logic manager (program in electronic health record). This is used more for family grievance process. If a resident has a complaint we chart it in quality assurance (QA) (another program in electronic health record) under ECS. I think our grievance official is, I guess it depends on what the concern is. We do not have 1 specific grievance official. If a resident has a concern I guess the nursing assistant has no way to help the resident to fill out a grievance form because they do not have access to the quality assurance in ECS. The nursing assistant or resident would have to report it to the nurse so she could put it in quality Assurance in ECS for investigation. The resident grievance will not get a letter like the family grievance would. I am not sure why there are two different systems for this.

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F 585 Continued From page 12 F 585

During interview on 11/01/18, at 9:13 a.m. nursing assistant (NA)-L stated, I don't think there is any grievance form for the residents to use and I have been here since June.

During interview on 11/01/18, at 12:58 p.m. nursing assistant (NA)-M stated, If I ever heard a resident who had a complaint, I would tell my trained medication aide (TMA) and then hopefully they would report it to the charge nurse which would be down on the TCU (trans care unit) for the evening shift. I am not sure how they get followed up on.

During interview on 11/01/18, at 1:40 p.m. licensed practical nurse (LPN)-E stated in response to residents filing a grievance, "If an aide came to me and told me a resident wanted to file a grievance or complaint, I am not sure, I would ask the charge nurse, maybe there is a form." LPN-E was unable to answer how the grievance system works and had to ask her charge nurse.

During interview on 11/01/18, at 1:51 p.m. registered nurse (RN)-F stated, as far as a resident complaint/grievance the process is the resident would have to come to licensed staff and they would put it in QA/incident in ECS. I am not sure how a TMA would file it, I would have to ask. If it is a complaint for another department other than nursing we would document that in logic manager. This is the one where they would receive a letter in response to the complaint. With nursing concerns we follow up verbally, it is not documented.

During interview on 11/1/18, at 3:44 p.m. director of nursing (DON) stated, I have worked here

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F 585	Continued From page 13 since 2013, when asked what the policy or process of how a resident files a grievance, and who the designated grievance official is and what action is taken to resolve the grievance, the DON verified the policy does not have a clear process for grievances. Facility policy, Patient/Resident Grievance and /or complaint Winona Health policy, revised 4/18, indicated the purpose: requires prompt reporting of all negative feedback for timely investigation and to initiate corrective actions as appropriate. Patients will be informed of any follow up actions. In the event a feedback is a grievance, the final resolution of the grievance must be given to the person in writing. Policy: negative feedback should be addressed at the level and at the time it originates. When negative feedback is received, it is entered into the electronic reporting system (Logic Manager) as soon as possible. The department director, manager or supervisor will 0. (No further plan identified).	F 585		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		12/11/18

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F 607	Continued From page 14 by: Based on interview and document review, the facility failed to ensure their abuse prohibition policy and procedures identified a definition of resident-to-resident abuse and reporting procedures for resident-to-resident abuse. This has the potential to effect all 89 residents in the building. Findings include: Review of The Vulnerable Adult Abuse Prevention Plan with a revision date of 3/18, revealed the policy did not include a definition of resident-to resident abuse. The Facility flow sheet for Resident-To-Resident Altercations dated 7/2014, included, "Did the resident act willfully in the altercation?" and included the definition of "willful" as the individual intended the action itself that he/she knew or should have known could cause physical harm, pain or mental anguish. Even though a resident may have cognitive impairment, he/she could still commit a willful act. The flow chart directed staff that if the willful act did not result in physical harm, pain, or mental anguish, the act was not reportable. During an interview on 10/31/18, at 2:50 p.m. social services (SS)-A verified by reviewing the Vulnerable Adult Abuse Prevention Plan, it did not include a definition of resident-to resident abuse. SS-A stated, "I guess I am not seeing it either (referring to definition of resident-to resident abuse)." SS-A stated at the nurse stations there was a flow sheet for resident-to-resident altercations for staff to follow. SS-A stated the flow sheet directed staff if there was no intent to	F 607	F607 Develop and Implement Abuse/Neglect Policies The LWM VA policy was updated with current definition of resident-to-resident abuse on 11/27/2018. All LWM staff will be trained on VA Policy by 12/11/2018. 5 Random audits of behavior documentation will occur weekly x 8 to monitor for compliance to reporting requirements by a Social Worker or designee. Results will be brought to the QA/QI Committee for further recommendations.	

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F 607	Continued From page 15 not report. The State Operations Manual (SOM) Appendix PP dated 11/22/17, defined the definition of willful as used in this definition of abuse, "means the individual mush have acted deliberately, not the individual must have intended to inflict injury or harm."	F 607		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		12/11/18

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F 676	Continued From page 16 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cares were provided for oral hygiene and bathing for 1 of 5 residents (R34), reviewed for activities of daily living (ADLs). Findings include: R34's admission Minimum Data Set (MDS), dated 9/4/18, indicated R34 had moderate cognitive impairment, required one assist with personal hygiene and bathing and activity of bathing did not occur during entire period. R34's care plan, dated 9/21/18, included I need assistance with my ADLs and approaches included oral hygiene set up assist and for bathing I would like to try a whirlpool bath to see if it helps my back. R34's nursing assistant care sheet included bathing: dependent with one person physical assist, resident request tub bath one time a week on the p.m. shift. Oral care: upper full set, four natural teeth on the bottom. Grooming: independent with set up. During interview on 10/29/18, at 3:03 p.m., R34	F 676	F676 ADLS-Care plans and NA task lists were reviewed and updated for R34 on 11/29/2018. R78 no longer resides at this facility. Standard work for oral care and the Resident□s Personal Appearance and Hygiene Policy were reviewed and updated on 11/29/2018. All nursing staff will be trained on new standard work by 12/11/2018. 5 random audits of both oral care and bathing records will be performed weekly x 5 by the Nurse Manager or Designee. Results will be brought to the QA/QI Committee for further recommendations	

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F 676	Continued From page 17	F 676		

stated they do not offer me a bath or shower anymore. I am washed up in the bathroom in my room. I only get a scrub down. I do not know what the scoop is. I have had my hair washed one time and that was in the shower that I had once.

During interview on 10/29/18, at 3:22 p.m. R34 stated I do not always get help with brushing my teeth. I do not know if that is my fault or not. I do not ask. They offer once in a blue moon. The last time I had my teeth brushed was a couple months ago.

During observation on 10/31/18, at 8:26 a.m., R34 laid in bed dressed eating breakfast. R34 stated my upper denture plate was cleaned last night. When asked if her four natural teeth in her mouth had been brushed this morning with cares, R34 stated no, I should have had them brushed at the time I was dressed. Everything is in such a rush when they come in to help you get dressed.

R34's record identified the following information was documented for bathing by the nursing assistants: 9/10/18 tub bath given, 9/17/18 bed bath given and 10/8/18 hair shampooed and shower given.

During interview on 10/31/18, at 9:19 a.m., nursing assistant (NA)-B stated she had assisted R34 with a.m. cares. When asked if she had offered or brushed R34's four bottom natural teeth when providing morning cares, NA-B stated I gave R34 her upper denture, but I did not offer or brush R34's natural teeth.

During interview on 10/31/18, at 3:30 p.m., the director of nursing (DON) confirmed R34's care plan as above. DON stated the facility protocol for

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F 676	Continued From page 18 oral hygiene was to be completed with morning and evening cares, anytime needed and at request. DON stated she would expect oral hygiene to be completed every a.m. or offered. During interview on 11/01/18, at 7:53 a.m., NA-C stated R34 received a bath on Monday evenings and the nursing assistant's document completion of the bath under the nursing assistant charting in the computer system. During interview on 11/01/18, at 10:09 a.m., the DON reviewed R34's record and confirmed the above three times of bathing having been documented. DON stated there was no other documentation of any other times bathing had been completed for R34. DON stated staff may have missed charting a bath for R34, but she would not expect to see that many gaps of documentation not being completed for bathing. DON stated if the resident had refused, she would expect staff to document the refusal. The facility policy Care Plans and Care Conferences, dated 4/16, indicated a multidisciplinary approach is used to individualize each resident's care plan to achieve and maintain the resident's optimal physical, communicative, psychosocial, functional, spiritual and emotional status.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		12/11/18

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F 677	Continued From page 19 by: Based on observation, interview, and document review the facility failed to ensure timely toileting assistance for 1 of 5 residents (R78) reviewed for activities of daily living. Findings include R78's Diagnoses List dated 11/1/18, included diagnoses of malignant neoplasm of bladder, constipation, and chronic renal disease stage 4. R78's annual Minimum Data Set (MDS) dated 10/11/18, indicated R78 cognitive skills for daily decision making were severely impaired. The MDS further indicated R78 required extensive of assistance from two staff for transfer and extensive assistance from one staff for toileting. The MDS also indicated R78 was frequently incontinent of bladder and bowel and was not on a toileting program. R78's urinary incontinence Care Area Assessment (CAA) that was printed on 11/1/18, did not include a date of completion. The CAA indicated R78 required assistance with toileting, was taking diuretic medication that caused urge incontinence and anticholinergic's that made lead to overflow incontinence. The further indicated R78 had diabetes, bladder cancer, and had stress incontinence with urgency. The CAA also indicated, "revise current care plan." R78's self-care deficit care plan for toileting care plan dated 10/3/18, directed staff to use 1-2 staff assist depending on R78's mood and to assist every two hours and as needed. The care plan further directed staff if R78 was resistive to toileting return later and attempt again. R78's skin	F 677	F677 R78s is no longer a resident at the facility. Toileting standard work was created on 11/30/2018. All nursing staff will be trained on the toileting standard work by 12/11/2018. 5 Random audits weekly of toileting completion will occur x 6 weeks by the Nurse Manager or designee. Results will be brought to the QA/QI Committee for further recommendations.	

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care plan dated 10/4/18, indicated R78 was at risk for impaired skin integrity related to incontinence and directed staff to keep skin clean and dry and to apply barrier cream after any incontinent episode.

R78's progress note dated 10/16/18, included: Resident is totally dependent on staff for all toileting needs. He is incontinent of both, but he will have bowel movements in the toilet if staff gets him there in time. He doesn't tell staff when he needs to use the toilet, but becomes increasingly anxious when needs to have a bowel movement and that is a cue for the staff.

During an observation on 10/31/18, at 7:38 a.m. R78 laid in bed with his eyes closed. Nursing assistant (NA)-E indicated sometimes R78 was a one assist or two assist depending on what his mood was in the morning. NA-E attempted gently to wake R78 up and folded down the top sheet and blankets. The top sheet, mattress protector pad and fitted bottom sheet were noted to be saturated with urine. R78's incontinent brief and gown were also saturated. At 7:47 a.m. NA-F entered the room to assist NA-E. R78 became resistive to get out of bed. While NA-F changed R78's gown and replaced the urine saturated top sheet with a fresh clean sheet, NA-E put new socks on R78's feet. During the observation neither NAs offered to take R78 to the bathroom nor did the attempt to offer or change the soiled brief or linen.

During an interview on 10/31/18, at 8:52 a.m. NA-E stated she attempted to get R78 up again, however, he was not ready to get up. NA-E she had not provided any cares, however, the nurse checked his blood sugar.

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During an observation on 10/31/18, at 10:01 a.m. NA-E knocked on R78's room and entered. R78 laid in bed with his eyes closed and snoring. NA-E stated R78 could sleep all day. NA-E asked R78 if he wanted to get up and get ready, R78 did not respond. NA-E then left R78's room without checking R78's linen or offering to take R78 to the restroom.

During an observation on 10/31/18, at 11:34 a.m. registered nurse (RN)-C and NA-F entered R78's room. R78 was agreeable to get up out of bed and allowed NA-F and NA-G to assist with morning cares. R78's brief, mattress protector pad, and fitted bottom sheet were saturated with urine.

During an interview on 10/31/18, at 11:43 a.m. NA-F stated she had thought the other NA had offered and/or checked and changed R78's brief and linen as she had been in there prior to her arriving in the room that morning. NA-F stated if she would have known that was not completed during the first attempt to get him out of bed, she would have asked and/or changed the soiled linen. NA-F stated the linen should been attempted to be changed and R78 should have been offered toileting and/or checked and changed.

During an interview on 11/1/18, at 8:31 a.m. registered nurse (RN)-A stated R78 was supposed to be toileted every two hours and if he was in bed he was supposed to be checked and changed every two hours. RN-A indicated sometimes R78 displayed aggressive behaviors and approach was key, if R78 had behaviors the expectation was for staff to leave and

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F 677	Continued From page 22 re-approach until cooperative. RN-A stated R78 could not tell staff when he needed to use the bathroom. RN-A stated it was expected staff change and/or offer toileting and if R78 refused multiple times then the nurse or clinical manager should have been made aware. During an interview on 11/1/18, at 11:20 a.m. director of nursing (DON) stated staff should have offered toileting or checked and changed R78 as per the care plan. DON further indicated if R78 was incontinent staff should not have waited another hour to re-approach to remove the soiled garments and linen and should have reported the refusals of care to the nurse in order to come up with another intervention. Policy relating to incontinence/toileting was requested and not received.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide ongoing assessment/monitoring or care for edema (fluid retention) for 3 of 3 residents (R78, R7 & R73) reviewed with cardiac and respiratory	F 684	F684 Care plans for R7 and R73 were reviewed and updated to include edema monitoring instructions by 11/30/18 . R78 is no longer a resident at the facility. New standard	12/11/18

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F 684	Continued From page 23 complications. Also the facility failed to ensure a dressing change was implemented as written per the physician orders for 1 of 1 resident (R1) and failed to ensure a follow-up physician visit was completed for 1 of 1 resident (R34) following a visit to the emergency room. Findings include: EDEMA MONITORING: R78's Diagnosis List dated 11/1/18, included diagnosis of congestive heart failure, hyperkalemia (high potassium), chronic kidney disease stage 4, and vascular dementia. R78's annual Minimum Data Set (MDS) an assessment, dated 10/11/18, indicated R78's cognitive skills for daily decision making was severely impaired, identified the diagnosis of congestive heart failure (CHF), and received diuretic medications during all days of the assessment period. R78's physician orders dated 11/1/18, included: -Furosemide (diuretic medication) 40 milligrams (mg) twice per day (start date 7/17/18). -Tubular bandage/Ted hose (compression stockings) to both lower extremities on during the day and off at night (start date 10/4/18) R78's care plan dated 11/1/18, did not identify diagnosis of CHF nor goals for treatment and management. The skin integrity care plan dated 9/15/18, directed staff to observe skin with cares for any redness signs and symptoms of skin breakdown and update nurse to evaluate as needed, Ted stockings on in the morning and off at bed time, encourage resident to elevate legs	F 684	work was developed on Edema monitoring and Aseptic Dressing Changes on 11/30/18. All residents screened for necessity of edema monitoring and care plans updated accordingly. All licensed staff will be trained on new standard work and policy updates by 12/11/2018. Weekly audits of 5 residents appropriate for edema checks will be performed by the Nurse Manager or designee x 6 weeks. Results will be brought to the QA/QI Committee for further recommendations. Provider Notification standard work was updated on 11/30/2018 to include actions related to discharge provider visit recommendations. All Licensed Nursing staff and Health Unit Coordinators will be educated on standard work by 12/11/2018. 2 Random audits of standard work will be performed by a Health Unit Coordinator or designee weekly x 6 weeks. Results will be brought to the QA/QI Committee for further recommendations.	

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during the as tolerated.

R78's record was reviewed from 8/6/18 through 11/1/18; the record lacked evidence of ongoing edema monitoring. The only edema assessment in the record during that period included the following:
-R78's ANNUAL/SCSA Assessment: 10/10/18, EDEMA indicated, no edema was present, had peripheral pulses, and has diagnosis of CHF and received Lasix. Weights stable.

During an observation on 10/29/18, at 2:34 p.m. R78 sat in wheelchair with his eyes closed; R78 legs had Tubular bandages on. R78's legs were edematous; right leg was more swollen than the left when compared.

During an observation on 10/31/18, at 7:38 a.m. R78 laid in bed, had gripper socks on. Nursing assistant (NA)-E removed the gripper socks; the skin above the ankle where the top of the gripper sock had been was indented. NA-E then put clean socks on.

During an interview on 10/29/18, at 2:48 p.m. family member (FM)-A stated R78 had more swelling in both his legs than he has had before. FM-A was not sure if R78 received a diuretic medication however, stated he used the "tubi grips" to help with the swelling. FM-A stated R78 had a weight gain since last care conference of at least 3-4 pounds.

On 11/1/18, at 9:25 a.m. registered nurse (RN)-A reviewed R78's record and verified there was not documentation of edema and/or not consistent. RN-A indicated the overall documentation of monitoring and assessment of edema was

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lacking. RN-A stated edema should routinely be monitored and documentation should include location, extent, and determination if interventions were effective.

During an interview/observation on 11/1/18, at 9:34 a.m. R78 sat in his wheelchair in his room with tubular bandages to both legs. RN-A removed the bandages, stated the left leg had trace edema was not pitting. RN-A then stated R78's right leg had 3+ edema from foot to mid-calf.

During an interview on 11/1/18, at 11:20 a.m. director of nursing (DON) stated, monitoring of edema should be done daily; documentation should include location and extent of edema. DON then stated weekly more comprehensive assessments should be done.
R7 had been interviewed on 10/29/18, 3:56 p.m. at this time R7 was noted to have significant swelling of both lower legs and noted there were compression wraps in place. When asked about the edema, R7 said he thought he was on some medication for the swelling, but could not remember. When asked if the facility was monitoring his edema he was unable to say. When asked if the staff encouraged him to lay down or to put if feet up, R7 demonstrated how he could tilt his feet up while sitting in his wheelchair. He then lowered his feet back down.

R7 was observed on 10/30/18, 9:00 a.m. and 12:45 p.m. and legs were not elevated.
On 10/31/18, when observed at 7:17 a.m., 9:30 a.m., 10:50 a.m. and 12:00 p.m. R7 was not noted to have his feet elevated at any time.

A review of R7's progress notes failed to indicate

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any regular monitoring of edema.

According to an interview on 11/01/18, 9:37 a.m. RN-F confirmed that R7 did not have regular edema monitoring/assessments. RN-F was unable to state how much edema R7 currently had, but did know he came to the facility with "Ready Wraps" (to control swelling) which, according to R7's care plan, are to be applied by the nursing assistants daily. When asked about when a nurse would assess R7's edema, RN-F said that "he has been pretty stable" so would only assess if he had a change in condition because "this is his home." RN-F said a general assessment is done on all resident quarterly, but nurses would rely on nursing assistants to report on a change in condition.

During an interview on 11/01/18, 1:20 p.m. the director of nursing (DON) said that the decision to monitor edema would be made according to the chronicity and acuteness of a resident's condition and that "quarterly is not frequent enough." When asked about R7, given an extensive history of cardiac and respiratory issues including a past history of hospitalization for fluid overload, DON stated R7 should have edema monitoring on a regular basis and no less than weekly.

R7's current physician orders included an order for Bumex (bumetanide), a diuretic medication to reduce fluid retention.

R7's care plan states that R7 is at risk for fluid volume deficit related to his ordered diuretic. Also includes nursing assistants to assist R7 with dressing, including application of the "Ready Wraps." however, the care plan lacked monitoring/assessments and at what frequency

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and to watch/report any signs symptoms of fluid overload.
R73's change of condition Minimum Data Set (MDS) an assessment dated 10/4/18, identified R73 had diagnoses including Dementia, other fracture and hypertension. The MDS also identified R73 had short term memory problems, moderately impaired decision making skills for daily living and was administered diuretic medications.

R73's physician orders dated 10/12/18, included: Furosemide (diuretic medication) 80 milligrams (mg) daily in the morning for congestive heart failure.

R73's nutritional care plan dated 10/26/18, indicated R73 on 9-28-18 had significant weight gain in 30/180 days caused by edema. 10/2/18, Decreased intake, Fall with elbow fracture 9-30-18. 10-26-18 significant planned weight loss with decrease in edema. Approach: Offer ensure at meals if not eating 50%.

R73's fluid volume deficit care plan dated 10/1/18, included Potential for fluid volume deficit, related to daily use of Lasix. Goal: Electrolytes within normal limits, will have no indicators of dehydration. Approach: Nurses---observe for s/s (signs and symptoms) dehydration, encourage fluids between meals. Update NP/MD (nurse practitioner/medical doctor) as needed with concerns. Nurse Aides---update with changes in weight, encourage fluids between meals, update nurse with any signs or symptoms of dehydration (constipation, fever, dry oral membranes, increased confusion, low BP (blood pressure), increased pulse etc.) The care plan did not address edema monitoring and/or management.

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On 10/30/18, at 9:41 a.m. during an observation and interview with registered nurse (RN)-A at the time. RN-A
stated R73 had 3 plus pitting edema up to her mid calves. RN-A stated R73 used to have pitting all the way to her knees and hard edema extend all the way to her mid thighs, had some sacral edema. RN-A stated R73's edema was much improved. RN-A stated R73 was also not eating well, some was weight loss and some was fluid loss. RN-A stated the nurses completed pathway charting for the edema daily as R73 had congestive heart failure. RN-A encouraged R73 to elevate her legs. R73 allowed RN-A to put her feet on the tray table base.

R73's physician progress note dated 8/31/18 included, Assessment and Plan: 1. CHF (congestive heart failure) Probable diagnoses especially given sacral edema in addition to lower extremity edema. Her weight is up pretty considerably. I doubt it is from increased oral intake. The pressure is also up significantly. I would anticipate this is diastolic dysfunction although we do not have any previous echocardiograms. I do not think it would be overall beneficial to obtain a cardiogram at this time. While she does have congestive heart failure exacerbation, treatment would be furosemide whether or not it is systolic or diastolic dysfunction. Given her advanced age she would be a poor candidate for ischemic workup. She does have known vascular calcifications and so therefore, there is a high likelihood that she also has cardiovascular calcifications. We will start her on furosemide 20 mg daily. May need to be increased to 40 mg daily. She will likely need this medication long term.

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R73's certified nurse practitioner visit note dated 10/30/18 included, CHF the patient has lost approximately 26 pounds since the initiation of furosemide at the end of August. She is also on potassium supplement 10 mEq (milliequivalents per liter) daily. Her lower extremity edema is about 2+ from feet to below the knees. Lings clear and no SOB (shortness of breath) complaints. Blood pressures have been under good control. She has been on 80 mg of furosemide daily since 10/12/18. Continue this dosing. Patient is resistant to compression stocking or elevating her feet. She does become a bit more complaint when her daughter is visiting.

R73's progress notes were reviewed for September and October 2018. For the month of September one progress noted was found that included a comprehensive assessment of R73's edema that included a description of edema and degree of pitting. In October two progress notes were found that included a comprehensive assessment of R73's edema that included a description of the edema and degree of pitting.

On 11/01/18, at 1:56 p.m. registered nurse (RN)-C was asked what should be charted for edema monitoring. RN-C stated should chart the edema and stated the degree of pitting should be in the notes to help determine whether or not it's the edema getting worse. RN-C stated for example whether or not it is one plus or two plus pitting edema. RN-C stated would also look at other factors such as weights or other symptoms of shortness of breath, all pieces that fit together in the puzzle. RN-C stated need to assess all the component of edema and really need to use your

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assessment skills when assessing the patient.

On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of edema. At 4:15 p.m. RN-A pulled up progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema.

A policy and procedure on edema monitoring was requested and not provided.
DRESSING CHANGE:
R1's Diagnosis List, dated 11/1/18, included diagnosis of localized edema (dependent bilateral lower extremity edema).

R1's current physician treatment orders identified an order dated 10/30/18, Treatment: to left lower extremity (LLE): 1. Cleanse with normal saline or wound cleanser 2. Pat dry with gauze (gentle) 3. Apply no-sting barrier to intact and macerated skin 4. Apply adaptic to small anterior open area and ABD (abdominal pad) 5. Secure with kling and tape, tubigrip and ace 6. Change once daily. Treatment: to right lower extremity (RLE): 1. Cleanse with normal saline or wound cleanser 2. Pat dry with gauze (gentle) 3. Apply no-sting barrier to intact and macerated skin 4. Cover weeping areas with maxorb (calcium alginate) and ABD 5. Secure with kling and tape, ace

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wraps 6. Change twice daily, once drainage is under control change once daily.

During observation on 10/31/18, at 10:31 a.m., registered nurse (RN)-D provide a dressing change treatment to R1's lower legs. RN-D removed the old dressings from R1's lower legs and cleansed both lower legs with SAF-Clens AF Dermal Wound Cleanser and 4 x 4 gauze pad. RN-D placed a 4 x 4 Vaseline gauze pad on the skin of the shin area of the right and left leg and placed an 8 x 10 abdominal pad over the top of the Vaseline gauze. RN-D stated she applied the Vaseline gauze to keep the dressing from sticking to R1's legs. RN-D lifted up the abdominal pads and placed a 4 x 4 gauze pad underneath the abdominal pads on each leg, wrapped both legs with Kerlix (cling wrap) and secured the Kerlix in place with tape. RN-D applied a tubigrip (compression) over each lower leg. R1 refused to have ace wraps applied to each lower leg.

During interview on 11/01/18, at 10:04 a.m., the director of nursing stated she would expect staff to follow R1's physician orders for treatment of the lower legs.

FOLLOW UP PHYSICIAN VISIT:
R34's Diagnosis List, dated 11/1/18, included diagnoses of chest pain unspecified and chronic obstructive pulmonary disease.

R34's resident progress note, dated 10/13/18, identified resident complains of neck pain. Rates it as 8 out of 10. Resident took scheduled pain medication. She elected to go to the ER (emergency room) due to concerns of possible cardiac issues. Resident felt that she was having a stroke. BP (blood pressure) elevated, skin

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clammy, and complaints of neck pain, which she has a history of. Resident had three strokes in the past and that could lead to a heart attack. I just want to get it checked out. Resident told me that she was feeling hot but not clammy. She complained of neck pain and shortness of breath. Resident denied having any chest pain. Resident voiced concerns that she thought she was having a heart attack. I took residents vitals at 21:45 (9:45 p.m.) and got temperature of 98.1, O2 (oxygen) saturation 90% on one liter, BP 212/81, pulse 85, respirations 22. BP 197/74 at 22:00 (10:00 p.m.). Resident decided he wanted to go to the ER.

R34's emergency department (ED) note dated 10/13/18, included Impression and Plan: follow up with physician within one to two weeks.

R34's record lacked documentation R34's primary physician was informed R34 was seen in the ED and lacked documentation of a physician follow up within one to two weeks as recommended per the ED note.

During interview on 11/01/18, at 10:19 a.m., RN-F stated R34 had not been seen by the physician after the ED visit and R34's record had no documentation R34's primary physician was informed R34 was seen in the ED on 10/13/18.

During interview on 11/01/18, at 10:27 a.m., the DON stated if an order to be seen by the physician in 1 to 2 weeks was not written on the order sheet upon return form the emergency department (ED), then there was no order. DON stated staff can look at the ED progress note, but the plan to follow up with primary physician in one to two weeks was not an order.

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess new pressure ulcer on sacrum and provide services and treatments as assessed/ordered to promote healing and prevent new pressure ulcers from developing for 1 of 2 residents (R46) who had a stage 4 pressure ulcer to the sacram and developed a stage II ulcer in faciltiy. Also had a stage IV pressure ulcer on hip. As a result of not assessing new pressure ulcer and not providing repostioning services timely and as assessed R45 sustained harm. Findings include: The facility's policy Skin Care dated 3/2018, included the definitions of pressure ulcer stages: Stage 1- Non-blanchable erythema of intact skin. Intact skin with localized area of non-blanchable erythema (redness). The presence of blanchable erythema or changes in sensation, temperature	F 686	F686 R46s Care Plan was reviewed and updated to include specific offloading cares on 11/30/2018. Updated standard work for Chair Positioning as well as the Skin Care policy to define offloading and techniques was updated on 11/30/2018. All residents screened for necessity to update care plan with offloading techniques. All nursing staff will be trained on offloading standard work by 12/11/2018. 8 Random weekly audits will be performed by the Nurse Manager or Designee x 8 weeks. Results will be brought to the QA/QI Committee for further recommendations.	12/11/18

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or firmness may precede visual changes.

Stage 2-Partial-Thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. The stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns abrasions).

Stage 3-Full-thickness skin loss. Full-thickness skin loss of skin in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical locations: areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Facia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer.

Stage 4-Full-thickness and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole, undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable pressure

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ulcer.

R46's Diagnosis List located on admission form dated 11/1/18, included dementia without behavioral disturbance, and pressure ulcer of sacral region.

A physician visit note dated 8/8/18, indicated R46 had been admitted in June 2018, and was 99 years of age.

R46's quarterly Minimum Data Set (MDS) assessment dated 9/6/18, indicated R46's cognitive skills for daily decision making were severely impaired, and indicated R46 had rejected care during 1 to 3 days of the assessment period. The MDS also indicated R46 was not ambulatory, required extensive assistance of one staff member for bed mobility, transfers, dressing, and personal hygiene, and required extensive assistance of two staff for toileting. The MDS further indicated R46 was frequently incontinent of urine and occasionally incontinent of bowel. In addition, the MDS indicated R46 was at risk for pressure ulcers, had a stage 4 pressure ulcer and an unstageable pressure ulcer. The interventions included: pressure reducing device for chair and bed, nutrition interventions, pressure ulcer care, and application of nonsurgical dressings.

R46's current physician orders included:
-Ultram (pain medication) 50 milligrams twice per day (start date 10/31/18)
-Regular diet with Ensure (dietary supplement) with all meals (start dated 10/4/18)
-Left hip treatment (area of eschar) observe area daily, right hip pad with Mepilex (white foam) and observe daily and change foam every three days

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(start date 9/5/18)
-Left hip treatment: keep area dry, apply maxorb over eschar and cover with Mepilex AG form or Kerracel. Secure with paper tape or Medipore tape if needed. Observe daily, you may use the same dressing, though and change dressing every three days. If area opens please notify registered nurse (RN)/wound care nurse. (start date 9/29/18)
-Sacral wound: 1)cleanse wound with wound cleanser, pat dry. 2) apply ¼ normal Dakins Solution damp to dry using kerlix, pack lightly. 3)cover with 4 x 4 ABD. 4) secure with tape. 5) change three times a day (start date 9/7/18).

R46's undated pressure ulcer Care Area Assessment (CAA) indicated R46 was newly admitted with an unstageable sacrum pressure ulcer that was infected. The CAA indicated R46 was at risk for pressure ulcers related to incontinence, poor nutrition, required staff assistance to move sufficiently to relieve pressure over any one site, and required pressure reducing mattress or seat cushion. Under the heading "Care Plan" included, "Revise current plan".

R46's care plan dated 10/11/18, indicated R46 was resistive to cares at times and directed staff to leave resident alone for short period of time and re-approach; if continued to be resistive have another staff approach. R46's skin impairment care plan dated 10/11/18, indicated R46 had a stage 4 sacral decubitus ulcer and black eschar to left hip, did not identify the lower sacral wound that was identified on 9/11/18, and further indicated R46 had impaired skin integrity related impaired cognition, impaired mobility, incontinence, and was resistive to cares. Interventions included:

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-Staff to assist resident with repositioning every one hour and as needed and when in bed attempt to avoid having her lay on her back repositioning from side to side if she will tolerate.
-Nursing to monitor and chart weekly on all skin concerns, consult with wound nurse as needed.
-Nursing to update MD/NP (medical doctor/nurse practitioner) as needed with changes or concerns to skin status.
-encourage fluids, offer lotion to skin
-nursing staff to follow wound care orders updating wound care nurse from clinic or MD/NP as needed with concerns
-Offer snacks between meals, Ensure and Prostat
-assist resident with bathroom needs every two hours and as needed with goal to keep skin clean and dry; staff to update nurse if dressing to sacral wound noted to be soiled to change as needed
-observe skin for redness, bruising, or signs and symptoms of breakdown and update nurse to evaluate, update nurse with any verbalizations up pain to evaluate as needed
-pressure reducing pad to wheelchair when up
-2 staff with lift sheet, to move resident up in bed as needed
-assure foam padding intact to left hip.

R46's Nursing Assistant Care Plan dated 10/11/18, included: REPOSITIONING: I need 1-2 staff assist for repositioning every hour due to my continued risk for further skin breakdown.

R46's Skin Alterations notes included the following documented measurements:
-9/5/18, note included: Sacral stage IV (4) 2.2 centimeters (cm) x 1.0 cm x 2.5 cm, 6 o'clock tunnel 4 cm. Continue with Dakin's damp to dry changing as directed. Area does appear to be

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slough today. Drainage was thick and straw colored, no odor noted. Continue to provide repositioning.
-9/11/18, note included: Sacral wound dressing change completed this evening. Upon assessment a small red open area about an inch below sacral wound was noted. Assessment did not include measurements of the sacral wound nor the new open area.
-9/12/18, note included: Wound on sacrum appears unchanged from yesterday, drainage pinkish brown in color. New open area size of pencil point just below the initial ulcer is noted with care this morning. Resident verbalizes a lot of pain and fear with care to wounds and repositioning in bed. The note did not reflect a comprehensive assessment of the sacral wound or of the new wound below the stage IV wound.
-9/14/18, note included: The original sacral wound is 2 x 1 x 4 cm, with tunneling and communication to a second opening that is 0.5 cm x 0.5 cm, measuring 3.5 cm from one wound to the other. There is undermining circumferentially, measuring 4 cm in some areas. Pt (patient) has pressure relieving cushion and continues to be repositioned by staff. Continue with dressings, at this point there is not another dressing that will be better for infection control.
-9/20/18, note included: Ulcer on buttocks measures 2.5 cm length x 1.5 cm width x 2.5 cm deep, serous drainage with no odor. Tiny hole underneath where ulcer tunnels through 0.7-0.8 cm x 0.3-4 cm.
-9/25/18, note included: Stage 4 sacral ulcer 2.3 cm x 1.5 cm 2.5 cm. Circumferential undermining at 12 o'clock: 2 cm, wound communication to second opening along gluteal cleft: second opening measures 0.2 cm x 0.1 cm and the length between the superior open area and

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F 686	Continued From page 39 communicate is 3.5 cm. The note further indicated the wound is chronic and may deteriorate depending on patients nutrient intake and other factors. At this time she prefers to sit up in her chair. Wounds like this do not typically heal when sitting up on it and patients usually are on bed rest with side to side positioning. Patient does have two areas on her hips that are problem caused by both pressure and hardware migration, so side to side repositioning would be difficult unless she has a different support surface. Since patient is up in chair and likes to participate in activities, will keep treatment unless staff report any concerns. -9/26/18, Sacral ulcer stage IV, 2.8 cm x 1.8 cm x 2.8 cm, tunneling at 6 o'clock 3.3 cm and 2.0 cm at 12 o'clock, unable to visualize tunneling. -10/4/18, note indicated sacral wound treatment was done; moderate amount of bloody yellow drainage. Just below wound bed a pen tip hole noted. -10/8/18, note indicated stage 4 sacral wound measured 1.5 cm x 2.5 cm x 2.8 cm, tunneling at 6 and 12 o'clock positions. Second open area below the larger sacral ulcer measuring less than 0.5 cm in diameter. (did not include a depth). -10/10/18, note indicated sacral region had two openings: lowest one measured 1.4 cm x 1 cm and upper opening is 2 cm by 1.2 cm wound tunnels from 6 o'clock 4.2 cm. From 6 o'clock to 11 o'clock is undermined about 1.2 cm. -10/17/18, note indicated sacral ulcer less than 2 cm length, less than 1 cm width, depth 6 o'clock and 12 o'clock but filling in with tissue less than 1.5 cm. Smaller one below tunneling 1 cm x 0.5 cm with 2 cm depth. -10/23/18, note included: sacral ulcer 2 cm x 1.5 cm with 1.75 cm depth but filling in with tissue. Smaller hole underneath 0.75 cm x 1.2 cm with	F 686		

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2.5 cm depth. Applied dressings as ordered.

R46's record lacks evidence of documentation of refusals to reposition/offload.

R46's last physician visit dated 10/8/18, indicated primary physician had treated R46's wound empirically with antibiotics related to question of infection and new on-set of tunneling in the wound. The note indicated since that time the sacral ulcer had improved and was stable. The note referenced areas of impaired skin which included the left hip and Stage 4 sacral ulcer that measured 2.8 cm by 1.8 cm with a depth of 2.8 cm. The physician visit note did not reflect the development of the new wound that measured less than 0.5 cm in diameter the same day as visit.

During an observation on 10/31/18, at 7:15 a.m. R46 was transferred from bed to bedside commode. R46's sacral dressing was dry and intact. R46 cried out "ohhhh" during the transfer. Licensed practical nurse (LPN)-C stated she had pain medication already that morning and had completed the dressing change to sacral wound. LPN-C indicated R46 had a pea sized open area with tunneling to a wound right below. After morning cares were provided by trained medication assistant (TMA)-A and nursing assistant (NA)-H, R46 was transferred to her wheelchair via full body lift at 7:40 a.m.
-At 7:53 a.m., R46 was wheeled out of her room to the dining room for breakfast.
-At 8:07 a.m. R46's meal tray was placed in front of her and was assisted by staff to eat her meal until 8:41 a.m.
-At 8:42 a.m. R46 was wheeled to an adjacent table in the dining room by NA-I.

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F 686	Continued From page 41 -At 8:48 a.m. TMA-A and NA-E removed R46 from the dining room and wheeled her back to her room, offered toileting, and repositioned her to a straight sitting position. NA-E stated, R46 did not have to use the restroom, and verified R46's bottom was shifted from the left to the right because she had been leaning more to the left. NA- confirmed the repositioning was not offloading (the removing of pressure to pressure points to prevent tissue damage) of pressure to the sacral region. -At 9:15 a.m. R46 was wheeled into her room and offered toileting by TMA-A. TMA-A and NA-I transferred R46 via full body mechanical lift to the commode; the sacral dressing was observed to be soiled by watery loose stool. -At 9:37 a.m. LPN-C entered the room. NA's transferred R46 into her bed. LPN-C washed hands, donned gloves and removed soiled dressing which revealed 2 sacral wounds that were both soiled with watery loose stool. LPN-C removed gloves, sanitized hands, donned new gloves, cleansed wound, and repeated hand hygiene to apply ordered treatment. LPN-C stated the lower wound is newer and are conjoined at the bottom of the wound. LPN-C stated the lower wound was not packed with anything and the upper wound packing could be visualized at the bottom of the lower wound. -At 10:15 a.m. R46 wanted to get out of bed. -At 10:45 a.m. R46 was observed in the activity room sitting up in her chair. -At 10:50 a.m. R46 was wheeled to another activity that was located down the hallway. -At 11:18 a.m. R46 continued to be in the activity sitting in wheelchair. -At 12:01 p.m. TMA-A stated she and NA-J had pulled R46 aside and shifted her bottom from the left to the right. However, had not removed	F 686		

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F 686	Continued From page 42 pressure for any length of time to the buttock area. During an interview on 10/31/18, at 4:22 p.m. TMA-D indicated repositioning had to do with making sure the resident was positioned correctly in their chair; making sure they were not leaning and/or back far enough. TMA-D then stated offloading was used to keep pressure off of the area. TMA-D stated offloading to reduce pressure should be done for about five minutes. During an interview on 10/31/18, at 4:26 p.m. nursing assistant (NA)-K used the terms repositioning and offloading interchangeably. NA-K then stated if someone had a pressure ulcer on their bottom then you would have to get them off the area of pressure to relieve pressure. NA-K indicated unawareness of how long offloading should occur for tissue re-perfusion. During an interview on 10/31/18, at 4:33 p.m. LPN-C stated residents should be repositioned/offloaded for at least 2 minutes for tissue re-perfusion. LPN-C indicated ideally the resident should be laid down in bed. LPN-C indicated R46 was supposed to be repositioned/offloaded every hour. LPN-C indicated R46 did not like to lay in bed, and used a standing lift which was harder on her arms, and that would be worse. During an interview on 11/1/18, at 9:01 a.m. registered nurse (RN)-A reviewed wound assessment notes and verified not all wound assessments were complete and the second wound had not been comprehensively assessed. RN-A stated the second wound should have been comprehensively assessed when identified.	F 686		

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RN-A stated she was not aware if the second wound was a part of the first wound. RN-A stated the physician is supposed to be alerted with changes in skin condition or changes to existing wounds. RN-A indicated there was no record the physician had been notified of the development of the second wound (located below the stage IV on sacrum). RN-A indicated residents should be repositioned/offloaded off of pressure areas for at least 1-2 minutes for tissue re-perfusion. RN-A indicated staff should have attempted and/or offered R46 repositioning/offloading; and shifting of her bottom while in the chair would not adequately relieve pressure to the sacral area because of the location. RN-A further stated if R46 refused, staff should have re-approached her, reported to the nurse, and document refusals.

During an interview on 11/1/18, at 11:04 a.m. the director of nursing (DON) indicated each wound should be comprehensively assessed individually and at a minimum of weekly. DON was informed the NA's moved the resident from side to side while in the wheel chair and called it off loading. The DON said that the NA's could have done a better job with repositioning/offloading to shift pressure off the wound. DON stated residents should be repositioned/offloaded off the area of pressure for 1-2 minutes in order for tissue re-perfusion.

Facility Skin Care policy dated 3/2018, also indicated purpose to: provide care and services to prevent pressure ulcer development, promote the healing of pressure ulcers/wounds that are present and to prevent the development of additional pressure ulcers/wounds.
III. Nursing personnel will utilize results of the

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physical exam and the skin assessment tools to determine an individualized skin care plan for each resident. This may include interventions: A) protect skin against the effects of pressure, friction, shearing, moisture, or bruising interventions B) encourage optimal nutrition and hydration. Update dietary staff to review for appropriate protein supplement C) educate staff, residents, and families on risk factors and preventative measures D) Institute an immediate prevention plan when potential areas are identified E)update care plan, MAR/TAR with specific interventions and treatment.
IV. When a skin ulcer or other wound is identified, an assessment of that specific wound will be completed and documented in the electronic medical record by the nurse. The assessment will include: A) measure pressure ulcer, other wound or bruising, noting condition of wound bed, condition of surrounding tissue, and any other signs of infection. Weekly skin assessments of the area should be added to the MAR/TAR. B) Treatment of the wound or pressure ulcer being implemented. C) A review of the resident's care plan and medical status-any other possible risk factors to be identified. D) Identify type of skin ulcer. E. Update the wound care nurse as needed to consult. F. If the wound has not improved, contact the MD/NP/Wound specialist for change in treatment.
V. any resident education will be documented.
VI. Nursing staff who will be providing care for receive ulcer education annually. They will also be instructed on interventions specific for each resident.

Facility protocol Standard Work Chair Repositioning dated 6/12/14, indicated the purpose to help prevent skin breakdown for

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F 686	Continued From page 45 residents unable to reposition themselves. Major steps included: 1) residents should be repositioned every two hours if they are unable to do so themselves. 2) Resident can be repositioned in chair by moving a pillow to one side or the other to shift the weight or by reclining the resident. 3) Document the change of position and the time.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for root cause analysis related to falls and implement interventions to minimize the risk for injury for 2 of 3 residents (R73 & R78) reviewed for accidents. Findings include: R73's change of condition Minimum Data Set (MDS) an assessment dated 10/4/18, identified R73 had diagnoses including Dementia, other fracture and hypertension. The MDS also identified R73 had short term memory problems, moderately impaired decision making skills for daily living and required extensive assistance for bed mobility, transfers, dressing, toilet use and	F 689	F689 R73s Care Plan was reviewed and updated by 11/28/2018. R78 No longer resides at the facility. The Quality Assurance Reports/Grievances policy was updated to include required root cause analysis. All licensed nursing staff will be educated by 12/11/18. Random Audits of post fall assessments will occur weekly x 5 by a nurse manager or designee. Results will be brought to the QA/QI Committee for further recommendations.	12/11/18

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personal hygiene.

R73's care plan included, Problem: fall risk traumas Related to: impaired mobility, pain recent fx (fracture) of left elbow, cognitive impairment. Goal: Will have no major injury as a result of a fall. Approaches: Assist with ambulating transfers, toileting. Check comfort level every two hours. Bed in lower, locked position. Encourage to ask for assistance. Keep control to alter position of recliner out of view. Offer reminders to call staff for any assist needed. (per family ok) call light to be hooked to bed at all times and bell on tray table d/t (due to) call light on chair causing resident increased agitation and she will unhook and throw on the floor. Assure non-skid pad in resident's personal chair, and increased 1-hour checks during night when sleeping in personal chair no bed, (No alarms per daughters request).

R73 was observed on 10/29/18, 4:12 p.m. to be sitting in her recliner in her room watching television; call light was attached to her recliner.

R73 was observed on 10/31/18, at 6:57 a.m. sitting in her recliner in her room, with the tray table in front of her, using a pen and is scribbling on the paper. The bell was on the tray table; the soft call light was next to her attached to the recliner and she was wearing gripper socks.

R73 was observed on 10/31/18, at 8:04 a.m. sitting in her recliner, feet propped on base of tray table, with a spoon in her coffee mug stirring it, watching television, call light in reach attached to her recliner, bell on tray table.

R72 was observed on 10/31/18, at 9:54 a.m. in her recliner, footrest was elevated at this time;

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call light attached to recliner, bell on tray table and was sleeping.

R72 was observed at 11/01/18, at 7:46 a.m. in her room asleep in the recliner, pillows placed for positioning, bell on tray table, feet were positioned on the floor, dressed for the day, and call light was clipped to her recliner.

R73's incident report dated 9/30/28, included, resident was found seated beside the bed, legs straight out in front of her back and head leaning against the side of the bed. Moderate amount of fresh blood noted on the floor, bleeding and scalp. Quarter size hematoma with a small laceration noted, bleeding had stooped spontaneously. BP (blood pressure) 117/64, P (pulse) 68 Resident assisted to feet with three staff and gait belt and walker. Further assessment reveals area reddened mid back and reluctance to use left arm, pain with rising arm appears to be in the shoulder area. Follow up BP (blood pressure) 87/58, P (pulse) 64. Pupils unequal but reactive to light, initial responses sluggish. Unable to follow directive in part to hearing deficit. Was fall observed: No. Did fall result in injury: Yes. Hematoma and laceration on scalp, left shoulder pain. Indicate degree of harm: moderate harm event. Why do you think you fell: unable to respond. Footwear: slippers and gripper socks. Physical status at time of the fall: unsteady gait, impaired mobility/transfers. Mental status at time of the fall: Disorientated unable to follow directions. Resident activity: unknown. Call button within reach: Yes. Call light on at time of fall: No. Immediate intervention: personal alarm. Has the resident had a fall in the last 30 days: Yes 8-14-18. Care plan updated: No. Date of Fall: 9/30/18. Time of fall 7:45 a.m.

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R73's post fall investigation dated 9/30/18 at 8:51 p.m. Date of incident: 9/30/18. Time of incident: 7:45 a.m. Day of week Sunday. Did fall result in injury? Yes, laceration to back of head and left arm pain which was later dx (diagnosed) in urgent care as a fx (fracture) of the left elbow and resident was placed in long-term hard splint and returned with sling to help bearing of weight. Risk Factors: On assessment, this is a 90 year old female resident with noted dx (diagnosis) congestive heart failure, venous stasis dermatitis, osteoarthritis, mild cognitive impairment, noted lung nodules, and hx (history) of anemia. Her vision is very poor in which she reports she can only see shadows and you have to be very close to her as her hearing is significantly impaired. Her ability to always recognize her needs and limitations is significantly impaired and often she does not ask for assistance and does not like her call light in which she has hx (history) of un-hooking call light and throwing it across the room in which she was given a bell to use and has been more cooperative at times. She has hx (history) of getting up independently and not always using her walker has in the past been noted to come out in hall using her bedside table as support but is almost always cooperative with redirection and staff assistance when they have seen her walking independently. She has had no recent complaints of being dizzy although has had recent increase in Lasix secondary to significant lower extremity edema, which extended to upper thigh region and was offering increased complaints of lower back and leg pain. Medication status: Lasix, ultram. New medication in the past week: Lasix increased on 9/23/18. Was care plan updated at time of the fall: Yes- reviewed by RN personal alarm has been

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implemented at this time d/t (due to) her significant impaired mobility with inability to use left arm. Resident fall risk score: Score prior to fall: 6. Score following fall: 10. Resident is at high risk for falls: yes.

R73's ED(emergency department)/urgent care provider note dated 9/30/18, included chief complaint: Resident is here after falling around 0800 this morning. Patient has laceration to back of her head and sore left elbow. History of Present Illness-Provider: R73 is 90-year-old female presents today with her daughter after falling at Lake Winona Manor. Patient does not recall falling and does have a history of dementia. Patient reports a great deal of left arm pain. It is reported by the nurse from Lake Winona Manor that is nauseous consciousness. It is reported that this occurred at 8 AM. She has laceration to the back of the head on the left side as well as pain in the elbow. Patient is reporting mostly pain in the left elbow. She does not recall why she is here. She denies any other systemic systems or concerns. Patient is incredibly hard of hearing.

On 10/31/18, at 3:11 p.m. trained medication aide (TMA)-A stated R73 would always get agitated by her call light cord if it was hooked to her chair and stated she does have a bell on her tray table that she can ring if she needs us. At 3:16 p.m. during an observation, R73's call light was observed to be clipped to her recliner. TMA-A stated it was care planned to not be attached to her recliner and was observed to remove the call light from the recliner attach the call light to her bed.

On 11/01/18, at 1:07 p.m. registered nurse (RN)-A stated R73 had a history of getting up on her own; she fell out of bed and fractured her

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elbow. RN-A stated when R73 was asked what happened she was unable to respond. RN-A stated the activity at time of fall was unknown. RN-A stated R73 had cognitive impairment. RN-A verified the fall documentation was not a complete investigation of the incident, as it did not include a root cause analysis of the fall, did not include staff interviews regarding the fall and did not include if the care plan was being followed. RN-A stated self-transferring was the reason for the fall, but we do not know why she was trying to self-transfer. RN-A verified the intervention put into place at the time of the fall was a personal alarm, but stated was no longer being used per daughters request. RN-A verified without completing a root cause analysis of the fall the facility would be unable to determine what interventions would be appropriate to be implemented to minimize the risk of further falls. RN-A verified the care plan for R73 included to not clip the call light to the recliner as when she first came in, she would unclip the call light and throw it off. RN-A stated she expected staff to follow the care plan to not have it clipped to her recliner. On 11/01/18, at 1:18 p.m. RN-A verified through observation call light was clipped to the recliner and stated would reassess.
R78's Diagnosis List dated 11/1/18, included diagnoses of history of falls, congestive heart failure, hypertension, diabetes type II, and chronic renal disease stage 4.

R78's annual Minimum Data Set (MDS) dated 10/11/18 indicated R78's cognitive skills for daily decision making was severely impaired. The MDS also indicated R78 required extensive assistance from two staff for transfers and bed mobility, and required extensive assist from one staff for ambulation, dressing, and toileting. The

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MDS further indicated had one fall without injury since admission or the last assessment period.

R78's care plan dated 10/4/18, included; Problem: fall risk goal of will not have major injury as a result of a fall. The interventions dated 10/14/18, included the following: assist with ambulating, transferring, and toileting. Check comfort levels every 2 hours. Bed in lower, locked position. Encourage to ask for assistance. Resident is to be wear his shoes or have gripper socks on at all times. Personal alarm on wheelchair and bed. Check at 9:00 p.m. to ensure R78 was not attempting to self-transfer. Frequent checks to ensure that personal alarm was in place and functioning. Dycem no-skid pad in wheelchair/recliner when up. R78 was to be assisted to bed by 8:30-9:30 p.m. per family request otherwise they ask that he be out by staff and not left in his room on night shift.

During an observation on 10/29/18, at 2:30 p.m. R78 sat in his wheelchair in his room next to family member (FM)-A. R78 had his eyes closed, underneath his right eye was a fading bruise and just above his eyebrow was a fading scar approximately 2-3 inches long. R78 had a personal safety alarm on his wheelchair.

During an observation on 11/1/18, at 9:32 a.m. R78 sat in his wheelchair in his room with no staff present. R78 had personal safety alarm on his wheelchair. At 9:33 a.m. an unidentified NA walked into the room.

R78's progress note dated 10/13/18, at 10:51 p.m. indicated R78 was transferred to the emergency department related to fall with significant contusion with laceration above his left

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eye.

R78's incident report dated 10/14/18, indicated the date of fall was 10/13/18, at 10:32 p.m. and the writer of the report was down another hallway when a loud bang was heard. R78 was found in the hallway lying on the floor face down, slightly on his side, about 10 feet from his door. The report further indicated R78's personal alarm was activated, did not have an incontinent brief on at the time, and there was a pool of blood on the floor. The report also indicated R78 had contusion the size of an egg with a deep laceration above his right eye. The report then indicated the fall was not witnessed, a cold compress was applied, and the degree of harm was minor harm event. In response to the report question, Why do you think the you fell: resident unable able to respond secondary to significant cognitive deficits. Immediate interventions: resident assisted off the floor with the full body lift and into his wheelchair. New interventions: assist into bed at 10:00 p.m. rounds.

R78's emergency department visit note dated 10/13/18, at 10:57 p.m. indicated R78 had fallen out of his chair and described as a fall from ground level. The note indicated R78 had struck his head and resulted in a hematoma and a large laceration around his right eye. The note further indicated the laceration was 6 centimeters in length with a superficial depth that required six sutures. R78 was then discharged back to the facility.

R78's Post Fall Risk Assessment dated 10/14/18, at 2:16 a.m. indicated R78 had a history of falls, was at high risk for falls, has diagnosis of dementia with behavioral disturbance, has

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F 689	Continued From page 53 incontinence. The assessment indicated R78 indicated the hallway where R78 had fallen was dimmed due to the time of night. R78's Post Fall Investigation dated 10/14/18, at 3:20 p.m. identified the recompilation of the incident report documentation and as a result of the fall R78 required 6 sutures to the laceration above his right eye. The investigation report indicated protective/safety devices that were in place during the fall were personal alarm which charting indicated that the alarm was going off but staff were not able to get to him before he fell. Risk Factors: On assessment this resident is a 86 year old male with noted diagnoses of mixed Alzheimer's with vascular dementia with behavioral disturbance, seizure disorder, and poorly controlled diabetes. This resident's cognition is significantly impaired and his ability to ask for assistance or recognize his needs is significantly impaired in which staff need to anticipate all his needs and very seldom used call light even with reminders. His mobility has remained unchanged and is able to ambulate with staff assist and walker although this as well depends on his mood/behaviors and is noted at times to become agitated and can become physically aggressive and will hit out. Last evening prior to the fall resident had been noted to be very agitated at times attempting to self-transfer followed by episodes of sleeping in his wheelchair in which this most likely why staff assisted to personal chair for comfort although he did then attempt to self -transfer which resulted in the fall. Resident's overall status has remained unchanged he has had not noted changes in respiratory status no urinary concerns, and up till this recent fall he had not been offering any reports of pain and had not appeared to be in any	F 689		

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discomfort. Secondary to noted increased agitation prior to fall during the shift care plan has been revised for resident to be assisted to be not in chair and per family request resident to be assisted to bed by 8:30-9:00 p.m. otherwise they ask that he be out by staff and not left in his room. The investigation report further indicated, no recent changes in status, had had two falls in the last 90 days, and pattern of falls identified as both occurred during his personal chair however, no pattern to time of the falls.

R78's fall incident report dated 10/19/18, indicated R78 had an unwitnessed fall without injury at 6:25 p.m. in the dining room. The report included: writer was coming off the elevator heard alarm going off. Went into the dining room to find resident on his left side on the floor. When asked what he was doing resident stated that he was trying to go home, can you please take me home. The report indicated R78 was wearing slippers, floor was slippery (report did not indicate why the floor was slippery), vital signs, and notifications to appropriate parties.

The incident report did not identify immediate and/or ongoing fall interventions.

R78's Post Fall Investigation dated 10/21/18, included the recompilation of the fall incident report and included; Risk Factors: cognitive loss and unsteady gait. General Health: baseline stable overall with progressing dementia, impaired mobility. The investigation indicated there was not a need for re-education for staff/resident/or family, and the care plan was reviewed by the registered nurse at the time of the fall. The investigation report further identified R78 as being high risk for falls, had 3 falls in the

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last three months and the relationship or pattern of the falls was indicated as "self-transfers".

The Investigation report lacked a comprehensive analysis and/or root cause of R78's fall on 10/19/18, and further lacked evidence of identification and/or evidence of implementation of interventions related to that fall occurrence.

During an interview on 10/29/18, at 2:30 p.m. family member (FM)-A stated R78 has had several falls and has had less falls since the facility initiated the low bed. FM-A stated R78 fell three weeks ago that resulted in an emergency room visit and sutures over his right eye. FM-A indicated R78 had been sitting in his recliner with an alarm on, and then he got up and walked out into the hallway without his walker. FM-A stated family requested the staff provide him with more supervision at night because he moved quickly, and didn't think staff were always in near proximity.

During an interview on 10/31/18, at 11:34 a.m. nursing assistant (NA)-F stated R78 was at risk for falls. NA-F indicated staff try to keep R78 out of his room and within view of staff, NA-F stated when R78 became agitated and attempted self-transfers they try to ambulate him and/or provide distractions.

During an interview on 11/1/18, at 8:37 a.m. registered nurse (RN)-A indicated after a fall occurred the nurse was supposed to complete fall charting and complete a fall risk assessment. RN-A then indicated the registered nurse would do the fall follow-up investigation which included talking with the team to determine what happened in order to evaluate and implement interventions.

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F 689	Continued From page 56 RN-A stated, after the fall with injury on 10/20/18, we discussed with family and determined the immediate intervention was to keep R78 out of his room and lay him down in bed at the requested times. RN-A reviewed the fall incident report and the fall investigation report and confirmed based on the documentation it could not be determined what potentially caused R78's agitation prior to the fall because there was not a behavior analysis. RN-A further indicated even though R78 was found in the hallway without incontinent brief on, a bowel and bladder assessment or diary had not been completed. RN-A then reviewed the fall incident report and post fall investigation from the fall that occurred on 10/19/18, and indicated the both the fall incident report and the fall investigation were incomplete. RN-A indicated the fall incident report lacked identification of immediate interventions and the post fall investigation lacked a comprehensive assessment of the fall, risk factors, did not include a root cause, and lacked identification of interventions. RN-A indicated the team did utilize a focus board to determine triggers for agitation, and when the team noticed thing it was talked about. RN-A further stated fall investigations were constant and ongoing and could not be completed all at once. During an interview on 11/1/18, at 11:20 a.m. director of nursing (DON) reviewed the incident and investigation reports for R78's falls that occurred on 10/13/18 and on 10/19/18. The DON stated the expectation of completed post fall analysis and documentation of a root cause analysis of why the fall could have occurred. The DON indicated the documentation should include details of everything they looked at in the investigation and what they did for interventions	F 689		

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F 689	Continued From page 57 and details of the team discussion in what they did. Facility policy Cumulative Fall record dated 1/2017, included the purpose: A cumulative fall record is kept in each resident's electronic medical record to facilitate identification of patterns of causative factors that may have contributed to the fall. The policy indicated/directed the following: A) Resident is not moved unless in jeopardy until a licensed nurse examines the resident and records the blood pressure and pulse. B) directed staff to notify family/significant other and chart in the electronic medical record. C) chart fall in ECS, reporting vital signs, neuro checks if applicable and chart follow-up assessment x 24 hours. D) Provider will be notified of all falls immediately for significant injury or change in resident status. Leaving a message/fax during clinic office hours if no significant injury. E) Care plan will be reviewed and updated if necessary after each fall. F) Falls discussed with interdisciplinary team, including therapy to determine appropriate interventions. G) Follow-up recommendations will be discussed at that time. H) Overall falls recorded will be reviewed quarterly by Quality Assurance team if specific patters noted.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		12/11/18

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F 692	Continued From page 58 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete comprehensive hydration/nutritional assessment and monitoring, prior to and/after discontinuation of tube feeding, in order to prevent dehydration for 1 of 1 resident (R56) reviewed for hospitalization. The facility's failures caused harm for R56 who becaming severely dehydrated and sustained acute renal failure. Findings include R56's Diagnosis List dated 11/1/18, included diagnosis of traumatic brain injury, dysphagia, chronic kidney disease, cardiomyopathy, mild cognitive impairment, diabetes type 2. Diagnoses added 9/17/18, included left kidney stone, hydronephrosis (a swelling of kidney due to urine build-up) and constipation. On 9/18/18, a	F 692	F692 R56s Care Plan and nutritional monitoring were updated 11/29/2018. The Hydration Management and Nutritional Risk Protocol policies will be updated by 12/4/2018. All tube fed residents were audited for hydration risk. Licensed nursing staff and Nutritional Specialists will be updated on new policy by 12/11/2018. 1 Random audit of the nutritional assessments will occur weekly x 5 by a Care Coordinator or designee. Results will be brought to the QA/QI Committee for further recommendations.	

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diagnosis of urinary tract infection was added.

R56's quarterly Minimum Data Set (MDS) assessment dated 6/21/18, indicated R56 had severe cognitive impairment, and required supervision with eating. The MDS indicated during the assessment period, R56 had complaints of difficulty or pain with swallowing, weighed 184 pounds, had no weight loss, had a physician prescribed diet for weight gain, had a feeding tube and also had orders for a mechanically altered diet. The MDS also indicated R56 received 51% of total calories and averaged 501 cubic centimeters (cc) or more of fluid via the feeding tube.

R56's annual MDS dated 9/19/18, indicated R56's cognitive skills for daily decision making were severely impaired and R56 required supervision for eating. The MDS also indicated the resident had no difficulty with chewing or swallowing, a weight of 179 pounds, was not on a physician prescribed diet for weight gain, did not receive tube feeding, and received a mechanically altered and therapeutic diet.

R56's nutritional care plan dated 9/21/18, identified R56 had been hospitalized on 9/7/18, related to dehydration and urinary tract infection, and had swallowing difficulty. The care plan goals included: weight will remain above 170 pounds (lbs) and would consume adequate intake to meet his needs. The care plan further included directives for staff to ensure adequate fluid intake, not use straws, and to give strawberry Ensure at 10:00 a.m. and chocolate Ensure at 2:00 p.m. (8 ounces) for additional calories. The care plan did not include any goal for fluid intake.

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R56's hospital discharge summary dated 9/17/18, indicated R56 was admitted to the hospital on 9/13/18. The hospital note included: R56 had long-standing history of traumatic brain injury, who just recently had his percutaneous endoscopic gastrostomy (PEG) tube removed on 8/24/18. He was admitted with obvious dehydration, hypernatremia (high sodium) and acute kidney injury. The discharge summary also indicated during the hospital course R56 was diagnosed with urinary tract infection and was started on a course of antibiotics.

R56's nutritional assessment dated 6/29/18, indicated R56 had been working with speech therapy to progress to eating by mouth and that at time the diet was mechanical soft textures. The assessment further indicated R56's oral intake had increased however, R56 continued to refuse breakfast on most days and may improve with further tube feeding reduction. Tube feeding was decreased on 6/18/18, to promote increased intake at meals. The note indicated another decrease in amount of tube feeding would begin. The Osmolite 1.5 would be decreased to three hours per day to run at 130 cc (cubic centimeters)/hr (hour) from 9:00 p.m. to 11:00 p.m., with continued 400 cc water flushes four times a day because oral intake remained inadequate. The assessment indicated R56 required 2590 cc's of fluid daily. The note also indicated a calorie count would be started for 5 days.

R56's nutritional assessment dated 7/5/18, indicated fluid intake at meal times was inadequate as well as between meals, and therefore R56 continued to receive water flushes between meals to prevent dehydration. The note

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also indicated the Osmolite 1.5 feeding would be held for one week to see if he continued to eat well and to determine if he could maintain weight between 185-190 lbs.; current weight was 189 lbs. and because fluid intake was inadequate water flushes would continue to be provided and fluid intake would be re-evaluated in one week. The assessment further indicated staff would monitor his fluid intake on a daily basis. The goal was to wean R56 from the tube feeding and need for fluids and medications via the tube.

R56's next nutritional assessment was dated 7/23/18, and indicated R56 was recently upgraded to a regular diet with ground or cut up meats, whereas he had previously also had a tube feeding. The assessment indicated he had been doing well with food intakes from 50-100% for lunch and dinner with some refusals for breakfast, because he liked to sleep in late. The assessment also indicated R56 received Ensure when he get up in the morning and his current weight was 197 lbs, however also indicated: "Oral intake of fluids remains inadequate."

R56's August 2018, Medication Administration Record (MAR) included the following physician orders: Tube feeding-120 ml (milliliters) manual flush daily at 4:00 p.m. to keep tube patent with a start date of 7/30/18, and end date of 8/24/18. The MAR further indicated the previous order that started on 6/29/18, which included Osmolite 1.5, 130 cc's an hour times three hours was discontinued on 8/5/18.

R56's progress note dated 8/13/18, included: no longer receives tube feeding; does receive 120 ml flush daily before supper. A subsequent progress note dated 8/13/18, indicated the nurse

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practitioner was updated on constipation since diet change and a new orders were obtained.

R56's record lacked assessment to determine fluid intakes were sufficient according to assessed needs.

R56's subsequent nutritional assessment was dated 8/14/18, and included: weight has decreased 8 lbs. in 30 days, on 7/25/18, the Mighty Shake supplement was changed to give only at dinner. Current weight 186 lbs. The note indicated a decrease in minimum weight; 180-190 lbs. The note further included; Resident is consuming 100% of breakfast in the last 3 days, refused x 2 days, consumes 75-100% at lunch, 50-100% at dinner, no problems with swallowing and current textures provided, no edema. Will review weight weekly. The assessment did not include evaluation of fluid intake.

R56's progress note dated 8/14/18, indicated R56 continued to be eating and drinking well at meals and did not have indicators of dehydration.

R56's next nutritional assessment was dated 8/17/18. The assessment indicated the purpose of the note was due to the resident's weight fluctuating. The additional comments section of the note included: "resident is on a regular diet, is eating at a supervised table and uses a divided plate, gripper mat, gets his meats chopped or ground up. His fluids continually improves. He receives Might Shake at dinner daily. His goal weight is 190-195 lbs. Staff continues to encourage intake of food and fluids. He will be followed monthly."

R56's next nutritional note was dated 8/21/18,

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indicated a weight of 183.2 lbs., decrease of 2.8 lbs. in one week, continue to monitor weight weekly.

R56's daily fluid record from 8/20-8/24/18 reflected the following:
8/20/18: breakfast= 370 cc, lunch=zero (resident refused lunch), dinner=290 cc, daily flush 120 cc. (Total 780 cc)
8/21/18: breakfast= 370 cc, lunch=180 cc, dinner=480 cc, daily flush 120 cc (Total 970 cc)
8/22/18: breakfast= zero (resident does not want breakfast), lunch 180 cc, dinner=510 cc. (Total 810 cc)
8/23/18: morning=180 cc, lunch=370 cc, dinner=300, daily flush 120 cc (Total 970 cc)
8/24/18: breakfast=180 cc, lunch=160 cc, dinner 120 cc. (Total 580 cc)

R56's surgery note dated 8/24/18, indicated reason for visit is to have PEG removed. The note indicated R56 had been able to eat a general diet, and had been thoroughly evaluated by a speech pathologist. The note also indicated the PEG tube had not been used for at least three months. The note further indicated R56's blood pressure was low and that findings had been communicated to the nurse at Lake Winona Manor to do more frequent checks to make sure it was stable.

R56's progress note dated 8/24/18, indicated R56 was incontinent twice with dark concentrated urine with hematuria (blood in urine) and staff would encourage fluids between meals. No further hematuria was indicated in progress notes until 8/28/18.

R56's record reflected the following daily fluid

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F 692	Continued From page 64 intake totals after PEG removal; the record continued to lack evidence of comprehensive evaluation of daily fluid intake, and failed to identify current hydration needs after removal of the PEG. 8/25/18: breakfast=180 cc, lunch=zero, dinner=340 cc. (Total 520 cc) 8/26/18: breakfast=zero resident does not want, lunch resident does not want, dinner 370 cc's. (Total 370 cc) 8/27/18: breakfast= 360 cc, lunch=zero, dinner=280 cc. (Total 640 cc) 8/28/18: breakfast=360 cc, lunch=not recorded, dinner=360 cc (total 720 cc) R56's progress note on 8/28/18, indicated R56 was incontinent twice with urine that was dark orange in color. 8/29/18: breakfast=150 cc's, lunch=zero resident does not want, nothing recorded for dinner (Total 150 cc) 8/30/18: breakfast=zero resident does not want, lunch resident does not want, dinner=360 cc. (Total 360 cc) R56's progress note dated 8/30/18, indicated R56 was not feeling well but demonstrated no outward symptoms. A progress note later that day at 3:35 p.m. indicated no further concerns with hematuria or concentrated urine, continued to drink fluids well, and had no indicators of dehydration. 8/31/18: breakfast=zero refused, lunch=160 cc, dinner=330. (Total 490 cc) 9/1/18: breakfast=zero refused, lunch=zero refused, nothing recorded for dinner. (Total zero cc) 9/2/18: breakfast=420 cc, lunch=zero refused,	F 692		

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dinner=zero refused. (Total 420 cc)
9/3/18: breakfast=360 cc, lunch=180 cc, nothing recorded for dinner. (Total 540 cc)
9/4/18: breakfast=420 cc, lunch=zero refused, dinner 300 cc. (Total 720 cc)

R56's next nutritional note dated 9/4/18, lacked an evaluation of the daily fluid deficit, however, indicated a weight loss over the prior two weeks; 8/27/18, weight was 181 lbs., 9/4/18, weight was 175.4 lbs., The note indicated R56 agreed to drink Ensure supplement at all meals.

R56's record from 9/5 through 9/7/18, continued to reflect fluid deficits even with the addition of Ensure supplement.
9/5/18: breakfast=610 cc, lunch=190 cc, dinner=420 cc. (Total of 1220 cc)
9/7/18: breakfast=420 cc, lunch zero resident refused, dinner 460 cc. (Total 880 cc)

R56's progress note dated 9/7/18, indicated R56 had cloudy urine with no burning and to push fluids.

R56's record revealed no nutritional assessment was conducted immediately after the PEG tube was removed (8/24/18) until 9/7/18. The 9/7/18, assessment indicated R56's daily fluid requirements was reduced from 2590 cc per day to 2390 cc, indicating R56 consumed 1500-2000 cc/day, and was at "LOW RISK" for dehydration even though, the daily fluid intake monitoring between 8/24 through 9/7/18, reflected a daily average liquid consumption of only 495 cc per day. The assessment further indicated R56's weight was 175.4 lbs. with an ideal body weight of 128-161 lbs. Nutritional needs required: KCAL 1450-2190, protein 58-73 grams, and was given

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nutritional supplement with meals. The note further indicated R56 was refusing dinner and lunch often however, was drinking 100% of Ensure, was walking more, and was not snacking as much. The assessment further indicated R56 was a high nutrition risk-class 4, and weight was reviewed weekly.

R56's intake record from 9/8 through 9/11/18, continued to reflect fluid deficits following the nutritional assessment on 9/7/18. The total daily assessed fluid intake needs identified 9/7/18 =2390 cc.
On 9/8/18 the resident's fluid intake included: breakfast other=250 cc, lunch 420 cc, dinner 180 cc. (Total 850 cc)

R56's progress note dated 9/8/18, indicated R56 was having difficulty swallowing his pills earlier in day; R56 told staff that he had been having a hard time swallowing recently. A subsequent progress note indicated later that evening R56 again had a hard time swallowing pills, however, eventually was able to get them down.

R56's intake 9/9/18 included: breakfast=zero refused, lunch=zero refused, dinner=300 cc. (Total 300 cc)

R56's progress notes from 9/9/18, indicated R56 did not eat breakfast or lunch, and did not each much for supper. A progress note indicated he took his medication slowly like he was remembering how to swallow.

R56's intake 9/10/18 included: breakfast=240 cc, lunch=190 cc, dinner=200 cc. (Total 630 cc)

R56's progress notes from 9/10/18, indicated he

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did not eat well for breakfast or lunch and was slow to swallow water and medications. The progress notes indicated at 4:05 p.m. on 9/10/18, the nurse practitioner (NP) was updated related to occasional periods of holding medications in mouth, as well as not wanting as many snacks as in past. In addition the NP was informed that although R56 was eating his meals, he had noted weight loss.

R56's intake 9/11/18 included: breakfast 120 cc, lunch=zero resident did not want, dinner 20 cc. (Total 140 cc)

R56's progress notes dated 9/11/18, from a Provider Visit included: "past two days had been verbalizing sore throat and had increased difficulty swallowing at times." A progress note at 4:00 p.m. indicated a discussion with R56's power of attorney and included: "although is still drinking and eating well for meals, past three days has verbalized sore throat at times although upon assessment no noted redness."

R56's nutritional assessment note from 9/11/18, did not include a comprehensive evaluation of fluid intake. The assessment indicated R56's weight on 9/10/18, was 173.4 lbs., down two pounds in one week. The note indicated Ensure had been started with meals, but R56 had some swallowing problems noted so would be evaluated by speech therapist.

R56's intake 9/12/18 included: breakfast=zero refused, lunch=zero refused, dinner=zero refused. (Total zero cc)

R56's progress note dated 9/12/18, indicated R12 had not had a bowel movement in five days, had

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F 692	Continued From page 68 been complaining of abdominal discomfort, a suppository was given and R56 expelled an extra large amount of sticky stool that required digital assistance. Progress note at 4:09 p.m. indicated R56 was seen by MD (medical doctor) related to weight loss, periods of refusing to eat, and recent concerns of constipation: MD ordered labs. R56's physician visit note from 9/12/18, included: "He had a feeding tube for many months but his oral intake was much better and the tube was discontinued. Recently he has not been eating as well and has been complaining of abdominal discomfort. Nursing felt that this was related to constipation. He is much more sedated than he has been in the past." The physical exam indicated no qualifying data for vital signs and measurements, less alert than he previously has been, and had active bowel sounds. The assessment and plan included: "it is apparent that his status is changed considerably since last seen and labs will be ordered to see if there is anything reversible here." R56's intake 9/13/18 included: breakfast=360 cc, lunch=zero refused, dinner= resident was not there. R56's progress note dated 9/13/18, at 1:24 p.m. indicated his physician had called with orders to transfer R56 to the emergency room for intravenous fluids because his lab work reflected "severe dehydration." R56's emergency department visit dated 9/13/18, indicated nursing staff had reported decreased intakes over the past week, labs had been ordered related to weakness, and R56 had been sent to the emergency department for further	F 692		

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evaluation. The diagnosis that was given was "dehydration." The notes included: dehydration/acute kidney injury: patient was sent from Lake Winona Manor for further evaluation. Patient had PEG tube removed on 8/24/18, likely unable to keep up fluid needs. The note indicated the patient presented with blood pressures between 99/61 and after intravenous fluids given blood pressure improved to 115/71. The note further indicated the patient reported constipation and had a distended abdomen with no complaints of pain; imaging study would be decided after hospital admission. Physical exam indicated ears, nose, mouth, and throat had dry mucous membranes. Labs on 9/13/18, at 11:05 a.m. included: sodium of 149 mEq/L (high), BUN 77 mg/dl (high), and Creatinine 2.42 mg/dl (high).

During an observation on 10/31/18, at 7:55 a.m. R56 laid in bed with his eyes closed. Nursing assistant (NA)-G stated she had already provided morning cares however, R56 refused to get out of bed. NA-G stated somebody would take him in a nutritional supplement and offer him that for breakfast.

During an observation on 11/1/18, at 7:50 a.m. R56 sat in his wheelchair at the dining room table. R56 stated ever since they took out the PEG tube he had been struggling with constipation.

During an interview on 10/31/18, at 4:46 p.m. registered nurse (RN)-J stated R56 was eating and drinking ok. RN-J stated the nursing assistants documented the amount of fluid intake after each meal. RN-J indicated an unawareness if total daily fluid intake was assessed and was not aware of who was assessing the total amount

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F 692	Continued From page 70 of fluid intake in order to ascertain deficits that could lead to dehydration. RN-J stated if R56 had a decrease in fluid intake, or was not drinking, RN-J would encourage fluids. RN-J further stated the documentation should indicate a deficit and interventions attempted or used to replace the fluid deficit. RN-J was asked about R56's change in urine integrity; RN-J stated usually they would not call the doctor unless there were three symptoms of urinary tract infection. However, RN-J also stated it would also be dependent on nursing judgement. During an interview on 11/1/18, at 7:57 a.m. RN-A stated R56 had been admitted to the facility with the PEG tube; the reason for PEG tube was not certain. RN-A stated R56 had worked with speech and R56 worked really hard to eat so the PEG could be removed. RN-A stated R56's intakes were monitored by dietary and he was weaned off the formula when his intakes were sufficient to sustain daily recommended nutritional needs. RN-A stated the Osmolite formula started being held on 7/30/18, with 400 cc's flushes three times a day until 7/30/18, then the flushes were decreased to 150 cc's once per day. RN-A reviewed R56's nutritional assessments and verified the record lacked evidence of a nutritional assessment prior to or immediately following the PEG tube removal to identify daily fluid intake requirements. RN-A also confirmed R56's record lacked evidence of daily fluid intake totals and evaluations to determine fluid deficits even after the 9/7/18, nutritional assessment that that identified R56 required daily fluid amount of 2390 cc. RN-A stated prior to R56's hospitalization, R56 had seemed to drink and eat less than he had been. RN-A stated R56 did not have an order for strict intake and output monitoring prior to the	F 692		

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F 692	Continued From page 71 hospitalization; so the amounts entered probably weren't accurate. RN-A reviewed the documentation related to R56's change in urine integrity and indicated although there was hematuria documented, the symptoms resolved after a couple of days with no other symptoms, so it may have been appropriate not to call the physician and just push fluids. During an interview on 11/1/18, at 10:23 a.m. nutrition specialist (NS) reviewed the record and confirmed neither the registered dietian, nor dietary supervisor had completed a comprehensive assessment of R56's daily fluid intake requirements prior to, or immediately after, the removal of the PEG. The NS said the assessment dated 9/7/18 did not reflect fluid intakes as documented. The NS also verified nutrition progress notes prior to, and after removal of the PEG tube, lacked evaluation of daily fluid requirements and deficits. The NS also stated she was unsure whether nursing was evaluating daily fluid intakes. During an interview on 11/1/18, at 11:42 p.m. director of nursing (DON) stated the expectation that nutritional assessment should have been completed prior to, and/or immediately following the PEG removal, to identify daily fluid requirements. The DON further stated R56's fluid intakes should have been monitored and evaluated daily. The facility's Hydration Management policy dated 6/2017, indicated the purpose was: To ensure risk factors for dehydration are identified and steps are taken to determine that a resident has sufficient fluid intake to maintain proper hydration and health status. The policy included the	F 692		

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F 692	Continued From page 72 following risk factors for dehydration: weight loss, tube feedings, resident dependent on staff for intake, diuretic use, cardiovascular agents, renal disease, history of refusing fluids, limited fluid intake, resident lacking sensation of thirst. -Nursing assessment: A) Residents' dehydration risk is assessed on admission, quarterly, and as needed thereafter. B) Nursing should update provider if dehydration is suspected so resident may be evaluated further. C) Some common symptoms include: thirst, dark urine, headache, tenting of skin. -Care Plans: risk factors for dehydration should be identified by nursing assessment, appropriate care plan and interventions should be documented. The facility's Nutrition Risk Protocol dated 5/6/17, identified nutritional risk categories, and included and/or identified categories of risk specific for dehydration.	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		12/11/18

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F 725	Continued From page 73 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure sufficient staffing was available for the evening shift, in order to provide timely assistance with personal cares according to the resident's assessed need for 8 of 8 residents (R8, R17, R3, R50, R82, R1, R49 & R43) assessed to need staff assistance with activities of daily living (ADL). Findings include: R8's quarterly, Minimum Data Set (MDS) and assessment dated 8/2/18, indicated intact cognition and needed extensive assist with activities of daily living (ADL). R17's annual, MDS, dated 8/9/18, indicated intact cognition and needed extensive assist with ADL. R3's quarterly,MDS, dated 8/2/18, indicated intact cognition. R50's quarterly, MDS, dated 9/13/18, indicated intact cognition and needed extensive to total assist with ADL.	F 725	F725 The staffing guidelines in the facility assessment and staff schedule were revisited and updated by 11/30/2018 for residents on LVC. All licensed nursing staff and scheduling staff will be instructed on staffing recommendations by 12/11/2018. Random audits of 5 residents weekly will be done by a Social Worker or designee to determine feedback on staff response. All results will be brought to the QA/QI Committee for further recommendations.	

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R82's quarterly, MDS, dated 10/11/18, indicated intact cognition and needed extensive assist with ADL's.

R41's quarterly, MDS, dated 8/30/18, indicated intact cognition.

R49's quarterly, MDS, dated 9/13/18, indicated intact cognition and needed supervision with toileting.

R43's quarterly, MDS, dated 8/30/18, indicated intact cognition and needed extensive assist with ADL's.

RESIDENT INTERVIEWS:

R8 attended the resident council meeting on 10/31/18, at 10:59 a.m. R8 stated, sometimes they forget to put your call light on you and then you have to yell for help, then they (the staff) get mad at you for yelling for help. R8, R17, R3, R50, R82, and R41 said that they have been unable to reach their call light because staff forgot to give it to them. R41 stated, "What good will it do if you can't reach your call light?" R82 stated, I fell one time because they did not answer my call light, I waited 20 min, I had to go to the bathroom, I couldn't wait anymore, I know I need help, but I didn't want to go in my pants, so I tried to go myself and I fell. This was during the day about 6 months ago. I didn't get hurt bad, but I was sure sore for a few days. At 11:05 a.m. R43 stated, a lot of people won't complain because it doesn't do any good anyways. We have been talking about them turning off our call lights for a long time now in these meetings and it was never fixed, so why bother complaining?, it doesn't change. At 11:06

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a.m. R17 stated, I have been yelled at by the staff and asked, why are you turning on your light? Several residents nod their heads in agreement. At 11:07 a.m. 6 of 9 residents stated they have waited over an hour for call light assistance. When asked what is the longest you have had to wait for a response to the call light, they responded with: R43, R8, R17, R82, R3 all stated over an hour. R50 stated, wait time was 1 hour and 45 minutes. At 11:10 p.m. when asked if anyone had ever soiled their pants from waiting so long, R8, R17, R3, R50, and R82 all said they had. R82 stated, "I felt deserted when I felt no one answering my call light when I had to go to the bathroom so bad." The worst staffing is during the evening shift, several residents nodded their heads in agreement. R8, R17, R3, R50, R82, R41, R49, and R43 said that staffing is worse on the evening shift. At 11:13 a.m. R82 stated, "We need more help, we are too short staffed." At 11:16 a.m. R8 stated, another concern is when they put you on the toilet, it seems like you sit there for an hour, and when you need to get help to get off the toilet your butt can get pretty sore. R82 stated, "Yes your butt does get awful sore!" R17, and R50 all nodded yes in agreement.

STAFF INTERVIEWS:

During interview on 11/01/18, at 9:13 a.m. nursing assistant (NA)-L stated I mainly work day shift, I work every fourth weekend and they always ask me to stay late on the weekend. Sometimes when we are short staffed and R42 will get changed a half hour late. I always work lake view court (LVC), we have group 1 and group 2, and we have 2 aides scheduled for each group for day and evening shift. Sometimes an aide will

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call-in or won't be scheduled and we only have 3 aides to work. This is when we are short. This doesn't happen as often on day shift, mostly on evening shift. I think our being short on staff is more of a scheduling issue not a calling in issue, it happens more on evening shift.

During interview on 11/01/18, at 9:35 a.m. NA-O stated I have worked here 2 years, I work mostly day shift. Staffing is not good on the evening shift, especially once the college kids go back to school in the fall. I have heard there was issues with call lights during the evening.

During phone interview on 11/01/18, at 1:08 p.m. NA- M stated, I work evening shift and almost every weekend I work I get asked to stay late. We are usually really short staffed on the weekends. As far as staffing goes, it gets bad on evenings after supper, we will have like 8 call lights on at the same time and they all want to go to the bathroom and then to bed. What would be ideal is to have an extra float person on from supper until we get everybody to bed, this would help with our call light problems. I know residents have wet their pants waiting, I try my best to get to them. I bust my butt and I try to get to everybody, especially the people I know can't hold it for very long. I know we do turn off the call lights and we mean to get back to the resident right away, but it isn't always possible and I feel bad, I am doing the best I can. The scheduling is a problem, sometimes an aide is not scheduled, sometimes they call in, and sometimes they are late. So we end up working an aide is short most weekends for sure and sometimes during the week too. If we wanted to get those call lights answered timely we should have two aides for group 1 and group 2, with a float to help with call

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lights after supper time until we get everyone to bed.

During interview on 11/01/18, at 1:40 p.m. licensed practical nurse (LPN)-E stated, I work strictly day shift, we have no concerns with staffing during the day. On evening shift they have 1 registered nurse (RN) that floats, then trained medication aides and NA's. I have heard from other staff that there have been issues with call lights being answered during the evening, they have been brought up at resident council, and this was maybe a couple months ago. I think the call light wait time is the biggest concern, no concerns with staffing on the day shift, just the call lights.

During interview on 11/1/18, at 12:50 p.m. maintenance (M)-A stated, I checked with persons on electrical crew and at this time we have no way to run reports on the call lights (such as when they go on and when they are turned off).

During interview on 11/01/18, at 4:39 p.m. the director of nursing (DON) was informed of the issue with call lights being answered without care being provided to the residents in need, residents wetting their pants because call lights are not answered timely, long call light wait times, a fall because resident did not get call light answered timely and tried to take herself to the bathroom knowing she needed assistance, and residents voicing complaints about being left on the toilet. THe DON stated, I want all my residents to be treated with dignity and respect.

The facility's Nurse Staffing Guidelines revised 3/18, indicated the purpose was to assure there

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F 725	Continued From page 78 are sufficient qualified nursing staff members to meet the nursing care needs of residents throughout the facility. The policy further indicated the nurse staff coordinator or charge nurse (during non business hours) will ensure there is a qualified number of staff to handle acuity/workload.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		12/26/18

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F 726	Continued From page 79 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff have the knowledge, competencies and skill sets to provide care, and respond to each resident's individualized assessed needs safely in a manner that promotes each person centered care, basic nursing skills, infection control and identification of changes in condition, mental and psychosocial well-being. This practice was evident for 2 of 2 registered nurses (RN-D and RN-E). Finding include: Refer to 880: RN-E hand not preformed hand hygiene after glove removal, had not removed contaminated gloves and soiled gloves touched other areas had not worn a gown for protection and had not cleaned scissors during wound cares dressing changes. RN-D had not preformed hand hygiene after glove removal and had not cleansed scissors for wound care dressing changes. Competencies were provided for RN-E, however the competencies did not include pressure ulcer wound care. No competencies were provided for RN-D. During interview on 11/01/18, at 3:25 p.m., the director of nursing confirmed RN-D and RN-E had no competencies as noted above.	F 726	F726 Standard work for Aseptic Dressing Changes was developed on 11/30/2018 for licensed nursing staff. All licensed staff will undergo competency testing of compliance by 12/26/2018. 2 Random audits of wound or dressing care will be performed weekly by a Nurse Manager or designee. All results will be brought to the QA/QI Committee for further recommendations.	
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education.	F 730		12/11/18

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F 730	Continued From page 80 The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure annual performance reviews were conducted for 5 of 5 employees (E-1, E-2, E-3, E-4, and E-5) reviewed who had been employed over 1 year. This had the potential to affect all residents in the facility who had the potential to have interaction with these staff. Findings include: An undated Employee Roster Report identified employee (E-1) was hired 12/6/05, and employee record lacked any evidence an annual performance review having been completed for greater than 10 years. E2 was hired 8/22/16, and employee record lacked any evidence an annual performance review had been completed since E2 was hired over two years ago. E3 was hired 5/31/17, and employee record lacked any evidence an annual performance review had been completed since E3 was hired over a year ago. E4 was hired 5/10/10, and employee record lacked any evidence an annual performance review had been completed since E4 was hired eight years ago. E5 was hired 9/11/17, and employee record	F 730	F730 An Annual performance review process for nurse aides was developed and implemented 11/30/2018. All nurse aides will receive an annual review during mandatory competency labs during the calendar year. All nurse aids and management staff will be trained on annual review process by 12/11/2018. The Staff Development Coordinator or Designee will audit review compliance biannually following the competency labs. All results will be brought to the QA/QI Committee for further recommendations.	

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F 730	Continued From page 81 lacked any evidence an annual performance review had been completed since the employee was hired. During interview on 11/01/18, at 5:08 p.m. when the director of nursing (DON) was asked, "if you don't do performance evaluations on your staff, how do you know what training to provide them if you don't know their areas of weakness?" The DON stated, we do not do formalized performance reviews currently, "it is a work in progress." The DON verfied staff receive verbal follow up as corrections are necessary. The DON also reported the facility conducts leader rounding monthly for staff, which is a way to do formal rounding for all employees to verify employee progress, but don't maintain formal documentation. A Performance Review Policy was requested, however was not received.	F 730		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		12/11/18

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personnel to have access to the keys.

§483.45(h)(2) 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 properly secure medications for 2 of 5 medication carts observed, and failed to ensure that expired medications were removed from medication storage and destroyed in a timely manner for 5 of 5 carts observed and 2 of 3 overflow medication storage units.

Findings include:

On 10/31/18, 8:11 a.m. LPN-C was observed to leave a Humalog insulin pen unsecured on top of a medication cart and walk across the hall to give medications to another resident. Following this, LPN-C walked further down the hall to check on a resident to see if she was done with breakfast. At 8:37 a.m. LPN-C returned to the medication cart and prepared the insulin pen for administration.

During an interview on 10/31/18, at 11:55 a.m. LPN-C stated that she leaves the insulin pen on top of the cart as a reminder so she "doesn't forget it." LPN-C stated "I thought it was okay because it doesn't have a needle when it's sitting

F 761

F761
Standard work for Medication Administration and Medication Expiration Dates were reviewed on 11/29/18. All licensed staff and Trained Medication Assistants will be re-educated on these by 12/11/2018. On 10/28/18 a review of medication storage areas, including medication carts, was completed and expired medications removed. A random audit by the pharmacy consultant or designee will occur monthly on each unit x 3 months for expired meds. 5 observations per week x 5 of medication administrations will be done by the Nurse Manager or designee to monitor compliance of Expired Medication and Med Administration standard work. The Nurse Manager or designee will complete full review of medication expirations for each unit monthly starting in 12/2018. All results will be brought to the QA/QI Committee for further recommendations.

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there."

According to the director of nursing (DON) who was interviewed on 11/01/18, 1:37 p.m. it was expected that all persons responsible for administering medications would keep pharmaceuticals in a secure locked area when not being used.

On 10/29/18, at 5:10 p.m. while observing LPN-D and the Lakeview Court (LC) North medication cart a vial of Refresh Tears (a moisturizing eye drop) was found with an expiration date of September/2019 was found but the label had September 11 written on it. LPN-D was unsure as to whether that was the date when the bottle was open or of when the eye drop should be disposed. LPN-D then went to the medication overflow storage to get a different bottle. The bottle LPN-D returned with was marked as having been opened September 12, 2018.

According to a document listing expiration dates for various medications used in the facility, all eye drops are considered expired 28 days after being opened. This document is available on all medication carts according to a note written of the page provided.

On 10/30/2018, 11:30 a.m. LPN-B was observed at the second floor medication cart for the south hall. Another eye drop, Lumigan 0/01% (eye drops to treat elevated pressure in the eye) was noted as being in the cart without documentation of the date it was open. LPN-B stated, "it should be okay for six months after opening." Manufacturer instruction state that the medication should be disposed of 4 weeks after opening. Also, found in the same medication cart:

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-Artificial tears (lubricating eye drops) marked as having been opened 11/9/17 and expired 3/24/18
-Artificial tears with an expiration date of 8/10/18 and no date opened
-Ear drops 6.5% (generic ear drops to soften ear wax) with no date opened but delivered from the pharmacy 4/15/18.
-Lantus insulin (a long acting insulin) pen with no open date but marked as having been delivered to the facility on 9/28/18. LPN-B stated, "it is only good for 28 to 30 days after opening." LPN-B removed the pen from the cart.
-Milk of Magnesia (mineral suspension given for gastric upset or constipation) marked as having been opened 2/25/2012 and with a pharmacy expiration date of 2/25/2018.
-Theragesic (a topical arthritis rub) with an expiration date of 8/15/15
-Nystop 100,000 units (an anti-fungal powder for the skin) with an expiration date of 10/27/18

On the same floor but the north cart, when observing TMA-B, a container of Artificial tears was found that was marked as having been opened 2/28/18. When asked if it could still be used, TMA-B stated, "I think they are good for 6 months. "At end of day, TMA-B found the surveyors and indicated that the eye drops had been disposed of because, "they were expired."

Medication storage for over flow medication on the LC unit was examined with RN-F for expired medication on 11/01/18, 7:53 a.m. and the following were discovered:
-Metoclopramide (a medication to treat heartburn) expired 8/3/18
-Sumatriptan succinate (a migraine medication)-two bottles, expired 5/11/18 and 10/12/13

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-Spironolactone (a diuretic to treat high blood-pressure) expired 10/29/18
-Senexon (a bowel stimulant) expired 10/23/18
-Levothyroxine (a thyroid medication) expired 9/1/18
-Omeprazole (stomach acid reducer) expired 9/15/18
-Losartan (for high blood pressure) expired 8/14/18
-Triamcinolone (steroid cream) expired 8/18/18
-Hydrophor 42% (moisturizing ointment) expired 9/14/18
-Refresh Liquidgel 1% (moisturizing eye drops)opened 9/12/2018
-Citalopram (an antidepressant) expired 2/2/18
-Acidophilus (probiotics for gastric problems) expired 10/18

Following the finding of the above expired medications, RN-F, nurse manager for the LC unit was asked to explain the facility process that assures expired medications are removed. RN-said she thought the PM shift TMAs were supposed to be doing this but any nurse who would notice expiration dates during medication administration should "pull the medications".

The LC south medication cart was examined for expired medications on 11/01/18, 9:18 a.m. with LPN-C. The following were discovered:
-Triamcinolone 0.15 expired 8/14/18 and triamcinolone 0.1% expired 8/10/18 and triamcinolone 0.1% expired 8/19/18
-Bisac-evac (bowel stimulant suppository) expired 7/2018
-Ventolin HFA AER (an inhaler to treat spasms in the airways) expired 7/13/18
-hydrocortisone (a steroid) expired 8/8/18

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F 761	Continued From page 86	F 761		

The Bluffview Transitional Care Unit (TCU) medication cart was examined for expired medications on 11/01/18, 11:11 a.m. with RN-G. The following were discovered:
-Atorvastatin (a lipid reducer) expired 8/12/18
-Omeprazole 20 mg expired 6/17/18
-Warfarin (an anticoagulant) expired 6/16/18
-Systane balance (moisturizing eye drops) expired 7/2018
-Econazole 1% (antifungal cream) expired 5/2018
-Miconazole 2% (antifungal cream) expired 8/27/18

The medication over flow store room for the TCU was examined with RN-G as well, and the following were discovered:
-Ipratropium Bromid & Albuterol (an aerosol solution to treat bronchospasms) expired 9/13/18
- Biotene Dry Mouth Oral (mouth rinse) expired 10/16/18

According to an interview with the DON on 11/01/18, 1:37 p.m. she stated an expectation for all person administering medications to be checking expiration dates. DON said, "We should be looking before administration, I would say they are not."

A facility provided document titled Standard Work: Medication Expiration Checks and last updated 6/3/2016 includes the following information: before administering medication check expiration date. Multi-dose inhalers, insulin pens, nitro, vaccinations must be dated when opened. Put date expires and initial. Refer to medication protocols in book on carts for exact amount (i.e. 30 days, 60 days.). A facility provided document titled Standard Work: Eye Drop Admin. And last updated 6/13/2016 includes the following

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F 761	Continued From page 87 information: Gather eye drops and be mindful of the expiration date. If a new bottle then it needs to be dated and initialed (bottles expire between 30-60 days depending on medication. A facility provided policy titled Storage-General and dated as having been reviewed 6/12 was provided and includes the following information: Medications and devices shall be stored to ensure their integrity, stability, and effectiveness. Medications and biologicals will be stored so that only authorized personnel have access ...All drugs and biologicals must be secure. The policy does not include information on who should monitor storage areas for expired medications.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		12/11/18

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F 812	Continued From page 88 by: Based on observation, interview and document review, the facility failed to ensure all items on room trays for the supper meal were covered for 5 of 5 room trays delivered on the second floor observed during the dining observation. Findings include: On 10/29/18, at 5:09 p.m. nursing assistant (NA)-D started to deliver room trays on the second floor. Five room trays were served to residents in rooms 246, 248, 250, 252 and 243. There were no covers on the beverages, which included water, coffee and hot chocolate. There were no covers on the small dishes of mandarin oranges on any of the room trays. On 10/29/18, at 5:14 p.m. NA-D verified none of the beverages or the small dishes of mandarin oranges had covers on them, when he delivered the room trays to the residents on the second floor. NA-D verified these items should have had covers. On 11/01/18, at 8:53 a.m. the certified dietary manager (CDM) stated all items on the room trays are to be covered. The CDM stated I know on Monday night there were instances that items were not covered. The CDM stated the next day we had brief meeting with all of the staff and talked about the expectation that everything that leaves the dining room must be covered. At 9:35 a.m., the CDM verified staff did not follow the policy to ensure all items were covered on the room trays. The LWM Meal Service Policy dated 11/1/16 included, "Resident's choosing to eat in their	F 812	F812 The Lake Winona Manor meal service policy was updated to include standard tray practices. All LWM Dietary and Nursing staff will be educated on the new policy by 12/11/2018. The Dietary Manager or designee will audit 15 room trays weekly x 5 weeks to monitor for compliance. All results will be brought to the QA/QI Committee for further recommendations.	

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F 812	Continued From page 89 rooms are able to fill out a menu for that meal and have the tray delivered to them by a nursing staff member ...b. All items that leave the dining room on a tray must be covered including beverages, desserts, fruit, etc.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		12/11/18

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F 880	Continued From page 90 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene during a wound dressing change for 2 of 3 residents (R33 and R1) and failed to ensure	F 880	F880 Glucometer standard work updated 11/29/2018. Medication Administration Standard Work updated 11/29/2018.	

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nebulizer equipment was cleaned after use for 1 of 1 residents (R37) and failed to establish an on-going infection control program, which included comprehensive surveillance of resident infections that did not require an antibiotic and analysis of infections to reduce the risk of spread within the facility. This practice had potential to affect all 89 residents residing in the facility. Also failed to ensure hand hygiene was practiced following medication passes for 3 of 7 resident (R67, R63 & R30) and for sanitizing a glucometer.

Findings include:

HAND HYGIENE:
R33 was observed on 10/31/18, at 8:29 a.m. to receive a pressure ulcer wound dressing change by registered nurse (RN)-E. RN- E washed hands, applied gloves, assisted R33 to roll over in bed (R33 laid on an cloth incontinent pad, which had a visible large amount of secretions from the sacral wound on the pad), removed old dressing from a sacral wound (saturated with secretions) and left gluteal fold pressure wounds, measured the sacral wound and removed gloves. RN-E applied clean gloves, cleansed the sacral wound and removed gloves. RN-E applied clean gloves, measured the left gluteal fold wound and removed gloves. RN-E applied gloves, applied four strips of carousel AG to the sacral wound bed, cut the strips of carousel AG (while in the wound bed) with scissors (unclean prior to use) to the right length, covered the wound with Kara foam dressing and removed gloves. RN-E applied gloves, placed dressing over the left gluteal wound, applied barrier cream to skin on R33's buttocks and removed gloves. RN-E applied gloves and changed the incontinent pad

Nebulizer standard work reviewed and updated on 11/29/2018. Wound Care standard work created 11/30/2018. All licensed nursing staff and Trained Medication Aides will be trained on the new standard work by 12/11/2018. 2 Random audits of wound or dressing care will be performed weekly by the LWM Infection Control Nurse or designee. 5 observations per week x 5 of medication administration will be done by the LWM Infection Control Nurse or designee to monitor compliance of equipment cleaning and hand hygiene. All results will be brought to the QA/QI Committee for further recommendations.

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(soaked with a large amount of secretions). RN-E with the same soiled gloves on handed R33 two Kleenexes, applied lotion to R33's arms, legs and removed gloves. RN-E applied gloves, applied tubigrip on R33's left leg and removed gloves. RN-H placed the soiled scissors on top of R33's tray table, with no barrier underneath the scissors. RN-E removed the soiled scissors from the tray table and placed the scissors into a dressing box on R33's counter. RN-E walked out of R33's room and washed hands in the dirty utility room.

During interview on 10/31/18, at 8:29 a.m., RN-E stated she had not cleansed the scissors prior to use or after use. RN-E confirmed she had washed hands at the start of the wound care and after leaving R33's room. RN-E confirmed she had not washed hands between glove changes during the wound care.

R34's current care plan included problem, dated 10/29/18, Infection sacral wound related to osteomyelitis, MRSA (Methicillin-resistant Staphylococcus aureus) and cellulitis.

During observations of the wound care gloves were the only personal protective equipment (PPE) worn. No gown was worn by RN-E to protect clothing from wound secretions during the wound care procedure.

The Centers for Disease Control (CDC) at https://www.cdc.gov/mrsa/healthcare/clinicians/precautions.html read Gowning Wear a gown that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or

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excretions is anticipated.

During interview on 10/31/18, at 11:18 a.m., RN-G confirmed R33 had MRSA infection in sacral wound. When asked what PPE staff should wear during the wound dressing change for R33's sacral wound, RN-G stated unless the drainage is not contained, standard precautions should be followed. If there is excessive drainage, staff should gown.

R1 was observed on 10/31/18, at 10:31 a.m., to receive dressing changes to both lower extremities by RN-D. RN-D washed hands, applied gloves, removed old dressings from both lower extremities (LE) (left LE dressing had moderate amount of green drainage), cleansed both LE with wound cleanser and removed gloves. RN-D applied gloves, applied 4 x 4 Vaseline gauze pads (cut the Vaseline gauze with scissors pulled out of uniform pocket) to both LE, and applied 4 x 4 gauze pad and abdominal pad over the Vaseline gauze, wrapped both LE with Kerlix (cling wrap) and removed gloves. RN-D applied tubigrip to both LE. RN-D picked up scissors, washed the scissor in soapy water in R1's bathroom, dried the scissors and placed the scissors back into uniform pocket. RN-D washed hands.

During interview on 10/31/18, at 10:59 a.m., RN-D verified had not washed hands in between glove changes during the dressing change for both LE. RN-D verified she had not sanitized the scissors prior to use and had cleansed with soap and water after use.

During interview on 10/31/18, at 3:34 p.m., the director of nursing (DON) stated she would

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expect handwashing in between glove changes.

NEBULIZER:
R37 stated on 10/29/18, at 4:19 p.m., he has had a respiratory problem for a couple months now with a cough that will not go away. R37 stated facility staff started using that thing over there (pointing to nebulizer machine sitting on his bed). The nebulizer equipment set on the bed, was fully connected and had moisture in the medication cup.

During observation of R37's room on 10/31/18, at 7:18 a.m., nebulizer equipment set on a stand by R37's T.V. The medication cup had visible moisture inside. At 9:27 a.m., the nebulizer equipment remained the same.

During observation on 10/31/18, at 9:31 a.m., RN-H confirmed the nebulizer equipment was together with moisture in the medication cup. RN-H stated we had respiratory therapy training as part of nursing skills station and we were trained the equipment does not have to be rinsed after each use, we replace all of the equipment once a week. RN-H stated I think the training was in July.

During interview on 10/31/18, at 3:35 p.m., DON stated facility standard was to rinse the nebulizer equipment after each use. DON stated the training was washing the machine once a week, but staff should still be rinsing out the equipment after each use. That was what staff were trained on.

The facility Standard Work sheet, last updated 8/9/18, directed wash mask/medication cup with soap and water or vinegar, let air dry, 1 X/week

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(one time per week) on Wednesdays.

SURVEILLANCE:
During interview on 10/31/18, at 10:23 a.m., nursing assistant (NA)-A stated we had scabies up here on the south hall (second floor). NA-A stated she started itching like crazy and had open sores on her leg from the scabies. NA-A stated she was not aware the residents had scabies, as her and another co-worker had to find out why they were itching so badly. NA-A stated the scabies occurred mid-September. NA-A stated we found out residents had scabies after staff members went to urgent care.

The facility Monthly Infection Reports dated from months of 5/18 through 9/18 and Antibiotic Use sheets for 10/18 indicated the following:
5/18:1 pneumonia, 2 urinary tract infection (UTI) without catheter
6/18: 1 UTI with catheter, 1 conjunctivitis, 2 wound
7/18: 1 pneumonia, 2 UTI with catheter, 1 UTI without catheter
8/18: 1 upper respiratory, 2 UTI with catheter, 2 UTI without catheter, 1 wound
9/18: 1 pneumonia, 1 UTI with catheter, 1 wound
10/18: 2 UTI without catheter, 2 cellulitis, 1 presumed bronchitis

There was no documentation from the sheets regarding scabies.

During interview on 11/01/18, at 12:59 p.m., RN-I stated I do not document analysis of infections, I gather data for infections. RN-A stated I do not document as needed education provided for employees about communication for infections when occur on how to prevent the spread of

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infections. RN-I stated I do not track viruses. RN-I stated the facility had scabies in house last month. RN-I stated she had no documented information regarding surveillance of the scabies, action taken and outcome. RN-I provided information that indicated 15 residents in the facility had been treated with Permethrin topical (works by disrupting the function of the neurons of lice and scabies mites) for scabies. RN-I stated the medical director was informed and the staff were offered treatment.

The facility policy Hand Hygiene, dated 7/18, indicated VI. Indications for hand hygiene: Always perform hand hygiene in the following situations. B. Before and after performing invasive procedures. Although gloves are worn for certain procedures, hand hygiene before donning gloves and after removal is necessary because of the possibility of tears or holes in the gloves. D. Between care activities on the same patient involving different body sites (care of Foley/IV/wound/trach). E. After contact with blood, body fluids or excretions, or wound dressings. F. Before exiting the patient's care area after touching the patient or the patient's immediate environment.

The facility policy Standard Precautions, dated 1/17, indicated II. Personal Protective Equipment (PPE): PPE is worn when there is potential for contact with blood or body fluids. B. Gowns 1. Wear an impervious gown to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretion or excretions is anticipated.

The facility policy Infection Management Plan,

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undated, indicated Surveillance, prevention and control program: 1. Surveillance is the process of case finding and analysis used to report and assess infection concerns and to identify risks. 2. Prevention is the comprehensive process of identifying potential risk and utilizing appropriate actions prevent untoward events. 3. Control is the process, which establishes for actions necessary to respond to outbreaks, clusters, or individual cases of infection requiring isolation precautions. Reporting: 1. The infection Control Coordinator will analyze and present the surveillance data to infection control committee and nursing leaders.

R67 received medications during a medication pass on 10/31/18, 8:13 a.m. when licensed practical nurse (LPN)-C was observed returning to a medication cart after administering medications. LPN-C was wearing gloves and removed them, but failed to do hand hygiene upon removal. LPN-C then proceeded to set up medications for R67, touching the medication cart, computer for documentation, resident medication containers, and medication cups. LPN-C then applied gloves and went to R67's room and administered medications. Following this, LPN-C again returned to the medication cart, removed gloves and failed to perform hand hygiene. LPN-C then documented the administration on the computer.

R63 received medications on 10/31/18, 8:37 a.m. when LPN-C was observed returning to the medication cart after administering medications down the halls and ready to prepare an insulin injection for R63. LPN-C failed to perform hand hygiene upon return to the cart and before preparing the insulin pen for injection. LPN-C cleaned the insulin pen with alcohol and attached

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 98	F 880		

a needle to the pen. Following this, LPN-C went to R63's room where hand hygiene was performed and gloves applied. The insulin was administered and LPN-C then returned to the medication cart, removed the contaminated needle, returned the pen to the cart and removed gloves. LPN-C then failed to perform hand hygiene.

R63 had a blood sugar check done on 10/31/18, 11:33 a.m. when LPN-C was observed performing a blood sugar check on R63. During the observation, LPN-C was noted to take the glucometer (a machine to check blood sugar) to R63's room where nurse performed handwashing and applied gloves, cleansed R63's finger with alcohol and collected a blood sample from R63's finger with the glucometer. Then LPN-C carried the soiled glucometer from the room, returned to the medication cart and set it down without any barrier between the soiled equipment and the cart. Following this, LPN-C removed gloves but did not perform hand hygiene. LPN-C stated the proper cleaning wipes were not available and cleansing would have to wait. The soiled glucometer remained on top of the medication cart where medications are prepared for administration.

R30 received medications on 10/31/18, 11:36 a.m. when LPN-C was observed to prepare R30's medications and enter resident's room without having performed hand hygiene. LPN-C applied gloves and administered medications and flush R30's gastric tube without hand hygiene. Following these tasks, LPN-C removed gloves and left the room to return to the medication cart where hand hygiene was done.

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	245240	A. BUILDING ______ B. WING ______	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

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F 880	Continued From page 99	F 880		

Continued From page 99

During an interview on 10/31/18, 11:49 a.m. LPN-C was asked when it was appropriate to do hand hygiene when administering medications. LPN-C said hand hygiene should be done before administering medications and if called to a different room, to "do it again." When asked about appropriate hand hygiene related to hand hygiene, LPN-C said, "I should be doing it when I remove gloves." LPN-C also stated that the facility provided frequent education related to hand washing and she had received education.

During the same interview, LPN-C stated she would clean the glucometer by wiping it thoroughly three times with a disinfecting wipe and then let it sit for two minutes to dry. Shortly after, LPN-C picked up the glucometer and went down the hall with it and set it on a counter near the nurses' station without providing a barrier between the counter and the soiled glucometer while she got the appropriate disinfecting wipes. LPN-C did not apply gloves, but wiped the glucometer off and returned it to the cart. The counter and surface of the medication cart were not cleansed with the disinfecting wipes.

During an interview on 11/01/18, 1:27 p.m. the director of nursing (DON) stated she would expect general principles for infection control to be followed by placing a barrier to protect a clean surface from contamination. DON said that glucometers should be cleaned between uses.

At 11/01/18, 1:30 p.m. the DON was asked about expectations related to hand hygiene during medication administration. The DON said that hand hygiene should be done before and after medication administration and "in-between as needed, between dirty to clean" tasks.

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F 880	Continued From page 100	F 880		

A policy for handwashing and glove use during medication administration was requested and none provided.

A policy for glucometer cleaning was requested and a document titled Standard Work-Chemstrips and dated 4/6/2017 was supplied. This document instructs licensed practical nurses and trained medication aides to wash hands and apply gloves prior to testing. Furthermore, after testing it directs the user to immediately dispose of the test strip and to clean the entire meter with "Super Sani-Cloth/purple top wipes" then remove gloves and wash hands. An additional document was supplied by the facility titled, Winona Health NOVA StatStrip Blood Glucose Meter Direct Observation [COMPETENCY]. The first two steps to perform stated: "follow proper Standard Precautions Policy Guidelines" and "wash hands with soap and water and put on gloves." Then the meter should be readied. The competency indicates gloves should be changed for patient testing. After testing, the competency directs that the meter should be cleaned with "correct wipes (Sani-clothe Plus. Wipes wet not dripping)" and then the meter to be stored. Both documents fail to provide the process for correctly cleaning the glucometer with the exception of which wipes to use. The documents do not address maintaining a clean environment in response to soiled equipment.

The Centers for Disease Control recommend health professionals practice hand hygiene before and after direct contact with a patient's skin, after contact with blood or body fluids, after contact with the patient's environment and after glove removal.

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

F5240030

PRINTED: 12/03/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245240	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

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K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Lake Winona Manor) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
FM.HC.Inspections@state.mn.us

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/30/2018

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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	245240	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**10/30/2018**

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K 000	Continued From page 1 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. Lake Winona Manor is a 2-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1962 and 1964 was determined to be of Type II(111) construction. In 2000, addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the 1962 and 1964 buildings and the 2000 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 110 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211	Means of Egress - General	K 211		11/23/18

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K 211 SS=F	Continued From page 2 CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18/19.2.2 through 18/19.2.11, 18.2.1, 19.2.1, 7.1.10.1) This deficient practice could affect the safety of all (89) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:30 AM and 12:30 PM on 10/30/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During walk-through of the facility observed the Chapel Exit Door required a force greater than 15# to open and the door did not self-close and latch when tested This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 211	K211- During walk-through of the facility observed the Chapel Exit Door required a force greater than 15# to open and the door did not self-close and latch when tested 1. The clearance on the Chapel exit door will be adjusted so that the door opens and closes with a force less than 15#. 2. All other exit doors in the facility that will be checked and adjusted to ensure that the door will open will less than 15 pounds of force and be able to close to the latched position. 3. A quarterly security guard tour will be added include checking that all exit doors pull the doors closed to the latched position and open door with less than 15 pounds of force. 4. The quarterly security guard tour will be performed by the Security Team and monitored by the Facilities Operations Manager, and report all deficiencies to the EOC committee on the quarterly basis. 5. Work order #102296 was created and will be completed by November 23, 2018.	11/12/18
K 300	Protection - Other	K 300		

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K 300 SS=F	Continued From page 3 CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (NFPA 101, 19.3.2.5, 19.3.2.5.3(9)*) This deficient practice could affect the safety of all (89) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:30 AM and 12:30 PM on 10/30/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During walk-through of the facility observed the stove located in the Physical Therapy Room did not have a power lock-out or disconnect This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 300	K300- During walk-through of the facility observed the stove located in the Physical Therapy Room did not have a power lock-out or disconnect 1. The Stove in the Physical Therapy room will be plugged into a power lock-out electrical receptacle 2. All other stove locations will be audited for the use of a power lock-out disconnect. 3. New work procedures were implemented right away. Staff are required to use this every time. 4. The execution of the lock out procedures will be added to the weekly safety rounding checks. This will audit that staff are locking up the lock after use. 5. Work order #102296 was created and was completed on November 12th, 2018.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		11/8/18

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K 341	Continued From page 4 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8) This deficient practice could affect the safety of all (89) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:30 AM and 12:30 PM on 10/30/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During walk-through of the facility observed a cover plate missing from a fire alarm wiring junction-box above the ceiling tile by Door 133 This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 341	K341- During walk-through of the facility observed a cover plate missing from a fire alarm wiring junction-box above the ceiling tile by Door 133 1. The fire alarm junction box will receive the proper cover plate. 2. A campus wide audit has been done to locate other junctions boxes with missing cover plates 3. Electrical contractors will be required to follow all local, state, and federal codes. 4. All electrical contractors will be closely monitored during and after all work to ensure they follow all electrical codes, including adding cover plates to all junction boxes. 5. Work order #102298 was created and a cover plate was added on November 8th.	

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K 341	Continued From page 5 discovery.	K 341		
K 919 SS=E	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (Chapter 10 (NFPA 99)) This deficient practice could affect the safety of all (89) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:30 AM and 12:30 PM on 10/30/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During walk-through of the facility observed the usage of triple-tap electrical outlet adapters in the following locations: 1st FL - adjacent to Door 123; 2nd FL - Nurses Station. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 919	K919- During walk-through of the facility observed the usage of triple-tap electrical outlet adapters in the following locations: 1st FL - adjacent to Door 123; 2nd FL - Nurses Station. 1. All temporary triple-tap electrical outlet adapters were remove immediately. 2. A campus wide audit has been done to locate other triple-tap electrical outlet adapters. 3. Triple-tap electrical outlet adapters will not be allowed in the facility. 4. The use of triple-tap electrical outlet adapters will be added to the weekly safety rounding checks. 5. Work order #102222 was created and all triple-tap electrical outlet adapters have been removed from the facility on November 12, 2018.	11/12/18
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		11/12/18

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K 920	Continued From page 6 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (10.2.4., 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) This deficient practice could affect the safety of all (89) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:30 AM and 12:30 PM on 10/30/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following:	K 920	K920- During walk-through of the facility observed in the Dining Room / T.V. Room an electrical cord being used as permanent wiring. 1. The electrical cord was removed immediately and an electrical outlet was added per code. 2. A campus wide audit has been done to locate other electrical cords being used as permanent wiring. 3. Staff will be retrained to follow the rule of electrical cords are only allowed for temporary use (24 hours or less) and	

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K 920	Continued From page 7 During walk-through of the facility observed in the Dining Room / T.V. Room an electrical cord being used as permanent wiring This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	should never be used for permanent use. 4. The misuse use of all electrical cords will be added to the weekly safety rounding checks. 5. Work order #102301 was created and the electrical cords has been removed and a new outlet for the TV was added on November 12, 2018.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K 923		12/11/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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LAKE WINONA MANOR	**865 MANKATO AVENUE** **WINONA, MN 55987**

(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 923	Continued From page 8 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (5.1.3.3.2 and 5.1.3.3.3.) This deficient practice could affect the safety of all (89) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:30 AM and 12:30 PM on 10/30/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During walk-through of the facility observed mixed storage of cylinders and no empty / full signage in the Oxygen Storage Room This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	K923- Oxygen Full/Empty signage was placed in Oxygen storage room by 11/28/18. Facilities and nursing staff will be updated on new storage signage by 12/11/2018. Random storage audits for compliance will be performed weekly by a Health Unit Coordinator or designee x 5 weeks to monitor compliance. Results will be brought to the QA/QI for further recommendations.	