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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ISKC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**
2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

4. TYPE OF ACTION: **7**
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 **11/20/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **47** (L18)

13.Total Certified Beds **47** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 11/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 01/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/30/1991
(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.
00400
(L31)

30. REMARKS
Posted 01/02/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/15/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On November 20, 2014 a health and FMS PCR was completed and verified correction of deficiencies issued pursuant to a PCR completed on October 17, 2014. Based on our visit, we have determined the facility has corrected the deficiencies pursuant to the October 17, 2014 revisit, effective November 20, 2014.

As a result of the November 20, 2014 PCR and the facility achieving substantial compliance, this Department discontinued the Category 1 remedy of State monitoring, effective November 20, 2014.

In addition, this Department recommended to the CMS Region V office the following actions related to the imposed remedies in their letters of July 8, 2014 and November 3, 2014:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014 be discontinued effective November 20, 2014. (42 CFR 88.417 (b))

• Per day civil money penalty of $800.00, effective October 17, 2014, be discontinued, effective November 20, 2014.
• Mandatory Termination of your Medicare and Medicaid Provider Agreements, effective November 22, 2014, be rescinded.

Refer to the CMS 2567b for both the health FMS for the results of this visit.

Effective November 22, 2014 the facility is certified for 47 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245535

November 25, 2014

Mr. Gary Hjelmstad, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

Dear Mr. Hjelmstad:

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 November 20, 2014 the above facility is certified for:

47 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 47 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

November 25, 2014

Mr. Gary Hjelmstad, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535025; S5535027

Dear Mr. Hjelmstad:

On October 29, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 2, 2014. (42 CFR 488.422)

On July 8, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of July 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

This was based on the deficiencies cited by this Department for a standard completed on May 22, 2014 and a Federal Monitoring Survey (FMS) completed on June 27, 2014 and failure to achieve substantial compliance at the health and FMS Post Certification Revisits (PCRs) completed on August 12, 2014. The most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 17, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a health and FMS PCR, completed on August 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2014. Based on our visit, we have determined that your facility had not corrected the deficiencies issued pursuant to our PCR, completed on August 12, 2014.

The October 17, 2014 revisit resulted in an extended survey where substandard quality of care (SQC) was identified. The most serious deficiencies were found to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H), whereby corrections were required. As a result of this visit, the Category 1 remedy of State monitoring remained in effect.

In addition, CMS Region V office notified you of the following actions related to the imposed remedies in their letter of November 3, 2014:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014 remains in effect. (42 CFR 488.417 (b))

In accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014

Furthermore, CMS Region V office notified you in their letter of November 3, 3014, that the following additional remedies were being imposed:

- Per day civil money penalty of $800.00, effective October 17, 2014 (and continues to accrue until substantial compliance is achieved). (42 CFR 488.430 through 488.444)

- Mandatory Termination of your Medicare and Medicaid Provider Agreements, effective November 22, 2014

As CMS Region V office notified you in their letter of July 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

On November 20, 2014 a health and FMS PCR was completed and verified correction of deficiencies issued pursuant to a PCR completed on October 17, 2014. Based on our visit, we have determined the facility has corrected the deficiencies pursuant to the October 17, 2014 revisit, effective November 20, 2014.

As a result of the November 20, 2014 PCR and the facility achieving substantial compiance, this Department discontinued the Category 1 remedy of State monitoring, effective November 20, 2014.

In addition, this Department recommended to the CMS Region V office the following actions related to the imposed remedies in their letters of July 8, 2014 and November 3, 2014:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014 be discontinued effective November 20, 2014. (42 CFR 88.417 (b))

- Per day civil money penalty of $800.00, effective October 17, 2014, be discontinued, effective November 20, 2014.

• Mandatory Termination of your Medicare and Medicaid Provider Agreements, effective November 22, 2014, be rescinded.

The CMS Region V office will notify you of their determination regarding the imposed remedies.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5535r3_FY14&15_htlh&FMS

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	11/20/2014

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **11/20/2014**
ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **11/20/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/20/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/20/2014**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0490** Reg. # **483.75** LSC	Correction Completed **11/20/2014**
ID Prefix **F0496** Reg. # **483.75(e)(5)-(7)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **11/20/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	11/25/2014	18617	11/20/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/22/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	11/20/2014

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/20/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/20/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **11/20/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	11/24/2014	18617	11/20/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/27/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ISKC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**
2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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 **10/17/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **47** (L18)

13.Total Certified Beds **47** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 11/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/30/1991
(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.
00400
(L31)

30. REMARKS
Posted 01/02/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/15/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5535

On October 17, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 12, 2014. At the time of the PCR an extended survey was conducted and determined conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. We presumed based on your plan of correction, that the facility had corrected these deficiencies as of October 3, 2014. Based on our revisit, we have determined that the facility has not obtained substantial compliance with the deficiencies issued pursuant our PCR, completed on August 12, 2014. The deficiencies not corrected pursuant to our PCR conducted October 13, 14, 15, 2014 and the extended survey conducted October 16 and 17, 2014 are as follows:
F0279 -- S/S: E -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: G -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: H -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

At the time of our PCR and extended survey, the following deficiencies were identified:
F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)
F0241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality
F0272 -- S/S: D -- 483.20(b)(1) -- Comprehensive Assessments
F0276 -- S/S: E -- 483.20(c) -- Quarterly Assessment At Least Every 3 Months
F0281 -- S/S: D -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards
F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
F0356 -- S/S: C -- 483.30(e) -- Posted Nurse Staffing Information
F0490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being
F0496 -- S/S: F -- 483.75(e)(5)-(7) -- Nurse Aide Registry Verification, Retraining
F0497 -- S/S: F -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
In addition, this Department conducted the revisit related to the FMS. The deficiencies not corrected are as follows:
F0279-Develop Comprehensive Care Plans-483.20(d), 483.20(k)(1)
F0282-Services By Qualified Persons/per Care Plan-483.20(k)(3)(ii)
F0309-Provide Care/services For Highest Well Being-483.25
F0520-Qaa Committee-Members/meet Quarterly/plans-483.75(o)(1)
Furthermore, at the time of the FMS PCR the following deficiencies were identified:
F0157-Notify Of Changes (injury/decline/room, Etc)-483.10(b)(11)
F0465-Safe/functional/sanitary/comfortable Environ-483.70(h)
The most serious deficiencies in the facility during the October 17, 2014 visit were found to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H), whereby corrections are required.
As a result of the revisit findings, the Category 1 remedy of State monitoring will remain in effect.
In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 8, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014, remain in effect. (42 CFR 488.417 (b))

The facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.
Furthermore, this Department recommended the following additional enforcement action to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F309, effective October 17, 2014 (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F314, effective October 17, 2014 (42 CFR 488.430 through 488.44

Refer to the CMS 2567b, CMS 2567 along with the facility's plan of correction for the results of this visit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 29, 2014

Mr. William Eckblad, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535025, S5535027

Dear Mr. Eckblad:

On July 8, 2014, CMS Region V Office, informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014. (42 CFR 488.417 (b))

In addition, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

On August 28, 2014, this Department inform you that the following enforcement remedy was being imposed:

- State Monitoring effective September 2, 2014. (42 CFR 488.422)

This was based on deficiencies cited by this Department for a standard survey completed on May 22, 2014, a comparative Federal Monitoring Survey (FMS) completed on June 27, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on August 12, 2014. The most serious deficiencies at the time of the PCR were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 17, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 12, 2014. At the time of the PCR an extended survey was conducted and determined conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. We presumed based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2014.

Based on our revisit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant our PCR, completed on August 12, 2014. The deficiencies not corrected pursuant to our PCR conducted October 13, 14, 15, 2014 and the extended survey conducted October 16 and 17, 2014 are as follows:

F0279 -- S/S: E -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: G -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: H -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

At the time of our PCR and extended survey, the following deficiencies were identified:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)
F0241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality
F0272 -- S/S: D -- 483.20(b)(1) -- Comprehensive Assessments
F0276 -- S/S: E -- 483.20(c) -- Quarterly Assessment At Least Every 3 Months
F0281 -- S/S: D -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards
F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
F0356 -- S/S: C -- 483.30(e) -- Posted Nurse Staffing Information
F0490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being
F0496 -- S/S: F -- 483.75(e)(5)-(7) -- Nurse Aide Registry Verification, Retraining
F0497 -- S/S: F -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice

In addition, this Department conducted the revisit related to the FMS. The deficiencies not corrected are as follows:

F0279-Develop Comprehensive Care Plans-483.20(d), 483.20(k)(1)
F0282-Services By Qualified Persons/per Care Plan-483.20(k)(3)(ii)
F0309-Provide Care/services For Highest Well Being-483.25
F0520-Qaa Committee-Members/meet Quarterly/plans-483.75(o)(1)

Furthermore, at the time of the FMS PCR the following deficiencies were identified:

F0157-Notify Of Changes (injury/decline/room, Etc)-483.10(b)(11)
F0465-Safe/functional/sanitary/comfortable Environ-483.70(h)

The most serious deficiencies in your facility during the October 17, 2014 visit were found to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of State monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 8, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014, remain in effect. (42 CFR 488.417 (b))

As CMS Region V Office notified you in their letter of July 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

Furthermore, this Department is recommending the following additional enforcement action to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F309, effective October 17, 2014 (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F314, effective October 17, 2014 (42 CFR 488.430 through 488.444)

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

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

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of

care. Therefore, Jourdain Perpich Extended Care Facility is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective August 22, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 22, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 November 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions related to this eNoice

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 10/13/14, 10/14/14, 10/15/14, 10/16/14, and 10/17/14, to determine compliance with Federal deficiencies issued during a resurvey exited on 8/12/14. During this visit substandard quality of care was noted at F314 related to failure to provide appropriate pressure ulcer treatment and 3 residents sustained harm as result of the non-compliance. An extended survey was conducted by the Minnesota Department of Health on 10/16/14-10/17/14.	{F 000}		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		11/18/14

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

Electronically Signed | 11/07/2014

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician was notified of a change in condition related to wound development for 1 of 1 resident (R4) in the sample who had a wound develop on the right great toe and third toe that was not identified and reported to the physician to ensure appropriate treatment was provided. Findings include: R4's Cumulative Diseases Index Report dated 2/12/14, indicated R4's diagnoses included diabetes, anemia, blindness, alcohol induced persisting amnesic disorder, chronic kidney disease, edema and a history of non-compliance with medical treatment which presented hazards to his health. R4's quarterly Minimum Data Set (MDS) dated 7/4/14, indicated R4 had impaired cognition and physical and verbal behavioral symptoms that significantly interfered with his cares. The MDS also indicated R4 had diabetic foot ulcers. (A quarterly MDS should have been completed by 10/4/14, however, it was not completed and the	F 157	R4 has had family and physician notifications completed to wound on great toe. The quarterly MDS that was due on 10/4/14 has been completed and submitted. A policy and procedure for Resident Change of Condition Notifications has been reviewed by the Medical Director. Staff have had training on the policy/procedure for Resident Change of Condition Notifications. The DON or designee will be responsible for audits for compliance conducted daily x 2weeks, weekly x4 weeks and monthly x 2 months. Audit results will be reviewed by the QA Committee and action plans developed as needed to maintain compliance. ADDENDUM F157 11/10/14 MD will be notified via phone or fax within 24 hours of any pressure or non-pressure related skin condition as stated in the policy for timely notification of change of condition. Family will be notified via telephone by the licensed staff within 24	

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F 157	Continued From page 2 data was not available). Review of R4's medical record revealed missing or a lack of documentation related to skin issues and ulcers. R4's physician progress notes on 8/14/14, indicated R4 had a new ulcer on the dorsum of the left second toe which was to be treated with Bactroban and dry dressings daily. R4's physician rounding note dated 9/22/14, had not mentioned any issues related to open skin wounds. The rounding note identified stasis dermatitis on bilateral lower extremities with hyperpigmented skin from stasis dermatitis. R4's physician orders dated 9/22/14, identified the following orders: Una boot to right leg as needed for swelling. A&D ointment to bilateral lower extremities twice a day. Left second toe apply Bactroban, cover with gauze dressing and change BID (twice a day) until resolved. Wash legs daily and apply moisturizing cream BID. R4's nurse progress notes and wound documentation from 9/1/14-10/14/14, revealed the following: -on 9/20/14, licensed practical nurse (LPN)-C documented R4 had two new wounds on toes and one wound on right big toe. The registered nurse (RN) to assess. Wounds cleansed and A&D ointment, gauze applied and Koban. R4's left plantar toe has a skin tear 3.0 centimeters (cm) in length and 3.0 cm in width, area cleansed, A&D ointment, gauze applied and wrapped with Koban. -on 9/24/14, RN documentation indicated R4's wound dressing was changed, however, the note	F 157	hours and all notifications will be documented in the medical record. Staff has been educated on 11/13/14 of this policy and procedure. Daily audits will be completed during daily stand-up during the week and the charge nurse will review on weekends and provide oversight for those residents that have new or changing pressure or non-pressure related wounds.	

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F 157	Continued From page 3	F 157		

did not identify which dressing was changed or where it had been.

R4's medical record lacked indication the physician was notified of the wound on the right great toe or indication of a management plan related to this wound which had developed.

The wound book documentation from 9/1/14-10/14/14 was reviewed and there was no documentation related to R4 having open wounds on the right foot, nor any treatment implemented.

On 10/16/14, at approximately 10:50 a.m. RN-B confirmed R4 had a history of foot wounds, however, stated he was unsure if he had any new or current ones.

On 10/16/14, at 10:53 a.m. nursing assistant (NA)-C stated on this past Monday R4 had a sore on his right toe and the scab had fallen off during his bath. NA-C stated the wound appeared red and had started to bleed "a little bit." NA-C stated she had not notified a nurse regarding the wound.

On 10/16/14, at 11:03 a.m. RN-C stated as of two weeks ago R4's skin was intact, free from sores. RN-C stated she was totally unaware R4 had a new wound on his foot or a scab had fallen off during his bath.

On 10/16/14, at 11:44 a.m. RN-C stated R4 did not have any pressure sores and had a history of diabetic foot ulcers. RN-C also stated R4's skin was currently intact, free of any sores. RN-C stated staff continued to monitored the tip of R4's right toes for open areas and were directed to notify the physician should they open up.

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F 157	Continued From page 4 On 10/16/14, at 1:46 p.m. the director of nursing (DON) stated she was not sure when R4's right great toe and third toe wounds had occurred because R4's medical record had not identified any feet related skin issues. The DON confirmed the physician was not notified of R4's right foot wounds so appropriate treatment could be initiated. The DON stated she would have expected the licensed nurses to notify the physician of the wounds. A policy for notification to the physician was requested from the DON but was not provided. On 10/16/14, at approximately 2:00 p.m. the facility provided a picture of R4's right great toe dated 10/16/14, which revealed an open ulcer the approximate size of a pea on the dorsal surface of the right great toe. On 10/17/14, at 9:33 a.m. R4 was observed seated on the edge of the bed and was interviewed. During the interview R4's right great toe was observed to have a pea size open ulcer and the third toe of the right foot was macerated and bloody. It was noted that there was an apparent circulation problem with the right lower extremity as the leg was purple in color. There was no dressing on the right great toe or right foot 3rd toe wound.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		11/18/14

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F 241	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure respect and dignity was promoted for 1 of 1 resident (R4) in the sample who was observed repeatedly calling out for transferring assistance without being provided assistance as requested. Findings include: R4's Cumulative Diseases Index Report dated 2/12/14, indicated R4's diagnoses included diabetes, anemia, blindness, alcohol induced persisting amnesic disorder, chronic kidney disease, edema and a history of non-compliance with medical treatment which presented hazards to his health. R4's quarterly Minimum Data Set (MDS) dated 7/4/14, indicated R4 had impaired cognition, highly impaired vision and physical and verbal behavioral symptoms that significantly interfered with cares. The MDS also indicated R4 required maximum assistance of two staff for transfers and bed mobility. R4's care plan dated 10/6/14, revealed no planned interventions related to R4 being unable to use a call light and developing a plan to assist R4 in summoning staff in another manner rather than repeatedly yelling from his bedroom. On 10/14/14, at 8:40 a.m. R4 was observed dressed, seated in the wheelchair with breakfast. -at 9:00 a.m. R4 was heard yelling from his room	F 241	R4 has been reassessed for the type of device he can utilize to notify staff he needs assistance. The care plan has been updated to reflect his current needs. Staff have been re-educated on the importance of meeting the residents needs/requests in a timely manner. A policy/procedure for Call Light Response Time has been reviewed by the Medical Director. Staff have been educated on the Resident Bill of Rights and the Policy for Call Light Response Time. The DON or designee will be responsible for audits for call light placement and timely response to the residents request daily x 2 weeks, weekly x 4 weeks and monthly x 2 months. Audit results be reviewed by the QA Committee and action plans developed as needed to maintain compliance. ADDENDUM F241 11/10/14 Resident R4 has had his communication and behaviors reassessed by the SW and a care plan developed to better meet his needs. Staff will be educated on the behavior plan and interventions added to the NAR care sheet on 11/13/14. All other residents that this may affect will have their behavior reassessed and monitored by Social Services beginning with those that have difficulty in communication of needs and then those residents with the most challenging	

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	245535	A. BUILDING _____ B. WING _____	R 10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 241	Continued From page 6 "hey hey hey!" R4 could be heard repeating this throughout two of the nursing units approximately 75 feet away. - At 9:37 a.m. continued to holler out from his room. R4 was observed in his room seated in the wheelchair. R4 was asked by the surveyor what he wanted and he clearly stated he wanted to go to bed. R4 did not have his call light available. At that time this surveyor reported to nursing assistant (NA)-C that R4 was yelling from his room for assistance because he wanted to go to bed. NA-C stated, "OK I will take care of it." -at 9:47 a.m. R4 had continued to repeatedly yell from his room and this surveyor again went down to his room and observed R4 had remained seated in the wheelchair with no call light available. R4 again stated he wanted to go to bed. At that time this surveyor reported to NA-B that R4 was yelling from his room because he wanted to go to bed. NA-B stated, "OK I will find someone to help." -at 9:57 a.m. R4 continued to repeatedly yell out from his room and again stated he wanted to go to bed. This surveyor reported to trained medication aide (TMA)-A that R4 had been yelling from his room for over an hour that he wanted assistance to go back to bed and this surveyor had asked two other nursing assistants to assist R4 without success. -at 10:05 a.m. TMA-A and NA-C assisted R4 to bed in which R4 was observed to rest and remain quiet. No further yelling was heard. On 10/14/14, at 10:05 a.m. NA-B stated the NAs were working short of help and that was the reason R4 did not receive timely assistance back to bed. On 10/14/14, at 11:13 a.m. R4 was again heard	F 241	behaviors. Care plans and NAR care sheets will be updated with interventions to use for challenging behaviors. All will be completed within the next 30 days by 12/10/14. Daily audits on varying shifts will be completed by an assigned nurse to observe for any resident with verbal calling out issues and results will be documented on the audit tool and forwarded to the IDT for review and adjustment to plan of care. Immediate intervention will be implemented by the nurse when needed. ADDENDUM 2 F241 Staffing levels are monitored daily to ensure there are enough staff available to respond to resident needs. Please refer to F353 for revised staffing plans.	

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F 241	Continued From page 7 yelling from his bedroom "Hey Hey Hey I want to go to bed." R4 was heard to repeatedly yell this until 11:46 a.m. when R4 was assisted back to bed. R4 was observed to remain quiet after being assisted to bed. Review of the resident council meeting minutes dated 5/30/14, revealed the following:"Residents would like staff to know how 'disturbing' it is for them to hear other residents calling out for help and make loud sounds. Residents request for staff to help these people right away so they don't have to hear that." On 10/15/14, at 1:04 p.m. the director of nurses (DON) stated R4 was blind and did not use a call light to summon for assistance, rather R4 would yell from his room to obtain needed assistance. The DON stated the goal for providing assistance when residents summoned for assistance with a call light was less than 10 minutes. The DON confirmed that allowing a resident to repeatedly yell for assistance for longer than an hour was not respectful nor dignified treatment. The DON stated she thought he facility staff had gotten used to R4 repeatedly yelling for assistance and because it happened so frequently the staff started to ignore the loud yelling R4 used to summon assistance. A policy and procedure related to the timeliness of staff assistance or dignified treatment was requested, but not provided.	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		11/18/14

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F 272	Continued From page 8 reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 272	The facility will conduct initially and	

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F 272	Continued From page 9 facility failed to complete a comprehensive Minimum Data Set (MDS) within 366 days from the last comprehensive assessment or after admission to the facility as required for 3 of 3 residents (R2, R24, R59) who were due for a comprehensive MDS. Findings include: R2 had a significant change MDS assessment completed on 10/1/13. R2's comprehensive MDS assessment was due to be completed on 10/2/14, and as of 10/15/14, it had not been competed (13 days past due). R24's comprehensive MDS assessment was due 9/20/14, and as 10/15/14, it had not been competed (25 days past due). R59 was admitted to the facility on 6/16/14. As of 10/15/14, a comprehensive MDS assessment had not been completed (107 days past due). On 10/15/14, at 10:07 a.m. registered nurse (RN)-B (MDS nurse) confirmed R59 did not have a current comprehensive MDS completed and knew he was behind on some of the quarterly and comprehensive MDS assessments. On 10/17/14, at 3:21 p.m. the director of nursing (DON), with the Administrator present, verified they had been aware for over a year that the facility was behind on the completion and submission of the MDS assessments. On 10/20/14, at 9:57 a.m. a telephone interview	F 272	periodically a comprehensive, accurate, standardized reproducible assessment for each resident's functional capacity. Residents R2, R24, and R59 have had a comprehensiveMDS assessment completed and submitted to CMS. All other residents affected by this practice have had MDS's scheduled, completed and submitted per policy and procedure. The policy and procedure for comprehensive MDS assessments has been reviewed and updated as needed. A system for scheduling and maintenance of the MDS process has been implemented. The MDS RN has been educated on November 13th on the scheduling and completion process per CMS guidelines. The DON or designee will be responsible for auditing of MDS completion per the schedule weekly for 4 weeks then monthly for 3 months. Audit results will be reported to the QA Committee and action plans developed as needed to ensure compliance. ADDENDUM F272 11/10/14 The problem with the MDS completion occurred when the previous NHA terminated the previous MDS coordinator without a plan in place to carry the system forward. The DON will meet with the MDS coordinator weekly to review the schedule and plan for the week. The DON will then review all validation reports on all submissions and match it against the schedule to ensure all required MDS's have been completed, submitted and been accepted by CMS. An auditing tool has been created denoting the entire	

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F 272	Continued From page 10 was conducted with the facility MDS consultant. The MDS consultant stated she was aware of the number of MDSs the facility was behind on in completing. She stated she made a weekly list of all the MDSs the facility was behind on and would give it to the DON. The consultant stated the DON would respond by stating, "We know, we know." The facility's policy [untitled] dated 6/12/14, directed staff to complete the comprehensive assessment on any new resident with seven days of admission, quarterly and yearly. The purpose of the policy was to gather resident information, initiate a care plan and complete the required assessment instruments including the MDS. The facility's Electronic Transmission of the MDS policy [undated] indicated all MDS assessments would be completed and electronically submitted in accordance with current federal and state regulations. The facility's MDS Completion and Submission Timeframes policy [undated] indicated the facility would conduct and submit resident assessments in accordance with current federal and state submission time frames. These time frames were specifically outlined in the policy.	F 272	census and the planned required MDS's. In addition, at the newly implemented daily IDT/stand-up team meetings, a review of the 24 hour board is in place for any significant changes and if needed this MDS will be added to the schedule. The Melyx computer software system will be utilized to review scheduling and planning for the future. Contingency planning for a secondary MDS RN will be facilitated by the DON. Presently, an RN nurse consultant is assisting the facility with MDS coordination and completion.	
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	F 276		11/18/14

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F 276	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive Minimum Data Set (MDS) re-assessment for 10 of 10 residents (R38, R22, R46, R44, R42, R4, R14, R31, R21, R25) residing in the facility who were due for a comprehensive re-assessment. Findings include: R38's comprehensive MDS re-assessment was due on 9/10/14, as of 10/15/14, it had not been completed (35 days past due). R22's comprehensive MDS re-assessment was due on 9/16/14, as of 10/15/14, it had not been completed (29 days past due). R46's comprehensive MDS re-assessment was due on 9/16/14, as of 10/15/14, it had not been completed (29 days past due). R44's comprehensive MDS re-assessment was due on 9/27/14, as of 10/15/14, it had not been completed (18 days past due). R42's comprehensive MDS re-assessment was due on 9/29/14, as of 10/15/14, it had not been completed (16 days past due). R4's comprehensive MDS re-assessment was due on 10/4/14, as of 10/15/14, it had not been completed (11 days past due). R14's comprehensive MDS re-assessment was due on 10/8/14, as of 10/15/14, it had not been completed (7 days past due).	F 276	The facility will assess each resident using the quarterly review instrument specified by the state and approved by CMS not less frequently that at least every 3 months. Residents R38, R22, R46, R44, R42, R4, R14, R31, R21, and R25 had a quarterly MDS completed and submitted to CMS. the policy and procedure for scheduling and completion of quarterly MDS's has been reviewed and revised to reflect current standards. The MDS RN has educated on November 13th on the scheduling and completion of quarterly MDS's. The DON or designee will be responsible for auditing for quarterly MDS completion weekly for 4 weeks and then monthly for 3 months. Audit results will be reported to the QA committee and action plans developed as needed to ensure compliance. ADDENDUM F276 11/10/14 The problem with the MDS completion occurred when the previous NHA terminated the previous MDS coordinator without a plan in place to carry the system forward. The DON or designee will meet with the MDS coordinator weekly to review the schedule and the plan for the week. The DON or designee will then review all validation reports on all submissions and match it against the schedule to ensure all required MDS's have been completed, submitted and been accepted by CMS. An auditing tool has been created	

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F 276	Continued From page 12 R31's comprehensive MDS re-assessment was due on 10/11/14, as of 10/15/14, it had not been completed (4 days past due). R21's comprehensive MDS re-assessment was due on 10/11/14, as of 10/15/14, it had not been completed (4 days past due). R25's comprehensive MDS re-assessment was due on 10/12/14, as of 10/15/14, it had not been completed (3 days past due). On 10/15/14, at 10:07 a.m. registered nurse (RN)-B (MDS nurse) confirmed he was behind on some of the quarterly and comprehensive MDS assessments. RN-B provided a Standard Schedule Due Report which identified the residents whose comprehensive re-assessment MDS were overdue. On 10/17/14, at 3:21 p.m. the director of nursing (DON), with the Administrator present, verified the facility had been aware they have been behind on the completion and submission of the MDS assessments for over a year. On 10/20/14, at 9:57 a.m. a telephone interview was conducted with the facility MDS consultant. The MDS consultant stated she was aware of the number of MDSs the facility was behind on in completing. She stated she made a weekly list of all the MDSs the facility was behind on and would give it to the DON. The consultant stated the DON would respond by stating, "We know, we know." The facility's policy [untitled] dated 6/12/14, directed staff to complete the comprehensive assessment on any new resident with seven days of admission, quarterly and yearly. The purpose	F 276	denoting the entire census and the planned required MDS's. In addition, at IDT/stand-up team will review the 24 hour reports for any significant changes and if needed this MDS will be added to the schedule. The Melyx computer software system will be utilized to review scheduling and planning for the future. Contingency planning for a secondary MDS RN will be facilitated by the DON. Presently, an RN nurse consultant is assisting the facility with MDS coordination and completion.	

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F 276	Continued From page 13 of the policy was to gather resident information, initiate a care plan and complete the required assessment instruments including the MDS. The facility's Electronic Transmission of the MDS policy [undated] indicated all MDS assessments would be completed and electronically submitted in accordance with current federal and state regulations. The facility's MDS Completion and Submission Timeframes policy [undated] indicated the facility would conduct and submit resident assessments in accordance with current federal and state submission time frames. These time frames were specifically outlined in the policy.	F 276		
{F 279} SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	{F 279}		11/18/14

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{F 279}	Continued From page 14 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the written care plan included appropriate interventions for monitoring 24 hour fluid intake for 3 of 3 residents (R59, R46, R61) receiving dialysis. In addition, the facility failed to develop a behavior care plan which included target behaviors for 1 of 3 residents (R38) reviewed for antipsychotic medications. Findings include: R59 was on a 1500 milliliter (ml) 24 hour prescribed fluid restriction and her comprehensive care plan did not direct staff to daily total and monitor the 24 hour intake. R59's care plan dated 6/24/14, identified R59's diagnoses as congested heart failure (decrease in heart function to pump blood), diabetes, hypertension (high blood pressure), open wound on buttock and on 9/3/14, a new problem area of chronic kidney disease with renal dialysis was added. The care plan also identified a problem with nutrition and potential for fluid overload. The approaches identified on 9/3/14, included intake and output monitoring and a 1500 ml fluid restriction with delineation of the fluid distribution for 60 ml to be given with medications and 420 ml with each meal. However, the care plan lacked direction for staff to total the fluid intake daily and what approaches to do if R59 should exceed the 1500 ml/day restriction.	{F 279}	The facility will use the results of the assessment to develop, review and revise the resident's comprehensive care plan to include measurable goals and timetables to meet the resident's medical, nursing and mental and psychological needs that have been identified in the comprehensive assessment. Residents R59, R46, and R61 have had their care plans updated to include appropriate interventions for monitoring of 24 hour fluid intake. Resident R38 has had their care plan updated to include target behaviors for the use of antipsychotic medications. All other residents affected by this practice have had their care plans reviewed and updated to reflect monitoring of 24 hour fluid intake and those residents currently having orders for antipsychotic medications will have their care plan updated to reflect target behaviors. The professional nursing staff and the IDT have been trained on November 13th on care plan updating to reflect resident's current assessed needs per the comprehensive assessment. The DON or designee will be responsible for auditing 3 care plans per week for 4 weeks then 2 monthly for 3 months to ensure care plan is current for 24 hour fluid monitoring and target behaviors. Audit results will be reports to the QA Committee and action plans developed as	

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{F 279}	Continued From page 15 R59's Physician Orders & Progress Notes dated 9/12/14, indicated R59 was on a 1500(ml)/24 hour fluid restriction and staff were directed to monitor intake and output (I&O). On 10/16/14, at 10:35 a.m. the DON confirmed her expectations were that the staff would follow the individual care plan for R59 and as changes were needed the care plan should be reassessed and updated to meet the needs of the resident. R46 was on a prescribed 1500 cubic centimeter (cc) daily fluid restriction and the facility had not developed care plan interventions which addressed monitoring of R46's daily fluid intake. R46's Admission Face Sheet indicated R46 was diagnosed with end stage renal disease (ESRD) secondary to chronic kidney disease, type II diabetes mellitus, intercerebral hemorrhage and cerebrovascular disease. R46's care plan last revised on 9/23/14, indicated a 1500 cc fluid restriction with 420 cc fluid allowed with each meal, 80 cc with each med pass, was to have no water pitcher at bedside and fluid with meals and evening as fluid restrictions allowed. R46's physician orders revealed on 12/18/13, the physician ordered a 1500 cc per day fluid restriction due to chronic kidney disease and need for hemodialysis.	{F 279}	needed to ensure compliance.	

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{F 279}	Continued From page 16 R46's Treatment Administration Records (TAR) from 10/3-10/13, revealed daily total fluid intake was not calculated and monitored consistently. The revealed R46's total daily fluid intake had not been calculated on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/11, and 10/12/14, (8 of 10 days since the date of correction on 10/3/14.) On 10/14/14, R46's intake was noted to have been 1620 cc (120 cc over the fluid restriction). There was no evidence that action was taken related to the excess fluid intake on 10/14/14. On 10/15/14, at 10:30 a.m. the DON confirmed R46's care plan did not identify how the daily total fluid intake was going to be monitored. R61 was on a prescribed 1500 cc fluid restriction in which staff did not monitor or calculate total daily fluid intake. R61's Admission Face Sheet indicated R61 was diagnosed with end stage renal disease (ESRD). R61's physician orders revealed on 8/5/14, the physician ordered a 1500 cc per day fluid restriction due to chronic kidney disease and need for hemodialysis. R61's TAR 10/3-10/13/14, revealed that daily total fluid intake had not been calculated and monitored consistently. R61's total daily fluid intake was not calculated on 10/3, 10/4, 10/5,	{F 279}		

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{F 279}	Continued From page 17 10/6, 10/7, 10/8, 10/9, 10/10,10/11, and 10/13/14, (10 of 10 days since the date of correction on 10/3/14.) R61's care plan dated 8/19/14, revealed R61 was on a 1500 cc fluid restriction. However, the care plan had not delineated how much fluid each discipline would provide R61 (i.e.. dietary, nursing, activities) nor who would be responsible for monitoring the 24 hour total fluid intake. On 10/15/14 at 12:53 p.m. the DON the care plan had not delineated how much fluid each discipline would provide nor who would be responsible for monitoring the 24 hour total fluid intake. The Intake, Measuring and Recording policy [undated], specified as its purpose to accurately determine the amount of liquid a resident consumed in a 24 hour period. The Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs. R38 had observable behaviors and the facility failed to develop a care plan to include identification of target behaviors. R38's Face Sheet dated 2/2/14, identified R38 was diagnosed with an intracranial injury, traumatic brain injury and a subarachnoid hemorrhage.	{F 279}		

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{F 279}	Continued From page 18	{F 279}		

R38's nurse notes for 9/14, (none for October) revealed R38 had behaviors which consisted of banging his head on head board, yelling and swearing at the staff, kicking and biting the staff, throwing objects in the dining room, disrobing and voiding in inappropriate places. The notes also revealed R38 had psychotropic medication changes 9/14 and was followed by a psych professional.

R38's care plan dated 12/20/14, indicated R38 moved self from his bed onto the mattress that laid next to his bed and required hourly safety checks. The care plan also indicated R38 would crawl out into the hallway and call out for help. The head board of the bed was removed due to an injury hazard due to R38 kicking and hitting. The care plan directed staff to document behaviors and interventions as they occur. No target behaviors were indicated.

On 10/15/14, at 10:10 a.m. R38 was observed in a low bed anxiously moving about, banging on the side rails and slapping his hand on the bed.

On 10/15/14, at 1:50 p.m. R38 was observed in bed restlessly moving about. The wall above R38's head board was observed with shredded wallpaper and deep gouges which exposed plaster.

On 10/16/14, at 8:36 a.m. R38 was observed in bed watching TV. When attempts were made to communicate with R38 he appeared to attempt to verbally communicate then threw his pillow on the floor and quickly scooted self off his bed onto a

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{F 279}	Continued From page 19 mattress which laid on the floor next to his bed, retrieved the pillow and put it back up onto his bed. On 10/16/14, at 9:16 a.m. R38 was observed in bed with no incontinent product / underwear on. R38's penis was exposed and he was openly touching himself and periodically saying "f---, f----, f---." The door to R38's room was open and R38 was visible to all who passed by his room. On 10/15/14, at 10:20 a.m. registered nurse (RN)-C confirmed R38 had a traumatic brain injury. When asked what inappropriate behavior R38 displayed RN-C stated he would swear stating " f---, f---, f---." RN-C stated R38 was not physically abusive but would pull at his bed and scratch at the walls and also would remove his incontinent product and throw it about his room. On 10/16/14, at 10:05 a.m. the DON verified R38 had behaviors which consisted of hitting, biting, throwing objects and scooting self out in the hall without appropriate clothing on. The DON confirmed R38's target behaviors were not addressed on his care plan and they should have been. The Comprehensive Care Plan Development & Review policy dated 9/2/14, indicated the comprehensive care plan should be a dynamic tool, changing with changes in the resident's status and these changes should be documented and addressed in the medical record.	{F 279}		

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F 281	Continued From page 20	F 281		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a temporary admission/ initial care plan to include current pressure ulcers and identification/care of a right chest dialysis catheter for 1 of 1 (R62) newly admitted residents. Findings include: R62's 24 Hour-Vital Sign Record indicated R62 was admitted to the facility on 10/2/14. R62's Discharge Summary dated 10/2/14, indicated R62's diagnoses included two pressure ulcers, diabetes, chronic kidney disease with dialysis treatments via a portacath (a small medical appliance that is installed beneath the skin in which a catheter connects the port to a vein). R62's Admission/Readmission Care Plan was undated and blank. The undated nursing assistant (NA) worksheet lacked identification of the pressure ulcers and dialysis catheter placement nor care of the catheter site. R62's October Medication Administration Record indicated R62 received dialysis via a right chest portacath and a wound treatment order to be completed every other day. On 10/15/14, at 9:29 a.m. R62 stated she had	F 281	The facility will provide services that meet professional standards of quality. Resident R62 has had a comprehensive care plan developed following the comprehensive assessments and the MDS completion to include pressure ulcers and their care and treatment and identification and care of the right chest dialysis catheter. All other newly admitted residents have had a temporary care plan developed based on observation, interview and document review to direct care and treatment until the comprehensive assessment process is completed and the comprehensive care plan is developed per the RAI process. The policy and procedure for temporary care plan upon admission has been reviewed and revised as needed to meet the current standards of quality. Professional nursing staff have been educated on November 13th on development of a temporary care plan upon admission that will direct quality care for each individual resident. the DON or designee will audit all new admission temporary care plans weekly for 2 months and monthly for 3 months. Audit results will be reported to the QA	11/18/14

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F 281	Continued From page 21 sores on her hip. On 10/15/14, at 9:45 a.m. registered nurse (RN)-C was observed to provide R62's wound treatment. An approximate quarter size stage two (partial thickness skin loss involving epidermis, dermis or both) and an approximate dime size stage two ulcer was observed on the right lower, mid buttock. On 10/15/14, at 1:03 p.m. trained medication aide (TMA)-A stated she was unaware of a formal initial or temporary care plan. On 10/15/14, at 1:07 p.m. licensed practical nurse (LPN)-A verified an initial care plan was not developed for R62 nor did the NA cheat sheet identify the portacath or pressure wounds. On 10/15/14 at 2:39 p.m. RN-B stated an admission / initial care plan was to be developed as soon as a resident was admitted to the facility. RN-B verified R62 had a portacath and pressure ulcer and stated he would expect to see both the identification and care of the portacath along with any skin conditions on the initial care plan. RN-B confirmed R62 did not have an initial care plan developed and stated it was not completed. On 10/15/14, at 3:00 p.m. R62 was observed receiving dialysis. A portacath was observed on R62's right chest. The dialysis RN stated the dialysis staff changed R62's portacath dressing, however, stated the nursing home staff should monitor the site for dislodgement and bleeding while R62 was at the nursing home. On 10/16/14, at approximately 12:00 p.m. the director of nursing stated the facility did not have a policy and procedure related admission temporary/initial care plans.	F 281	Committee and action plans developed as needed to ensure compliance. ADDENDUM F281 11/10/14 The facility is currently not taking admissions to the facility. Once the admissions begin again, the temporary care plan will be audited within 48 hours of admission by the DON or designee to ensure compliance. Staff will be re-educated/coached/disciplined as needed as audit results dictate.	
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	{F 282}		11/18/14

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{F 282}	Continued From page 22 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the written care plan related to wound assessment and measurement for 2 of 2 residents (R59, R42) who had a pressure ulcer. Findings include: R59 had a stage 4 pressure ulcer (ulcer with full thickness loss of tissue with exposed bone, tendon or muscle) which had increased in size and was not monitored and measured according to her care plan. R59's care plan dated 6/24/14, identified R59's diagnoses as congested heart failure (decrease in heart function to pump blood), diabetes, open wound on buttock and on 9/3/14, a new problem area of chronic kidney disease with renal dialysis was added. R59's care plan also identified impaired skin integrity with a goal for R59's coccyx wound to decrease in size by 1.0 cm in the next 90 days. R59's care plan directed staff to photograph and measure the coccyx wound every two weeks and document this information. On 10/14/14, at 11:10 a.m. upon the surveyors request, the director of nursing (DON) measured and confirmed R59's coccyx wound measurements were 5.0 centimeters (cm) in	{F 282}	The services provided or arranged by the facility will be provided by qualified persons in accordance with each residents written plan of care. Resident R59 and R42 have had their care plans reviewed and updated with current status of pressure ulcers and their care and treatment. Nursing assistant assignment sheets have been updated as needed to reflect current care needs. All other residents with current pressure areas have had their care plans reviewed and updated as needed and nursing assistant assignment sheets updated to reflect current care needs. The policy and procedure for following the plan of care has been reviewed and updated as needed. Professional nursing staff and nursing assistants have been educated on November 13th on the policy and procedure for follow through on the plan of care ant treatment of pressure ulcers. The DON or designee is responsible for auditing that care plans are being followed related to pressure ulcer care and treatment per policy and procedure. Through direct observation audits will be completed on 5 residents with pressure ulcers to observe that the care plan	

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{F 282}	Continued From page 23 length, 5.0 cm in width and 1.5 cm in depth with 0.5 cm of undermining (separation of tissue from the surface on the edge of a wound) at the eleven o'clock through 1 o'clock area of the wound. The wound had a moderate amount of exudate (drainage) and slough (dead tissue). The DON stated the wounds were to be measured weekly by facility staff. The Photographic Wound Documentation Form dated 8/13/14, identified R59 as having a stage 4 wound which measured 4.1 cm in length, 3.4 cm in width and a depth of 1.5 cm. with undermining of 1.5 cm at 12 o'clock, 1.2 cm at 3 o'clock and 0.9 cm at 9 o'clock. The DON confirmed an assessment, measurements and photo of R59's wound was last completed on 8/13/14 (63 days ago). R59's nursing notes (NN) reviewed from 8/13/14, until 10/15/14, lacked consistent documentation of the assessment, measurement and monitoring of the coccyx wound. - on 9/3/14, NN indicated the wound was measured and determined to be 5.6 cm length, 5.4 cm in width, and 1.7 cm in depth. -on 9/11/14, NN indicated the coccyx area dressing was changed and the wound was noted to have some light green drainage and odor. On 10/14/14, at 1:30 p.m. the DON confirmed she didn't know why there was a gap in documentation with regards to the assessment, measurement and photographing of R59's wound between 8/13/14, when the last photograph of the wound was taken, till today when the DON measured the wound, however no photograph was taken. The DON verified the wound had increased in size from the 8/13/14, date to the	{F 282}	interventions are being followed weekly for 2 months and monthly for 3 months. Audit results will be reported to the QA Committee and action plans developed as needed to ensure compliance. ADDENDUM F282 11/10/14 At least two observational audits will be conducted daily on rotating shifts for one month to observe for care being provided per the plan of care with a special focus on pressure ulcer prevention and treatment. Audit schedule will then be as stated above unless otherwise directed by the QA committee. The DON will review audits and re-educates, coaches, and disciplines clinical staff as needed.	

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{F 282}	Continued From page 24 measurement which had been done that day. On 10/16/14, at 10:35 a.m. DON confirmed her expectations were that the staff would follow the individual plan of care for R59. R42 had a stage 4 pressure ulcer and staff failed to consistently assess, monitor and implement interventions to assist with pressure ulcer healing as directed by the care plan. R42's Admission Face Sheet dated 5/28/14, identified R42's diagnoses included a stage 4 coccyx pressure ulcer, type II diabetes mellitus, sepsis and chronic anemia. R42's care plan dated 7/3/14, identified R42 had an alteration in skin integrity related to a coccyx ulcer and vulnerable area on right ankle. Interventions included the following: medication and treatments as ordered to coccyx and right ankle. Monitor for signs and symptoms of infection. Weekly skin checks, wound clinic as ordered. Photo documentation and measurements at least every 2 weeks. Air mattress on bed and pressure relief cushion on wheelchair. PRAFO (specialized splint devices for the lower extremities) bilaterally. The care plan did not address R42's repositioning plan. R42's wound clinic documentation dated 9/26/14, indicated R42's wound healing was complicated by diabetes, pressure, and stool incontinence with associated skin maceration. The wound on the sacrum measured 4.0 cm x 1.3 cm x 0.6 cm with circumferential undermining. There is a 1.7 cm tunnel at 5:00 o'clock. The wound clinic	{F 282}		

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{F 282}	Continued From page 25	{F 282}		

documentation identified the following plan: Hydrofera blue for the next month to help with bioburden. Heavy SensiCare application to sacrum and intergluteal cleft for skin barrier. Continue pressure alleviation efforts to her bottom. General surgery consult for colostomy if patient is interested. The written clinic referral for this visit on 9/26/14, identified "Patient needs Roho cushion [a specialized cushion that optimizes weight redistribution] ordered ASAP [as soon as possible]."

A comprehensive pressure ulcer assessment for R42 was requested, but was not provided by the facility. Registered Nurse (RN)-B who was responsible for the comprehensive assessments was interviewed on 10/15/14, at 2:55 p.m. stated that he was not sure that R42 had a comprehensive pressure ulcer assessment. RN-B provided a Care Area Assessment summary completed on 1/6/14, which identified R42 was at mild risk for skin breakdown, had a stage 4 ulcer to coccyx with dressing changes as ordered and a licensed nurse was to do a weekly skin assessment after baths and nursing assistants were to monitor skin with cares and report concerns to the nurse.

The Photographic Wound Documentation form dated 8/13/14, indicated R42 had a healing stage 4 pressure ulcer which measured 3.7 cm x 2.4 cm x 1.1 cm. The pressure ulcer had no exudate, the wound bed, wound edges and surrounding tissue / skin was normal. No further wound monitoring, assessment or documentation by the facility could be found in R42's medical record since 8/13/14.

On 10/14/14, at 9:13 a.m. R42 was observed in

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{F 282}	Continued From page 26 her room, seated in a wheelchair. R42 did not have a pressure redistribution cushion underneath the buttocks to minimize pressure. R42 was interviewed at this time and was asked how long she sat up in the wheelchair every day and how long it had been since she had a cushion to sit on while seated in the wheelchair. R42 stated she sat up in the wheelchair 3-4 times a day for over an hour each time and had not had a cushion in her wheelchair "for a long time." On 10/14/14, at 11:15 a.m. the DON confirmed R42's care plan should have been followed and measurements and pressure ulcer interventions including the pressure reducing cushion should have been implemented as directed. The DON also confirmed the last documentation from facility staff regarding R42's pressure ulcer assessment and measurements was completed on 8/13/14, (63 days ago). The Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs and that documentation must be consistent with the residents' plan of care.	{F 282}		
{F 309} SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		11/18/14

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{F 309}	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a non pressure related wound was appropriately assessed, monitored or treated for 1 of 3 residents (R4) in the sample reviewed for non pressure related skin issues. This deficient practice caused actual harm for R4. In addition, the facility failed to consistently monitor daily fluid intake for 3 of 3 residents (R46, R61, R59) who had chronic kidney disease, received dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R62) dialysis access catheter site nor develop a care plan to include interventions related to the monitoring and emergency care of the access site. Findings include: R4 had identified wounds on the right great toe and 3rd toe that had not been appropriately assessed, monitored and treated. R4's Cumulative Diseases Index Report dated 2/12/14, indicated R4's diagnoses included diabetes, anemia, non-compliance with medical treatment, blindness, alcohol induced persisting amnesic disorder, chronic kidney disease, edema and a personal history of non-compliance with medical treatment which presented hazards to health. R4's quarterly Minimum Data Set (MDS) dated 7/4/14, indicated R4 had impaired cognition with physical and verbal behaviors that significantly interfered with the resident's care. The MDS also indicated R4 had diabetic foot ulcers. (A quarterly MDS should have been completed by 10/4/14,	{F 309}	Each resident will receive the necessary care and services to attain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and care plan. Resident R4 has been reassessed for skin risk and all wounds have been assessed and treatment plan have been care planned per the assessment. Weekly wound measurements have been completed and the treatment and care plan have been adjusted as directed by the physician. Residents R46, R59 and R61 will have daily I&O monitored per policy and procedure. Care plans have been updated to reflect monitoring of fluid intake. Resident R62 has had the dialysis access catheter monitored per policy and the care plan has been updated to include monitoring and emergency care for the access site. All other residents that may be affected by these practices have had their care plans reviewed and updated to reflect current status. The policy and procedure for wound care and monitoring will be reviewed and updated to include weekly measurements, and the process of updating of care plan. The policy and procedure for I&O monitoring for residents on fluid restriction has been reviewed and revised as needed to include updating of care plans when	

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{F 309}	Continued From page 28 however, it had not been completed and the data was not available). R4's physician progress notes dated 8/14/14, indicated R4 had a new ulcer on the dorsum of the left second toe to be treated with Bactroban and dry dressings daily. A physician's rounding note dated 9/22/14, did not mention any issues related to open skin wounds. The rounding note indicated R4 had stasis dermatitis on bilateral lower extremities with hyperpigmented skin from the stasis dermatitis. Review of R4's physician orders dated 9/22/14, identified the following: Una boot to right leg as needed for swelling. A&D ointment to bilateral lower extremities twice a day. Left second toe apply Bactroban, cover with gauze dressing, change BID (twice a day) until resolved. Wash legs daily apply moisturizing cream BID. R4's nurse progress notes and wound documentation from 9/1/14-10/14/14, revealed the following: -on 9/20/14, licensed practical nurse (LPN)-C documented R4 had two new wounds on toes and one wound on right big toe. The documentation indicated the registered nurse (RN) was to assess. Wounds cleansed and A&D ointment, gauze applied and Koban. The note indicated R4's left plantar toe had a skin tear 3.0 centimeters (cm) in length and 3.0 cm in width, area cleansed, A&D ointment, gauze applied and wrapped with Koban. -on 9/24/14, RN documentation indicated R4's wound dressing was changed, however, the note did not identify which dressing was changed. There was no further documentation related to the foot wounds found in R4's progress notes nor was there an RN assessment of the wounds found in the medical record from 9/20/14-10/14/14. R4's medical record also	{F 309}	indicated. The policy and procedure for monitoring of dialysis access sites has been reviewed and revised as needed to include updating of care plans. All professional nursing staff have been educated on the policies and procedures for I&O monitoring, wound monitoring and dialysis site catheter site care and monitoring on November 13, 2014. This will include updating of care plans as needed with changes in condition. The DON or designee will be responsible for auditing 5 residents with one or more of these care issues weekly of 2 months then monthly for 3 months. Results will be reported to the QA Committee and further action plans developed as needed to ensure compliance. ADDENDUM F309 11/10/14 MD's have been contacted to obtain needed fluid restriction orders. Care plans have been updated and restrictions added to NAR care sheets. Daily audits of intake and output documentation for all four residents currently on dialysis, R46, R59, R61, and R62 will be conducted by licensed nurses on varying shifts to ensure fluid restriction is being monitored and totaled each day. Audits will be sent to the DON daily for needed follow-up and staff intervention based on observation and record review. At least two observational audits will be conducted by licensed nurses daily on rotating shifts for one month to observe for care being provided per the plan of care with a special focus on pressure ulcer prevention and treatment. Audit	

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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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{F 309}	Continued From page 29 lacked indication the physician had been notified of the wound on the right great toe, or any indication that a management plan related to the wound had developed. Review R4's Treatment Administration Record (TAR) was reviewed from 10/1/14-10/14/14. The TAR notes revealed the nurse was directed to perform a weekly skin integrity assessment and to provide diabetic nail care. There was no documentation to indicate this task had been completed at all during the month of October 2014. The wound book documentation from 9/1/14-10/14/14, was reviewed and there was no documentation related to R4 having an open wound on any toes, nor any treatment implemented. On 10/13/14, at 3:02 p.m. LPN-B who was responsible for the care of R4, stated R4 still had a foot ulcer on the left foot second toe, however, could not identify what treatment was provided for the wound. At 3:04 p.m. LPN-B stated she was mistaken, that R4 did not have any wounds on either foot and stated all of R4's wounds were currently healed, that nursing staff continued to monitor R4's right great toe, and that if the area on the toe opened up the physician would be notified. LPN-B then again stated R4 did not have any open foot wounds. At 3:06 p.m. R4 was asked if an observation of his feet could be made. R4 became upset and yelled for the surveyor and LPN-B to leave his room. R4's request was honored. On 10/16/14, at approximately 10:50 a.m. RN-B confirmed R4 had a history of foot wounds, however, stated he was unsure whether R4 had any new or current foot wounds. On 10/16/14, at 10:53 a.m. nursing assistant (NA)-C stated that this past Monday R4 had a	{F 309}	schedule will then be as stated above unless otherwise directed by the QA committee. Please refer to F314 for revised skin/pressure ulcer protocols. The DON will review audits and re-education, coaching, and discipline of staff as needed.	

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{F 309}	Continued From page 30	{F 309}		

sore on his right toe and that the scab had fallen off during his bath. NA-C stated the wound appeared red and had started to bleed "a little bit." NA-C stated she had not notified a nurse regarding the wound.
On 10/16/14, at 11:03 a.m. RN-C stated that as of two weeks ago R4's skin was intact and free from sores. RN-C stated she was totally unaware R4 had a new wound on his foot or that any scab had fallen off during his bath.
On 10/16/14, at 1:46 p.m. the director of nursing (DON) stated she was not sure when R4's right great toe and third toe wounds had occurred because R4's medical record did not identify any foot related skin issues. The DON confirmed the physician was not notified of R4's right foot wounds so appropriate treatment could be initiated. The DON stated she would have expected the licensed nurses to notify the physician of the wounds.
On 10/16/14, at approximately 2:00 p.m. the facility provided a picture of R4's right great toe dated 10/16/14, which revealed an open ulcer the approximate size of a pea on the dorsal surface of the right great toe.
On 10/17/14, at 9:33 a.m. R4 was observed seated on the edge of the bed and was interviewed. During the interview R4's right great toe was observed to have a pea size open ulcer and the third toe of the right foot was macerated and bloody. In addition R4's right lower extremity was observed to be purplish in color. There was no dressing on the right great toe or right foot 3rd toe wound.
DIALYSIS:
R46 was on a prescribed 1500 cubic centimeter (cc) fluid restriction and his daily fluid intake was not monitored.
R46's Admission Face Sheet indicated R46's

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{F 309}	Continued From page 31 diagnoses included end stage renal disease (ESRD) secondary to chronic kidney disease, type II diabetes mellitus, intercerebral hemorrhage and cerebrovascular disease. R46's physician orders indicated on 12/18/13, the physician ordered a 1500 cc per day fluid restriction due to chronic kidney disease and need for hemodialysis. R46's care plan last revised on 9/23/14, indicated R46's was on a 1500 cc fluid restriction and was to have 420 cc fluid with each meal, 80 cc with each med pass, no water pitcher at bedside and fluids with meals and evening as fluid restrictions allowed. R46's TAR from 10/3-10/13/14, revealed that daily total fluid intake was not calculated and monitored consistently. R46's total daily fluid intake was not calculated on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/11, and 10/12/14. On 10/14/14, R4's fluid intake was 1620 cc (120 cc over the fluid restriction). There was no evidence that action was taken related to the excess fluid intake on 10/14/14. On 10/15/14, at 10:30 a.m. the DON confirmed R46's total fluid intake was not totaled and monitored consistently. R61 was on a prescribed 1500 cc fluid restriction which was not consistently totaled and monitored and a plan for delineation of fluid provided by each department had not been developed. R61's Admission Face Sheet indicated R61 was diagnosed with ESRD.	{F 309}		

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{F 309}	Continued From page 32 R61's physician orders revealed on 8/5/14, an order for a 1500 cc per day fluid restriction due to chronic kidney disease and need for hemodialysis. R61's care plan dated 8/19/14, indicated R61 had a 1500 cc daily fluid restriction. However, the care plan had not delineated how much fluid each discipline would provide R61 (i.e.. dietary, nursing, activities) and who would be responsible for monitoring the 24 hour total fluid intake. R61's TAR records from 10/3-10/13/14, revealed that daily total fluid intake had not been calculated and monitored consistently. R61's total daily fluid intake had not been calculated on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, and 10/13/14. On 10/15/14, at 12:53 p.m. the DON confirmed R61's daily total fluid intake monitoring had not been completed and the care plan had not delineated how much fluid each discipline would provide or who would be responsible for monitoring the 24 hour total fluid intake. R59 was on a prescribed 1500 milliliter (ml) 24 hour fluid restriction and her 24 hour intake was not consistently totaled or monitored. R59's care plan dated 6/24/14, indicated R59's diagnoses included congested heart failure (decrease in heart function to pump blood), diabetes, hypertension (high blood pressure), open wound on buttock, a history of myocardial infarction (heart attack) and on 9/3/14, a new problem area of chronic kidney disease with renal dialysis was added. The care plan also indicated R59 had a problem with nutrition and a potential	{F 309}		

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{F 309}	Continued From page 33	{F 309}		

for fluid overload. The approaches identified on 9/3/14, included intake and output monitoring and a 1500 ml fluid restriction with delineation of the fluid distribution for 60 ml to be given with medications and 420 ml with each meal.

R59's medical record lacked a completed MDS review, however, RN-B provided a Care Area Assessment (CAA) summary dated 6/23/14, which indicated R59 had moderate cognitive impairment and was independent with eating after tray set-up assistance.

R59's Physician Orders and Progress Notes dated 9/12/14, indicated R59 was on a 1500 ml /24 hour fluid restriction and directed staff to monitor intake and output. In addition, R59 had dialysis three days a week (Monday, Wednesday and Friday).

R59's October 2014, TAR indicated R59 was on a 1500 ml / 24 hour fluid restriction. The documentation indicated the following:

· 10/1/14 - lacked documentation for the amount of fluid consumed during the night and the 24 hour total was not completed (the fluid total for the shifts documented equaled 1540 ml - exceeding the fluid restriction for the day by 40 ml).
· 10/2/14 - lacked documentation for the amount of fluid consumed in the evening and the 24 hour total was not completed.
· 10/3 & 4/14 - lacked documentation for the 24 hour fluid intake total.
· 10/5/14 - resident was out on pass.
· 10/6/14- lacked documentation for the amount of fluid consumed on the day shift and the 24 hour total.
· 10/7-9/14 - lacked documentation for the 24

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{F 309}	Continued From page 34 hour fluid intake total (the fluid total for the shifts documented on 10/9/14, equaled 1520- exceeding the fluid restriction for the day by 20 ml). · 10/10/14 - 24 hour fluid intake documented and totaled (1060 ml) · 10/11-12/14 - lacked documentation for the 24 hour fluid intake total. · 10/13/14 - 24 hour fluid intake documented and totaled (1320 ml) · 10/14/14 - 24 hour fluid intake documented and totaled (1640 ml - exceeding the fluid restriction for the day by 140 ml). The registered dietician's (RD) Medical Nutrition Therapy Notes dated 9/4/14, indicated R59 was on a 1500 ml fluid restriction. The RD's Medical Nutrition Therapy Notes dated 9/30/14, indicated it was difficult for her to ascertain actual intake from the medication administration record. On 10/15/14, at 1:52 p.m. trained medication aide (TMA)-A confirmed any resident on dialysis should have a 24 hour total fluid intake recorded daily. TMA-A confirmed it was the responsibility of the night staff to total R59's 24 hour total intake and that this total should be documented on her treatment record. TMA-A confirmed for the month of October 2014, R59's total fluid intake had only been tallied on 10/10/14, 10/13/14, and 10/14/14. The total fluid intake on 10/14/14, was 1640 ml, which exceeded the 24 hour fluid restriction by 140 ml for the day. On 10/15/14, at 1:52 p.m. the dialysis unit RN confirmed she was familiar with R59 and her care. The dialysis RN verified that on 10/13/14, R59 had come in for her scheduled dialysis treatment at 70 kilograms which was 5.5	{F 309}		

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kilograms over her dry weight (the amount of body weight without extra fluid). The dialysis nurse confirmed R59's dry weight goal was 64.5 kilograms and R59 had routinely come in for her dialysis treatments around 66 kilograms. The dialysis RN confirmed the facility should have been monitoring R59's fluid intake and staying within her 1500 ml/day fluid restriction. The dialysis RN stressed it was very important to monitor R59's total fluid intake and she should never be over four kilograms on fluid (which she was on 10/13/14). This lack of monitoring and exceeding the 24 hour fluid intake restrictions of 1500 ml would place R59 at risk for clinical complications such as congested heart failure, heart attack or respiratory failure.

On 10/15/14, at 2:18 p.m. the DON verified the 24 hour total fluid intake records for R59 where incomplete and that three out of the 14 days for the month of October 2014, the totals had not been tallied.

On 10/16/14, at 10:35 a.m. the DON confirmed her expectations were that the staff would follow the individual care plan for R59.

The facility's Intake, Measuring and Recording policy [undated], specified as its purpose to accurately determine the amount of liquid a resident consumed in a 24 hour period.

The facility's Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs and that documentation must be consistent with the residents' plan of care.

R62 received dialysis via a right chest portacath

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{F 309}	Continued From page 36 (a small medical appliance that is installed beneath the skin in which a catheter connects the port to a vein) and the facility failed to monitor the site and develop a care plan to identify the access site nor the emergency care procedures to be provided should dislodgment and/or bleeding occur. R62's History and Physical dated 10/1/14, indicated R62 was recently started on dialysis post renal failure onset. R62's 24 Hour-Vital Sign Record indicated R62 was admitted to the facility on 10/2/14. R62's Discharge Summary dated 10/2/14, indicated R62's diagnoses included diabetes and chronic kidney disease with dialysis treatments via a portacath. R62's Admission/Readmission Care Plan was undated and blank. R62's progress note dated 10/2/14, indicated R62 was cognitively alert. The 24 Hour - Vital Sign Record dated 10/2/14, indicated following admission R62 left the facility at 2:30 p.m. for dialysis. The record further indicated R62 returned from dialysis at 10:00 p.m., however, the record lacked notation regarding the appearance of the catheter site dressing or how R62 tolerated the dialysis.	{F 309}		

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{F 309}	Continued From page 37 The Nurses' Admission Assessment dated 10/3/14, identified R62 had a central line inserted in the right chest. The undated nursing assistant (NA) cheat sheet lacked identification of R62's dialysis catheter placement nor care of the catheter site. The Physician Orders dated 10/8/14, indicated R62 was to receive dialysis every three times a week. R62's October 2014, Treatment Sheets identified the right chest portacath for dialysis access and directed staff to change the dressing as needed if soiled. The staff signature section was blank. The Treatment Sheets lacked indication of monitoring of the access site nor emergency care. R62's October 2014, Medication Administration Records (MAR) lacked indication of monitoring of the portacath site. On 10/15/14 at 1:07 p.m. LPN-A confirmed R62 did not have a temporary care plan developed. On 10/15/14, at 2:39 p.m. RN-B stated an admission/readmission care plan was to be completed as soon as a resident was admitted to the facility. RN-B stated R62 received dialysis, had a left arm access site and was not to have blood pressures taken from the left arm. However, RN-B stated he wasn't sure if the NAs were aware of that or not. RN-B verified he was responsible to complete the care plans, however, stated he did not have "a lot" of information on R62. RN-B confirmed R62's admission care plan was blank and stated it should have been	{F 309}		

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{F 309}	Continued From page 38 developed to include dialysis access site, emergency care of the site as well as any restrictions such as no blood pressures on the left arm. On 10/15/14 at 3:00 p.m. R62 was observed in the dialysis unit of the adjoining hospital receiving dialysis. The portacath insertion site was observed covered with a clean, white dressing. The dialysis nurse stated the dressing was changed weekly during dialysis services. On 10/15/14, at 3:01 p.m. the dialysis unit RN confirmed dialysis staff changed R62's portacath dressing weekly and stated there was no nursing home protocol to monitor the access site. However, the RN stated staff should have been monitoring the catheter site for dislodgment and/or bleeding. The RN stated if bleeding occurred, staff should apply pressure and if unable to control the bleeding, R62 would need to be seen in the emergency department. on 10/15/14, at 3:04 a.m. R62 stated no one at the facility had looked at her dialysis access site. On 10/15/14, at 3:09 p.m. NA-B verified she occasionally worked with R62 and stated she was not sure where R62's access site was. On 10/16/14, at 7:58 a.m. TMA-A confirmed R62 had a right chest dialysis catheter in place in which the dialysis unit staff took care of the dressing. TMA-A stated she monitored R62's catheter site for bleeding three times a day, however, verified there was no documentation indicating such. At 12:00 p.m. the DON stated the facility did not	{F 309}		

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{F 309}	Continued From page 39 have a policy and procedure related to the development of temporary admission care plans. The facility's Hemodialysis Access Care policy and procedure dated 5/13, indicated the catheter must be kept clean and dry at all times and to never pull or tug on catheter tubing. The policy also indicated the general nurse should document each shift in the resident's medical record as follows: 1. location of the catheter will be documented in the MAR with the notation not to take blood pressures in the arm, if a shunt is placed. 2. The condition of the dressing and any interventions, if needed. 3. If dialysis was done during shift. 4. Any part of a report the dialysis nurse may have provided post-dialysis. 5. observations post dialysis. The facility's Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs and that documentation must be consistent with the residents' plan of care.	{F 309}		
{F 314} SS=H	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	{F 314}		11/18/14

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{F 314}	Continued From page 40 by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R59, R42, R62) with current pressure ulcers were consistently assessed, monitored and provided interventions to promote healing of current pressure ulcers, and prevent the development of new pressure ulcers. The facility's failure to assess, monitor and implement interventions resulted in a pattern of actual harm for R42, R59, and R62. Findings include: R59 had a stage 4 pressure ulcer (ulcer with full thickness loss of tissue with exposed bone, tendon or muscle) which had increased in size without adequate monitoring and assessment of the pressure ulcer. R59's discharge assessment Minimum Data Set (MDS) dated 6/23/14, indicated R59 required extensive assist of one staff for bed mobility, transfers and was non ambulatory. The MDS also indicated R59 was at risk for pressure ulcers, had a stage 4 pressure ulcer, was on a turning and repositioning schedule and utilized a pressure redistribution device in both the bed and wheelchair. R59's Pressure Ulcer Care Area Assessment (CAA) dated 6/23/14, which indicated R59 had moderate cognitive impairment, required extensive assist with bed mobility, transferring, toileting and personal hygiene. The CAA also indicated R59 had a stage 4 pressure ulcer on her coccyx (tailbone) area which required a daily dressing change and	{F 314}	The facility will ensure that residents that enter the facility without pressure ulcers will not develop pressure ulcers unless the individual clinical condition demonstrates that they are unavoidable and a resident that has a pressure ulcer receives the care and services necessary to promote healing, prevent infection and prevent new sores from developing. Residents R42, R59, and R62 have been comprehensively reassessed for pressure ulcer risk, care plans updated to reflect assessment findings and nursing assistant assignment sheet updated to reflect care plan interventions. All other residents with current pressure ulcers and those with a Braden score of 15 or below have been reassessed and care plans and nursing assistant assignment sheets updated to reflect assessment findings and care needs. The policy and procedure for treatment and prevention of pressure ulcers has been reviewed and revised to reflect current standards of practice. All professional nursing staff has been educated on November 13, 2014 on pressure ulcer prevention and treatment to include weekly assessments and current treatment protocols. Nursing assistants have been educated on November 3, 2014 on follow-through on the plan of care including turning and positioning per assignment sheet interventions. The DON or designee will be responsible for auditing of 5 resident with wounds weekly for two months and monthly for 3	

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{F 314}	Continued From page 41 monthly follow up by the wound clinic. R59's medical record lacked a current MDS. R59's Care Plan For Skin Integrity dated 6/20/14, indicated R59 was at risk for development of a pressure ulcer and weekly skin assessments should be completed by a licensed nurse. R59's care plan dated 6/24/14, indicated R59's diagnoses included congested heart failure (decrease in heart function to pump blood), diabetes, hypertension (high blood pressure), open wound on buttock, a history of myocardial infarction (heart attack), and on 9/3/14, a new problem area of chronic kidney disease with renal dialysis was added. R59's care plan dated 6/24/14, also identified a problem area of impaired skin integrity with a goal for R59's coccyx wound to decrease in size by 1.0 cm in the next 90 days. R59's care plan directed staff to photograph and measure the coccyx wound every two weeks and document this information. The care plan also indicated R59 had decreased mobility, required one staff assistance for mobility, was non ambulatory and utilized an air mattress on bed and pressure redistribution in the wheelchair. The care plan directed staff to turn and reposition R59 every hour and to monitor skin for persistent red areas and to report areas to the licensed nurse. R59's Checklist of Skin Risk Factors & Interventions dated 7/25/14, indicated R59 was at a high risk for the development of a pressure	{F 314}	months that weekly assessments are completed and care plans are updated. Audit results will be reported to the QA Committee and action plans developed as needed to ensure compliance. ADDENDUM F314 11/10/2014 The week of November 3, 2014 all licensed nurses had 1:1 education on skin protocol including the body audit tool, incident reporting and skin assessment. Additional training will be completed on November 12, 2014. Formal education will occur on licensed all staff training on 11/13/14 related to pressure and non-pressure related skin issues and related interventions, repositioning, pressure relief devices and other appropriate interventions to prevent pressure ulcers. Resident R42 was assessed by the consultant RN for appropriate wound treatments, weekly wound measurements have been completed and at this time treatment is appropriate. Resident R59 was assessed by the consultant RN for appropriate wound treatments, weekly wound measurements and assessments have been completed and at this time treatments are appropriate. Resident R62s wounds are currently healed but skin is being checked weekly by licensed staff to look for any breakdown. Nursing staff will be educated on completion of weekly body audits and reporting changes to the nurse and pressure and non-pressure related skin issues will be called to the MD for orders	

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{F 314}	Continued From page 42 ulcer and identified R59 had a stage 4 pressure ulcer on her coccyx area. Interventions included weekly skin assessment by a licensed staff member, wound care consultation as ordered, turn and reposition every two hours and to use pressure relieving devices in her wheelchair and bed. R59's most current Braden Scale (tool utilized to predict pressure sore risk) dated 9/6/14, indicated R59 was at a moderate risk for developing a pressure sore. R59's Treatment Sheet order dated 9/23/14, directed staff to change coccyx wound dressing every other day and PRN (when needed). The wound was to be cleansed with normal saline, Aquacel (a wound dressing that supports wound healing by absorbing wound exudate) was to be applied to the wound bed and the wound covered securely with a dressing. On 10/14/14, R59's coccyx wound was scheduled for a dressing change. R59's nursing notes (NN) reviewed from 8/13/14, until 10/15/14, lacked documentation of the assessment, measurement and monitoring of the coccyx wound. On 10/14/14, at 10:45 a.m. the director of nursing (DON) was observed to gather her supplies to perform R59's dressing change. R59 was observed positioned in her bed laying slightly on her right side and the head of the bed was elevated. R59 was observed to have a pressure	{F 314}	and care plan updated to address the issues identified. ADDENDUM 2 F314 Daily observation audits will be done for residents with pressure ulcers to assure treatments are being completed as ordered.	

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{F 314}	Continued From page 43 relieving mattress on her bed. The DON introduced the surveyor and permission was requested to observe the DON conduct the dressing change. R59 responded that she did not want the surveyor to watch the dressing change. The surveyor queried the DON if she was going to measure the wound. The DON responded she wasn't planning on it, however, she sure could. The surveyor requested for a measurement of the wound to be completed. On 10/14/14, at 11:10 a.m. the DON confirmed the measurements of R59's coccyx wound were 5.0 centimeters (cm) in length, 5.0 cm in width and 1.5 cm in depth with 0.5 cm of undermining (separation of tissue from the surface on the edge of a wound) at the eleven o'clock through 1 o'clock area of the wound. The DON stated the wound had a moderate amount of exudate (drainage) and slough (dead tissue). The DON confirmed R59's wound should be assessed and measured weekly. A photograph of the wound was not taken. Upon request, the DON provided the most recent wound measurements for R59's coccyx wound. On the Photographic Wound Documentation Form dated 8/13/14, indicated R59's wound type was identified as a stage 4, measured 4.1 cm in length, 3.4 cm in width and a depth of 1.5 cm with undermining of 1.5 cm at 12 o'clock, 1.2 cm at 3 o'clock, and 0.9 cm at 9 o'clock. The DON confirmed the date written on the photograph and verified 8/13/14, was the last time the wound was assessed or measured	{F 314}		

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{F 314}	Continued From page 44 R59's Nurses Admission Assessment form dated 9/3/14, indicated R59's coccyx wound measured 5.6 cm length, 5.4 cm in width and 1.7 cm in depth. R59's Hospital Encounter dated 9/16/14, indicated R59 had a stage 4 pressure ulcer. The wound measurements were 4.4 cm in length, 4.0 cm in width, and 0.7 cm in depth with 1.4 cm area of undermining from 12 o'clock to 2:00 o'clock. R59's most recent Sanford Bemidji Medical Center wound care clinic visit dated 9/23/14, indicated the wound measured 4.5 cm in length, 4.0 cm in width and 1.5 cm in depth with an area of undermining from 8 o'clock to 1 o'clock. The certified nurse practitioner (CNP)-A , who assessed the wound also indicated in her assessment that there was some devitalized tissue (dead tissue) in the center of the wound over the most prominent area of granulation (new tissue) that appeared to be recent tissue injury from unrelieved pressure. CNP-A indicated in her plan that pressure abatement measures should be continued. Despite the increase in size of the pressure ulcer, the facility failed to conduct a comprehensive pressure ulcer assessment for R59. On 10/14/14, at 1:30 p.m. the DON stated she did not know why there was a gap in R59's wound assessment/measurement/photograph documentation between 8/13/14, to 10/4/14. The DON verified the wound had increased in size from 8/13/14, to 10/14/14.	{F 314}		

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{F 314}	Continued From page 45	{F 314}		

R59's Pressure Ulcer Healing Chart (tool to monitor trends in wound healing) initiated and completed on 10/14/14, by the DON, indicated R59 scored a 15 (score range of 0-17, with 0 indicating the wound was healed to the highest score of 17).

On 10/15/14, at 9:21 a.m. CNP-A, confirmed she had assessed and treated R59 at the wound care clinic and was familiar with R59's wound process and treatment. CNP-A also verified her notes from R59's visit on 9/23/14. CNP-A verified the wound clinic had seen several residents from the facility and stated she often had to reiterate to staff the importance of keeping pressure off of the bottom, importance of repositioning and continued pressure abatement interventions. CNP-A stated she was often frustrated when a resident with a wound was only seen once a month at the wound care clinic and when they are seen it was the facility had not followed the pressure abatement interventions recommended. CNP-A was unsure of the resources they had available at the facility, however, stated they often had to reiterate their recommendations to promote wound healing.

On 10/16/14, at 10:35 a.m. the DON confirmed her expectations were that staff would follow R59's individual care plan.

On 10/16/14, at 1:50 p.m. the DON, with the administrator present, stated the wound program at the facility had broken down. The DON stated the nurse she had assigned the wound program

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{F 314}	Continued From page 46 was evidently not doing it. The DON confirmed she ultimately had responsibility for oversight of the wound program. The DON stated it was evident the facility was not in compliance for pressure ulcer care. R42 had a stage IV pressure ulcer that was not assessed, monitored, and interventions were not consistently implemented in order to promote pressure ulcer healing. The pressure ulcer has increased in size. R42's Admission Face Sheet dated 5/28/14, indicated R42's diagnoses included a pressure ulcer stage IV (coccyx), type II diabetes mellitus, sepsis, chronic anemia, rheumatoid arthritis and depressive disorder. R42's quarterly MDS dated 6/29/14, indicated R42 had intact cognition, required extensive assistance of two staff for bed mobility, extensive assist of one staff for transferring, utilized a wheelchair for locomotion and displayed no inappropriate behavioral symptoms. R42's care plan dated 7/3/14, identified R42 had an alteration in skin integrity related to a coccyx ulcer and vulnerable area on the right ankle. Interventions included the following: medication and treatments as ordered to coccyx and right ankle. Monitor for signs and symptoms of infection. Weekly skin checks, wound clinic as ordered. Photo documentation and measurements at least every 2 weeks. Air mattress on bed and pressure relief cushion on wheelchair. PRAFO (specialized splint devices for the lower extremities) bilaterally. The care plan	{F 314}		

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{F 314}	Continued From page 47 had not addressed a repositioning plan for R42. A comprehensive pressure ulcer assessment for R42 was requested, but was not provided by the facility. R42's Photographic Wound Documentation dated 8/13/14, indicated R42 had a healing stage four ulcer on the coccyx which measured 3.7 cm x 2.4 cm x 1.1 cm. with no exudate, a normal wound bed and the surrounding skin and wound edges were normal. No further wound monitoring by the facility could be found for R42 since 8/13/14. Review of R42's wound clinic documentation visit information dated 9/26/14, indicated R42's wound healing was complicated by diabetes, pressure and stool incontinence with associated skin maceration. The form also indicated the sacrum wound measured 4.0 cm x 1.3 cm x 0.6 cm with circumferential undermining with a 1.7 cm tunnel at 5:00 o'clock. The documentation identified the following plan: Hydrofera blue for the next month to help with bioburden, heavy SensiCare application to sacrum and intergluteal cleft for skin barrier, continue pressure alleviation efforts to her bottom and general surgical consult for colostomy if patient was interested. The written clinic referral for this visit dated 9/26/14, indicated instructions that "Patient needs Roho cushion [a specialized cushion that optimizes weight redistribution] ordered ASAP [as soon as possible]." Despite the worsening of the pressure ulcer, the facility failed to conduct a comprehensive pressure ulcer assessment.	{F 314}		

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{F 314}	Continued From page 48	{F 314}		

Review of the last visit R42 made to her primary care provider on 10/13/14, the physician had requested a surgical consult for a colostomy due to R42's chronic diarrhea and stool incontinence.

On 10/13/14, at 3:09 p.m. licensed practical nurse (LPN)-B stated R42 had a stage IV pressure ulcer on the coccyx and was not aware of any issues with R42 being noncompliant related to turning and repositioning.

On 10/14/14, at 9:13 a.m. R42 was observed in her bedroom, seated in a wheelchair. R42 did not have a pressure redistribution cushion underneath the buttocks to minimize pressure. At this time R42 was asked how long she sat up in the wheelchair every day and how long it had been since she had a cushion to sit on while seated in the wheelchair and R42 stated she sat up in the wheelchair 3-4 times a day for over an hour each time and had not had a cushion in her wheelchair "for a long time."

On 10/14/14, at 9:15 a.m. nursing assistant (NA)-F stated she had just finished giving R42 a bed bath and assisted her into her wheelchair. NA-F stated that she had not allowed R42 to sit up in the wheelchair longer than 30-60 minutes because she did not want R42's pressure sore getting worse. NA-F stated R42 would independently change position and was not aware R42 being noncompliant with pressure relief of refusing repositioning assistance.

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{F 314}	Continued From page 49 On 10/14/14, at 11:15 a.m. the DON confirmed R42's care plan should have been followed and measurements and pressure ulcer interventions including the pressure reducing cushion should have been implemented as directed. The DON verified the last documentation regarding a pressure ulcer assessment and measurements were completed on 8/13/14, (63 days ago). On 10/15/14, at 10:26 a.m. LPN-B was observed to provide the pressure ulcer dressing change. Upon completion of the dressing change, LPN-B measured the wound at the request of the surveyor and the following was revealed: 5.0 cm x 2.1 cm x 1.8 cm with a tunnel at 6:00 o'clock that measured 0.6 cm. When the measurements were compared to the measurements obtained by the wound clinic on 9/26/14, it was evident the wound had increased in size and depth. On 10/15/14, at 12:35 p.m. the DON stated R42 was non-compliant with repositioning needs at times. The DON also stated the risks related to R42's non-compliance had not been explained to R42 nor documented and care planned in R42's medical record. The DON confirmed R42's sacral pressure ulcer had increased in size/depth and the wound had not been consistently measured and monitored at least every two weeks as indicated by R42's care plan. The DON verified the ulcer was not reassessed nor were further interventions implemented because the facility was unaware the pressure ulcer had increased in size and depth. The DON stated she had found a pressure redistributing cushion and placed it in R42's wheelchair until one could be ordered and	{F 314}		

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{F 314}	Continued From page 50 implemented for R42. On 10/15/14, at 2:55 p.m. RN-B who was responsible for the comprehensive assessments stated he was not sure if R42 had a comprehensive pressure ulcer assessment completed. RN-B stated that he was new to the position of completing comprehensive assessments and provided a CAA summary completed on 1/6/14, which identified the following "...Braden score is 15 which is mild risk for skin breakdown.[R42] has stage 4 ulcer to coccyx with dressing changes as ordered. [R42] is extensive AO1-2 [extensive assist of 1-2] for bed mobility and able to assist with turning and repositioning using bilateral upper 1/2 length side rails. LN [licensed nurse] does weekly skin assessment after bath and nail care as needed. Nursing assistance monitor skin with cares and report concerns to nurse. Her risk factors are weight-loss, infections, worsening of pressure ulcers, dehydration, and discomfort." R62 had two stage two (partial thickness loss of dermis) pressure ulcers and the facility failed to identify and assess the presence of pressure ulcers upon admission to the facility so interventions could be implemented. The facility also failed to complete wound care treatment as ordered by the physician. R62's History and Physical dated 10/1/14, indicated R62 was profoundly weak, required total staff assistance from the bed to the chair and had a sore on the right hip. The progress note dated 10/1/14, indicated R62	{F 314}		

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{F 314}	Continued From page 51 was cognitively intact and had a small pressure ulcer over the right ischial (back lower portion of the hip bone) area. R62's 24 Hour-Vital Sign Record nursing note section indicated R62 was admitted to the facility on 10/2/14, and had an open area on the right hip. R62's Discharge Summary dated 10/2/14, indicated R62's diagnoses included diabetes, chronic kidney disease, renal failure with dialysis treatments and anemia. The summary also indicated R62 had two small ulcers on the right hip. R62's Admission/Readmission Care Plan form was undated and blank. R62's Care Plan For Skin Integrity was undated and blank. R62's The Checklist of Skin Risk Factors & Interventions form was undated and blank. The undated nursing assistant (NA) "cheat sheet" indicated R62 required staff assistance for bed mobility and directed staff to turn and reposition R62 every two hours. However, the sheet lacked indication R62 had current pressure ulcers and was at risk for the development of pressure ulcers. The progress note dated 10/2/14, indicated R62 was totally dependent on staff for bed mobility,	{F 314}		

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required a mechanical lift for transfers, had not walked in over a year, had not stood for six weeks, had limited range of motion on both shoulders with the left shoulder frozen and strength in all extremities was weak.

The Nurses Admission Assessment dated 10/2/14, identified one 1.8 cm by 1.0 cm open area on the right buttock.

The nurses notes dated 10/5/14, indicated R62's right hip dressing change was completed with light, green drainage noted. No further documentation related to wound drainage could be found.

The CNA 7-Day Charting Note dated 10/6/14, indicated R62 could assist with repositioning and would call for staff assistance when she wanted to reposition.

The Other Skin Conditions Form (Not For Pressure, Arterial, Venous, or Neuropathic Ulcers) dated 10/8/14, indicated small open areas and old scars on body. The picture diagram identified "small sores" on right upper buttock with the measurement of 1.4 cm X 1.0 cm written beside it. No written summary related to this assessment was found.

The Turning and Repositioning (tissue tolerance) Observation form dated 10/8/14, indicated R62 had an open area on the right hip and was to be assisted with turning and repositioning every two

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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(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 314}	Continued From page 53 hours. R62's physician order's dated 10/8/14, indicated R62 had a right hip open area and directed staff to cleanse area with normal saline, apply Mupricin to wound bed and cover with Allevyn. The orders directed staff to change the dressing every other day. The progress note dated 10/10/14, indicated R62 had a small amount fibrinous tissue over two small ulcer areas over the right ischium. The Medical Nutrition Therapy Notes dated 10/13/14, indicated R62 had a right ischial ulcer. The Braden Scale-For Predicting Pressure Sore Risk dated 10/14/14, indicated R62 was at risk for pressure ulcers. R62's October 2014, Treatment Sheets directed the nurses to complete a skin integrity check weekly with R62's bath, however, the nurse signature sections were blank. The sheets also directed staff to cleanse the right hip open area with normal saline, apply Muprocin and cover with Allevyn every other day. However, the nurse signature section of the form indicated the dressing was changed on 10/5/14, 10/8/14, (three days between dressing changes). On 10/10/14, and again on 10/15/14, (five days between dressing changes). There was no documentation regarding the description of wound such as the size, drainage or number of wounds present.	{F 314}		

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{F 314}	Continued From page 54	{F 314}		

On 10/15/14, at 9:29 a.m. R62 was observed being assisted back to her room from a bath via a bath chair with two staff assist. Both staff assisted R62 to bed. Once in bed R62 was observed positioned on her right side. At this time R62 confirmed she was admitted to the facility with a sore on her hip and does not know if it was healing or not. She stated she was currently working with therapy to regain strength. R62 verified staff did assist her with repositioning and had informed her of the need for pressure relief, however, stated she did not feel staff assisted her with repositioning as often as they should. R62 stated she repositioned about four times a day when in bed and was up in the wheelchair from noon until about 3:00 p.m. daily.

On 10/15/14, at 9:45 a.m. RN-C entered R62's room to complete the wound treatment. R62 was observed to turn to her left side with use of the siderail on command. An Allevyn dressing was observed on R62's right buttock with the date 10/10/14, written on it. RN-C removed the dressing and revealed an approximate quarter size stage two open area with white fibrinous type tissue covering the center of the wound on the right mid buttock. To the left of the wound another stage two dime size open area was observed. No drainage was noted. RN-C stated R62's physician thought the wound was from a past shingles outbreak and not pressure related. Immediately following the treatment, RN-C verified the removed dressing was dated 10/10/14 , and verified the date indicated the day the dressing was last changed. RN-C stated the dressing change should have been completed every three days as ordered. RN-C added, "When

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{F 314}	Continued From page 55	{F 314}		

we work with one nurse and two medication aids it was difficult to get everything done and stated pressure related wounds were the priority to complete first." RN-C confirmed R62's treatment should have been completed as ordered and stated this was "not good."

On 10/15/14, at 10:01 p.m. two NAs were observed to transfer R62 from bed into a wheelchair via a mechanical lift. A pressure redistribution cushion was observed in R62's wheelchair.

On 10/15/14, at 1:03 p.m. the trained medication aide (TMA)-A stated when a resident was admitted to the facility the nurses assessed their skin condition then completed a questionnaire (skin, clothing brought in, if they wore glasses, if they had dentures) which this information was then passed onto the NAs so they were aware of a residents needs. TMA-A stated this was considered the admission care information and stated the facility did not utilize a formal temporary/admission care plan.

On 10/15/14, at 1:07 p.m. LPN-A stated R62's wound documentation was lacking and was not descriptive and verified no further wound/skin documentation could be found. LPN-A also confirmed a temporary / admission care plan was not developed and the NA cheat sheet did not identify the presence of the wounds. LPN-A stated R62's wounds were from a previous outbreak of shingles and stated R62 scratched them. LPN-A stated when a physician ordered a dressing change to be completed every two days it was expected that the treatment would be provided as ordered and it was "unacceptable" if it was not.

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{F 314}	Continued From page 56 On 10/15/14, at 1:29 p.m. LPN-B stated the 24 hour nurse admission sheet provided a brief description of a residents care needs which was given to LPN-A in order to add the information to the NA cheat sheet. LPN-B stated wound treatments must be completed as ordered and it was "not acceptable" to leave a dressing on for five days with an order to change every two days. On 10/15/14, at 2:39 p.m. RN-B stated a resident's admission/readmission care plan was to be completed as soon as a resident was admitted to the facility. RN-B verified R62's admission care plan was not completed and stated if completed, he would expect to see the wound identified and on it. RN-B also stated he had not seen R62's wounds but believed she had one on her hip and stated it could possibly be from shingles. RN-B stated R62's wound could also possibly be a deep tissue pressure related wound and had requested staff (qualifications of staff unknown) to check the wound yesterday to see if the wound was "squishy" in order to determine if it was a deep tissue wound or not. RN-B stated the staff had reported to him the wound was "not squishy." RN-B also stated he could not find any information in R62's chart to indicate if the wound was pressure related or not. RN-B went on to state there was not a lot of information on R62. RN-B stated he usually did not personally observe the resident's wounds rather refers to a nurse's documentation for wound information. On 10/15/14, at 3:09 p.m. NA-B confirmed she occasionally provided care for R62 and stated she thought R62 had a wound on her backside but she was not sure.	{F 314}		

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{F 314}	Continued From page 57 On 10/16/14, at 7:55 a.m. RN-C was observed providing wound treatment. The larger wound measure 1.0 cm X 1.0 cm with no drainage. The second wound measured 0.5 cm X 0.5 cm with no drainage visible. Both wounds had white slough like material throughout the center with red edges. On 10/16/14, at 7:58 a.m. TMA-A stated the nurse completed the wound treatments/dressing changes. TMA-A stated R62 was admitted to the facility with "just one" small wound on her right hip. On 10/16/14, at 8:02 a.m. NA-C stated she had not seen nor was aware of any sore on R62's bottom because the nurse would manage it. On 10/16/14, at 8:05 a.m. RN-C stated R62 had both wounds on admission. When reviewed the admission assessment form which identified only one wound on admission, RN-C stated she thought she had measured both of them. RN-C verified the admission assessment lacked identification of the second wound, its description, location and size. RN-C also stated the wound dressing she removed yesterday was the same dressing the applied on 10/5/14, when the physician had looked at it. On 10/16/14 at 8:54 a.m. the DON stated she did not believe R62's wounds were related to pressure. At 9:10 a.m. the DON was observed to complete R62's wound dressing change and confirmed R62 had two open areas. The DON again stated R62's wounds were not pressure related rather	{F 314}		

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were wounds from a history of shingles. When asked if she would expect staff to document the identification, description and assessment to determine the cause of the wound the DON stated "yes." The DON stated she would expect to see complete wound documentation which included wound assessments, descriptions, identification and monitoring documented in R62's medical record.

On 10/16/14, at 9:51 a.m. RN-B provided the surveyor with R62's Care Plan For Skin Integrity, Checklist For Skin Risk Factors and Interventions which were all blank. RN-B stated due to the presence of skin wounds, the assessments should have been completed when R62 was admitted and were not.

On 10/16/14, at 10:16 a.m. R62's medical doctor (MD)-A along with the DON and surveyor observed R62's wounds as well as recent progress notes and MD-A confirmed R62's wounds were pressure related ulcers not shingle related wounds. When informed the DON disagreed with the pressure ulcer determination of the wounds, MD-A responded saying if I said they were pressure ulcers then they are pressure ulcers and "I stand by my documentation." MD-A went on to state R62 had recent long term hospitalizations which put her at high risk for the development of pressure ulcers. The DON confirmed knowledge of the MD-A's diagnoses of R62's pressure ulcers.

The facility's Pressure Ulcer Risk Assessment policy [undated] directed staff to routinely assess and document the condition of the resident's skin. The policy also directed the nurses to conduct skin assessments at least weekly to identify

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{F 314}	Continued From page 59 wound changes. The policy further directed staff to document in the chart the condition of the resident's skin to include size and location of any red or tender areas. The facility's Pressure Ulcer Treatment policy [undated] directed staff to document in the resident's record all assessment data which included color, size, pain, drainage, etc. when inspecting the wound. The facility's Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs and that documentation must be consistent with the residents' plan of care	{F 314}		
F 353 SS=F	. 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353		11/18/14

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F 353	Continued From page 60 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate licensed nurse staffing was provided for all 37 residents residing in the facility. Findings include: On 10/16/14, at 4:17 p.m. Licensed Practical Nurse (LPN)-D stated that most all of the LPN's were working extra shifts and double shifts. LPN-D stated the evening shift had not had two licensed nurses work in over two weeks. LPN-D also stated resident care suffered because there was no time to complete scheduled dressing changes and documentation. LPN-D stated both the director of nursing and the administrator were notified by LPN-D on many occasions within the last 60 days of the lack of staffing but the response was a promise to hire more licensed nursing staff. LPN-D stated new licensed staff had not been hired and the licensed nurse staff	F 353	the facility will have sufficient nursing staffing to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care on a 24 hour basis. The prior staffing model was established as a sign-up methodology. The new DON held two mandatory clinical staff meetings on November 3. The 2567's were reviewed with the team and expectations for attendance and performance standards anticipated in the future. The team agreed to 1:1 meetings with the DON (held 11/7 - 11/12) to review their routine schedules and to establish each staff members preferred two week period and to establish that schedule as a baseline going forward. Staff members have volunteered to come forward to fill in extra shifts.	

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F 353	Continued From page 61 currently employed continued to leave employment because they could not handle providing substandard care to the residents. Refer to F314 regarding the details related to this complaint. On 10/17/14, at 8:55 a.m. the director of nursing stated the normal staffing pattern was the following: - for the day shift was two licensed nurses and seven nursing assistants (NAs). - for the evening shift was two licensed nurses and five NAs. -for the night shift one licensed nurse and three NAs. The DON stated she had not noticed a lack of licensed nursing staff for the evening shift. The DON was again interviewed on 10/17/14, at 10:23 a.m. and the actual staffing for the evening shift was reviewed from 10/2/14-10/14/14. The DON confirmed that the census was between 37 and 39 residents during this time period and verified only one LPN was scheduled for the evening shift for those days. The DON confirmed the licensed nurses notified her that they had not been able to complete all the care required by the residents. The DON confirmed that licensed nurse's have quit employment with the facility as of recent due to the poor working conditions and lack of staffing. The DON stated she had entered into a contract with a licensed pool staff agency within the past six weeks, however the pool staff agency was not able to provide the facility with the DON's requested staffing needs. The DON confirmed she had not sought out any other	F 353	A bonus program has been implemented to assist with an incentive package to help encourage attendance. Two external staffing agencies were contacted to provide additional staff. Zellner Senior Health Consulting has been engaged to provide clinical oversight and MDS assistance. The DON will provide daily monitoring of staffing hours to ensure adequate professional nurse and nursing assistant staff are available to provide necessary care and services to the residents of the facility. ADDENDUM F353 11/10/14 Staffing per shift is determined based on resident need and acuity levels. The DON is responsible for oversight and management of all clinical staff. Staff call-ins will be managed by the staffing coordinator (HUC) during the day shifts and the charge nurse on evening and night shifts and weekends. Staff will be required to follow mandating coverage of care. The DON is contacted to assist with problem solving staffing issues 24/7 which is a new practice for this facility. Attendance will be tracked and staff were educated on November 3, 2014 on expectations on attendance. A total of 23 separate staffing agencies were contacted to attempt to obtain traveling nurses and CNAs. One agency is providing three licensed staff to serve in extended contracts. Of the existing staff, six CNAs/TMAs have been moved to floor to serve staff for CNA positions. Other staff has been reassigned to provide direct care to	

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F 353	Continued From page 62 licensed pool staff agency's to try and meet the facility's need for licensed nurse staffing because the administrator would not allow her to sign another contract with a licensed pool staff agency. The DON confirmed that evening licensed nurse staffing had not been adequate for the month of October but that she was actively recruiting staff. On 10/17/14, at 11:49 a.m. LPN-A stated the topic of lack of staffing was discussed almost daily with the DON and administrator. LPN-A stated both the DON and administrator had been promising the staff relief from the short staffing for a couple of months now but the relief has not occurred. LPN-A stated the common response to her voiced concern of lack of staff was "we are working on it." LPN-A stated the licensed staff had been working with a lack of staff for approximately six months and stated she was at her breaking point. LPN-A stated residents complain to her about lack of getting appropriate care about once a week and residents have reported to LPN-A that their dressings had not been changed or they had not receive a scheduled treatment. Refer to F314 regarding the details related to this complaint. On 10/17/14, from 11:59 a.m. until 12:23 p.m. registered nurse (RN)-B stated he was responsible for completing the required comprehensive resident assessments. RN-B stated the 13 of 13 required comprehensive assessments that were significantly late was because since he was hired to complete the	F 353	provide better coverage to meet resident needs. Clinical staff members have been meeting 1:1 with the DON to participate in creating a structured staffing schedule that will rotate in an every two week cycle. This is a new format as recently staff only signed up for desired shifts, some nursing assistant and licensed staff were not assigned to weekends. The nursing assistant identified as not being on the registry is resolved and is now back working her assigned shifts on the floor. Refer to F496. A pick up bonus incentive plan has been approved by the Tribal Health Director on November7, 2014 to address weekend and weekday shifts for a set period of time for clinical staff. The incentive program will be evaluated by the DON and NHA for effectiveness and need until staffing is more fully stabilized. Advertising will be updated to impact permanent staffing by November 17, 2014. The NHA and DON promptly respond to job applications. The attendance policy has been reviewed and a new tracking program will be initiated to impact the consistent communication and attendance for staff. The office Manager will track and audit the data and the NHA will provide monitoring and oversight of the process starting November 17, 2014.	

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F 353	Continued From page 63 comprehensive assessments on 9/30/14, he had received no hours to complete them. RN-B stated when he arrived to work each day he would be notified that he had to provide direct patient care instead of doing the comprehensive assessments. RN-B stated he notified the DON and the Administrator that 13 of the assessments were past due and was told a plan would be made to get them caught up, however, RN-B stated he had little faith he would be afforded the time to complete the assessments. RN-B stated that approximately two weeks previous to this interview the licensed staff met with the DON and administrator and expressed their concern related to their feeling of lack of staff and lack of leadership. The DON and administrator promised the staff things would "get better" but a written action plan was not developed to address the issue. Additionally, RN-B researched and found a licensed pool staff agency that would provide licensed nurse staffing for the facility. RN-B stated the administrator dismissed the idea of bringing in a pool staff agency at the time of this meeting. Please refer to F272 and F276 for details related to the comprehensive assessments not being completed timely. The facility's Resident Council Minutes dated 10/30/13, through 8/27/14, were reviewed and revealed the following: * The minutes dated 2/24/14, indicated the residents were able to notice when there was a shortage of workers on the floor. This item was to be addressed by administration/nursing. There was also a comment that on payday the workers don't come in and no one does anything about it.	F 353		

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F 353	Continued From page 64 * The minutes dated 3/25/14, indicated that administration had not responded to the action forms submitted. * The minutes dated 7/30/14, indicated residents had complained of short staffing, how there were times when only one nursing assistant was on the floor. The resident council members felt the facility should look into their concern and determine how to fix it. The residents stated they were paying money and the facility was responsible for providing them care. In addition, the minutes reflected that the administrator had explained the facility was not short staffed, but that workers were calling in. He acknowledged that the facility needed licensed nursing staff (licensed practical nurses (LPN)s and registered nurses (RN)s) and that he had contacted the tribal human resource department. * The minutes dated 8/27/14, indicated the residents were aware that staff were working 16 hour shifts. The residents felt it was pretty bad for the residents who lived at the facility and that they were the ones which have been affected. Another comment noted in the minutes, indicated an unidentified resident was having problems and the resident who spoke up at the resident council meeting stated they were unable to find someone to help. This resident commented "a lot of us look out after each other or yell." In addition, reflected in the minutes were comments regarding the nursing assistants working overtime, sometimes there were only two nursing assistants working on a shift and that the residents just hoped the nursing assistants would show up today.	F 353		

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F 353	Continued From page 65 On 10/17/14, at approximately 11:00 a.m. the social worker verified the above resident council concerns and stated approximately three times a week a resident had verbally voiced their concerns related to staffing to her. The social worker also stated the DON and the administrator were well informed by staff of the staffing concerns and nothing was done about it.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356		11/18/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 356	Continued From page 66 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the posted nurse staffing information was posted accurately. This had the potential to affect all current residents (37) and visitors to the facility. Findings include: The posted hours and the actual working schedule was reconciled from 10/3/14-10/10/14 during which it was noted the posted hours were not reconciled to reflect the actual staffing for all shifts. The following issues were identified with the hours posting: On 10/3/14, the posted nursing assistant (NA) hours were inaccurate. The posted hours identified that 5 nursing assistants worked from 6:00 a.m.-2:30 p.m., however, the schedule identified 3 nursing assistants actually worked the aforementioned shift. There was no posted hours for 10/4/13, and 10/5/13. On 10/6/14, the licensed practical nurse (LPN) posted hours identified no LPN scheduled for the 6:00 p.m.-6:00 a.m., however, the working schedule identified there was one LPN scheduled for this shift. On 10/7/14, the posted hours identified there was one RN that worked 6:00 a.m.-6:00 p.m., 1 LPN that worked 6:00 a.m.-2:30 p.m., and 2 LPN's that worked 2:00 p.m.-10:30 p.m. The working schedule identified that one RN worked 6:00	F 356	The facility will post on a daily basis at the beginning of each shift the daily staffing per regulation in a format that is clear and readable and in a prominent place readily accessible to resident and visitors. The form for daily posting of staffing has been revised to meet the regulation. Form will be posted at the beginning of each day and updated daily to match the working schedule. The staffing coordinator has been trained on the procedure on November 13, 2014. The DON will be responsible for auditing of the daily staffing posting daily for 2 weeks and then weekly for 2 months. Audit result will be reported to the QA committee and action plans developed as needed to ensure compliance.	

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F 356	Continued From page 67 a.m.-2:30 p.m., one LPN worked 6:00 a.m.-2:30 p.m., one LPN worked 2:30-10:30 p.m., one LPN worked 8:00 a.m.-4:30 p.m., one LPN worked 6:00 p.m.-6:00 a.m. and one LPN worked 6:00 p.m.-10:00 p.m. On 10/8/14, the posted hours identified there was one RN that worked 6:00 a.m.-2:30 p.m., one RN that worked 6:00 p.m.-6:00 a.m., one LPN worked 6:00 a.m.-2:30 p.m., one LPN that worked 8:00 a.m.-2:30 p.m. and one LPN that worked 6:00 a.m.-6:00 p.m. The working schedule identified that one RN worked 6:00 a.m.-2:30 p.m., one RN worked 6:00 p.m.-6:00 a.m., one LPN worked 6:00 a.m.-2:30 p.m., one LPN worked 6:00 a.m.-6:00 p.m., one LPN worked 6:00 p.m.-10:00 p.m. and one LPN worked 8:00 a.m. to 6:00 p.m. On 10/9/14, the posted hours identified there was one RN that worked 6:00 a.m.-2:30 p.m., one RN that worked 6:00 p.m.-6:00 a.m., one LPN that worked 8:00 a.m.-4:30 p.m. and one LPN that worked 6:00 a.m.-6:00 p.m. The working schedule identified that 1 RN worked 8:00 a.m.-4:30 p.m., one RN worked 6:00 p.m.-6:00 a.m., one LPN worked 8:00 a.m.-4:30 p.m. and one LPN worked 6:00 a.m.-10:00 p.m. On 10/10/14, the posted hours identified there was one RN that worked 6:00 a.m.-2:30 p.m., one RN that worked 8:00 a.m.-4:30 p.m., one LPN that worked 6:00 a.m.-2:30 p.m., one LPN that worked 10:00 p.m.-6:00 a.m., one LPN that worked 2:00 p.m.-10:30 p.m. and one LPN that worked 8:00 a.m.-4:30 p.m. The working schedule identified that 1 RN worked 6:00 a.m.-2:30 p.m., one RN worked 8:00 a.m.-4:30 p.m., one LPN worked 6:00 a.m.-2:30 p.m., one LPN worked 10:00 p.m.-6:00 a.m. and one LPN worked 8:00 a.m.-4:30 p.m. The working schedule had not identified any RN or LPN	F 356		

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F 356	Continued From page 68 working during the evening shift. The director of nursing (DON) was interviewed on 10/17/14, at 10:23 a.m. and confirmed that both the daily staff posting and the working schedule was not accurate. The DON stated that when staff hours changed it wasn't consistently recorded correctly on the working schedule. The DON stated the health unit coordinator (HUC) was responsible for keeping the posted hours correctly. The DON was asked how she would figure out which licensed nursing staff worked and at what time. The DON stated she would look at the medication administration record for the residents and identify which staff signed off the medications to determine who was working that shift. The health unit coordinator was interviewed on 10/17/14, at 10:50 a.m. and confirmed that the posted hours did not reflect the actual staffing on any of the days from 10/3/14-10/10/14. A facility policy related to daily posting of staff hours was requested but not provided.	F 356		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490		11/3/14

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F 490	Continued From page 69 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility administration failed to ensure residents were provided appropriate care based on a comprehensive assessment. The facility had systemic problems with failure to conduct resident assessment timely so appropriate interventions could be implemented; failed to adequately oversee care to ensure treatment and services were provided to prevent pressure and skin ulcer development which resulted in a harm level deficiencies; failed to ensure appropriate licensed staff resources were available for the residents which resulted in a deficiency at sufficient staffing; and failed to develop corrective action plans for identified quality of care/life deficiencies. These administrative failures had the potential to affect all 37 residents residing in the facility. Findings include: The administrator and director of nursing(DON) had knowledge of problems with insufficient staffing, improper management of pressure ulcers, and untimely Minimum Data Set (MDS) assessment for over a year, yet did not take appropriate action to address these issues. Refer to F272 and F276: The facility failed to ensure a comprehensive Minimum Data Set (MDS) for 3 of 3 residents (R2, R24, R59) and a comprehensive MDS reassessment for 10 of 10 residents (R38, R22, R46, R44, R42, R4, R14, R31, R21 and R25) had been completed and successfully submitted in a timely manner. Refer to F309: The facility failed to ensure	F 490	Both the DON and nursing home administrator were replaced by highly skilled and seasoned interim leadership professionals and both started onsite full-time on November 3, 2014. In addition, both leaders are on-call to establish operational oversight and planning. ADDENDUM F490 11/10/14 The Tribal Health Director will receive a weekly report from the NHA providing operational updates and progress on key improvement focus areas in progress. The Tribal Health Director will round the facility weekly for direct access and oversight of the operation. The Tribal Health Director will audit the NHA's performance monthly. Weekly reports from the interim NHA and DON have been completed since October 31, 2014. The reports are an executive summary of the weekly actions, key topics, progress of QA factors being addressed, and other care updates. A senior care health consulting company has been contracted through October 2015 to provide clinical and management expertise to the skilled care facility weekly. In addition, this consulting company provided a professional interim DON and interim NHA for the operation. The consulting company will be participating in on-boarding the future permanent DON and NHA, provide mock surveys throughout the year, provide clinical standards of practice expertise and systems.	

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F 490	Continued From page 70 wounds were assessed and monitored for 1 of 3 resident (R4) who had skin ulcers that had not been assessed and monitored. In addition, daily fluid intake had not been totaled or monitored for 3 of 4 residents (R61,R46, R59) who were receiving dialysis treatment and on prescribed fluid restrictions. Refer to F314: The facility failed to provide consistent assessment, monitoring and/or provide interventions to ensure current pressure ulcers were healing. R42, R59 and R62 experienced actual harm due to the development and/or worsening of an existing pressure ulcer. Refer to F353: The facility failed to provide sufficient staff to ensure residents received the care and services as directed by their individual care plans and/or that the needs of the residents had been identified to appropriately be reflected on the residents' care plans. Refer to F520: The facility failed to develop corrective action plans to address identified quality of care and/or life deficiencies. On 10/17/14, at 3:32 p.m. the DON, with the administrator present, confirmed they had been aware of the following concerns: short staffing, MDSs not being completed in a timely manner and the breakdown in the overall pressure ulcer program. The DON nor the administrator were able to provide a written action plan for the above noted areas of concern. The DON stated they had been aware of the staffing concerns for the past several months and with regards to the MDSs not being done in a timely manner, they had been aware of this concern for over a year.	F 490	Meetings with the Tribal Health Director and Tribal Chairman were conducted on November 10, 2014 to address the planned overview, communication, expectation, audits, and reporting with the new leadership. The Tribal Council will be provided a monthly summary report from the skilled facility monthly with a monthly presentation from the NHA or a designee for the 12 months. The first Tribal Council presentation will occur on November 12, 2014.	

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F 490	Continued From page 71 Facility Memorandum dated 1/3/13, indicated the current administrator was authorized to carry out the full functions of the Jourdain/Perpich Extended Care Center including assuming the supervisory role over all staff effective 1/4/13.	F 490		
F 496 SS=F	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.	F 496		11/18/14

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F 496	Continued From page 72 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 26 nursing assistants (NA-G) employed by the facility was listed on the State's nursing assistant registry as required. This had the potential to affect 37 residents residing in the facility in which NA-G provided care for. Findings include: On 10/17/14, a review of nursing assistant registration with the State agency revealed NA-G, hired on 9/12/07, was not listed on the registry. Verbal information received from the State agency on 10/17/14, indicated NA-G was removed from the registry 3/11/13, after the facility informed the State agency NA-G's end date of employment at the facility was 3/11/13. On 10/17/14, the director of nursing (DON) stated she had called the State agency which confirmed NA-G was not listed on the registry as required. The DON also stated the facility ran semi annual nurse registry reports to ensure all staff remained on the registry. The facility's semi annual nurse aide registry report dated 6/2/14, revealed NA-G was not identified on the nurse aide registry. On 10/17/14, at 2:40 p.m. the administrator and	F 496	There had been 2 employees with the same first name that had been misfiled internally regarding the NA registry update. The employee NA-G has been taken off the schedule until she has clarity and completion of the proper registry approval. A secondary review was completed by the NHA to assure all other employees are properly registered. No other employees are out of compliance. The administrator will provide oversight of this area of compliance ongoing. ADDENDUM F496 11/10/14 The personnel files will be audited every quarter by the Office Manager reporting the results to the Administrator for follow-up action if any employee does not have a current registry documentation.	

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F 496	Continued From page 73 the DON both verified NA-G was not identified on the most recent semi annual nurse aide registry report and stated they had missed that. However, both verified NA-G remained an employee at the facility without a break in service and stated a facility employee must have entered the 3/11/13, end date of employment for the wrong employee on one of the semi annual submission reports. Both the administrator and DON verified NA-G continued to work as an NA and trained medication aide approximately 40-60 hours per pay period throughout the facility. At this time the DON stated the facility did not have a policy related to the nurse aide registry employment requirements. On 10/17/14, at 3:45 p.m. the administrative secretary stated NA-G continued to work at the facility approximately 40-60 hours per pay period, and worked throughout the building care for all residents.	F 496		
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE 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. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497		11/18/14

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F 497	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on interview and document review, 1 of 5 nursing assistant (NA-D) personnel records reviewed did not have an annual performance evaluation completed. In addition, 5 of 5 (NA-A, NA-B, NA-D, NA-E, NA-F) nursing assistants did not receive 12 hours of annual continued education training as required. This had the potential to affect all 37 residents currently residing in the facility. Findings include: EVALUATIONS Nursing assistant (NA)-D did not have an annual performance evaluation. NA-D was hired on 3/1/13. His personnel file lacked documentation of any annual performance evaluation. NA-D was assigned to work throughout the building. INSERVICE EDUCATION NA-A, NA-B, NA-D, NA-E and NA-F had all worked in the facility greater than 12 months and their personnel files lacked documentation that they had received the required 12 hours of in-service training per year. All of the identified NAs work throughout the building. NA-A was hired on 5/21/11. Her personnel file indicated she had received eight continuing education units (CEU)s in 2013, and based on the Hierarchy Credit Hours report from the on-line	F 497	Personnel evaluations. Employee NA-D presently has a completed annual evaluation in place. In addition, a completed review of all evaluations was completed and all other employees have updated and completed evaluations. Inservice education: Employees NA-A, NA-B, NA-D, NA-E and NA-F have completed their online training from the contracted Educare software. The facility has an established computer for access to complete the training. The Educare online Learning policy has been reviewed by the new DON and NHA and approved. Staff members were contacted individually by the administrator to establish the needed 2014 modules that need to be completed online. Monitoring will be completed by the NHA or designee going forward for the education sessions oversight, staff communication, and scheduling of the modules on a monthly basis. ADDENDUM F497 11/10/14 All personnel reviews for the past calendar year will be completed prior to November 18, 2014. Going forward, the Office Manager will provide a list of the employees due for evaluation one month prior to the needed date to the department supervisors. The Administrator will audit the process to assure compliance per policy and timeliness.	

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F 497	Continued From page 75	F 497		

training program NA-A had received 5.5 CEUs so far for 2014.

NA-B was hired on 7/22/1993. Her personnel file indicated she had received 9.5 CEUs for 2013, and lacked documentation for CEUs which had been accrued for 2014.

NA-D was hired on 3/1/2013. His personnel file indicated he had received two CEUs for 2013, and based on the Hierarchy Credit Hours report from the on-line training program NA-D had received 8.5 CEUs so far for 2014.

NA-E was hired on 1/4/2011. Her personnel file indicated she had received seven CEUs for 2013, and based on the Hierarchy Credit Hours report from the on-line training program and her personnel file NA-E had received 4.75 CEUs so far for 2014.

NA-F was hired on 4/7/2008. Her personnel file indicated she had received ten CEUs for 2013, and based on the Hierarchy Credit Hours report from the on-line training program NA-F had received 6.5 CEUs so far for 2014.

On 10/17/14, at 9:37 a.m. the administrative secretary confirmed the facility had implemented the on-line training program in March of this year. She stated staff members were provided CEU certificates for all of their in-services they had attended and these certificates would be in each staff members personnel file. The administrative secretary confirmed the director of nursing (DON) was responsible for overseeing that the NAs received the required number of CEUs per year.

On 10/17/14, at 1:55 p.m. the DON stated she

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F 497	Continued From page 76 was behind on doing performance reviews. The DON verified the required 12 CEUs are based on a calendar year. The facility's Employee Performance Evaluation policy [undated and unsigned] specified every employee following their probation period (90 days) would receive a performance evaluation annually. The facility's Educare Online Learning policy [undated and unsigned] indicated the purpose of the policy was to assist the staff in maintaining the required CEUs to maintain their licensure. In addition, the policy indicated three training modules would be assigned to each staff person every quarter and this would be monitored by the DON.	F 497		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	{F 520}		11/18/14

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{F 520}	Continued From page 77 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure quality assurance plans had been developed for identified quality concerns. This had the potential to affect all 37 residents residing in the facility. Findings include: On 10/17/14, at 3:21 p.m. the quality assessment and assurance (QAA) program was reviewed with the director of nursing (DON) and the administrator. The DON stated the QAA committee met monthly and their meeting was structured around a standing agenda. She stated the plan of correction from the post certification revisit (PCR) exit date 8/12/14, had been presented to the QAA committee. The DON confirmed the facility had focused specifically on the portion of the deficiency cited, however, it was her expectation that the facility would be in compliance with the regulation in its entirety. The DON further stated the facility did not have a system in place to identify or solicit suggestions for improvement from staff, residents or family members, besides the information from the resident council meetings. The DON, with the	{F 520}	The new DON and NHA have completed comprehensive action plans reflecting the areas of pressure ulcers, MDS, and staffing concerns as initial focus areas for improvement. In addition, two other key quality initiatives have been initiated for quality improvement. The QA Committee will meet on November 12, 2014 to review action plans, revise the plans, and the plans were initiated. The work of the QA committee will be communicated to all staff so they are aware of action plans being worked on for quality improvement. The NHA is responsible for the oversight and monitoring of the QA program. Inclusion of other department leaders and line staff will continue. ADDENDUM F520 11/10/14 Policy review of the committee structure is complete with a new agenda created by the new interim DON and NHA. The staff quality assurance education was initiated with Staff Education and updates on November 3, 2014 with staff mandatory meetings conducted. The initial three action plans regarding staffing, MDS assessment process, and pressure	

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{F 520}	Continued From page 78 administrator present, confirmed they had been aware of the following concerns: short staffing, Minimum Data Set (MDS) not being completed in a timely manner, and the breakdown in the overall pressure ulcer prevention program. The DON verified that a written plan of action had not been developed for the above noted areas.	{F 520}	ulcers have been initiated for the November 12, 2014 meeting. The committee members will participate in revisions and full implementation improvements. The committee meeting cycle will be monthly until determined that the core planning areas are established. Routine committee members are the Medical Director, NHA, DON, Maintenance Director, Social Services, and the pharmacist. Other employees are invited as topics and projects further develop. Education and communication will be managed with written memo updates, postings, action plans, and audit results. The Administrator will be responsible for oversight and management of this process. Please refer to F314, F353, and F272 to related initial quality assurance topic and action area details.	

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{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 10/13/14, 10/14/14, 10/15/14, 10/16/14, and 10/17/14, to determine compliance with Federal deficiencies issued during a FMS resurvey exited on 8/12/14. During this revisit the following regulations were determined to be not corrected.	{F 000}		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		11/18/14

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

Electronically Signed | 11/07/2014

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician was notified of a change in condition related to wound development for 1 of 1 resident (R4) in the sample who had a wound develop on the right great toe and third toe that was not identified and reported to the physician to ensure appropriate treatment was provided. Findings include: R4's cumulative Diseases Index Report dated 2/12/14, indicated R4's diagnoses included diabetes, anemia, blindness, alcohol induced persisting amnesic disorder, chronic kidney disease, edema and a history of non-compliance with medical treatment which presented hazards to his health. R4's quarterly Minimum Data Set (MDS), dated 7/4/14, indicated R4 had impaired cognition and physical and verbal behavioral symptoms that significantly interfered with his cares. The MDS also indicated R4 had diabetic foot ulcers. (A quarterly MDS should have been completed by 10/4/14, however, it was not completed and the data was not available). Review of R4's medical record revealed missing or a lack of documentation related to skin issues and ulcers.	F 157	R4 has had family and physician notifications completed related to wound on right great toe. The quarterly MDS that was due on 10/04/14 has been completed and submitted. A policy and procedure for Resident Change of Condition Notifications has been reviewed by the Medical Director. Staff have had training on the Policy and Procedure for Resident Change of Condition Notifications. The DON or designee will be responsible for audits for compliance conducted daily x 2 weeks, weekly x 4 weeks and monthly x 2 months. Audit results will be reviewed by the QA Committee and action plans developed as needed to maintain compliance. ADDENDUM F157 MD will be notified via phone or fax within 24 hours of any pressure or non-pressure related skin condition as stated in the policy for timely notification of change in condition. Family will be notified via telephone by the licensed staff within 24 hours and all notifications will be documented in the medical record. Staff have been educated on 11/13/14 of this policy and procedure. Daily audits will be completed during daily stand-up during the week and the charge	

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F 157	Continued From page 2 R4's physician progress notes on 8/14/14, indicated R4 had a new ulcer on the dorsum of the left second toe which was to be treated with Bactroban and dry dressings daily. R4's physician rounding note dated 9/22/14, had not mentioned any issues related to open skin wounds. The rounding note identified stasis dermatitis on bilateral lower extremities with hyperpigmented skin from stasis dermatitis. R4's physician orders dated 9/22/14, identified the following orders: Una boot to right leg as needed for swelling. A&D ointment to bilateral lower extremities twice a day. Left second toe apply Bactroban, cover with gauze dressing and change BID (twice a day) until resolved. Wash legs daily and apply moisturizing cream BID. R4's nurse progress notes and wound documentation from 9/1/14-10/14/14, revealed the following: -on 9/20/14, licensed practical nurse (LPN)-C documented R4 had two new wounds on toes and one wound on right big toe. The registered nurse (RN) to assess. Wounds cleansed and A&D ointment, gauze applied and Koban. R4's left plantar toe has a skin tear 3.0 centimeters (cm) in length and 3.0 cm in width, area cleansed, A&D ointment, gauze applied and wrapped with Koban. -on 9/24/14, RN documentation indicated R4's wound dressing was changed, however, the note did not identify which dressing was changed or where it had been. R4's medical record lacked indication the physician was notified of the wound on the right great toe or indication of a management plan	F 157	nurse will review on weekends and provide oversight for those residents that have new or changing pressure or non-pressure related wounds.	

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F 157	Continued From page 3	F 157		

related to this wound which had developed.

The wound book documentation from 9/1/14-10/14/14 was reviewed and there was no documentation related to R4 having open wounds on the right foot, nor of any treatment being implemented.

On 10/16/14, at approximately 10:50 a.m. RN-B confirmed R4 had a history of foot wounds, however, stated he was unsure if he had any new or current ones.

On 10/16/14, at 10:53 a.m. nursing assistant (NA)-C stated on this past Monday R4 had a sore on his right toe and the scab had fallen off during his bath. NA-C stated the wound appeared red and had started to bleed "a little bit." NA-C stated she had not notified a nurse regarding the wound.

On 10/16/14, at 11:03 a.m. RN-C stated as of two weeks ago R4's skin was intact, free from sores. RN-C stated she was totally unaware R4 had a new wound on his foot or a scab had fallen off during his bath.

On 10/16/14, at 11:44 a.m. RN-C stated R4 did not have any pressure sores and had a history of diabetic foot ulcers. RN-C also stated R4's skin was currently intact, free of any sores. RN-C stated staff continued to monitored the tip of R4's right toes for open areas and were directed to notify the physician should they open up.

On 10/16/14, at 1:46 p.m. the director of nursing (DON) stated she was not sure when R4's right great toe and third toe wounds had occurred

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F 157	Continued From page 4 because R4's medical record had not identified any feet related skin issues. The DON confirmed the physician was not notified of R4's right foot wounds so appropriate treatment could be initiated. The DON stated she would have expected the licensed nurses to notify the physician of the wounds. A policy for notification to the physician was requested from the DON but was not provided. On 10/16/14, at approximately 2:00 p.m. the facility provided a picture of R4's right great toe dated 10/16/14, which revealed an open ulcer the approximate size of a pea on the dorsal surface of the right great toe. On 10/17/14, at 9:33 a.m. R4 was observed seated on the edge of the bed and was interviewed. During the interview R4's right great toe was observed to have a pea size open ulcer and the third toe of the right foot was macerated and bloody. It was noted that there was an apparent circulation problem with the right lower extremity as the leg was purple in color. There was no dressing on the right great toe or right foot 3rd toe wound.	F 157		
{F 279} SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	{F 279}		11/18/14

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{F 279}	Continued From page 5 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure to ensure the written care plan included appropriate interventions for monitoring 24 hour fluid intake for 3 of 3 residents (R59, R46, R61) receiving dialysis. In addition, the facility failed to develop a behavior care plan which included target behaviors for 1 of 3 residents (R38) reviewed for antipsychotic medications. Findings include: R59 was on a 1500 milliliter (ml) 24 hour prescribed fluid restriction and her comprehensive care plan did not direct staff to daily total and monitor the 24 hour intake. R59's care plan dated 6/24/14, identified R59's diagnoses as congested heart failure (decrease in heart function to pump blood), diabetes, hypertension (high blood pressure), open wound on buttock and on 9/3/14, a new problem area of chronic kidney disease with renal dialysis was added. The care plan also identified a problem	{F 279}	The facility will use the results of the assessment to develop, review and revise the resident's comprehensive care plan to include measurable goals and timetables to meet the resident's medical, nursing and mental and psychosocial needs that have been identified in the comprehensive assessment. Residents R59, R46 and R61 have had their care plans updated to include appropriate interventions for monitoring of 24 hour fluid intake. Resident R38 has had their care plan updated to include target behaviors for the use of antipsychotic medications. All other resident affected by this practice have had their care plans reviewed and updated to reflect monitoring of 24 hour fluid intake and those currently having orders for antipsychotic medications will have their care plan updated to reflect target behaviors. The professional nursing staff and the IDT have been trained on November 13 on	

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{F 279}	Continued From page 6 with nutrition and potential for fluid overload. The approaches identified on 9/3/14, included intake and output monitoring and a 1500 ml fluid restriction with delineation of the fluid distribution for 60 ml to be given with medications and 420 ml with each meal. However, the care plan lacked direction for staff to total the fluid intake daily and what approaches to do if R59 should exceed the 1500 ml/day restriction. R59's Physician Orders & Progress Notes dated 9/12/14, indicated R59 was on a 1500 (ml)/24 hour fluid restriction and staff were directed to monitor intake and output (I&O). On 10/16/14, at 10:35 a.m. the DON confirmed her expectations were that the staff would follow the individual care plan for R59 and as changes were needed the care plan should be reassessed and updated to meet the needs of the be resident. R46 was on a prescribed 1500 ml daily fluid restriction and the facility had not developed care plan interventions which addressed monitoring of R46's daily fluid intake. R46's Admission Face Sheet indicated R46 was diagnosed with end stage renal disease (ESRD) secondary to chronic kidney disease, type II diabetes mellitus, intercerebral hemorrhage and cerebrovascular disease. R46's care plan last revised on 9/23/14, indicated a 1500 ml fluid restriction with 420 cubic centimeter (cc) fluid allowed with each meal, 80 cc with each med pass, was to have no water pitcher at bedside and fluid with meals and	{F 279}	care plan updating to reflect resident's current assessed needs per the comprehensive assessment. The DON or designee will be responsible for auditing 3 care plans per week for 4 weeks then 2 monthly for 3 months to ensure care plan is current for 24 hour fluid monitoring and target behaviors. Audit results will be reported to the QA Committee and action plans developed as needed to ensure compliance.	

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{F 279}	Continued From page 7 evening as fluid restrictions allowed. R46's physician orders revealed on 12/18/13, the physician ordered a 1500 ml per day fluid restriction due to chronic kidney disease and need for hemodialysis. R46's Treatment Administration Records (TAR) from 10/3-10/13, revealed daily total fluid intake was not calculated and monitored consistently. The revealed R46's total daily fluid intake had not been calculated on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/11, and 10/12/14. On 10/14/14, R46's intake was noted to have been 1620 cc (120 cc over the fluid restriction). There was no evidence that action was taken related to the excess fluid intake on 10/14/14. On 10/15/14, at 10:30 a.m. the DON confirmed R46's care plan did not identify how the daily total fluid intake was going to be monitored. R61 was on a prescribed 1500 ml fluid restriction in which staff did not monitor or calculate total daily fluid intake. R61's Admission Face Sheet indicated R61 was diagnosed with ESRD. R61's physician orders revealed on 8/5/14, the physician ordered a 1500 cc per day fluid restriction due to chronic kidney disease and need for hemodialysis. R61's TAR 10/3-10/13/14, revealed that daily total fluid intake had not been calculated and monitored consistently. R61's total daily fluid intake was not calculated on 10/3, 10/4, 10/5,	{F 279}		

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{F 279}	Continued From page 8 10/6, 10/7, 10/8, 10/9, 10/10,10/11, and 10/13/14. R61's care plan dated 8/19/14, revealed R61 was on a 1500 cc fluid restriction. However, the care plan had not delineated how much fluid each discipline would provide R61 (i.e.. dietary, nursing, activities) nor who would be responsible for monitoring the 24 hour total fluid intake. On 10/15/14 at 12:53 p.m. the DON confirmed the care plan had not delineated how much fluid each discipline would provide nor who would be responsible for monitoring the 24 hour total fluid intake. The Intake, Measuring and Recording policy [undated], specified as its purpose to accurately determine the amount of liquid a resident consumed in a 24 hour period. The Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs. R38 had observable behaviors and the facility failed to develop a care plan to include identification of target behaviors. R38's Face Sheet dated 2/2/14, identified R38 was diagnosed with an intracranial injury, traumatic brain injury and a subarachnoid hemorrhage. R38's nurse notes for 9/14, (none for October) revealed R38 had behaviors which consisted of banging his head on head board, yelling and swearing at the staff, kicking and biting the staff,	{F 279}		

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{F 279}	Continued From page 9	{F 279}		

throwing objects in the dining room, disrobing and voiding in inappropriate places. The notes also revealed R38 had psychotropic medication changes 9/14 and was followed by a psych professional.

R38's care plan dated 12/20/14, indicated R38 moved self from his bed onto the mattress that laid next to his bed and required hourly safety checks. The care plan also indicated R38 would crawl out into the hallway and call out for help. The head board of the bed was removed due to an injury hazard due to R38 kicking and hitting. The care plan directed staff to document behaviors and interventions as they occur. No target behaviors were indicated.

On 10/15/14, at 10:10 a.m. R38 was observed in a low bed anxiously moving about, banging on the side rails and slapping his hand on the bed.

On 10/15/14, at 1:50 p.m. R38 was observed in bed restlessly moving about. The wall above R38's head board was observed with shredded wallpaper and deep gouges which exposed plaster.

On 10/16/14, at 8:36 a.m. R38 was observed in bed watching TV. When attempts were made to communicate with R38 he appeared to attempt to verbally communicate then threw his pillow on the floor and quickly scooted self off his bed onto a mattress which laid on the floor next to his bed, retrieved the pillow and put it back up onto his bed.

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{F 279}	Continued From page 10 On 10/16/14, at 9:16 a.m. R38 was observed in bed with no incontinent product / underwear on. R38's penis was exposed and he was openly touching himself and periodically saying "f---, f----, f---." The door to R38's room was open and R38 was visible to all who passed by his room. On 10/15/14, at 10:20 a.m. registered nurse (RN)-C confirmed R38 had a traumatic brain injury. When asked what inappropriate behavior R38 displayed RN-C stated he would swear stating " f---, f---, f---." RN-C stated R38 was not physically abusive but would pull at his bed and scratch at the walls and also would remove his incontinent product and throw it about his room. On 10/16/14, at 10:05 a.m. the DON verified R38 had behaviors which consisted of hitting, biting, throwing objects and scooting self out in the hall without appropriate clothing on. The DON confirmed R38's target behaviors were not addressed on his care plan and they should have been. The Comprehensive Care Plan Development & Review policy dated 9/2/14, indicated the comprehensive care plan should be a dynamic tool, changing with changes in the resident's status and these changes should be documented and addressed in the medical record.	{F 279}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	{F 282}		11/18/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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{F 282}	Continued From page 11 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the written care plan related to wound assessment and measurement for 2 of 2 residents (R59, R42) who had a pressure ulcer. Findings include: R59 had a stage 4 pressure ulcer (ulcer with full thickness loss of tissue with exposed bone, tendon or muscle) which had increased in size and was not monitored and measured according to her care plan. R59's care plan dated 6/24/14, identified R59's diagnoses as congested heart failure (decrease in heart function to pump blood), diabetes, open wound on buttock and on 9/3/14, a new problem area of chronic kidney disease with renal dialysis was added. R59's care plan also identified impaired skin integrity with a goal for R59's coccyx wound to decrease in size by 1.0 cm in the next 90 days. R59's care plan directed staff to photograph and measure the coccyx wound every two weeks and document this information. On 10/14/14, at 11:10 a.m. upon the surveyors request, the director of nursing (DON) measured and confirmed R59's coccyx wound measurements were 5.0 centimeters (cm) in length, 5.0 cm in width and 1.5 cm in depth with	{F 282}	The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Resident R59 and R42 have had their care plans reviewed and updated with current status of pressure ulcers and their care and treatment.. Nursing assistant assignment sheets have been updated as needed to reflect current care needs. All other resident with current pressure areas have had their care plans reviewed and updated as needed and nursing assignment sheets updated to reflect current care needs. The policy and procedure for following the plan of care has been reviewed and updated as needed. Professional nursing staff and nursing assistants have been educated on November 13 on the policy and procedure for follow-through on the plan of care related to care and treatment of pressure ulcers. The DON or designee is responsible for auditing that care plans are being followed related to pressure ulcer care and treatment per policy and procedure. Through direct observation audits will be completed on 5 residents with pressure ulcers to observe that care plan	

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{F 282}	Continued From page 12 0.5 cm of undermining (separation of tissue from the surface on the edge of a wound) at the eleven o'clock through 1 o'clock area of the wound. The wound had a moderate amount of exudate (drainage) and slough (dead tissue). The DON stated the wounds were to be measured weekly by facility staff. The Photographic Wound Documentation Form dated 8/13/14, identified R59 as having a stage 4 wound which measured 4.1 cm in length, 3.4 cm in width and a depth of 1.5 cm. with undermining of 1.5 cm at 12 o'clock, 1.2 cm at 3 o'clock and 0.9 cm at 9 o'clock. The DON confirmed an assessment, measurements and photo of R59's wound was last completed on 8/13/14 (63 days ago). R59's nursing notes (NN) reviewed from 8/13/14, until 10/15/14, lacked consistent documentation of the assessment, measurement and monitoring of the coccyx wound. - on 9/3/14, NN indicated the wound was measured and determined to be 5.6 cm length, 5.4 cm in width, and 1.7 cm in depth. -on 9/11/14, NN indicated the coccyx area dressing was changed and the wound was noted to have some light green drainage and odor. On 10/14/14, at 1:30 p.m. the DON confirmed she didn't know why there was a gap in documentation with regards to the assessment, measurement and photographing of R59's wound between 8/13/14, when the last photograph of the wound was taken, till today when the DON measured the wound, however no photograph was taken. The DON verified the wound had increased in size from the 8/13/14, date to the measurement which had been done that day.	{F 282}	interventions are being followed weekly for 2 months and monthly for 3 months. Audit results will be reported to the QA committee and action plans developed as needed to ensure compliance. ADDENDUM F282 11/10/2014 At least two observational audits will be conducted daily on rotating shifts for one month to observe for care being provided per the plan of care with a special focus on pressure ulcer prevention and treatment. Audit schedule will then be as stated above unless otherwise directed by the QA Committee. The DON will review audits and re-educates, coaches, and disciplines clinical staff as needed.	

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{F 282}	Continued From page 13 On 10/16/14, at 10:35 a.m. DON confirmed her expectations were that the staff would follow the individual plan of care for R59. R42 had a stage 4 pressure ulcer and staff failed to consistently assess, monitor and implement interventions to assist with pressure ulcer healing as directed by the care plan. R42's Admission Face Sheet dated 5/28/14, identified R42's diagnoses included a stage 4 coccyx pressure ulcer, type II diabetes mellitus, sepsis and chronic anemia. R42's care plan dated 7/3/14, identified R42 had an alteration in skin integrity related to a coccyx ulcer and vulnerable area on right ankle. Interventions included the following: medication and treatments as ordered to coccyx and right ankle. Monitor for signs and symptoms of infection. Weekly skin checks, wound clinic as ordered. Photo documentation and measurements at least every 2 weeks. Air mattress on bed and pressure relief cushion on wheelchair. PRAFO (specialized splint devices for the lower extremities) bilaterally. The care plan did not address R42's repositioning plan. R42's wound clinic documentation dated 9/26/14, indicated R42's wound healing was complicated by diabetes, pressure, and stool incontinence with associated skin maceration. The wound on the sacrum measured 4.0 cm x 1.3 cm x 0.6 cm with circumferential undermining. There is a 1.7 cm tunnel at 5:00 o'clock. The wound clinic	{F 282}		

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{F 282}	Continued From page 14	{F 282}		

documentation identified the following plan: Hydrofera blue for the next month to help with bioburden. Heavy SensiCare application to sacrum and intergluteal cleft for skin barrier. Continue pressure alleviation efforts to her bottom. General surgery consult for colostomy if patient is interested. The written clinic referral for this visit on 9/26/14, identified "Patient needs Roho cushion [a specialized cushion that optimizes weight redistribution] ordered ASAP [as soon as possible]."

A comprehensive pressure ulcer assessment for R42 was requested, but was not provided by the facility. Registered Nurse (RN)-B who was responsible for the comprehensive assessments was interviewed on 10/15/14, at 2:55 p.m. stated that he was not sure that R42 had a comprehensive pressure ulcer assessment. RN-B provided a Care Area Assessment summary completed on 1/6/14, which identified R42 was at mild risk for skin breakdown, had a stage 4 ulcer to coccyx with dressing changes as ordered and a licensed nurse was to do a weekly skin assessment after baths and nursing assistants were to monitor skin with cares and report concerns to the nurse.

The Photographic Wound Documentation form dated 8/13/14, indicated R42 had a healing stage 4 pressure ulcer which measured 3.7 cm x 2.4 cm x 1.1 cm. The pressure ulcer had no exudate, the wound bed, wound edges and surrounding tissue / skin was normal. No further wound monitoring, assessment or documentation by the facility could be found in R42's medical record since 8/13/14.

On 10/14/14, at 9:13 a.m. R42 was observed in

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{F 282}	Continued From page 15 her room, seated in a wheelchair. R42 did not have a pressure redistribution cushion underneath the buttocks to minimize pressure. R42 was interviewed at this time and was asked how long she sat up in the wheelchair every day and how long it had been since she had a cushion to sit on while seated in the wheelchair. R42 stated she sat up in the wheelchair 3-4 times a day for over an hour each time and had not had a cushion in her wheelchair "for a long time." On 10/14/14, at 11:15 a.m. the DON confirmed R42's care plan should have been followed and measurements and pressure ulcer interventions including the pressure reducing cushion should have been implemented as directed. The DON also confirmed the last documentation from facility staff regarding R42's pressure ulcer assessment and measurements was completed on 8/13/14, (63 days ago). The Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs and that documentation must be consistent with the residents' plan of care.	{F 282}		
{F 309} SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		11/18/14

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{F 309}	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a non pressure related wound was appropriately assessed, monitored or treated for 1 of 3 residents (R4) in the sample reviewed for non pressure related skin issues. This deficient practice caused actual harm for R4. In addition, the facility failed to consistently monitor daily fluid intake for 3 of 3 residents (R46, R61, R59) who had chronic kidney disease, received dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R62) dialysis access catheter site nor develop a care plan to include interventions related to the monitoring and emergency care of the access site. Findings include: R4 had identified wounds on the right great toe and 3rd toe that had not been appropriately assessed, monitored and treated. R4's Cumulative Diseases Index Report dated 2/12/14, indicated R4's diagnoses included diabetes, anemia, non-compliance with medical treatment, blindness, alcohol induced persisting amnesic disorder, chronic kidney disease, edema and a personal history of non-compliance with medical treatment which presented hazards to health. R4's quarterly Minimum Data Set (MDS) dated 7/4/14, indicated R4 had impaired cognition, physical and verbal behaviors that significantly interfered with the resident's care. The MDS also indicated R4 had diabetic foot ulcers. (A quarterly	{F 309}	Each resident will receive the necessary care and services to attain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and care plan. Resident R4 has been reassessed for skin risk and all wounds have been assessed and treatment plan have been care planned per the assessment. Weekly wound measurements have been completed and the treatment and care plan have been adjusted as directed by the physician. Residents R46, R59 and R61 will have daily I&O monitored per policy and procedure. Care plans have been updated to reflect monitoring of fluid intake. Resident R62 has had the dialysis access catheter monitored per policy and the care plan has been updated to include monitoring and emergency care for the access site. All other residents that may be affected by these practices have had their care plans reviewed and updated to reflect current status. the policy and procedure for I&O monitoring for resident on fluid restrictions has been reviewed and revised as needed to include updating of care plan. The policy and procedure for monitoring dialysis access sites has been reviewed and revised as needed to include updating of care plans.	

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{F 309}	Continued From page 17 MDS should have been completed by 10/4/14, however, it had not been completed and the data was not available). R4's physician progress notes on 8/14/14, identified R4 had a new ulcer on the dorsum of the left second toe to be treated with Bactroban and dry dressings daily. The physician rounding note dated 9/22/14, had not mentioned any issues related to open skin wounds. The rounding note identified stasis dermatitis on bilateral lower extremities with hyperpigmented skin from stasis dermatitis. Review of R4's physician orders dated 9/22/14, identified the following: Una boot to right leg as needed for swelling. A&D ointment to bilateral lower extremities twice a day. Left second toe apply Bactroban, cover with gauze dressing, change BID (twice a day) until resolved. Wash legs daily apply moisturizing cream BID. R4's nurse progress notes and wound documentation from 9/1/14-10/14/14, revealed the following: -on 9/20/14, licensed practical nurse (LPN)-C documentewd R4 had two new wounds on toes and one wound on right big toe. The registered nurse (RN) to assess. Wounds cleansed and A&D ointment, gauze applied and Koban. R4's left plantar toe has a skin tear 3.0 centimeters (cm) in length and 3.0 cm in width, area cleansed, A&D ointment, gauze applied and wrapped with Koban. -on 9/24/14, RN documentation indicated R4's wound dressing was changed, however, the note did not identify which dressing was changed or where it had been.	{F 309}	All professional nursing staff have been educated on the policy and procedure for I&O monitoring, wound monitoring and dialysis catheter site care and monitoring on November 13. This will include updating of care plans as needed with change of condition. the DON or designee will be responsible for auditing 5 residents with one or more of these care issues weekly for 2 months then monthly for 3 months. Results will be reported to the QA Committee and further action plans developed as needed to ensure compliance. ADDENDUM F309 11/10/2014 MDs have been contacted to obtain needed fluid restriction if needed. Care plans have been updated and restrictions added to NAR care sheets. Daily audits of intake and output documentation for all four residents currently on dialysis, R46, R59, R61 andR62 will be conducted by licensed nurses on varying shifts to ensure fluid restriction is being monitored and totaled each day. Audits will be sent to the DON daily for needed follow-up and staff intervention based on observation and record review. At least two observational audits will be conducted by licensed nurses daily on rotating shifts for one month to observe for care being provided per the plan of care with a special focus on pressure ulcer prevention and treatment. Audit schedule will then be as stated above unless otherwise directed by the QA Committee.	

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{F 309}	Continued From page 18 There was no further documentation related to the foot wounds found in R4's progress notes nor was there an RN assessment of the wounds found in the medical record from 9/20/14-10/14/14. R4's medical record also lacked indication the physician was notified of the wound on the right great toe or indication of a management plan related to related to this wound which had developed. Review R4's Treatment Administration Record (TAR) from 10/1/14-10/14/14, revealed the nurse was directed to perform a weekly skin integrity assessment and provide diabetic nail care. The charting showed that this task had not been completed at all during the month of October 2014. The wound book documentation from 9/1/14-10/14/14 was reviewed and there was no documentation related to R4 having an open wound on any toes, nor any treatment provided. On 10/13/14, at 3:02 p.m. LPN-B who was responsible for the care of R4 stated R4 still had a foot ulcer on the left foot second toe, however, could not identify what treatment was provided for the wound. At 3:04 p.m. LPN-B then stated she was mistaken, that R4 did not have any wounds on either foot and stated all of R4's wounds were currently healed and nursing staff continued to monitor R4's right great toe and if it opened up the physician would be notified. LPN-B again stated at this point, R4 did not have any open foot wounds. At 3:06 p.m. R4 was asked if an observation of his feet could be made in which R4 became upset and yelled for the surveyor and LPN-B to leave his room. R4's request was	{F 309}	Please refer to F314 for revised skin/pressure ulcer protocols. The DON will review audits and re-education, coaching and discipline of staff as needed.	

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{F 309}	Continued From page 19 honored. On 10/16/14, at approximately 10:50 a.m. RN-B confirmed R4 had a history of foot wounds, however, stated he was unsure if he had any new or current ones. On 10/16/14, at 10:53 a.m. nursing assistant (NA)-C stated on this past Monday R4 had a sore on his right toe and the scab had fallen off during his bath. NA-C stated the wound appeared red and had started to bleed "a little bit." NA-C stated she had not notified a nurse regarding the wound. On 10/16/14, at 11:03 a.m. RN-C stated as of two weeks ago R4's skin was intact, free from sores. RN-C stated she was totally unaware R4 had a new wound on his foot or a scab had fallen off during his bath. On 10/16/14, at 1:46 p.m. the director of nursing (DON) stated she was not sure when R4's right great toe and third toe wounds had occurred because R4's medical record had not identified any feet related skin issues. The DON confirmed the physician was not notified of R4's right foot wounds so appropriate treatment could be initiated. The DON stated she would have expected the licensed nurses to notify the physician of the wounds. On 10/16/14, at approximately 2:00 p.m. the facility provided a picture of R4's right great toe dated 10/16/14, which revealed an open ulcer the approximate size of a pea on the dorsal surface of the right great toe. On 10/17/14, at 9:33 a.m. R4 was observed seated on the edge of the bed and was	{F 309}		

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{F 309}	Continued From page 20	{F 309}		

interviewed. During the interview R4's right great toe was observed to have a pea size open ulcer and the third toe of the right foot was macerated and bloody. It was noted that there was an apparent circulation problem with the right lower extremity as the leg was purple in color. There was no dressing on the right great toe or right foot 3rd toe wound.

DIALYSIS:

R46 was on a prescribed 1500 cubic centimeter (cc) fluid restriction and his daily fluid intake was not monitored.

R46's Admission Face Sheet indicated R46's diagnoses included end stage renal disease (ESRD) secondary to chronic kidney disease, type II diabetes mellitus, intercerebral hemorrhage and cerebrovascular disease.

R46's physician orders indicated on 12/18/13, the physician ordered a 1500 cc per day fluid restriction due to chronic kidney disease and need for hemodialysis.

R46's care plan last revised on 9/23/14, indicated R46's was on a 1500 cc fluid restriction and was to have 420 cc fluid with each meal, 80 cc with each med pass, no water pitcher at bedside and fluids with meals and evening as fluid restrictions allowed.

R46's TAR from 10/3-10/13/14, revealed that daily total fluid intake was not calculated and monitored consistently. R46's total daily fluid intake was not calculated on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/11, and 10/12/14. On 10/14/14, R4's fluid intake was 1620 cc (120 cc

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{F 309}	Continued From page 21 over the fluid restriction). There was no evidence that action was taken related to the excess fluid intake on 10/14/14. On 10/15/14, at 10:30 a.m. the DON confirmed R46's total fluid intake was not totaled and monitored consistently. R61 was on a prescribed 1500 cc fluid restriction which was not consistently totaled and monitored and a plan for delineation of fluid provided by each department had not been developed. R61's Admission Face Sheet indicated R61 was diagnosed with ESRD. R61's physician orders revealed on 8/5/14, an order for a 1500 cc per day fluid restriction due to chronic kidney disease and need for hemodialysis. R61's care plan dated 8/19/14, indicated R61 had a 1500 cc daily fluid restriction. However, the care plan had not delineated how much fluid each discipline would provide R61 (i.e.. dietary, nursing, activities) and who would be responsible for monitoring the 24 hour total fluid intake. R61's TAR records from 10/3-10/13/14, revealed that daily total fluid intake had not been calculated and monitored consistently. R61's total daily fluid intake had not been calculated on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, and 10/13/14. On 10/15/14, at 12:53 p.m. the DON confirmed R61's daily total fluid intake monitoring had not been completed and the care plan had not delineated how much fluid each discipline would	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

(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 309}	Continued From page 22 provide or who would be responsible for monitoring the 24 hour total fluid intake. R59 was on a prescribed 1500 milliliter (ml) 24 hour fluid restriction and her 24 hour intake was not consistently totaled or monitored. R59's care plan dated 6/24/14, indicated R59's diagnoses included congested heart failure (decrease in heart function to pump blood), diabetes, hypertension (high blood pressure), open wound on buttock, a history of myocardial infarction (heart attack) and on 9/3/14, a new problem area of chronic kidney disease with renal dialysis was added. The care plan also indicated R59 had a problem with nutrition and a potential for fluid overload. The approaches identified on 9/3/14, included intake and output monitoring and a 1500 ml fluid restriction with delineation of the fluid distribution for 60 ml to be given with medications and 420 ml with each meal. R59's medical record lacked a completed MDS review, however, RN-B provided a Care Area Assessment (CAA) summary dated 6/23/14, which indicated R59 had moderate cognitive impairment and was independent with eating after tray set-up assistance. R59's Physician Orders and Progress Notes dated 9/12/14, indicated R59 was on a 1500 ml /24 hour fluid restriction and directed staff to monitor intake and output. In addition, R59 had dialysis three days a week (Monday, Wednesday and Friday). R59's October 2014, TAR indicated R59 was on a 1500 ml / 24 hour fluid restriction. The documentation indicated the following:	{F 309}		

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	245535	A. BUILDING _____ B. WING _____	R 10/17/2014

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{F 309}	Continued From page 23 · 10/1/14 - lacked documentation for the amount of fluid consumed during the night and the 24 hour total was not completed (the fluid total for the shifts documented equaled 1540 ml - exceeding the fluid restriction for the day by 40 ml). · 10/2/14 - lacked documentation for the amount of fluid consumed in the evening and the 24 hour total was not completed. · 10/3 & 4/14 - lacked documentation for the 24 hour fluid intake total. · 10/5/14 - resident was out on pass. · 10/6/14- lacked documentation for the amount of fluid consumed on the day shift and the 24 hour total. · 10/7-9/14 - lacked documentation for the 24 hour fluid intake total (the fluid total for the shifts documented on 10/9/14, equaled 1520- exceeding the fluid restriction for the day by 20 ml). · 10/10/14 - 24 hour fluid intake documented and totaled (1060 ml) · 10/11-12/14 - lacked documentation for the 24 hour fluid intake total. · 10/13/14 - 24 hour fluid intake documented and totaled (1320 ml) · 10/14/14 - 24 hour fluid intake documented and totaled (1640 ml - exceeding the fluid restriction for the day by 140 ml). The registered dietician's (RD) Medical Nutrition Therapy Notes dated 9/4/14, indicated R59 was on a 1500 ml fluid restriction. The RD's Medical Nutrition Therapy Notes dated 9/30/14, indicated it was difficult for her to ascertain actual intake from the medication administration record. On 10/15/14, at 1:52 p.m. trained medication aide (TMA)-A confirmed any resident on dialysis	{F 309}		

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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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{F 309}	Continued From page 24 should have a 24 hour total fluid intake recorded daily. TMA-A confirmed it was the responsibility of the night staff to total R59's 24 hour total intake and that this total should be documented on her treatment record. TMA-A confirmed for the month of October 2014, R59's total fluid intake had only been tallied on 10/10/14, 10/13/14, and 10/14/14. The total fluid intake on 10/14/14, was 1640 ml, which exceeded the 24 hour fluid restriction by 140 ml for the day. On 10/15/14, at 1:52 p.m. the dialysis unit RN confirmed she was familiar with R59 and her care. The dialysis RN verified that on 10/13/14, R59 had come in for her scheduled dialysis treatment at 70 kilograms which was 5.5 kilograms over her dry weight (the amount of body weight without extra fluid). The dialysis nurse confirmed R59's dry weight goal was 64.5 kilograms and R59 had routinely come in for her dialysis treatments around 66 kilograms. The dialysis RN confirmed the facility should have been monitoring R59's fluid intake and staying within her 1500 ml/day fluid restriction. The dialysis RN stressed it was very important to monitor R59's total fluid intake and she should never be over four kilograms on fluid (which she was on 10/13/14). This lack of monitoring and exceeding the 24 hour fluid intake restrictions of 1500 ml would place R59 at risk for clinical complications such as congested heart failure, heart attack or respiratory failure. On 10/15/14, at 2:18 p.m. the DON verified the 24 hour total fluid intake records for R59 where incomplete and that three out of the 14 days for the month of October 2014, the totals had not been tallied.	{F 309}		

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	245535	A. BUILDING _____ B. WING _____	R 10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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{F 309}	Continued From page 25 On 10/16/14, at 10:35 a.m. the DON confirmed her expectations were that the staff would follow the individual care plan for R59. The facility's Intake, Measuring and Recording policy [undated], specified as its purpose to accurately determine the amount of liquid a resident consumed in a 24 hour period. R62 received dialysis via a right chest portacath (a small medical appliance that is installed beneath the skin in which a catheter connects the port to a vein) and the facility failed to monitor the site and develop a care plan to identify the access site nor the emergency care procedures to be provided should dislodgment and/or bleeding occur. R62's History and Physical dated 10/1/14, indicated R62 was recently started on dialysis post renal failure onset. R62's 24 Hour-Vital Sign Record indicated R62 was admitted to the facility on 10/2/14. R62's Discharge Summary dated 10/2/14, indicated R62's diagnoses included diabetes and chronic kidney disease with dialysis treatments via a portacath. R62's Admission/Readmission Care Plan was undated and blank. R62's progress note dated 10/2/14, indicated R62 was cognitively alert.	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 10/17/2014

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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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{F 309}	Continued From page 26 The 24 Hour - Vital Sign Record dated 10/2/14, indicated following admission R62 left the facility at 2:30 p.m. for dialysis. The record further indicated R62 returned from dialysis at 10:00 p.m., however, the record lacked notation regarding the appearance of the catheter site dressing or how R62 tolerated the dialysis. The Nurses' Admission Assessment dated 10/3/14, identified R62 had a central line inserted in the right chest. The undated nursing assistant (NA) cheat sheet lacked identification of R62's dialysis catheter placement nor care of the catheter site. The Physician Orders dated 10/8/14, indicated R62 was to receive dialysis every three times a week. R62's October 2014, Treatment Sheets identified the right chest portacath for dialysis access and directed staff to change the dressing as needed if soiled. The staff signature section was blank. The Treatment Sheets lacked indication of monitoring of the access site nor emergency care. R62's October 2014, Medication Administration Records (MAR) lacked indication of monitoring of the portacath site. On 10/15/14 at 1:07 p.m. LPN-A confirmed R62 did not have a temporary care plan developed. On 10/15/14, at 2:39 p.m. RN-B stated an admission/readmission care plan was to be	{F 309}		

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{F 309}	Continued From page 27 completed as soon as a resident was admitted to the facility. RN-B stated R62 received dialysis, had a left arm access site and was not to have blood pressures taken from the left arm. However, RN-B stated he wasn't sure if the NAs were aware of that or not. RN-B verified he was responsible to complete the care plans, however, stated he did not have "a lot" of information on R62. RN-B confirmed R62's admission care plan was blank and stated it should have been developed to include dialysis access site, emergency care of the site as well as any restrictions such as no blood pressures on the left arm. On 10/15/14 at 3:00 p.m. R62 was observed in the dialysis unit of the adjoining hospital receiving dialysis. The portacath insertion site was observed covered with a clean, white dressing. The dialysis nurse stated the dressing was changed weekly during dialysis services. On 10/15/14, at 3:01 p.m. the dialysis unit RN confirmed dialysis staff changed R62's portacath dressing weekly and stated there was no nursing home protocol to monitor the access site. However, the RN stated staff should have been monitoring the catheter site for dislodgment and/or bleeding. The RN stated if bleeding occurred, staff should apply pressure and if unable to control the bleeding, R62 would need to be seen in the emergency department. on 10/15/14, at 3:04 a.m. R62 stated no one at the facility had looked at her dialysis access site. On 10/15/14, at 3:09 p.m. NA-B verified she occasionally worked with R62 and stated she was not sure where R62's access site was.	{F 309}		

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{F 309}	Continued From page 28 On 10/16/14, at 7:58 a.m. TMA-A confirmed R62 had a right chest dialysis catheter in place in which the dialysis unit staff took care of the dressing. TMA-A stated she monitored R62's catheter site for bleeding three times a day, however, verified there was no documentation indicating such. At 12:00 p.m. the DON stated the facility did not have a policy and procedure related to the development of temporary admission care plans. The facility's Hemodialysis Access Care policy and procedure dated 5/13, indicated the catheter must be kept clean and dry at all times and to never pull or tug on catheter tubing. The policy also indicated the general nurse should document each shift in the resident's medical record as follows: 1. location of the catheter will be documented in the MAR with the notation not to take blood pressures in the arm, if a shunt is placed. 2. The condition of the dressing and any interventions, if needed. 3. If dialysis was done during shift. 4. Any part of a report the dialysis nurse may have provided post-dialysis. 5. observations post dialysis. The facility's Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs and that documentation must be consistent with the residents' plan of care.	{F 309}		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465		11/11/14

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F 465	Continued From page 29 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain walls in good repair for 1 of 1 resident room (#W165) where the room wall was observed to have large gouges and exposed plaster. Findings include: On 10/15/14, at 1:50 p.m. R38 (room #W165) was observed in his room, in bed. The wall above R38's head board was observed to have an approximately two feet by two feet area which was wall paper was shredded, the wall had deep gouges with plaster missing. On 10/16/14, at 12:00 p.m. the director of nursing stated the wallpaper and plaster in room #W165 had been in disrepair for at least two weeks and the maintenance man was working on a plan to repair the damaged wall. On 10/16/14, at 1:16 p.m. the director of maintenance stated he was aware room #W165 was in disrepair and he had ordered some hard paneling to cover the ripped wall paper and plaster. The maintenance director also stated room #W165 had been in disrepair at least three or more weeks and did not have the time to fix the room properly.	F 465	Resident R38 has placed hard paneling at the head wall of the resident bed to address the gouges. A comprehensive room review was completed on November 5th with a completion date to improve all wallpaper issues in other resident rooms by November 11, 2014. The administrator will establish weekly rounds with the Maintenance Director to address any resident or common area wall repair needed with time action planning for improvement.	
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	{F 520}		11/18/14

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{F 520}	Continued From page 30 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure quality assurance plans had been developed for identified quality concerns. This had the potential to affect all 37 residents residing in the facility. Findings include: On 10/17/14, at 3:21 p.m. the quality assessment	{F 520}	The new DON and NHA have completed comprehensive action plans reflecting the areas of pressure ulcers, MDS and staffing concerns as initial focus areas for improvement. In addition, two other key quality initiatives have been initiated for quality improvement. The QA Committee met on November 12th to review action plans, revise the plans, and the plans were initiated. The work of the QA Committee will be	

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{F 520}	Continued From page 31 and assurance (QAA) program was reviewed with the director of nursing (DON) and the administrator. The DON stated the QAA committee met monthly and their meeting was structured around a standing agenda. She stated the plan of correction from the post certification revisit (PCR) exit date 8/12/14, had been presented to the QAA committee. The DON confirmed the facility had focused specifically on the portion of the deficiency cited, however, it was her expectation that the facility would be in compliance with the regulation in its entirety. The DON further stated the facility did not have a system in place to identify or solicit suggestions for improvement from staff, residents or family members, besides the information from the resident council meetings. The DON, with the administrator present, confirmed they had been aware of the following concerns: short staffing, Minimum Data Set (MDS) not being completed in a timely manner, and the breakdown in the overall pressure ulcer prevention program. The DON verified that a written plan of action had not been developed for the above noted areas.	{F 520}	communicated to all staff so they are aware of action plans being worked on for quality improvement. The NHA is responsible for the oversight and monitoring of the QA Program. Inclusion of other department leaders and line staff will continue. ADDENDUM F520 11/10/2014 Policy review of the committee structure is complete with a new agenda created by the interim DON and interim NHA. The staff quality assurance education was initiated with Staff Education and updates on November 3, 2014 with staff mandatory meetings conducted. The initial three action plans regarding staffing, MDS assessment process, and pressure ulcers have been initiated for the November 12, 2014 meeting. The committee members will participate in revisions and full implementation improvements. The committee meeting cycle will be monthly until determined that the core planning areas are established. Routine committee members are the Medical Director, NHA, DON, Maintenance Director, Social Services , an d the pharmacist. Other employees are invited as topics and projects further develop. Education and communication will be managed with written memo updates, postings, action plans, and audit results. The Administrator will be responsible for oversight and management of this process. Please refer to F314, F353, and F272 to related initial quality assurance topic and action area details.	

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Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	10/17/2014

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0155** Reg. # **483.10(b)(4)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/17/2014**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/17/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/22/2014	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	10/17/2014

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/17/2014**
ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **10/17/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	10/29/2014	32601	10/17/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/27/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ISKC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**

2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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 **08/12/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **47** (L18)

13.Total Certified Beds **47** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Theresa Gullingsrud, HFE NEII — 09/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/30/1991
(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.
00400
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/15/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5535

On August 12, 2014, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard, completed on May 22, 2014 and an FMS completed June 27, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 22, 2014.

The deficiencies not corrected are as follows:

F0155 -- S/S: D -- 483.10(b)(4) -- Right To Refuse; Formulate Advance Directives
F0159 -- S/S: E -- 483.10(c)(2)-(5) -- Facility Management Of Personal Funds
F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F0282 -- S/S: E -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0325 -- S/S: D -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable
F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

At the time of the revisit the following deficiency related to the standard survey was identified:

F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

In addition, our revisit to follow up on the deficiencies issued pursuant to the FMS survey determined the following deficiencies were not corrected:

F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

F0514 -- S/S: D -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible

Furthermore, at the time of the revisit the following deficiencies related to the FMS survey were identified:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in your facility pursuant to the standard survey and the FMS survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that the cility continues to not be in substantial compliance, this Department imposed the following category 1 remedy:

- State Monitoring effective September 2, 2014. (42 CFR 488.422)

In addition, this department is recommending the follow action related to the remedy imposed in their letter of July 8, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014, remain in effect. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Jourdain/Perpich Extended Care Facility is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 22, 2014. Post Certificatoin Revisit (PCR) to follow.

Refer to the CMS 2567 along with the facility's plan of corrections for the results of this visit.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 28, 2014

Mr. William Eckblad, Administrator
Jourdain/Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535025, S5535027

Dear Mr. Eckblad:

On June 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 22, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 27, 2014, a survey team representing the Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) at your facility. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found the most serious deficiency to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)

On July 8, 2014 CMS notified you of the results of the FMS and informed you they were imposing the following remedy:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014. (42 CFR 488.417 (b))

Furthermore, CMS notified you in their letter of July 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

On August 12, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard, completed on May 22, 2014 and an FMS completed June 27, 2014.

Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 22, 2014. The deficiencies not corrected are as follows:

F0155 -- S/S: D -- 483.10(b)(4) -- Right To Refuse; Formulate Advance Directives
F0159 -- S/S: E -- 483.10(c)(2)-(5) -- Facility Management Of Personal Funds
F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F0282 -- S/S: E -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0325 -- S/S: D -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable
F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

At the time of the revisit the following deficiency related to the standard survey was identified:

F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

In addition, our revisit to follow up on the deficiencies issued pursuant to the FMS survey determined the following deficiencies were not corrected:

F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens
F0514 -- S/S: D -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible

Furthermore, at the time of the revisit the following deficiencies related to the FMS survey were identified:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in your facility pursuant to the standard survey and the FMS survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility continues to not be in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective September 2, 2014. (42 CFR 488.422)

In addition, this department is recommending the follow action related to the remedy imposed in their letter of July 8, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014, remain in effect. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Jourdain/Perpich Extended Care Facility is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 22, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 November 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	8/12/2014

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN/PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0160 Reg. # 483.10(c)(6) LSC	08/12/2014	ID Prefix F0332 Reg. # 483.25(m)(1) LSC	08/12/2014	ID Prefix F0334 Reg. # 483.25(n) LSC	08/12/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By LB/mm	Date: 08/28/2014	Signature of Surveyor: 33562	Date: 08/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/27/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	8/12/2014

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN/PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0160** Reg. # **483.10(c)(6)** LSC	Correction Completed **08/12/2014**	ID Prefix **F0170** Reg. # **483.10(i)(1)** LSC	Correction Completed **08/12/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/12/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **08/12/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/12/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **08/12/2014**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **08/12/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **08/12/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	08/28/2014	33562	08/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/22/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 08/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveryors of this department on August 11, 12, 2014, to determine compliance with Federal deficiencies issued during a Federal monitoring survey exited on June 27,2014. During this visit the following regulations were determined to be not corrected.	{F 000}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan for the care of 1 of 1 resident (R59) identified with Clostridium difficile (C-diff).	{F 279}	Jourdain Perpich Extended Care Center performs comprehensive care planning with an interdisciplinary team. (IDT) A. R59's status is stable, she was and is	10/3/14

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

Electronically Signed | 09/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 08/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(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 279}	Continued From page 1 Findings include: R59's Hospital Discharge Summary dated 8/6/14, indicated R59 was diagnosed with Clostridium difficile colitis (a type of infectious diarrhea) and a chronic stage IV sacral pressure ulcer. R59's Interagency Transfer Orders dated 8/6/14, indicated an order for metronidazole 500 milligrams (an antibiotic medication used to treat C-diff) one tablet by mouth 3 times a day until 8/14/14. R59's care plan lacked identification of the infection, control protocols to minimize the risk of transmission of C-diff and interventions to direct the care of R59's infection. On 8/12/14, at 6:11 p.m. director of nursing (DON) confirmed that C-diff was not addressed on R59's care plan. She stated she would have expected interventions specific to R59's C-diff infection be addressed on the care plan. The Care Plans - Comprehensive policy dated October 2010, indicated the care planning/interdisciplinary team was responsible for the review and updating of care plans when the resident had been readmitted to the facility from a hospital stay.	{F 279}	currently symptom free. Care plan updated to reflect history of c-diff. B. All residents were audited regarding bowel status. Care plans on those residents that have a history of c-diff have been updated. C. Staff education will be provided on the importance of unusual bowel status incidents on Sept 8th, 2014. Audit completed on every resident for bowel symptoms. DON or designee will monitor new admissions or readmissions with diagnosis of c-diff to ensure that care plan include interventions and symptom monitoring. D. The plan of correction will be monitored by the DON or designee, then reported to QAPI committee at least quarterly.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		10/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 08/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(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 282	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer prescribed medication for 1 of 1 resident (R46) as directed by the plan of care. R46's physician orders signed 6/30/14, indicated R46 was diagnosed with diabetes with routine dialysis treatments. The order's also indicated an order for Renvela (a medication used to bind phosphorous in dietary intake and normalize phosphorous levels in patients who have renal disease) 800 milligrams (mg) 2 tablets 3 times a day and 2 tabs with snacks. Review of R46's care plan dated 6/19/14, indicated R46 received Renvela and directed staff to administer three times a day with meals and with snacks. R46's Medication Administration Record (MAR) for August 2014, revealed the times to administer R46's Renvela medication were at "7AM, 11AM, 5 PM, AM snack, PM snack." This was a total of five times per day. Review of the MAR for August 2014 revealed that R46 had not received the Renvela during snack times in the morning on August 2, 3, 4, 6, 7, 8 and 11. The Renvela was not administered during the afternoon snack on August 2, 3 and 8 and it was documented as refused on August 4, 5 and 6. The MAR did not include supporting documentation to indicate why the medication was not administered per the orders. The DON was interviewed on 8/12/14, at 9:09	F 282	Jourdain Perpich will provide services in accordance with each resident's written plan of care. A. R46's medication administration schedule has been reviewed and remains current. B. All residents on dialysis will be audited to assure that medications are not missed and administered per MD orders. C. Audits will be conducted daily x 7day, then 2 times a week for 2 weeks, then weekly x 2 weeks or until 100% compliance is achieved. Staff education will be provided on Sept 8th, 2014 regarding resident dialysis regimens and how to utilize care plans. D. The plan of correction will be monitored by DON or designee. Results will be reported to QAPI at least quarterly.	

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F 282	Continued From page 3 a.m. and confirmed R46's Renvela medication was not provided according to the written care plan for R46. The facility's Care Plans-Comprehensive policy dated 10/2010, indicated a comprehensive care plan would be developed to meet the resident's medical, mental and psychological needs The Care Plans - Comprehensive policy dated October 2012, did not direct the staff how to utilize the care plan.	F 282		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication related to kidney dialysis was consistently provided according to physician's orders for 1 of 1 resident (R46) in the sample reviewed for end stage kidney disease (ESRD). Findings include: R46's physician office visit form dated 8/5/14, indicated R46 was diagnosed with end stage	{F 309}	Jourdain Perpich will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being in accordance with the comprehensive assessment and plan of care. A. R46's medication administration schedule has been reviewed and remains current. B. All residents currently on dialysis will be audited to ensure that all medications are	10/3/14

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{F 309}	Continued From page 4 renal disease (ESRD) and type II diabetes mellitus. R46's physician orders included an order for Renvela (a medication used to bind phosphorous in dietary intake and normalize phosphorous levels in patients who have ESRD) 800 milligrams (mg) 2 tablets 3 times a day and 2 tabs with snacks. R46's care plan dated 6/19/14, indicated R46 received dialysis treatments three times per week and was prescribed Renvela to be given three times a day with meals and with snacks. The care plan also indicated R46 could self administer the medication after set up by staff. R46's Medication Administration Record (MAR) for August 2014, revealed the times to administer R46's Renvela medication were at "7AM, 11AM, 5 PM, AM snack, PM snack," five times per day. Review of the MAR for August 2014, revealed that R46 had not received Renvela with morning snacks on August 2, 3, 4, 6, 7, 8 and 11. The Renvela was not administered with afternoon snacks on August 2, 3 and 8. The MAR indicated R46 refused Renvela on August 4, 5 and 6. The MAR did not include documentation which identified the reason the medication had not been administered or why the resident had refused the medication. The director of nursing (DON) was interviewed on 8/12/14, at 9:09 a.m. and confirmed the MAR lacked documentation of why the medication was not administered.	{F 309}	not missed and administered per MD order. C. Audits will be conducted daily x7days by DON or designee, then 2x per week x 2 weeks, then, weekly x 2 weeks or until 100% compliance achieved. D. Plan of correction will be monitored by DON or designee. Results will be reported to QAPI at least quarterly.	
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	{F 329}		10/3/14

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{F 329}	Continued From page 5 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medical justification for continued use of psychoactive medications or attempt dosage reductions of antipsychotic and antianxiety medications. In addition, the facility failed to monitor the effectiveness of medications used to modify undesirable behaviors for 1 of 5 (R18) residents reviewed for unnecessary medications.	{F 329}	Jourdain Perpich Extended Care will ensure that will be free from unnecessary drugs, including antipsychotic drugs. A. R18's medication regimen will be reviewed by the consulting pharmacy and recommendations made to mental health provider. B. All residents that receive psychotropic medications will have their medications reviewed to ensure that they have proper	

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{F 329}	Continued From page 6 Findings include: Review of R18's physician's orders revealed R18 received the following psychotropic medications: Zyprexa (antipsychotic) 5 mg twice daily (BID), Zoloft (antidepressant) 100 mg daily (qd) and Ativan (antianxiety) 0.5 mg three times daily (tid). The resident's target behaviors included the following: refusal of cares, verbal abuse, swearing, demanding, and throwing. The resident had not displayed psychotic behavior including hallucinations and delusions. Further review of the resident drug regimen was completed and there was no way to confirm the date the resident first started taking the medication Ativan 0.5 mg tid. It was noted that the Ativan had been increased last on 1/11/14, from twice per day to three times a day, Zyprexa 5 mg BID had been started on 10/27/10, and last increased on 4/7/11, and the Zoloft 100 mg qd had been started on 4/27/11. There was no record that an attempted dose reduction had been attempted at any point since the Ativan, Zyprexa, and Zoloft medications had first been started. Review of the pharmacist monthly drug regimen review reports for June and July 2014, revealed that no recommendations were made regarding R18's medication regimen. During interview with the consultant pharmacist on 8/12/14, at 11:23 a.m. she stated that she has not had any recommendations in the last 6 months for R18. The consultant pharmacist stated she was not aware that she had to ensure R18 had the correct indication for the use of medications, that behavioral monitoring was to be	{F 329}	diagnosis, behavior monitoring and risk vs. benefit and effectiveness of medication. C. Audits will be done weekly x4 to ensure that behaviors are being documented and that GDR are being recommended. Consultant pharmacists to acquire copy of target behaviors of each resident on a psychotropic medication and attach to their MRR sheet. Consultant pharmacist to ensure that target behaviors are appropriate for medications. Spreadsheet will be updated by consultant pharmacist on a monthly basis during review. D. Plan of correction will be monitored by the DON or designee. Results will be reported at QAPI at least quarterly.	

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{F 329}	Continued From page 7	{F 329}		

reviewed to ensure proper target symptoms, and dementia with psychosis was not an adequate diagnoses for the use of an antipsychotic medication. The consultant pharmacist confirmed that R18 did not have psychotic behavior identified in his record.

The facility consultant pharmacist was again interviewed on 8/12/14, at 1:39 p.m. during which she confirmed that there was not an adequate indication for the antipsychotic medication. She confirmed there has not been an attempted dose reduction since all of the aforementioned medications had been implemented, and there was not a progress note written by a physician which identified adequate justification for ongoing use of the medications Ativan, Zyprexa, and Zoloft.

Review of the Care Area Assessment (CAA) Summary dated 5/28/14, noted that Ativan, Zyprexa and Zoloft were used "for management of depression, dementia and anxiety." Risk factors identified for the use of the three medications was listed as "behavioral changes, medication side effects, falls, pressure ulcers and weight changes." The CAA Summary indicated target behaviors included "refusal of cares or testing, verbal abuse/swearing/demeaning, throwing/knocking things on floor and yelling at staff when they approach to help." The CAA Summary noted that R18 was "currently receiving the lowest effective dose of Zoloft, Zyprexa and Ativan for managing symptoms." However, each medication was not assessed individually to determine the medical justification, analysis of risks and benefits of that medication for R18 or analysis of the effects of the medication in modifying R18's behaviors.

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{F 329}	Continued From page 8 Review of the mental health note dated 6/29/13, revealed "[R18] has long/short term memory impairment, irritability, poor comprehension, frustration, poor tolerance, mood swings, decreased attention span, distractibility, difficulty planning ahead, impulse control and anger outbursts...Target behaviors stable - no worsening. Behaviors include refusal or cares or testing, verbal abuse, swearing, demeaning, change in depression. At this time he is on lowest effective dose of Zoloft, Ativan and Zyprexa and symptoms are managed.... " During interview with registered nurse (RN)-A on 8/12/14, at 10:37 a.m. she stated that she does not know of any psychotic symptoms that R18 displays, and RN-A could not locate any documentation or progress notes written related to the resident's behavior since April 2014. During interview with the director of nursing (DON) on 8/12/14, at 3:01 she confirmed that R18 did not display psychotic behavior, and R18 had not had a dosage reduction of the Zyprexa and Ativan nor tapering of the dosage for the Zoloft. In addition, the clinical record had not identified a physician justification for the reasons R18 should not attempt a dosage reduction and tapering of the aforementioned medications.	{F 329}		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		10/3/14

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F 428	Continued From page 9 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified drug irregularities related to failure to provide medical justification for continued use of psychotropic medications, and lack of monitoring of the effectiveness of medications used to modify undesirable behaviors for 1 of (R18) 5 residents reviewed for unnecessary medications. Findings include: Review of R18's physician's orders revealed R18 received the following psychotropic medications: Zyprexa (antipsychotic) 5 mg twice daily (BID), Zoloft (antidepressant) 100 mg daily (qd) and Ativan (antianxiety) 0.5 mg three times daily (tid). The resident's target behaviors included the following: refusal of cares, verbal abuse, swearing, demanding, and throwing. The resident had not displayed psychotic behavior including hallucinations and delusions. Further review of the resident drug regimen was completed and there was no way to confirm the date the resident first started taking the medication Ativan 0.5 mg tid. It was noted that the Ativan had been increased last on 1/11/14, from twice per day to three times a day, Zyprexa 5 mg BID had been started on 10/27/10, and last increased on 4/7/11, and the Zoloft 100 mg qd	F 428	The drug regimen for all residents are reviewed by a licensed pharmacist. A. R18's medication regimen will be reviewed and revised by the consultant pharmacist B. The drug regimen for all the other residents will be reviewed with a focus on antipsychotic medications and any irregularities. Consultant pharmacists will review all behavior monitoring. C. Education will be provided Sept 8th, 2014 to nursing staff to train on parameters for use of psychoactive medications and specific behavior criteria for use. D. Plan of correction will be monitored by the DON and reported to QAPI at least quarterly.	

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F 428	Continued From page 10	F 428		

had been started on 4/27/11. There was no record that an attempted dose reduction had been attempted at any point since the Ativan, Zyprexa, and Zoloft medications had first been started.

Review of the pharmacist monthly drug regimen review reports for June and July 2014, revealed that no recommendations were made regarding R18's medication regimen.

During interview with the consultant pharmacist on 8/12/14, at 11:23 a.m. she stated that she has not had any recommendations in the last 6 months for R18. The consultant pharmacist stated she was not aware that she had to ensure R18 had the correct indication for the use of medications, that behavioral monitoring was to be reviewed to ensure proper target symptoms, and dementia with psychosis was not an adequate diagnoses for the use of an antipsychotic medication. The consultant pharmacist confirmed that R18 did not have psychotic behavior identified in his record.

The facility consultant pharmacist was again interviewed on 8/12/14, at 1:39 p.m. during which she confirmed that there was not an adequate indication for the antipsychotic medication. She confirmed there has not been an attempted dose reduction since all of the aforementioned medications had been implemented, and there was not a progress note written by a physician which identified adequate justification for ongoing use of the medications Ativan, Zyprexa, and Zoloft.

Review of the mental health note dated 6/29/13, revealed "[R18] has long/short term memory

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F 428	Continued From page 11 impairment, irritability, poor comprehension, frustration, poor tolerance, mood swings, decreased attention span, distractibility, difficulty planning ahead, impulse control and anger outbursts...Target behaviors stable - no worsening. Behaviors include refusal or cares or testing, verbal abuse, swearing, demeaning, change in depression. At this time he is on lowest effective dose of Zoloft, Ativan and Zyprexa and symptoms are managed.... " During interview with registered nurse (RN)-A on 8/12/14, at 10:37 a.m. she stated that she does not know of any psychotic symptoms that R18 displays, and RN-A could not locate any documentation or progress notes written related to the resident's behavior since April 2014. During interview with the director of nursing (DON) on 8/12/14, at 3:01 she confirmed that R18 did not display psychotic behavior, and R18 had not had a dosage reduction of the Zyprexa and Ativan nor tapering of the dosage for the Zoloft. In addition, the clinical record had not identified a physician justification for the reasons R18 should not attempt a dosage reduction and tapering of the aforementioned medications.	F 428		
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	{F 441}		10/3/14

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{F 441}	Continued From page 12 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to properly disinfect 1 of 1 resident (R59) room and care equipment in order to prevent the spread of clostridium difficile(infectious diarrhea) which had the potential to affect 2 of 2 residents residing in the same room. The facility failed to ensure a blood pressure cuff was properly disinfected prior to use	{F 441}	Jourdain Perpich will establish and maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A. Resident infection and staff illness will be investigated, controlled and the spread	

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{F 441}	Continued From page 13 for 1 of 1 resident (R58) observation. This practice had the potential to affect 28 of 40 residents who utilized the cuff. In addition, the facility failed to track, trend and analyze resident infections which had the potential to affect all 40 residents residing in the facility. Findings include: Clostridium difficile (C-diff): R59's Hospital Discharge Summary dated 8/6/14, indicated R59 was diagnosed with clostridium difficile colitis (C-Diff) and a chronic stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) sacral pressure ulcer. R59's Interagency Transfer Orders dated 8/6/14, indicated an order for metronidazole 500 milligrams (an antibiotic used to treat C-Diff) one tablet by mouth three times a day until 8/14/14. R59's care plan dated 6/24/14, indicated R59 was continent of bowel and directed staff to assist R59 to the commode or toilet, assist to pull up/down pants and provide peri-rectal cares after elimination. R59's care plan lacked identification of the C-Diff diagnosis and lacked care related interventions and infection control protocols in order to minimize the risk of the transmission of C-Diff. During the survey, R59 was out of the building on a leave. On 8/12/14, at 2:50 p.m. nursing assistant (NA)-G stated she had cared for R59 once since she was diagnosed with C-Diff and stated she	{F 441}	of infection prevented. R59 was asymptomatic of c-diff at time of readmission. The infection control log is completed to include location of infection, the type of organism if available and if a reculture was obtained. An analysis of staff and resident infection will be compiled on a monthly basis to determine any similarities or patterns of contamination. Updated policy and procedure will include appropriate cleansing solutions to be used on resident care equipment, depending on the piec of equipment and any resident contamination concerns. B. An infection control policy and procedure has been developed and implemented. All resident and staff illness will be monitored and tracked, appropriate measures will be taken to prevent the spread of illness and infection. C. Policy and procedures will be reviewed and updated on a yearly basis. The infection control nurse or DON will track and log all illnesses and implement the necessary measures to prevent the spread if infection and illness. The infection control nurse shall attempt to have completed logs, addressing symptoms and the organism if available as it may relate to antibiotic regimens. Staff shall be educated on the infection control policy and procedure and specifically how it related to cleaning and care of resident care equipment and cleansing resident units such as when c-diff is diagnosed. Staff will be provided education on September 10th, 2014. D. Infection control logs and tracking will	

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{F 441}	Continued From page 14 was instructed to use gown and glove precautions when caring for R59. NA-G stated R59 used a facility bedside commode and staff were instructed to clean the commode with a special solution. R59 shared a room and bathroom with an independent resident who did use the shared bathroom. However, NA-G stated R59 had not used the bathroom. NA-G brought the surveyor to R59's room to retrieve the cleaner, however, none was stored in the room or the shared bathroom. NA-G stated the solution was kept in the housekeeping closet. NA-G further stated R59 did have loose stools when she cared for her. On 8/12/14, at 2:57 p.m. NA-D verified she had worked with R59 once and state she observed R59 utilizing the shared bathroom on the evening shift of 8/11/14, however, she denied that R59 had a stool at that time. NA-D stated she used TB (tuberculosis) spray or Sani-wipes to clean the commode / equipment used by R59. NA-D brought the surveyor to the housekeeping closet and identified the spay used was TB Disinfectant Cleaner Ready to Use. NA-D also stated she had read on her computer based training program that a 10:1 bleach solution could be used to clean equipment with potential C-Diff contamination. NA-D indicated they had not had bleach solution to use and had been directed to use the TB disinfectant spray or Sani-wipes. On 8/12/14, at 3:05 p.m. NA-E stated R59 used a bedside commode and TB spray from the housekeeping closet was used to clean the commode. NA-E also indicated R59's roommate was independent and used the shared bathroom. On 8/12/14, at 3:19 p.m. NA-F stated sometimes	{F 441}	be monitored by DON. The infection control nurse in collaboration with the DON shall review all documented infections of staff and residents to analyze similarities. QAPI continue to be updated monthly by the infection control nurse or the DON.	

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{F 441}	Continued From page 15 R59 refused to use the commode and insisted upon using the shared bathroom. NA-F stated she had helped R59 in the shared bathroom and wiped the toilet down with Sani-wipes after R59's use. On 8/12/14, at 6:11 p.m. director of nursing (DON) confirmed R59's care equipment and room should have been cleaned with a 10:1 bleach solution and that neither TB disinfectant cleaner Ready To Use nor Sani-Cloth Plus wipes were effective against C-diff. The DON also confirmed C-diff was not addressed on R59's care plan and stated it should have been. 8/13/14, at 10:44 a.m. housekeeper (H)-A stated he cleaned the rooms on each of the halls in the facility and had cleaned R59's room. He indicated TB Disinfectant Cleaner Ready to Use was used to wipe down the bed and furniture. H-A indicated the floor was mopped with bleach water and stated he used a cupful of bleach in a 5 gallon bucket (a 1:10 solution equals 2 quarts to 5 gallons). H-A stated the nursing staff was responsible to clean R59's bedside commode. H-A stated the TB Disinfectant Cleaner was also used to clean the toilet and sink in the shared bathroom and the bleach water solution was used to mop the bathroom floor. H-A stated he had received training regarding C- diff and was told to use bleach water to kill it. The undated Clostridium Difficile policy directed staff to routinely clean and disinfect high-touch resident surfaces and equipment and indicated disinfection of items with fecal soil matter required 1:10 household bleach and water solution.	{F 441}		

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{F 441}	Continued From page 16 Blood pressure cuff: On 8/12/14, at 8:23 a.m. the trained medication aide (TMA)-A was observed to wheel an electronic blood pressure machine from the central nursing area down the hall 25 feet to R58's room. The blood pressure cuff fell out of the attached basket and landed on the floor. TMA-A proceeded to wheel the electronic blood pressure machine into R58's room, dragging the blood pressure cuff on the floor. -At 8:24 a.m. TMA-A was observed to squirt a 50 cent piece size of Aloe Vesta solution (a body wash and shampoo cleansing foam) on a dry disposable cloth and proceeded to wipe off the blood pressure cuff and place the cuff around R58's left arm. However, TMA-A was unable to obtain an accurate blood pressure reading the cuff was removed and placed on R58's right arm. On 8/12/14, at 12:29 p.m.TMA-A acknowledged the blood pressure cuff had fallen to the floor and was drug behind the blood pressure machine as it was wheeled into R58's room. TMA-A stated the Aloe Vesta cleansing foam was probably not the most appropriate solution to clean the dirty blood pressure cuff and she should have used an alcohol wipe or something stronger. On 8/12/14, at 3:59 p.m. the DON confirmed the Aloe Vesta cleansing foam was not an appropriate disinfectant and it should only be used for skin care. The DON verified a Sani-Cloth wipe (a disposable wipe utilized to disinfect reusable equipment) should have been used to clean the blood pressure cuff before placing the cuff on the patient. The Cleaning and Disinfection of Resident-Care	{F 441}		

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{F 441}	Continued From page 17 Items and Equipment policy revised on 10/2009, directed staff to follow current Center of Disease Control and Prevention (CDC) recommendations for cleaning and disinfecting resident care equipment including reusable items and durable medical equipment. Infection Control Logs: Review of the facility's infection control logs for July and August of 2014, revealed the logs lacked data which determined if the infection was cultured, the type of organism the infection was caused by and if the infection was re-cultured following antibiotic treatment was not completed. Additionally, the facility surveillance including where each infection had occurred in the building so that pattern and trends of the spread of infection could be reviewed was not completed. During interview on 8/12/14, at 3:39 p.m. the Director of Nursing (DON) confirmed the findings and verified the lack of appropriate tracking, trending and surveillance of infections.	{F 441}		
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	{F 514}		10/3/14

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{F 514}	Continued From page 18 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure treatments were accurately documented in the treatment administration records for 3 of 3 residents (R11, R16, R18) in the sample. Finding include: R11's undated Disease Index Report indicated R11's diagnoses included cellulitis and abscess, candidiasis of skin and nails and diabetes. R11's treatment sheets dated 8/1/14, to 8/31/14, identified an order dated 2/7/14, for Nystatin cream 100,000 units twice a day for the treatment of candidiasis and directed staff to apply a small amount to the affected area (abdominal folds) twice a day until resolved. Review of the sheets revealed the following blank A.M. (morning) entries: 8/9, and 8/10, and the following blank P.M. (evening) entries 8/6, 8/7, 8/10, and 8/11. A second treatment sheet indicated an nursing order dated 7/20/14, which directed staff to monitor R11's hip every shift for breakdown and apply A&D ointment with cares. The following A.M. entries were noted to be blank 8/9, and 8/10, and under the P.M. section, the entries were blank on 8/6, 8/7, 8/10, and 8/11. On 8/12/14, at 7:00 p.m. the director of nursing (DON) confirmed the documentation of treatments was not complete.	{F 514}	Jourdain Perpich Extended Care Center will maintain records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systemically organized, that will contain sufficient information to identify the resident, a record of the resident's assessments, the plan of care and services provided, the results of any preadmission screening conducted by the state and progress notes. A. R11, R16 and R18 will not have missed doses without reason. B. MAR and Treatment sheets will be audited daily and missed documentation of medications and treatment will be considered medication errors. C. Policy and Procedure for medication administration will be updated as needed and yearly. Audits will be conducted on the night shift and results submitted to the DON or designee. This will be ongoing. Staff education regarding the importance of complete documentation focusing on the medication and treatment record will be provided on September 8th, 2014. D. Plan of correction will be monitored by the DON and results reported to QAPI at least quarterly.	

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{F 514}	Continued From page 19	{F 514}		

R16's undated Diseases Index Report indicated R16 had diagnoses that included ulcer of other part of foot, pemphigoid bullous (skin disorder characterized by large blisters), and diabetes

R16's treatment sheets dated 8/1/14 to 8/31/14, indicated:
-"6/13/14 Wound & Skin Care Orders - Right heel - 1) apply Santyl ointment, 2) cover with gauze, 3) wrap with Kerlix and secure with tape, 4) change daily for decubitus ulcer of right heel." The order was discontinued 8/8/14. Further review under "Hour AM" from 8/5/14 to 8/8/14 revealed blank entries on the following days: 8/5 and 8/7.
-"3/18/14 Wound & Skin Care Orders - Sores on bilateral legs - 1) cleanse with soap and water, 2) apply bactroban ointment to all open areas, 3) cover with gauze - limit use of tape to skin, 4) change daily for bullous pemphigoid. " Further review under "Hours AM" revealed blank entries on the following days: 8/7, 8/9, 8/10, 8/11 and 8/12.
-"11/12/13 Wound & Skin Nursing Order - Apply Calazinc to buttock BID [twice a day]. Further review under "Hour AM" revealed blank entries on the following day: 8/7. Under "Hours PM" blank entries were noted on the following days: 8/5 and 8/6.
-"4/17/14 Wound and Skin Nursing Order - Right hip open area - apply A&D and Telfa open areas on right hip daily. " Further review under "Hour AM" revealed blank entries on the following days: 8/7 and 8/9.
-"8/8/14 Apply A&D to bilateral feet daily - paying attention to healed ulcer on right heel." Further review under "Hour AM" revealed blank entries on the following days: 8/8, 8/9 and 8/10.

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{F 514}	Continued From page 20 On 8/12/14, at 7:00 p.m. DON confirmed the documentation of treatments was not complete and contained blank entries. R18's current treatment sheet revealed that the facial treatment Tretinoin 0.01% had not been consistently documented and the reason for refusal had not been documented on all 11 of 11 days so far in August 2014. The facility treatment sheets identified the following treatment for R18: "Tretinoin 0.01% to face q [every] HS [hour of sleep]-may leave in med cup at bedside DX: [diagnosis] Facial cysts & open comedomes." R18's treatment sheets dated 8/1/14 to 8/31/14, indicated that the skin treatment had not been offered on 6 of the 11 days and R18 had refused the medicated skin treatment on the other 5 of 11 days. There was no documentation on the treatment administration record which identified the reason the treatment had not been provided or the reason R18 had refused the medicated skin treatment. Review of the physician progress notes and nurses notes from 8/1/14-8/11/14, revealed that the physician had not been notified that R18 had not been provided the Tretinoin 0.01% medicated skin treatment. The DON was interviewed on 8/12/14, at 3:31 p.m. during which she confirmed that the documentation of treatments was not complete and contained blank entries and refused medication. The DON further stated that if the resident refused any treatment the reason for the refusal should be documented on the back of the	{F 514}		

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{F 514}	Continued From page 21 treatment record.	{F 514}		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QA&A) committee implemented appropriate action plans for previously identified areas of concern during the recent recertification and federal monitoring surveys in order to prevent	F 520	Jourdain Perpich Extended Care Center will maintain a QAPI committee that consists of the DON, medical director and 3 other members of the facility staff. This committee will meet at least quarterly to identify issues, with respect to which	10/3/14

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F 520	Continued From page 22 repeat quality deficiencies. This had the potential to affect all 40 residents residing in the facility. The Findings include: On 8/12/14, at 7:45 p.m. the facility plan of correction (POC) was reviewed with the director of nursing (DON). The POC indicated the DON or designee would audit the rehabilitation notes and identify those at risk or have refusals of rehabilitation services x 4 weeks and monthly thereafter to ensure compliance. The POC also indicated staff education would be provided regarding the proper administration of Renvela and audits would be conducted by the DON or designee weekly x 4 weeks and then monthly thereafter. Additionally, the POC indicated audits would be conducted on all residents to ensure they had been vaccinated. On 8/12/14, at 8:10 p.m. the DON stated audits of rehabilitation notes, audits and staff education of the proper administration of Renvela and for resident immunizations had not been completed as indicated. Refer to F155 related to the lack of risk vs. benefit education provided when a resident refuses treatment. Refer to F309 related to lack of medication administration per the physician's order.	F 520	quality assurance activities are necessary and develop and implement appropriate plans of action to correct the identified quality deficiencies. The QAPI committee will address at a minimum incident and accident reporting, infection control and medication and pharmacy services. A. All audits will be completed as stated. B. A QAPI meeting will be held on September 10th, 2014 to discuss all tags, audit formats and findings. C. All issues will be added to the QAPI agenda. D. Plan of correction will be monitored by the director of nursing and administrator, QAPI will continue to meet on a monthly basis, but minimally quarterly.	

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{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on August 11, 12, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on May 22, 2014. During this visit the following regulations were determined to be not corrected.	{F 000}		
{F 155} SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to document education regarding risks and benefits of refusing restorative therapy services for 1 of 3 residents (R23) reviewed for	{F 155}	Jourdain Perpich honor all residents wishes regarding refusal of care. A. R23 will be re-evaluated by therapy, nursing will document re-assessment.	10/3/14

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

Electronically Signed | 09/05/2014

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

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{F 155}	Continued From page 1 therapy. Findings include: R23's significant change Minimum Data Set (MDS) dated 4/25/14, indicated R23 had diagnoses that included stroke, hemiplegia or hemiparesis, and Parkinson's disease. The MDS also indicated R23 had moderate cognitive impairment and required extensive assist of 1 person for bed mobility, transfer, and walking in the corridor. The MDS further indicated R23 had one-sided upper extremity impairment and participated in a restorative nursing program for active range of motion and walking. R23's progress note dated 2/10/14, and signed by the physical therapist recommended the rehab aide continue strengthening to lower extremities and passive range of motion to right upper extremity along with ambulation with forward wheeled walker and the assistance of one staff as tolerated 3-6 times per week. R23's care plan dated 7/30/14, indicated R23 required strengthening exercises as tolerated to left upper extremity and both lower extremities and passive range of motion to right upper extremity 3-6 times per week. The care plan directed staff to ambulate R23 with forward wheeled walker 3-6 times weekly. Review of R23's Rehabilitation Treatment Sheet dated 7/1/2014, to 7/31/2014, revealed R23 refused rehabilitative services on 7/2, 7/3, 7/4, 7/8, 7/9, 7,11, 7/15, 7/23, 7/24, and 7/30 (10 of 23 opportunities). It also revealed blank entries on the following days 7/1, 7/7, 7/17, and 7/18 (4 of 23 opportunities).	{F 155}	Nursing rehab aides will be re-educated on the importance of complete documentation. B. All records were reviewed for refusals of care. Nursing rehab aids will document all refusals of therapy and resident education regarding risk vs benefit. Documentation shall reflect attempts to determine root cause of refusal and follow up per policy and procedure. C. Will review policy and procedure and update as needed. Education will be provided to staff at the nursing meeting on September 8, 2014. DON or designee will audit the rehabilitation notes and identify those that are at risk or have refusals of rehabilitation services x 4 weeks and monthly there after to ensure compliance. D. The plan of correction will be monitored by the DON or designee and reported to QAPI Committee at least quarterly.	

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{F 155}	Continued From page 2 Review of R23's Rehabilitation Treatment Sheet dated 8/1/2014, to 8/12/2014, revealed R23 refused rehabilitative services on 8/7, (1 of 8 opportunities). It also revealed blank entries on the following days 8/1, 8/4, 8/5, 8/8, 8/11, and 8/12 (6 of 8 opportunities). On 8/12/14, at 4:26 p.m. nursing assistant (NA)-H stated R23 frequently refused rehabilitation services. NA-H indicated R23 preferred to stay in bed most of the day. She stated she used to be able to get R23 to attend rehab by telling him his room needed to be cleaned, however, indicated this no longer worked. NA-H stated R23 ambulated to appointments so she told him he had an appointment with her and that worked. Rehabilitation Treatment Sheets for July and August 2014, were reviewed with NA-H who confirmed R23 refused 10 of 23 opportunities in July and 1 of 8 opportunities in August. NA-H also confirmed blank entries on 4 of 23 days in July and 6 of 8 days in August. R23's record lacked documentation that education regarding the risk of refusing therapy had been given to R23. On 8/12/14, 6:30 p.m. director of nursing (DON) confirmed documentation regarding the risk and benefit to refusing therapy was not available in R23's record. A policy regarding resident refusal of treatment was requested but none was provided.	{F 155}		
{F 159} SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS	{F 159}		10/3/14

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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 159}	Continued From page 3 Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in	{F 159}		

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	245535	A. BUILDING _____ B. WING _____	R 08/12/2014

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{F 159}	Continued From page 4 section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents with personal trust fund accounts with the facility, had access to their money after business office hours and on the weekends. This had the potential to affect 31 of 40 residents residing in the facility who had personal trust funds accounts with the facility. Findings include: The administrator was interviewed on 8/12/14, at 11:00 a.m. and stated the facility had made arrangements for money to be kept in the locked medication room so that if a resident wanted access to money after business hours and on the weekend the charge nurse could accommodate the residents request for money. The administrator further stated that the only time a resident could access the money was for emergency purposes and having money to purchase candy or cigarettes was not an emergency and did not need to be accommodated. Review of the facility policy Resident Trust Fund--Emergency dated 6/17/14, identified the following: "...Normal business hours are 9:00 to 4:30 Monday through Friday, except holidays.	{F 159}	Resident Trust Funds are protected and available for resident use. A. The availability of money on weekends and evenings will be maintained through a money bag locked on the nurses cart. Nurses will have a listing of those residents with funds available. B. Funds are available for all residents with trust accounts. Business office will provide nursing staff with an updated list of those residents with funds available on a weekly basis. C. Policy and procedure was reviewed and updated on 8-22-14. Language was changed to eliminate the word emergency and allow for residents to use for any reason. D. The plan of correction will be monitored by the Administrator and the results will be reported to the QAPI Committee at least quarterly.	

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{F 159}	Continued From page 5 Resident trust funds are available during these hours. Trust funds will be available for emergencies on evenings and weekends. PROCEDURES 1. Resident will contact nursing staff of the need for emergency funds. A can of pop, bag of chips, or pack of cigarettes is not considered an emergency. 2. If an emergency exists, the nurse will check to see if the resident has funds available for withdrawal. The list will be provided by the business office. If so the funds will be available in the lock box in the Medication Room..." During further interview with the administrator on 8/12/14, at 11:00 a.m. he stated that he thought that funds for the residents whom the facility holds in trust only needed to be available on an emergency basis.	{F 159}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	{F 279}		10/3/14

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{F 279}	Continued From page 6 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan for the care of 1 of 1 resident (R59) identified with Clostridium difficile (C-diff). Findings include: R59's Hospital Discharge Summary dated 8/6/14, indicated R59 was diagnosed with Clostridium difficile colitis (a type of infectious diarrhea) and a chronic stage IV sacral pressure ulcer. R59's Interagency Transfer Orders dated 8/6/14, indicated an order for metronidazole 500 milligrams (an antibiotic medication used to treat C-diff) one tablet by mouth 3 times a day until 8/14/14. R59's care plan lacked identification of the infection, control protocols to minimize the risk of transmission of C-diff and interventions to direct the care of R59's infection. On 8/12/14, at 6:11 p.m. director of nursing (DON) confirmed that C-diff was not addressed on R59's care plan. She stated she would have expected interventions specific to R59's C-diff infection be addressed on the care plan. The Care Plans - Comprehensive policy dated October 2010, indicated the care planning/interdisciplinary team was responsible	{F 279}	Jourdain Perpich performs comprehensive care planning with an interdisciplinary care team. (IDT) A. R59's status is stable, she was and is currently symptom free. Care plan updated to reflect history of C-diff. B. All residents were audited regarding bowel status. Care plans on those residents that have a history of C-diff have been updated. C. Staff education will be provided on the importance of reporting unusual bowel status incidents on September 8th, 2014. Audit completed on every resident for bowel symptoms. DON or designee will monitor new admissions or readmissions with diagnosis of C-diff to ensure that care plans include interventions. D. The plan of correction will be monitored by the DON or designee and reported to the QAPI committee at least quarterly.	

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{F 279}	Continued From page 7 for the review and updating of care plans when the resident had been readmitted to the facility from a hospital stay.	{F 279}		
{F 282} SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the resident's written care plan for 1 of 1 resident (R3) who required incontinence care and safety interventions to minimize the risk for falls, for 1 of 3 residents (R4) reviewed with a significant weight loss who required mealtime assistance, for 1 of 3 residents (R30) who required repositioning to minimize risk for the worsening of a pressure ulcer, and for 1 of 1 resident (R46) who required medication prior to meals. Findings include: R3 was at risk for falls and the facility failed to implement a personal clip alarm as directed by the plan of care. R3's undated, Disease Index Report indicated R3's diagnoses included quadriplegia (muscle weakness affecting all four limbs), contracture of joints of multiple sites and dysphagia pharyngeal phase (difficulty with swallowing).	{F 282}	Jourdain Perpich will provide services in accordance with each residents written plan of care. A. R-3's care plan has been reviewed and updated. The clip alarm has been discontinued. Observation audits have been implemented to assure timely incontinence care. Addistionally, R3 has ongoing hourly visual checks to assure safety.Staff have been educated on the need to follow residents care plan regarding incontinence care. A 3 day bowel and bladder assessment revealed that there were no specific pattern and resident did not feel the need to void or communicate that need. R4 Please refer to F325 for details. R30 please refer to F314 for details. R46 please refer to F309 for details. B. All residents will be reviewed to ensure that appropriate incontinence care is provided as per the care plan with the focus being on incontinent residents. All residents will be reviewed to ensure that	10/3/14

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{F 282}	Continued From page 8 R3's care plan dated 6/5/14, indicated R3 was at risk for falls and directed staff to place a personal clip alarm on when R3 was up in a wheelchair and when in bed. In addition, every one hour falls/safety checks should be conducted. R3's care plan also indicated an alteration in elimination for both bowels and bladder and directed staff to check and change R3 every two hours, offering him a bedpan and or a urinal at these times. On 8/12/14, at 8:45 a.m. R3 was observed seated in a tilt back wheelchair in the main common area. No personal clip alarm (alarm which would alert staff when the resident stood) was visibly attached to R3 or R3's wheelchair. On 8/12/14, at 9:00 a.m. nursing assistant (NA)-A wheeled R3 back to his room. A personal clip alarm was observed to be affixed to R3's bed frame. NA-A and NA-B were observed to transfer R3 back to bed with the assistance of a mechanical lift. R3's brief was checked which was dry, however, R3 was not offered a bedpan or a urinal. NA-A attached the personal clip alarm to R3's right shoulder of his shirt. The bed was placed in the low position, a wedge placed under the mattress on the right side and a mat placed on the floor by R3's bed. -At 10:32 a.m. NA-A was observed to enter R3's room and repositioned a blanket. NA-A confirmed the last time a safety check had been conducted on R3 was at 9:09 a.m.(one hour and 23 minutes). -At 10:58 a.m. NA-A and NA-C were observed to enter R3's room and prior to transferring him to his wheelchair they checked his brief and he was dry, however, neither NA-A or NA-C offered R3 a bed pan or the urinal. Once in the chair, NA-A	{F 282}	they are receiving assistance with meals and food choices honored, care plans will be reviewed and updated as needed. All residents receiving dialysis will be reviewed to ensure that they are receiving the appropriate medications and documentation complete. C. Audits will be utilized to ensure compliance All house audits have been completed of all other residents to assure care plans match care delivery guids and services provided. Thereafter every week, 10% of all residents and 10% of the remaining residents shall be done weekly until 100% of resident care interventions are being completed as documented in the care plan. Staff education will be provided on September 10th, 2014 during all staff meeting. D. DON or designee will monitor audits and compliance daily x 7, then twice weekly x 2 weeks, then weekly x 2 weeks or until 100% compliance achieved. Will report findings to QAPI at least quarterly.	

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{F 282}	Continued From page 9 wheeled R3 out of his room and ten feet down the hallway. A clip alarm was not placed on R3 or his chair. - At 11:06 a.m. NA-A was queried by the surveyor about the missing personal clip alarm which remained affixed to R3's bed. NA-A verified the personal clip alarm should be on R3 when in bed and when up in the wheelchair. NA-A also verified in the morning at 9:00 a.m. when R3 had first been put back to bed, R3 had not had a personal clip alarm on when he was up in the wheelchair. NA-A stated the personal clip alarm had been left affixed to R3's bed frame and it should have been moved to the wheelchair when he was transferred to the wheelchair. On 8/12/14, at 3:30 p.m. the director of nursing (DON) confirmed R3's care plan directed staff to place a personal clip alarm to R3 when he was seated in a wheelchair, conduct safety/fall checks every one hour, check and change R3 every two hours and to offer a bedpan or a urinal at these times. The DON verified her expectation was for staff to follow R3's written care plan. R4 required assistance at meal time and the facility failed to provide the services as directed by the plan of care. R4's Face Sheet dated 2/12/14, revealed diagnoses of diabetes type II, anemia and blindness of both eyes. R4's care plan, dated 8/12/14, indicated R4 was independent in eating after staff set up of meal tray and directed staff to open and pour liquids,	{F 282}		

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{F 282}	Continued From page 10 arranged food (cut meat and butter bread) and explain food location as on the face of a clock and to guide R4's hands to the food locations. Additionally, the plan indicated R4 refused staff to feed him or offer assistance with eating at each meal. The care plan also directed staff to offer alternative food as needed, encourage intake of high protein foods (offer eggs every AM), increased portions of meat and provide extra desserts of pudding/jello. On 8/12/14, at 8:19 a.m. R4 was observed seated on the side of his bed with his meal tray in front of him and food debris lying on the floor. R4 was not being assisted to eat breakfast and the cheerios and milk carton were not opened. R4 stated he did not like cold cereal and was attempting to eat cookies and crackers. On 8/12/14, at 11:30 a.m., R4 was observed seated on the side of the bed with his meal tray in front of him. R4 was calling, "Help! Help! Help!" and stated he could not see his food. R4's lunch consisted of breaded chicken pieces, mashed potatoes, ice cream and a brownie on a blue paper placemat. Nursing assistant (NA)-A entered the room and began assisting R4 to eat. R4 stated he wanted to start with the desserts because they were easiest for him to see. R4 did not consume the chicken, and NA-A stated R4 did not like the chicken because it was too dry. No alternate food was offered to R4. R30 required repositioning assistance and the facility failed to provide the service as directed by the plan of care.	{F 282}		

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{F 282}	Continued From page 11	{F 282}		

R30's care plan dated 5/29/14, directed staff to provide extensive assist of one to turn and reposition or off load every (relieve pressure) 2 hours.

On 8/12/14, at 9:15 a.m. R30 was observed in her room seated in her electric wheelchair watching television. R30 stated she'd had a pressure ulcer to her lower back for 2 years.
-At 9:33 a.m. R30 was observed to wheel herself to the common area by the nurses.
-At 10:19 a.m. R30 was observed attending bingo in the activity area.
-At 10:50 a.m. R30 continued to play bingo in the activity area.
-At 11:19 a.m. R30 was observed to remain in her wheelchair while eating lunch in her room.
- At 11:59 a.m. R30 remained seated in her wheelchair in her room.

On 8/12/14, at 12:07 p.m. R30 stated she had been up in her chair since she got up at around 9:15 a.m.

At 12:10 p.m. NA-I stated she wasn't sure how long R30 was to sit up before she was repositioned but indicated the information would be in the nursing assistant book. NA-I also stated she had only worked at the facility for 3 weeks.

At 12:24 p.m. NA-J stated R30 told staff when she wanted to be repositioned. NA-J also stated R30 could sit up as long as 4 hours at a time or until her hip got sore. NA-J confirmed R30 had been up in her wheelchair since 9:15 a.m. NA-J further stated she had not been told to encourage R30 to reposition or offload for her pressure

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{F 282}	Continued From page 12 ulcer. On 8/12/14, at 12:36 p.m. NA-I and NA-J were observed to put R30 back to bed after she had been up in her wheelchair for 3 hours and 21 minutes. On 8/12/14, at 12:38 p.m. the DON stated R30 should have been repositioned or offloaded every 2 hours as directed by the plan of care. R46's medication administration was not provided according to the written care plan. R46's physician orders signed 6/30/14, indicated R46 was diagnosed with diabetes with routine dialysis treatments. The order's also indicated an order for Renvela (a medication used to bind phosphorous in dietary intake and normalize phosphorous levels in patients who have renal disease) 800 milligrams (mg) 2 tablets 3 times a day and 2 tabs with snacks. Review of R46's care plan dated 6/19/14, indicated R46 received Renvela and directed staff to administer three times a day with meals and with snacks. R46's Medication Administration Record (MAR) for August 2014, revealed the times to administer R46's Renvela medication were at "7AM, 11AM, 5 PM, AM snack, PM snack." This was a total of five times per day. Review of the MAR for August 2014 revealed that R46 had not received the Renvela during snack times in the morning on August 2, 3, 4, 6, 7, 8 and 11. The Renvela was not administered during the afternoon snack on August 2, 3 and 8 and it was documented as	{F 282}		

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{F 282}	Continued From page 13 refused on August 4, 5 and 6. The MAR did not include supporting documentation to indicate why the medication was not administered per the orders. The DON was interviewed on 8/12/14, at 9:09 a.m. and confirmed R46's Renvela medication was not provided according to the written care plan for R46. The facility's Care Plans-Comprehensive policy dated 10/2010, indicated a comprehensive care plan would be developed to meet the resident's medical, mental and psychological needs The Care Plans - Comprehensive policy dated October 2012, did not direct the staff how to utilize the care plan.	{F 282}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication related to kidney dialysis was consistently provided according to physician's orders for 1 of 1 resident (R46) in the sample reviewed for end stage	{F 309}	Jourdain Perpich will provide care/services to maintain or attain the highest well being. A. R46's medication administration schedule has been reviewed and remains	10/3/14

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{F 309}	Continued From page 14 kidney disease (ESRD). Findings include: R46's physician office visit form dated 8/5/14, indicated R46 was diagnosed with end stage renal disease (ESRD) and type II diabetes mellitus. R46's physician orders included an order for Renvela (a medication used to bind phosphorous in dietary intake and normalize phosphorous levels in patients who have ESRD) 800 milligrams (mg) 2 tablets 3 times a day and 2 tabs with snacks. R46's care plan dated 6/19/14, indicated R46 received dialysis treatments three times per week and was prescribed Renvela to be given three times a day with meals and with snacks. The care plan also indicated R46 could self administer the medication after set up by staff. R46's Medication Administration Record (MAR) for August 2014, revealed the times to administer R46's Renvela medication were at "7AM, 11AM, 5 PM, AM snack, PM snack," five times per day. Review of the MAR for August 2014, revealed that R46 had not received Renvela with morning snacks on August 2, 3, 4, 6, 7, 8 and 11. The Renvela was not administered with afternoon snacks on August 2, 3 and 8. The MAR indicated R46 refused Renvela on August 4, 5 and 6. The MAR did not include documentation which identified the reason the medication had not been administered or why the resident had refused the medication. The director of nursing (DON) was interviewed on	{F 309}	current. All medication refusals by R46 shall be documented for root cause of refusal. If a resident refusals inhibit the effectiveness of the medication, PCP shall be notified for direction. B. The policy and procedure for medication administration will be reviewed and updated as needed. All residents receiving dialysis will have medication regimens reviewed and care plans updated as needed, and have missed doses addressed as per R46. C. Facility will provide ongoing education on appropriate medication administration through designated online education program to the staff. Staff responsible for medication of Renvela, will monitor resident as to the medical necessity of Renvela and provide education to resident as needed. Additional staff education will be conducted on September 10, 2014 on medication administration and the protocol for administration of nutrient binding medications. Audits will be conducted daily x7days, 2x week x2 weeks, then weekly x2 or until 100% compliance achieved. D. The plan of correction will be monitored by the DON or designee and the results reported to QAPI at least quarterly.	

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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 309}	Continued From page 15 8/12/14, at 9:09 a.m. and confirmed the MAR lacked documentation of why the medication was not administered.	{F 309}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning / offloading (pressure relief) to promote healing and prevention for the further development of pressure ulcers as directed by the care plan for 1 of 2 residents (R30) identified with a current stage 4 (full thickness skin loss with exposed bone, tendon or muscle) pressure ulcer. Findings include: R30's undated Disease Index Report indicated R30's diagnoses included a pressure ulcer on the lower back, severe chronic kidney disease, diabetes and above knee amputation.	{F 314}	Jourdain Perpich has a plan in place to address possible pressure sores and provide for the treatment of skin break down. A. R30's care plan was reviewed and remains current. All staff were educated on the updated policy and procedure and specifically, the need to off-load for a minimum of 2 minute while R30 is in her chair as well as other residents as directed in the NA/R care book. B. All residents have been reviewed and those that are at risk have had their care plans reviewed and revised as needed. Policy and procedure for pressure sores reviewed and updated as needed. All NA/R care guides were audited to assure the guide corresponds to the individual offloading routines.	10/3/14

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{F 314}	Continued From page 16 R30's significant change Minimum Data Set (MDS) dated 5/23/14, indicated R30 had intact cognition, was non-ambulatory, required extensive assistance of two+ staff for bed mobility, extensive assistance of one staff member for toilet use, total staff assistance for transfers and had bilateral lower extremity limitation in functional range of motion. The MDS also indicated R30 had one stage 4 and one stage 3 (full thickness tissue loss with possible subcutaneous fat visible) pressure ulcers and also indicated R30 was on a turning and repositioning program. R30's Tissue Tolerance Assessment (a tool used to determine the length of time skin can withstand pressure without change) dated 5/23/14, indicated R30 was to be turned and repositioned every 2 hours while lying and sitting. R30's care plan dated 5/29/14, indicated R30 had impaired skin integrity, was non ambulatory, required total staff assistance for transfer with mechanical lift, had decreased mobility with inability to transfer, turn and reposition nor sit up independently. The plan directed staff to turn and reposition or offload (relieve pressure) R30 every two hours, pressure relieve air mattress on bed, a custom fitted wheelchair cushion and right Prevalon boot while in bed. R30's Sanford Bemidji Medical Center Wound Healing discharge summary signed 7/9/14, indicated R30 had a coccyx and ankle pressure ulcer and instructed staff to continue to limit the amount of pressure and sitting on the coccyx and	{F 314}	C. Staff education will be provided on the PUSH tool to monitor progress of pressure areas and wounds and repositioning as per the care plan on September 8th, 2014 all nursing staff meeting. D. DON or designee shall do observational audits for offloading on all residents with tissue tolerance or skin issues. Will complete audits daily x 5 days, then 3x week for 2 weeks, then weekly x 2 weeks or until 100% compliance. Will report to QAPI at least quarterly.	

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{F 314}	Continued From page 17 to continue to offload any pressure on the right ankle. R30's Nurses' Admission Assessment dated 7/23/14, indicated R30 had a coccyx wound which measured 3.0 centimeters (cm) x 3.6 cm x 0.5 cm and a right ankle pressure ulcer which measured 0.8 cm X 1.2 cm. R30's Braden Scale for Predicting Pressure Sore Risk assessment dated 7/28/14, indicated R30 was at moderate risk for pressure ulcers. The attached Checklist Of Skin Risk Factors & Interventions dated 7/28/14, indicated R30 was to be turned and repositioned every two hours. On 8/12/14, at 8:45 a.m. R30 was observed in bed, lying on her back. A pressure relieving mattress was observed on the bed. -At 9:15 a.m. R30 was observed in her own room, seated in her electric wheelchair. R30 stated she has had the coccyx pressure ulcer for two years. A pressure redistribution cushion was observed on R30's wheelchair seat. -At 9:33 a.m. R30 was observed to wheel herself to the common area by the nurses station in her electric wheelchair. -At 10:19 a.m. R30 was observed attending bingo in the activity area. -At 10:50 a.m. R30 continued to play bingo in the activity area. -At 11:19 a.m. R30 was observed to remain in her wheelchair while eating lunch in her own room. -At 11:59 a.m. R30 remained in her room, seated in the wheelchair. -At 12:07 p.m. R30 stated she had been up in her	{F 314}		

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{F 314}	Continued From page 18 chair since about 9:15 a.m. that morning. R30 stated sometimes her bottom got sore from sitting and said she tolerate sitting up for a couple of hours at a time. -At 12:10 p.m. nursing assistant (NA)-I stated she had worked at the facility for three weeks and wasn't sure how long R30 could sit up and how often she was to be repositioned but stated that information would be in the nursing assistant information book -At 12:24 p.m. NA-J stated R30 would inform staff when she wanted to be repositioned. NA-J also stated R30 could sit up for as long as four hours at a time without repositioning or offloading, or until her hip got sore. NA-J confirmed R30 had been up in her wheelchair since 9:15 a.m. and had not been instructed to encourage R30 to reposition or offload her pressure ulcer. -At 12:36 p.m. NA-I and NA-J were observed to assist R30 into bed via a mechanical lift. R30 remained seated in the wheelchair without repositioning or offloading for three hours and 21 minutes. On 8/12/14, at 12:38 p.m. the director of nursing (DON) confirmed R30 had a healing stage 4 pressure ulcer to her coccyx and verified R30's care plan and skin assessments indicated R30 required every two hour repositioning / offloading. The DON stated R30 should have been repositioned or offloaded every 2 hours as directed. The Prevention of Pressure Ulcers policy dated October 2010, indicated pressure ulcers were usually formed when a resident remained in the same position for an extended period of time	{F 314}		

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{F 314}	Continued From page 19 causing increased pressure or decrease of circulation to that area and subsequent destruction of tissue. The policy also indicated pressure ulcers were made worse by continuous pressure. The policy directed staff to reposition the resident at least every hour when in a chair and every two hours when in bed or more frequently when needed.	{F 314}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 ensure consistent implementation of fall interventions in order to minimize the risk of further falls for 1 of 1 resident (R3) identified at risk for falls. In addition, the facility failed to ensure side rails were removed for 1 of 3 residents (R12) reviewed for accidents who had a history of falls from bed and whose facility side rail assessment indicated they were unnecessary. Findings include: R3 was at risk for falls and the facility failed to	{F 323}	Jourdain Perpich has a plan in place to ensure the safety of all residents. A. R3's care plan has been updated to reflect current alarm usage. Clip alarms have been discontinued. Resident is on visual hourly checks on all shifts. R12 has had an assessment regarding his need for assistive devices, resident prefers to sleep with his head at the bottom of the bed. He does utilize half siderails to assist in self transferring and bed mobility. B. All residents will be reviewed for assistive devices and care plans updated as needed. C. Policy for comprehensive assessments was reviewed by Interdisciplinary team	10/3/14

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{F 323}	Continued From page 20 implement a personal clip alarm (tab alarm) to alert staff of attempts to stand while he was seated in the wheelchair. R3's undated, Disease Index Report indicated R3 was diagnosed with quadriplegia (muscle weakness affecting all four limbs), multiple contracture of joints and dysphagia pharyngeal phase (difficulty with swallowing). R3's Fall Risk Evaluation dated 6/1/14, indicated R3 was at risk for falls. R3's quarterly Minimum Data Set (MDS) dated 6/2/14, indicated R3 had severe cognitive impairment, required extensive assist with bed mobility, total staff assistance, was non ambulatory and had two or more falls since last assessment. R3's care plan dated 6/5/14, indicated R3 was at risk for falls and directed staff to perform hourly fall / safety visual checks and to clip a tab alarm on R3 when seated in bed or the wheelchair. The post scene investigation report dated 7/3/14, indicated R3 fell from bed onto floor mat. No injuries sustained. On 8/12/14, at 8:45 a.m. R3 was observed in the main common area, seated in a tilt back wheelchair without a tab alarm in place. On 8/12/14, at 9:00 a.m. nursing assistant (NA)-A was observed to wheel R3 back to his room. A tab alarm was observed affixed to R3's	{F 323}	and updated. Side rail and fall assessments will be done at within 7 days of admission, quarterly and yearly on all residents. Fall assessments will be completed after each fall. In reference to alarms and incontinence care-visual observation audits will be done daily x7days, bi-weekly x 2weeks and weekly thereafter until 100% compliance achieved. Staff will be reeducated on procedures on completing assessments at the September 8th, 2014. D. Plan of correction will be monitored by Director of nursing or designee and results will be reported to QAPI team at least quarterly	

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{F 323}	Continued From page 21	{F 323}		

bed frame. NA-A and NA-B were observed to transfer R3 into bed via a mechanical lift. NA-A attached the alarm to R3's right shoulder of his shirt. The bed was placed in the low position, a wedge was placed under the mattress on the right side and a mat was placed on the floor next to R3's bed.
-At 10:32 a.m. NA-A was observed to enter R3's room and reposition a blanket. At this time, NA-A stated the last time a visual safety check was conducted on R3 was at 9:09 a.m.(one hour and 23 minutes earlier).

At 10:58 a.m. NA-A and NA-C were observed to enter R3's room, check R3's incontinent brief and transfer him into the tilt back wheelchair via the mechanical lift and wheel R3 out into the hallway. A tab alarm was not applied to R3.

On 8/12/14, at 11:06 a.m. NA-A verified R3 did not have an alarm in place when assisted into the wheelchair and stated his bed alarm should have been moved to his wheelchair.

On 8/12/14, at 3:30 p.m. the director of nursing (DON) confirmed R3's care plan directed staff to place a tab alarm on R3 when seated in the wheelchair.

R12 was observed to utilize bilateral, lower bed side rails and the facility was unaware of their use and failed to assess for safety.

R12's care plan, dated 6/10/14, indicated R12's diagnoses included a stroke and dementia. The care plan also indicated R12 had a potential for decreased mobility, was at risk for falls and was independent with bed mobility. The care plan

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{F 323}	Continued From page 22 lacked indication of the use or need of side rails. R12's undated Side Rail Assessment form indicated R12 requested side rails for repositioning, bed mobility and independent bed control access as needed. The form also indicated R12 had weakness, orthostatic hypotension and a balance deficit. The conclusion of the assessment indicated side rails were not indicated. R12's Falls Risk Assessment dated 7/13/14, and 7/29/14, indicated R12 was at high risk for falls. Review of R12's nursing progress notes revealed multiple recent falls: -7/29/14, R12 fell between bed and wheelchair. -7/13/14, 9:00 a.m. R12 fell attempting to ambulate in the hallway, and at 12:20 p.m. R12 fell in room while attempting a self-transfer. - 6/28/14, R12 fell between bed and tray table. - 6/21/14, R12 was found lying on the floor next to the bed. -6/19/14, R12 was found lying on floor in front of bed. On 8/12/14, at 10:10 a.m. R12 was observed seated on the side of his bed drinking soda. R12 exhibited poor trunk control and was falling backward onto his bed. Bilateral quarter side rails were observed raised on the lower, foot ends of the bed. At 11:02 a.m. R12 was observed lying in bed on his left side. The lower, bed side rails were observed to remain raised. On 8/12/14, at 1:10 p.m. the DON stated siderail	{F 323}		

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{F 323}	Continued From page 23 assessments were supposed to be completed for each resident on a quarterly basis. The DON stated she was unsure if R12's undated, Siderail Assessment was the most current or not. When asked about the rails on R12's bed the DON stated she understood the problem. A policy regarding siderail assessments was requested, none was provided.	{F 323}		
{F 325} SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R4) who had experienced a significant weight loss was assessed for their food preferences, provided alternate meal items and provided assistance and cueing at meals to promote adequate intake. Findings include:	{F 325}	Jourdain Perpich will ensure that all residents maintain acceptable parameters of nutritional status unless medically explainable and receive a therapeutic diet when there is a nutritional problem. A. R4 has been reviewed and care plan updated. Residents food preferences have been documented and his plan of care updated to indicate staff will tell him his food set up on his plate based on a 24 hour clock.	10/3/14

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{F 325}	Continued From page 24 R4's Face Sheet dated 2/12/14, indicated R4's diagnoses included diabetes, anemia and blindness of both eyes. R4's quarterly Minimum Data Set (MDS), dated 7/4/14, indicated R4 had impaired cognition, required limited assistance of one staff to eat, had a weight loss of greater than 5% in the last 30 days or 10% in the last six months and was not on a planned weight loss program. R4's Care Area Assessment (CAA), dated 7/4/14, indicated R4 was only able to see shapes, required an explanation of food location as if on the face of a clock and guidance of his hands to the position of the foods at mealtime. R4's care plan, dated 8/12/14, indicated R4 had an alteration in nutrition related to diabetes with retinopathy/neuropathy, had a significant weight loss in last 180 days and impaired skin integrity and refusal of nutritional supplements. The care plan indicated R4's goal weight was 175-190 lbs (pounds). The plan also indicated R4 was independent in eating after staff set up R4's meal tray, opened and poured liquids, arranged food (cut meat and butter bread) and explained food location as on the face of a clock and guide hands to food locations. Additionally, the plan indicated R4 refused staff to feed him or offer assistance with eating at each meal. The care plan also directed staff to offer alternative food as needed, encourage intake of high protein foods (offer eggs every AM), increased portions of meat and provide extra desserts of pudding/jello. The care plan did not identify any of R4's food preferences. R4's Swallowing/Nutritional Status form dated	{F 325}	B. All residents will be monitored for significant weight loss by the registered dietitian on a quarterly basis unless there is a significant weight loss noted then on at least a monthly basis. Nursing staff will notify registered dietitian of all residents noted to have significant weight loss. Residents that have inaccurate weights will be reweighed. All residents shall have a food preference sheet completed and available to all staff responsible for the preparation and serving of resident meals. C. Policy and procedure was reviewed and updated reflecting reweights. Staff education will be provided on Sept 10th, 2014. Education of all staff will include review of policy and procedure as it relates to meal preparation and need for resident assist if indicated. D. Plan of correction will monitored by observation daily x7days, 3x weekly x 1 week, then weekly until 100% compliance with resident service achieved by DON or designee. QAPI will be updated on at least quarterly.	

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{F 325}	Continued From page 25 6/26/14, indicated R4 had experienced a 23% weight loss in the last 6 months and recommended a diet change to regular. An additional Medical Nutrition Therapy Re-Assessment form, dated 6/26/14, indicated to try mighty shakes twice daily. In addition, the form indicated R4's weight was 175 lbs and had an ideal body weight of 154-188 lbs. R4's medical therapy nutrition notes, dated 8/7/14, indicated R4's weight continued to fluctuate. The note also indicated R4's 170 lbs was a significant loss in 30 days & 27% loss in 180 days, if accurate. The note indicated R4 refused the mighty shakes and directed staff to continue same plan and assure increased calories at meals until next nutritional visit. The assessments did not identify R4's food preferences. On 8/12/14, at 8:19 a.m. R4 was observed seated on the side of his bed with his breakfast tray in front of him and food debris lying on the floor. R4 was not being assisted to eat breakfast by staff and had not opened his Cheerios or milk carton. R4 stated he did not like cold cereal and was observed attempting to eat cookies and crackers. -At 9:15 a.m. R4 was observed lying on his bed facing the window. Food debris remained on his room floor including pieces of what appeared to be chocolate cake. R4 did not respond when his name was called. -At 11:30 a.m. R4 was observed seated on the side of the bed, awaiting to eat his lunch which was placed in front of him. R4's lunch consisted of breaded chicken pieces, mashed potatoes, ice cream and a brownie on a blue paper placemat. R4 stated he could not see his food, and was calling "Help, help, help." Nursing assistant	{F 325}		

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{F 325}	Continued From page 26	{F 325}		

(NA)-A entered the room and began assisting R4 to eat. R4 stated he wanted to start with the desserts because they were easiest for him to see. R4 did not consume the chicken, and NA-A stated R4 did not like the chicken, as it was "Too dry for him." NA-A stated R4 liked soup, however no alternate food item was offered to him other than the chicken.

On 8/12/14, at 11:01 a.m. ward clerk / NA (WC)-B, stated R4 preferred soups, especially vegetable beef and tomato. WC-B stated R4 did not like cold cereal and preferred oatmeal. At the same time, licensed practical nurse (LPN)-A also stated these were R4's food preferences.

During a telephone interview on 8/12/14, at 1:09 p.m. Cook (C)-A stated R4 was on a regular diet and was usually given whatever was on the menu. C-A stated R4 drank a lot of milk and said oatmeal was available in morning if he wanted that. C-A stated nursing staff needed to let them know what R4's food preferences were as the kitchen staff were unaware of the likes and dislikes. C-A stated no one came to the kitchen to request an alternate meal at breakfast or lunch for him today. LPN-A was present during the telephone interview and stated she was aware of a food likes and dislikes form dietary was supposed to be completing for the residents, but had never seen the form on the resident charts.

During a telephone interview on 8/12/14, at 4:20 p.m. the registered dietician (RD) stated it was unlikely R4 was assessed for food preferences via the food likes and dislikes form and that offering choices of food would be important for him, as he refused supplements. The RD stated she was only in house every other week and tried

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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 325}	Continued From page 27 to watch R4 eat as able, but was unsure if the staff "consistently" offered him food choices. Policies regarding weight loss and food preference assessment were requested at approximately 4:20 p.m. on 8/12/14. A blank form entitled Resident Initial Nutritional Visit Form - Red Lake Hospital/Health Care Facility, dated 3/08, was provided that included a place to record preferred breakfast foods and other likes/dislikes. A policy entitled Nutritional Intervention Program, dated 6/12/14, indicated all residents with actual or potential for insidious or significant weight loss would receive appropriate interventions to encourage weight gain. Real food options would be given the first priority with commercial nutritional supplements to follow. The procedure section of the policy indicated increased portions, especially if specific food favorites of the resident was a potential weight-gain program option.	{F 325}		
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	{F 441}		10/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 08/12/2014

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{F 441}	Continued From page 28 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to properly disinfect 1 of 1 resident (R59) room and care equipment in order to prevent the spread of clostridium difficile(infectious diarrhea) which had the potential to affect 2 of 2 residents residing in the same room. The facility failed to ensure a blood pressure cuff was properly disinfected prior to use for 1 of 1 resident (R58) observation. This practice had the potential to affect 28 of 40 residents who utilized the cuff. In addition, the facility failed to track, trend and analyze resident infections which had the potential to affect all 40 residents residing in the facility.	{F 441}	Jourdain Perpich will establish and maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A. Resident infections and staff illnesses will be investigated, controlled and the spread of infection prevented. Resident was asymptomatic upon readmission to the facility. The infection control log is completed to include location of infection, the type of organism if available and if a reculture was obtained, based on policy	

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	245535	A. BUILDING _____ B. WING _____	R 08/12/2014

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{F 441}	Continued From page 29 Findings include: Clostridium difficile (C-diff): R59's Hospital Discharge Summary dated 8/6/14, indicated R59 was diagnosed with clostridium difficile colitis (C-Diff) and a chronic stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) sacral pressure ulcer. R59's Interagency Transfer Orders dated 8/6/14, indicated an order for metronidazole 500 milligrams (an antibiotic used to treat C-Diff) one tablet by mouth three times a day until 8/14/14. R59's care plan dated 6/24/14, indicated R59 was continent of bowel and directed staff to assist R59 to the commode or toilet, assist to pull up/down pants and provide peri-rectal cares after elimination. R59's care plan lacked identification of the C-Diff diagnosis and lacked care related interventions and infection control protocols in order to minimize the risk of the transmission of C-Diff. During the survey, R59 was out of the building on a leave. On 8/12/14, at 2:50 p.m. nursing assistant (NA)-G stated she had cared for R59 once since she was diagnosed with C-Diff and stated she was instructed to use gown and glove precautions when caring for R59. NA-G stated R59 used a facility bedside commode and staff were instructed to clean the commode with a special solution. R59 shared a room and bathroom with an independent resident who did	{F 441}	and procedure. An analysis of staff and resident infection will be compiled on a monthly basis to determine any similarities or patterns of cross contamination. Updated P&P will include appropriate cleansing solutions to be used on resident care equipment, depending on the piece of equipment and any resident contamination concerns. B. An infection control policy and procedure has been developed and implemented. All resident and staff illness will be monitored and tracked, appropriate measures will be taken to prevent the spread of illness. C. Policy and procedures will be reviewed and updated on a yearly basis. The infection control nurse will track and log all illnesses and implement the necessary measures to prevent the spread of illness and infection. The infection control nurse shall attempt to have completed logs, addressing symptoms and the organism if available as it may relate to antibiotic regimens. All staff shall be educated on the Infection Control Policy and Procedure and specifically as it relates to cleaning and care of resident care equipment and cleansing resident units when infections such as C-diff are diagnosed. Staff re-education will be provided on Sept 10th, 2014. D. The plan of correction will be monitored by the Director of Nurses. The infection control nurse in collaboration with the DON shall review all documented infections of staff and residents to analyze similarities. QAPI will continue to be updated monthly by the Infection Control	

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{F 441}	Continued From page 30 use the shared bathroom. However, NA-G stated R59 had not used the bathroom. NA-G brought the surveyor to R59's room to retrieve the cleaner, however, none was stored in the room or the shared bathroom. NA-G stated the solution was kept in the housekeeping closet. NA-G further stated R59 did have loose stools when she cared for her. On 8/12/14, at 2:57 p.m. NA-D verified she had worked with R59 once and state she observed R59 utilizing the shared bathroom on the evening shift of 8/11/14, however, she denied that R59 had a stool at that time. NA-D stated she used TB (tuberculosis) spray or Sani-wipes to clean the commode / equipment used by R59. NA-D brought the surveyor to the housekeeping closet and identified the spay used was TB Disinfectant Cleaner Ready to Use. NA-D also stated she had read on her computer based training program that a 10:1 bleach solution could be used to clean equipment with potential C-Diff contamination. NA-D indicated they had not had bleach solution to use and had been directed to use the TB disinfectant spray or Sani-wipes. On 8/12/14, at 3:05 p.m. NA-E stated R59 used a bedside commode and TB spray from the housekeeping closet was used to clean the commode. NA-E also indicated R59's roommate was independent and used the shared bathroom. On 8/12/14, at 3:19 p.m. NA-F stated sometimes R59 refused to use the commode and insisted upon using the shared bathroom. NA-F stated she had helped R59 in the shared bathroom and wiped the toilet down with Sani-wipes after R59's use.	{F 441}	Nurse or Director of Nursing.	

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{F 441}	Continued From page 31 On 8/12/14, at 6:11 p.m. director of nursing (DON) confirmed R59's care equipment and room should have been cleaned with a 10:1 bleach solution and that neither TB disinfectant cleaner Ready To Use nor Sani-Cloth Plus wipes were effective against C-diff. The DON also confirmed C-diff was not addressed on R59's care plan and stated it should have been. 8/13/14, at 10:44 a.m. housekeeper (H)-A stated he cleaned the rooms on each of the halls in the facility and had cleaned R59's room. He indicated TB Disinfectant Cleaner Ready to Use was used to wipe down the bed and furniture. H-A indicated the floor was mopped with bleach water and stated he used a cupful of bleach in a 5 gallon bucket (a 1:10 solution equals 2 quarts to 5 gallons). H-A stated the nursing staff was responsible to clean R59's bedside commode. H-A stated the TB Disinfectant Cleaner was also used to clean the toilet and sink in the shared bathroom and the bleach water solution was used to mop the bathroom floor. H-A stated he had received training regarding C- diff and was told to use bleach water to kill it. The undated Clostridium Difficile policy directed staff to routinely clean and disinfect high-touch resident surfaces and equipment and indicated disinfection of items with fecal soil matter required 1:10 household bleach and water solution. Blood pressure cuff: On 8/12/14, at 8:23 a.m. the trained medication aide (TMA)-A was observed to wheel an electronic blood pressure machine from the central nursing area down the hall 25 feet to	{F 441}		

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{F 441}	Continued From page 32	{F 441}		

R58's room. The blood pressure cuff fell out of the attached basket and landed on the floor. TMA-A proceeded to wheel the electronic blood pressure machine into R58's room, dragging the blood pressure cuff on the floor. -At 8:24 a.m. TMA-A was observed to squirt a 50 cent piece size of Aloe Vesta solution (a body wash and shampoo cleansing foam) on a dry disposable cloth and proceeded to wipe off the blood pressure cuff and place the cuff around R58's left arm. However, TMA-A was unable to obtain an accurate blood pressure reading the cuff was removed and placed on R58's right arm.

On 8/12/14, at 12:29 p.m.TMA-A acknowledged the blood pressure cuff had fallen to the floor and was drug behind the blood pressure machine as it was wheeled into R58's room. TMA-A stated the Aloe Vesta cleansing foam was probably not the most appropriate solution to clean the dirty blood pressure cuff and she should have used an alcohol wipe or something stronger.

On 8/12/14, at 3:59 p.m. the DON confirmed the Aloe Vesta cleansing foam was not an appropriate disinfectant and it should only be used for skin care. The DON verified a Sani-Cloth wipe (a disposable wipe utilized to disinfect reusable equipment) should have been used to clean the blood pressure cuff before placing the cuff on the patient.

The Cleaning and Disinfection of Resident-Care Items and Equipment policy revised on 10/2009, directed staff to follow current Center of Disease Control and Prevention (CDC) recommendations for cleaning and disinfecting resident care equipment including reusable items and durable medical equipment.

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{F 441}	Continued From page 33 Infection Control Logs: Review of the facility's infection control logs for July and August of 2014, revealed the logs lacked data which determined if the infection was cultured, the type of organism the infection was caused by and if the infection was re-cultured following antibiotic treatment was not completed. Additionally, the facility surveillance including where each infection had occurred in the building so that pattern and trends of the spread of infection could be reviewed was not completed. During interview on 8/12/14, at 3:39 p.m. the Director of Nursing (DON) confirmed the findings and verified the lack of appropriate tracking, trending and surveillance of infections.	{F 441}		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		10/3/14

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F 520	Continued From page 34 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QA&A) committee implemented appropriate action plans for previously identified areas of concern during the recent recertification and federal monitoring surveys in order to prevent repeat quality deficiencies. This had the potential to affect all 40 residents residing in the facility. The Findings include: On 8/12/14, at 7:45 p.m. the facility plan of correction (POC) was reviewed with the director of nursing (DON). The POC indicated the DON or designee would audit the rehabilitation notes and identify those at risk or have refusals of rehabilitation services x 4 weeks and monthly thereafter to ensure compliance. The POC also indicated staff education would be provided regarding the proper administration of Renvela and audits would be conducted by the DON or designee weekly x 4 weeks and then monthly thereafter. Additionally, the POC indicated audits would be conducted on all residents to ensure they had been vaccinated. On 8/12/14, at 8:10 p.m. the DON stated audits of	F 520	Jourdain Perpich Extended Care Center will maintain a QAPI committee consisting of the director of nursing, medical director and 3 other members of the facility staff. This committee will meet at least quarterly to identify issues, with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will address at a minimum incident and accident reporting, infection control and medication and pharmacy services. A. All audits will be completed as stated. B. An QAPI meeting will be held on September 10th, 2014 to discuss all tags, audit formats and findings. C. All issues will be added to the QAPI agenda. D. Plan of correction will be monitored by the director of nursing and administrator. QAPI will continue to meet on a monthly basis, but minimally quarterly.	

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F 520	Continued From page 35 rehabilitation notes, audits and staff education of the proper administration of Renvela and for resident immunizations had not been completed as indicated. Refer to F155 related to the lack of risk vs. benefit education provided when a resident refuses treatment. Refer to F309 related to lack of medication administration per the physician's order.	F 520		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ISKC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**

2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN/PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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 **05/22/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **47** (L18)

13.Total Certified Beds **47** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(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 :
Yvonne Switajewski, HFE NEII — 06/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 07/15/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/30/1991
(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.
00400
(L31)

30. REMARKS
Posted 07/15/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 10, 2014

Mr. William Eckblad, Administrator
Jourdain/Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesoa 56671

RE: Project Number S5535025

Dear Mr. Eckblad:

On May 22, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 1, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 1, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 22, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN/PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		7/1/14

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

Electronically Signed | 06/20/2014

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F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the risks and benefits related to the discontinuation of a range of motion (ROM) rehabilitation program were addressed with and documented for 1 of 1 resident (R12) in the sample reviewed for ROM services. Findings include: R12's quarterly Minimum Data Set (MDS) dated 2/24/14, indicated R12 was diagnosed with anemia and depression. The MDS also indicated R12 had intact cognition, one sided upper extremity impairment, communicated effectively, was Independent with eating, toileting and dressing. The MDS further indicated R12 was unable to put left hand behind head and was unable to fully close fingers on the left hand. R12's, Rehabilitation treatment sheet dated 5/2014, indicated R12's upper and lower extremity strengthening exercises were discontinued on 7/12/13. On 5/21/14, at 2:30 R12 was observed to independently ambulate down the hall with a walker. On 5/22/14, at 8:00 a.m. the rehabilitation aide stated R12's rehabilitation plan had changed per the physical therapist (PT)'s orders, therefore, R12 no longer received rehabilitation services. On 5/22/14, at 11:00 a.m. registered nurse (RN)-A verified the PT had discontinued R12's range of motion (ROM) program per R12's	F 155	Jourdain Perpich honor all residents wishes regarding refusal of care. A. Physical Therapist will re-evaluate R12 for range of motion, explain the risk vs. benefit to resident, if the resident refuses to participate in the program document in the therapy notes. B. Care plans will be reviewed for those residents who frequently refuse therapy services. Care plans will be updated to reflect refusals of therapy services or discontinuing of services and include that education was provided regarding risk vs. benefit. C. Will review policy and procedure and update as needed. Education will be provided to staff at the nursing meeting on June 24th, 2014. DON or designee will audit the rehabilitation notes and identify those that are at risk or have refusals of rehabilitation services x 4 weeks and monthly there after to ensure compliance. D. The plan of correction will be monitored by the DON or designee and reported to QAPI Committee at least quarterly.	

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F 155	Continued From page 2 request. On 5/22/14, at 1:15 p.m. the PT stated he had discontinued R12's ROM program because R12 did not want to participate in the ROM program. The PT verified he had not documented whether R12 was informed of the risk vs. benefits of stopping the program. A policy related to the explanation of risk vs. benefits to residents who decline rehabilitation services was requested and none was provided.	F 155		
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159		6/30/14

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F 159	Continued From page 3 funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 2 residents (R25, R13) with personal trust fund accounts with the facility, had access to their money on the weekends. Findings include: R25's quarterly Minimum Data Set (MDS) dated 4/15/14, indicated R25 was cognitively intact. On 5/19/14, at 3:55 p.m. R25 stated the business office was closed on the weekends and did not know if anyone was on call to come in if she needed her money.	F 159	Resident Trust Funds are protected and available for emergencies. A. The availability of money on weekends and evenings will be maintained through a lock box in the Medication room. Nurses will have a listing of those residents with funds available. The previous system was not working, and residents were accessing funds that they did not have. A policy will be written to identify the correct procedures to make sure that resident trust funds are not accessed inappropriately. B. Funds are available for all residents with trust accounts.	

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F 159	Continued From page 4 R13's quarterly MDS dated 4/13/14, indicated R13 was cognitively intact. On 5/19/14, at 4:11 p.m. R13 stated he was not able to get his money on the weekends. R13 stated you could get your money when the "bosses" were here. On 5/22/14, at 4:07 p.m. the administrator (ADM) stated they had tried a system of putting money in the medication carts for residents with trust accounts to use on the weekends. The ADM stated the nurses had a list of which residents had money and who could get money. However, the ADM stated the nurses gave residents money when they did not have sufficient funds. The ADM stated that system consisted of 10 envelopes which each contained $5.00. The ADM stated the resident's needs were for pop and candy so that was how they came up with the $5.00 amounts. The ADM verified the residents did not have access to their trust accounts on an on-going basis. The Resident Trust Fund policy dated 1/30/13, indicated resident trust funds were available during normal office hours which were 9:00 a.m. to 4:30 p.m. Monday through Friday, except holidays. The policy further indicated trust funds would be available for emergencies in which the resident could contact nursing staff and inform them of the need for emergency funds and the nurse would determine if the emergency could not wait until the next normal business day. The policy further indicated the availability of emergency funds was not intended to take the place of normal business hours.	F 159	C. A new system will be devised to provide for expanded access to trust funds. A policy will be revised and clarified. d. The plan of correction will be monitored by the Administrator and the results will be reported to the QAPI Committee at least quarterly.	

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F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to convey resident personal funds deposited into trust accounts, upon death for 3 of 4 residents (R6, R19, R9) who had discharged from the facility and did not have their money returned to their family or personal estate within 30 days of discharge as required. Findings include: The facility's trust fund report dated 5/22/14, indicated the following residents (who had died greater than 30-days earlier) did not have their funds returned within 30 days of discharge. R6 discharged on 1/12/14. R6's trust account balance of $181.54 had not been conveyed to their family or R6's estate until 4/4/14. R9 discharged on 3/31/14. R9's trust account balance of $200.01 had not been conveyed to their family or R9's estate until 4/4/14. R19 discharged on 2/9/14. R19's trust account balance of $250.01 had not been conveyed to their family or R19's estate until 4/4/14.	F 160	A. At the time of the survey, all funds for deceased residents had been correctly returned. Accounting will notify administration of any funds available after discharge. B. A review of all records indicates that the funds for all discharged or deceased residents have a zero balance. C. All trust funds of deceased or discharged residents are closed. D. The plan of correction will be monitored by the Administrator and the results will be reported to the QAPI Committee at least quarterly.	6/30/14

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F 160	Continued From page 6 A facility policy related to the conveyance of funds was requested from the facility administrator but was not provided. The facility administrator was interviewed on 5/22/14, at 4:46 p.m. and confirmed the above accounts were closed and verified the trust funds had not been dispersed within 30 days from the date of discharge.	F 160		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to deliver resident mail on Saturdays. This had the potential to affect all 43 residents who resided in the facility. On 5/22/14, at 10:00 a.m. the activity director (AD) stated resident and facility mail was picked up from the post office by the business office staff Monday through Friday and the activities staff helped deliver it to the residents. The AD confirmed they do not deliver resident mail on Saturday, however, she believed the post office was open on Saturdays, however, stated the facility business office was closed therefore the mail was not picked up. The AD indicated activities staff would be available to pick up and deliver resident mail on Saturdays, however they were not directed to do this.	F 170	A. Mail will be collected at the Post Office each Saturday by Activities. The key to the PO Box will be in the nursing station for access. B. The post office in Red Lake was contacted, and they confirmed that Saturday mail service is limited. C. A new policy will be written to assure that mail delivery of mail on Saturdays will continue. D. The plan of correction will be monitored by the Administrator and reported to the QAPI Committee at least quarterly.	7/1/14

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F 170	Continued From page 7 On 5/22/14 at 10:04 p.m. The administrative secretary (AS) stated she was responsible to pick up the mail each day. The AS indicated she sorted it and residents personal mail went to activity staff to deliver. The AS stated she usually didn't pick up the mail on Saturdays as it was "mostly junk mail." She indicated the only time she would pick up the mail on Saturday was if a resident was expecting something. The Resident Mail policy dated 1/30/13, indicated mail would be delivered to residents within 24 hours of delivery by the postal service. The procedure for delivery of mail indicated the facility received mail to a Post Office box with pick up times limited to the hours that the post office was open: 7:00 a.m. to 4:45 p.m. Monday through Friday, and 10:00 to 12:00 a.m. on Saturday.	F 170		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279		7/1/14

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F 279	Continued From page 8 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure that care plan interventions related to kidney dialysis were accurately developed for 1 of 1 (R46) resident in the sample reviewed for dialysis. The findings include: R46's ADMISSION FACE SHEET indicated R46 was diagnosed with end stage renal disease (ESRD) secondary to chronic kidney disease and type II diabetes mellitus, intercerebral hemorrhage and cerebrovascular disease. R46's physician orders indicated and order for Renvela (a medication used to bind phosphorous in dietary intake and normalize phosphorous levels in patients who have ESRD) 800 milligrams (mg) take 2 tablets three times a day and 2 tabs with snacks. R46 was interviewed on 5/21/14, at 11:15 a.m. and stated he had returned from dialysis at 10:30 a.m. and received his morning medications which also included Renvela. R46 stated he had not had breakfast or a snack at the time the Renvela was administered to him. At 11:24 a.m. R24 was observed to receive the noon meal. Trained medication aide (TMA)-A assigned to the care of R46's medication needs on the day shift	F 279	Jourdain Perpich performs comprehensive care planning with an interdisciplinary care team. (IDT) A. R46's care plan has been reviewed and updated to reflect that Renvela is to be administered with meals and snacks. This was added to the medication record. R46 was evaluated for the self administration of the Renvela and a physician order was obtained to allow resident to self administer Renvela when he is eating. R46's care plan and treatment record were updated to state that he is to receive no more than 1500 cc of fluid per day. It is to be divided as follows: 420 cc with each meal, 80 cc with each med pass. Resident is not to have a water pitcher at bedside and ongoing education from nursing staff as to the importance of being compliant with the fluid restriction. B. Every shift is to record the amount given to the resident during their shift in the nursing assistant record and the medication administration record. The night shift nurse is to total and monitor Intake and Output amounts. If there is non compliance noted the night shift nurse is to alert the DON or designee. C. Staff education will be provided on the importance of complete documentation. The DON or designee will audit	

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F 279	Continued From page 9 of 5/21/14, was interviewed at 11:32 a.m. and stated Renvela 800 mg 2 tabs was administered to R46 at 11:00 a.m. along with all of the other morning medications prescribed for him. The TMA stated she did not know Renvela had to be given at the time food was ingested and was also not aware Renvela was not supposed to be given together with other medications. R46's undated, current care plan indicated R46 had ESRD and received dialysis three days per week. The care plan indicated R46 was on a 1500 cubic centimeter (cc) daily fluid restriction and directed staff to set up R46's meal tray and to administer medications as ordered. The care plan lacked indication of which meds should be held prior to dialysis, the direction to give Renvela with food and not to administer with other medications an hour before the Renvela and up to 3 hours after Renvela administration. In addition, the care plan had not identified what type and where R46's dialysis access site was and did not direct licensed nurses to monitor for a thrill nor who to contact in case of an emergency related to dialysis. Lastly, the care plan had not delineated which discipline would provide fluids to equal 1500 cc's and who was responsible for monitoring R46's daily total fluid intake. Registered nurse (RN)-B was interviewed on 5/22/14, at 10:02 a.m. and confirmed R46's care plan had not delineated which discipline would provide fluids to equal 1500 cc and who was responsible for monitoring daily total fluid intake. RN-B also confirmed the care plan had not identified the directions for the use of Renvela, who to contact in case of an emergency related to dialysis, monitoring of a bruit and thrill on the access site and had not identified the type of	F 279	compliance weekly x 4. D. The plan of correction will be monitored by the DON or designee and reported to the QAPI committee at least quarterly.	

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	245535	A. BUILDING _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN/PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 279	Continued From page 10 access and where it was located.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 1 resident (R3) reviewed for incontinence care and side rail (SR) use and for 1 of 3 residents (R23) related to fall interventions reviewed for accidents. Findings include: R3's current care plan dated 9/16/13, indicated	F 280	Jourdain Perpich will develop a comprehensive care plan within 7 days of admission, and review quarterly. A. R-3- Side rail assessment completed on 5-28-14. Was assessed that siderails were not being consistently used. Physician order to discontinue side rails. Side rails have been removed from residents bed and from his care plan. A bowel and bladder assessment was	7/1/14

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F 280	Continued From page 11 R3 was to be checked and changed every 2-3 hours for incontinence. In addition, R3's care plan failed to address the use of bilateral side rail use. On 5/20/14, at 1:08 p.m. R3 was observed in bed, on his right side, asleep. The bed was up against the wall with a mat on the floor. There were bilateral half SRs raised on the bed. On 5/21/14, at 7:03 a.m. R3 was observed in bed with bilateral side rails raised. On 5/22/14, at 9:37 a.m. registered nurse (RN)-A verified R3's care plan needed to be revised to read incontinent brief change every 2 hours and not every 2-3 hours as written. RN-A stated according to the quarterly review dated 3/5/14, completed by RN-B, R3 was to receive a brief change every 2 hours and had also utilized bilateral SRs on his bed. . On 5/22/14, at 9:55 a.m. R3 was observed in his wheelchair in front of the nurses station. Nursing assistant (NA)-G stated she had assisted R3 in the wheelchair at 7:00 a.m. which was the last time R3's incontinent brief was changed. (a total of 3 hours later). At 10:00 a.m. NA-G and NA-F were observed to transfer R3 into bed via a mechanical left. R3's incontinent brief was observed wet. NA-F stated R3's incontinent brief was to be changed every 2 hours. NA-G stated she was going to check R3 at 9:00 a.m. however, she got "busy." (3 hours later). A care plan policy related to revision was requested and none was provided.	F 280	completed on 6-2-14. Resident is incontinent of bowel and bladder and must be checked every 2 hours and changed as needed. Tissue tolerance also completed on 6-2-14, resident is to be repositioned every 2 hours. Care plan reviewed and updated, NAR care sheets updated to reflect changes. R-23: Care plan was reviewed and updated to include the following falls interventions. Every one hour visual safety checks, hi low bed in lowest position and not to be left alone in his room in wheelchair. B. All residents that are at risk for skin breakdown and falls will have their care plans and assessments reviewed to ensure that adequate interventions are in place and care planned accordingly. C. Policy and Procedure for admission assessments reviewed and updated. DON or designee will randomly review at risk residents and admissions to ensure that all assessments and the care plan reflect the care that the residents are receiving. This will be ongoing. D. The plan of correction will be monitored by the DON or designee and reported findings to QAPI at least quarterly.	

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F 280	Continued From page 12 R23's current care plan dated 5/2/14, lacked fall interventions to include every one hour checks, hi-low bed in lowest position and not to be left unattended in him room in the wheelchair. On 5/20/14, at 1:08 p.m. R23 was observed sleeping in his room in bed with a sensor alarm, bed in low position and a fall mat on left side. On 5/21/14, at 8:30 a.m. R23 was observed in bed, sleeping. A sensor alarm was in place, R23's bed was low position and a fall mat was observed on the left side of the bed. On 5/21/14, at 1:50 p.m. trained medication aide (TMA)-A stated R23 was on one hour visual checks, however confirmed this intervention was not on R23's care plan. On 5/21/14, at 2:55 p.m. the director of nursing (DON) verified the identified fall interventions were lacking from R23's care plan. The DON stated the facility staff needed to work on this. On 5/23/14, at 2:00 p.m. registered nurse (RN)-A verified R23's care plan needed to be revised to include every one hour visual checks, hi-low bed in lowest position, and that staff were not to leave R23 unattended in his room while seated in the wheelchair.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		7/1/14

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F 282	Continued From page 13 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the resident's written care plan for 1 of 1 resident (R3) who required repositioning assistance, for 1 of 1 resident (R23) who required assistance with ambulation and for 1 of 3 residents (R7) who required the application of a hand splint to prevent further contractures. Findings include: R3 was not repositioned every two hours as directed by his care plan. R3's current care plan dated 9/16/13, indicated R3 had a potential for impaired skin integrity related to paralysis and directed staff to reposition R3 every 2 hours. On 5/21/14, R3 was continuously observed from 7:03 a.m. until 10:00 a.m. up in his wheelchair. At 10:00 a.m. nursing assistant (NA)-E and NA-F were observed to assist R3 into bed via a mechanical lift. A red indentation was observed across the back of R3's buttocks. NA-E stated she thought the indentation was from the lift sling R3 was seated on while in the wheelchair. At 10:04 a.m. NA-E stated R3 was to be repositioned every 2 hours and confirmed R3 was last repositioned when assisted into the wheelchair at 7:15 a.m. (2 hours & 45 minutes). At 10:28 a.m. the director of nursing (DON)	F 282	Jourdain Perpich will provide services in accordance with each residents written plan of care. A. R-3- Tissue tolerance assessment performed on 6-2-14. Resident is to be repositioned every 2 hours. Care plan and NAR assignment sheets reviewed and updated. R-23- Resident was assessed on 6-6-14 by physical therapy to clarify ambulation orders. New orders received to ambulate resident to and from dining room at lunch 5x week with FWW. Care plan was updated to reflect current order and to ensure that all ambulation orders that are on the care plan are consistent. R-7- was assessed by physical therapy on 6-6-14. Received orders to implement brace full time except during AM/PM cares. Care plan and NAR assignment sheet updated to reflect change. B. Residents that are at risk for skin breakdown will be identified and assessed at admission, quarterly and yearly. Comprehensive care plans updated with changes in status or orders. C. Audits will be utilized to ensure that repositioning, ambulation and the application of splints are being done appropriately every shift by the wing nurse. D. DON or designee will monitor audits and compliance weekly x4 then monthly thereafter. Will report findings to QAPI at least quarterly.	

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verified R3 was at risk for skin breakdown and stated R3 was to be repositioned every 2 hours as directed by the care plan. The DON confirmed R3's care plan was not followed.

On 5/22/14, at 9:55 a.m. R3 was observed seated in his wheelchair in front of the nurses station. NA-G stated she had assisted R3 into the wheelchair at 7:00 a.m. and confirmed R3 had not been repositioned since that time.

At 10:00 a.m. NA-G and NA-F were observed to transfer R3 into bed via a mechanical lift. NA-G stated R3 was to be repositioned every 2-3 hours. NA-G added, she was going to check R3 at 9:00 a.m. however, she got "busy."

A care plan implementation policy was requested and none was provided.

R23's care plan dated 5/2/14, directed staff to ambulate R23 to and from the dining room.

On 5/22/14, at 9:00 a.m. NA-G stated the NA's had never walked R23 to the dining room because staff did not think R23 was strong enough to walk that distance. NA-G added, she had never known R23 to walk to the dining room.

On 5/22/14, at 10:00 a.m. R23 was observed to ambulate 200 feet with a front wheeled walker (FWW) with the rehab aide. The rehab aide stated R23's ability to ambulate varied from day to day due to his Parkinson's disease and R23's refusals to ambulate.

At 9:10 a.m. licensed practical nurse (LPN)-A confirmed R23's care plan indicated R23 was to

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ambulate to and from meals with a FWW and directed staff to provide stand by assistance while he walked.

Shortly-thereafter, RN-B also confirmed R23's care plan indicated he was to walk to and from meals with a FWW and directed staff to provide stand by assistance.

R7 did not received application of a left hand splint as directed by her care plan.

R7's current care plan dated 5/20/14, directed staff to apply a left hand brace for contractures as ordered.

R7's physician orders dated 5/5/14, indicated R7's left hand splint was to be worn for 4 hours twice a day and throughout the night.

Splint Wear & Care instructions dated 9/16/13, indicated R7 was to wear the splint for 2 hours 4 times a day for 2 weeks followed by 4 hours twice a day and at night. The instruction directed staff to assess for redness.

On 5/21/14, during continuous observations from 7:03 a.m. through 9:29 a.m. R7's left splint was not observed in place. The splint was observed stored on a hamper in R7's room.

-At 11:20 a.m. R7 was observed seated at a dining room table. R7 was observed independently eating with her right hand. R7's left hand splint was not worn.

-At 1:25 p.m. R7 was observed resting in bed. R7's left hand splint was observed stored on a hamper next to R7's bed.

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F 282	Continued From page 16 -At 2:28 p.m. R7 was observed in bed, awake and alert. R7's splint remained stored on the hamper next to the bed. -At 3:08 p.m. R7 was observed to remain in bed with the splint not worn. On 5/22/14, at 10:21 a.m. NA-B stated she took care of R7 on 5/21/14, and confirmed R7's splint was to be worn for 2 hours. However, NA-B confirmed she had not applied R7's left hand splint at any time during the day on 5/21/14. On 5/22/14, at 3:17 p.m. the DON confirmed R7's orders directed the left hand splint be worn 4 hours twice per day and throughout the night The DON stated her she would expect R7's splint be applied as ordered.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that monitoring related to kidney dialysis had been consistently implemented for 1 of 1 resident (R46) in the sample reviewed for end stage kidney disease	F 309	Jourdain Perpich will provide care/services to maintain or attain the highest well being. A. Resident was assessed for self administration of Renvela. It was	7/1/14

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F 309	Continued From page 17 (ESRD). The findings include: R46's ADMISSION FACE SHEET indicated R46 was diagnosed with end stage renal disease (ESRD) secondary to chronic kidney disease and type II diabetes mellitus, intercerebral hemorrhage and cerebrovascular disease. R46's physician orders indicated and order for Renvela (a medication used to bind phosphorous in dietary intake and normalize phosphorous levels in patients who have ESRD) 800 milligrams (mg) 2 tablets 3 times a day and 2 tabs with snacks. R46 was interviewed on 5/21/14, at 11:15 a.m. and stated he had returned from having kidney dialysis at 10:30 a.m. and received his morning medications which included Renvela at that time. R46 stated he had not had breakfast or a snack at the time the Renvela was administered to him. At 11:24 a.m. R46 was observed in his room when the noon meal was served. Trained medication aide (TMA)-A assigned to the care of R46's medication needs on the day shift of 5/21/14, was interviewed at 11:32 a.m. and confirmed R46 was administered Renvela 800 mg 2 tabs at 11:00 a.m. along with all of the other morning medications prescribed to him. The TMA stated she did not know Renvela had to be given at the time food was ingested, and was not supposed to be given together with other medications. R46's undated, current care plan indicated R46 had ESRD and received dialysis three days per	F 309	assessed that resident is capable of administrating Renvela independently at meal times. Physicians order was obtained for resident to self administer Renvela. Care plan and medication record updated to reflect that Renvela is to only be administrated at meal time and with snacks. B. The policy and procedure for medication administration will be reviewed and updated as needed. C. Facility will provide ongoing education on appropriate medication administration through designated online education program to the staff. Staff responsible for medication of Renvela, will monitor resident as to the medical necessity of Renvela and provide education to resident as needed. Additional staff education will be conducted on June 24th on medication administration and the protocol for administration of nutrient binding medications. D. The plan of correction will be monitored by the DON or designee and the results reported to QAPI at least quarterly.	

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week. The care plan indicated R46 was on a 1500 cubic centimeter (cc) daily fluid restriction and directed staff to set up R46's meal tray and to administer medications as ordered. The care plan lacked indication of which meds should be held prior to dialysis, the direction to give Renvela with food and not to administer with other medications an hour before the Renvela and up to 3 hours after Renvela administration. In addition, the care plan had not identified what type and where R46's dialysis access site was and did not direct licensed nurses to monitor for a thrill nor who to contact in case of an emergency related to dialysis. Lastly, the care plan had not delineated which discipline would provide fluids to equal 1500 cc's and who was responsible for monitoring R46's daily total fluid intake.

R46's treatment sheets from 3/1/14-5/21/14, identified R46 had dialysis M-W-F's. The treatment sheets also indicated R46 had a left a/v fistula access site for dialysis and was on a 1500 cc daily fluid restriction and the 24 hour totals of total fluid consumption per day had been left blank.

The registered nurse (RN) clinical manager responsible for the dialysis care of R46 while at the outpatient kidney dialysis clinic was interviewed by telephone on 5/22/14, at 9:30 a.m. and stated the fluid gains R46 had between dialysis treatments were high (greater than 10 pounds of fluid weight) and further stated that the total daily fluid intake for R46 should have been monitored more closely to ensure R46 did not exceed the physician prescribed 1550 cc daily fluid restriction. The RN clinical manager further stated the medication Renvela should be given right with the first bite of food, and the facility

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F 309	Continued From page 19 should monitor the patients fistula for a thrill at least twice a day to ensure patency of the fistula. RN-B was interviewed on 5/22/14, at 10:02 a.m. and confirmed Renvela should not have been administered to R46 24 minutes before the meal had been provided and should not have been administered to R46 along with other medications. RN-B confirmed R43's total daily fluid intake had not been monitored to ensure the 1500 cc fluid restriction had been followed. RN-B also confirmed R43's medical record lacked evidence that a bruit and a thrill of R46's fistula had been monitored.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve and/or maintain the resident's ambulation ability for 1 of 1 resident (R23) reviewed who required ambulation assistance. Findings include: R23's significant change Minimum Data Set (MDS) dated 4/25/14, indicated R23 was diagnosed with a stroke with right sided hemiparesis (weakness on one side of the body), dementia, Parkinson's disease and diabetes. The	F 311	Jourdain Perpich assures that residents are given the appropriate treatment/services to improve/maintain ADLS. A. R23 received evaluation by the physical therapist on 6-6-14. Ambulation orders were clarified and resident is to ambulate with FWW to and from lunch only 5x's week, and to use wheelchair. Care plan and NAR assignment sheets were updated to reflect changes. B. Other residents were reviewed for appropriateness. The policy and procedure for ambulatory services will be	7/1/14

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F 311	Continued From page 20 MDS also indicated R23 had cognitive impairment and required extensive assistance with ambulation. R23's current care plan dated 5/2/14, indicated R23 had decreased mobility with potential for falls related to dementia, diabetes, a stoke with right sided hemiparesis and Parkinson's disease. The care plan directed staff to provide R23 with extensive assistance to ambulate to and from meals. Additionally, the care plan indicated R23 would ambulate with the rehab aide 280 feet over 15 minutes 3 times per week x 90 days. On 5/22/14, at 10:00 a.m. R23 was observed to ambulate 200 feet with a front wheeled walker (FWW) and the rehab aide's assistance. The rehab aide stated R23's ability to ambulate varied from day to day due to his Parkinson's disease and R23 refusing to ambulate. On 5/22/14, at 9:00 a.m. nursing assistance (NA)-G stated the NA's had never known R23 to ambulate to and from the dining room, therefore had never walked him because the NA's did not think R23 was strong enough to walk that distance. -At 9:10 a.m. licensed practical nurse (LPN)-A confirmed R23's care plan indicated R23 was to ambulate with a FWW to and from meals and directed staff to provide stand by assistance while he ambulated. At the same time registered nurse (RN)-B also confirmed R23's care plan and stated the NA assignment sheets (form used by NA's which indicated individual resident needs / care directives) lacked that directive and needed to be updated. Both confirmed R23 should have been ambulated as directed. In addition, RN-B and the	F 311	reviewed and updated as needed. C. Staff education will be provided in a nursing staff meeting to be held June 24th, 2014 regarding ambulation of residents. Resident is currently being ambulated to lunch as ordered, with the exception of when he refuses. Then it is documented as such. D. The plan of correction will be monitored by the DON or designee will monitor 5x/week that this is being done and QAPI updated at least quarterly.	

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F 311	Continued From page 21 Administrator stated R23 had fluctuating health from day to day due to the Parkinson's disease. -At 9:50 a.m. NA-A stated she had offered to ambulate R23 to meals but he had usually refused. -At 9:50 a.m. trained medication aide (TMA)-A stated it had been over 2 months since she had seen R23 ambulate to the dining room. -At 12:30 p.m. the physical therapist stated he was the person who developed R23's ambulation plan to include ambulating to and from meals. At the same time, LPN-A, stated NA-J had ambulated R23 to and from dinner without difficulty. A policy related to ambulation services was requested and none was provided.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident who	F 314	Jourdain Perpich has a plan in place to address possible pressure sores and	7/1/14

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F 314	Continued From page 22 was identified at risk for skin breakdown received timely repositioning according to his assessed need for 1 of 1 resident (R3) reviewed for positioning. Findings include: R3's quarterly Minimum Data Set (MDS) dated 3/5/14, indicated R3 had severe cognitive impairment and was diagnosed with quadriplegia (paralysis of all 4 limbs below the neck). The MDS also indicated R3 required extensive assistance with bed mobility and was totally dependent on staff for transfers via a mechanical lift. R3's Braden Scale (a tool for predicting pressure ulcer (PU) risk) dated 3/5/14, indicated R3 was at risk for PU development. R3's Tissue Tolerance Observation form dated 8/27/13, and reviewed by staff on 3/5/14, indicated R3 was to be repositioned every 2 hours. R3's current care plan dated 9/16/13, and reviewed by staff on 3/12/14, indicated R3 had a potential for impaired skin integrity related to paralysis and required every 2 hour repositioning. On 5/21/14, R3 was continuously observed from 7:03 a.m. until 10:00 a.m. -At 7:03 a.m. R3 was asleep on his left side in bed. -At 7:10 a.m. nursing assistant (NA)-A and NA-E was observed to turn R3 from side to side in bed and checked his brief for incontinence. -At 7:15 a.m. NA-A and NA-E transferred R3 from bed into the wheelchair via a mechanical lift. The	F 314	provide for the treatment of skin break down. A. R3 will continue to be repositioned every 2 hours. Nursing assistants were re educated of the importance of timely repositioning. Care plan was reviewed and updated. B. The repositioning of other residents was evaluated and no other problems were noted. The policy and procedure for assessing for risk of skin breakdown and all other comprehensive assessments will be reviewed and updated as necessary. C. Staff will continue to receive education via online education program. Staff will also be educated on the importance of repositioning in a timely manner in a staff meeting on June 24,2014. The comprehensive assessment policy has been reviewed and updated. D. Plan of correction will be monitored by the Director of Nursing or designee and results reported to the QAPI team at least quarterly.	

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F 314	Continued From page 23	F 314		

mechanical lift sling remained under R3 while seated in the wheelchair.
-At 7:23 a.m. NA-A stated they mark on the whiteboard, on the inside of R3's bathroom door what time R3 was placed in the wheelchair, and when their incontinent brief was changed.
-At 8:44 a.m. NA-I assisted R3 out of the dining room and placed him in front of the nurses station.
-At 8:58 a.m. the activity aide (AA)-A assisted R3 to the activity room.
-At 9:18 a.m. AA-A returned R3 back out in front of the nurses station.
-At 10:00 a.m. NA-E and NA-F assisted R3 into bed via the mechanical lift. R3's brief was changed and it was noted R3 had been incontinent of urine. A red indentation was observed across the back of R3's buttocks. NA-E stated she thought the indentation was from the mechanical lift sling that R3 was seated on in the wheelchair.

-At 10:04 a.m. NA-E stated R3 was to be repositioned every 2 hours. NA-E stated R3 was placed in the wheelchair at 7:15 a.m. and verified it had been 2 hours & 45 minutes since he was last repositioned.

-At 10:28 a.m. the director of nursing (DON) verified R3 was at risk for skin breakdown and that his care plan directed staff to reposition him every two hours. The DON confirmed R3's care plan was not followed as directed.

On 5/22/14, at 9:55 a.m. R3 was observed in his wheelchair in front of the nurses station. At this time, NA-G stated she had assisted R3 into the wheelchair at 7:00 a.m.

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F 314	Continued From page 24 -At 10:00 a.m. NA-G and NA-F were observed to transfer R3 into bed via the mechanical lift. R3's incontinent brief was changed and R3 was noted to be incontinent of urine. NA-G stated R3 was to be repositioned every 2-3 hours. NA-F stated R3's brief change was to be checked and changed every 2 hours. NA-G stated she was going to check R3 at 9:00 a.m. however, she got "busy." The Repositioning policy revised 10/10, indicated a resident would be assessed for repositioning needs and a care plan would be developed.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medical justification for the use of an indwelling catheter was provided for 2 of 2 residents (R46, R17) who were reviewed for urinary catheters. In addition, the facility failed to ensure timely incontinence care was provided according to the assessed need for 1 of 1 resident (R3) reviewed for	F 315	Jourdain Perpich will ensure that there will be medical justification for every indwelling catheter. A. R46 has diagnosis of neurogenic bladder. R17 is deceased. R3 will have incontinent care provided as per care plan. B. All medical records of residents with	7/1/14

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F 315	Continued From page 25 incontinence. Findings include: R46 had an indwelling catheter without medical justification for its use. R46 was admitted to the facility on 12/11/13, with an indwelling catheter. The Urinary Incontinence / Indwelling Catheter Care Area Assessment (CAA) dated 12/23/13, indicated R46 had urinary retention which required the use of the catheter. R46's quarterly Minimum Data Set (MDS) dated 3/19/14, indicated R46 was cognitively intact. The Diseases Index Report indicated R46 had end stage renal disease (ESRD). On 5/20/14, at 1:11 p.m. R46's catheter bag was observed hanging on the side of his bed. -At 4:10 p.m. R46 was noted to be able to communicate with a white erasable communication board. R46 stated the catheter was placed last November 2013, when he was in the hospital. R46 stated they had tried twice to remove the catheter and he was unable to empty his bladder resulting in the catheter needing to be reinserted. On 5/21/14, at 7:17 a.m. nursing assistant (NA)-A stated R46 had left for dialysis about 5:30 a.m. and would return at noon. On 5/22/14, at 11:03 a.m. registered nurse (RN)-B stated the indwelling catheter was placed on 11/17/13, while R46 was in the hospital. RN-B stated R46 was having urinary retention (inability to completely or partially empty the bladder) with	F 315	indwelling catheters will be reviewed to ensure that there is medical justification for the need of the indwelling catheter. C. Physician diagnosis will be obtained for any resident with an indwelling catheter. Care plan will be reviewed and updated as necessary. Policy and Procedure will be reviewed and updated as necessary. D. Plan of correction will be monitored by the Director of Nursing or designee. QAPI will be updated at least quarterly.	

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straight catheterization followed by the indwelling catheter placement. RN-B confirmed R46's medical record lacked documentation that R46 had seen a urologist (a physician who specialized in problems of the urinary tract) in order to determine the cause of the urinary retention. RN-B stated on 12/25/13, the catheter was discontinued, however, R46 was unable to void (empty his bladder) following the removal and had to be straight catheterized and the indwelling catheter was reinserted on 12/30/13.

-At 3:03 p.m. RN-B stated on 3/4/14, they attempted bladder retraining with R46, by clamping the catheter. RN-B stated R46 was experiencing pain so the bladder retraining was stopped and the indwelling catheter was kept in place. RN-B confirmed there had been no physician's order to send R46 to the urologist for an evaluation of the urinary retention.

-At 3:57 p.m. RN-B stated R46's medical record lacked documentation of the cause or medical indication of R46's urinary retention and indwelling catheter.

The facility's Urinary Incontinence policy revised 10/10, indicated if a resident was admitted with an indwelling catheter the attending physician would identify the rationale for the original placement. In addition, the physician would identify and refer, as appropriate, individuals who might benefit from urological procedures to improve continence.

R3 did not receive timely incontinence care as directed by the care plan.

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R3's Urinary Continence CAA dated 9/9/13, indicated R3 was incontinent of bladder and bowel and required every 2 hour check and changes of his incontinent brief.

R3's quarterly MDS dated 3/5/14, indicated R3 was diagnosed with quadriplegia (paralysis of all 4 limbs below the neck) and had severe cognitive impairment. The MDS also indicated R3 required extensive staff assistance with bed mobility and toileting, was totally dependent on staff for transfers with a mechanical lift and was always incontinent of bowel and bladder.

R3's current care plan dated 9/16/13, and reviewed by staff on 3/12/14, indicated R3 was to be checked and changed every 2-3 hours for incontinence.

On 5/21/14, R3 was continuously observed from 7:03 a.m. until 10:00 a.m.
-At 7:03 a.m. R3 was asleep on his left side in bed. NA-A stated she carried a piece of paper in her pocket so she could keep track of the times R3's incontinent brief was changed.
-At 7:10 a.m. NA-A and NA-E turned R3 from side to side in the bed and checked his brief for incontinence.
-At 7:15 a.m. R3 was assisted into the wheelchair with the mechanical lift by NA-A and NA-E.
-At 7:23 a.m. NA-A stated they mark on the whiteboard, on the inside of R3's bathroom door, what time R3 was assisted into the wheelchair and when his incontinent brief was changed.
-At 8:44 a.m. NA-I assisted R3 out of the dining room and placed him in front of the nurses station.
-At 8:58 a.m. the activity aide (AA)-A assisted R3

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to the activity room.
-At 9:18 a.m. AA-A assisted R3 back in front of the nurses station.
-At 10:00 a.m. NA-E and NA-F assisted R3 into bed via the mechanical lift. R3's brief was changed and he was observed to be incontinent of urine.

At 10:04 a.m. NA-E- confirmed R3 was assisted into the wheelchair at 7:15 a.m. and verified it had been 2 hours & 50 minutes since R3's incontinent brief was last checked or changed.

On 5/22/14, at 9:37 a.m. RN-A verified R3's care plan needed to be revised to direct staff to check and change R3's incontinent brief every 2 hours and not every 2-3 hours as written. RN-A stated according R3's quarterly review dated 3/5/14, completed by RN-B, R3 was to receive a brief change every 2 hours.

On 5/22/14, at 9:55 a.m. R3 was observed in his wheelchair in front of the nurses station. NA-G stated she had assisted R3 into the wheelchair 7:00 a.m. right after his brief change.

At 10:00 a.m. NA-G and NA-F were observed to transfer R3 into bed via the mechanical lift. R3's brief was changed and he had been incontinent of urine. NA-F confirmed R3 was to have his incontinent brief checked and changed every 2 hours. NA-G stated she was going to check R3 at 9:00 a.m. however, she got "busy." Both confirmed it had been 3 hours since R3's brief was last checked or changed.

R17 had an indwelling catheter without medical justification for use.

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R17's admission MDS dated 2/24/14, indicated R17 was admitted to the facility with an indwelling catheter on 2/18/14, with diagnoses that included renal failure, diabetes, edema and ascites (accumulation of fluid in the peritoneal cavity, causing abdominal swelling). The MDS further identified R17 had severe cognitive impairment and required extensive assistance of two plus staff for bed mobility and transfers and extensive assistance of one staff for toileting and personal hygiene.

The Nurse Practitioner chart review note dated 2/18/14, indicated R17 was transferred to the facility for end-of-life care and included orders for a palliative care referral for advanced CHF [congestive heart failure] and indwelling catheter and directed staff to change the catheter bag twice a month, change the catheter monthly and irrigate PRN. The note lacked documentation of the justification for the catheter.

R17's Urinary Incontinence / Indwelling Catheter CAA] dated 3/3/14, indicated R17 required extensive staff assistance for toileting secondary to an indwelling catheter. The CAA also indicated R17's catheter was changed every month and PRN [as needed] for malfunction. The CAA lacked indication of the justification for use of the catheter.

R17's current physician orders signed 4/29/14, indicated and order for the indwelling catheter, however, lacked indication of the justification for the use of the catheter.

On 5/19/14, at 4:24 p.m. R17 was observed in bed. A urinary catheter drainage bag was

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observed to be covered and hanging from the bed frame.

On 5/22/14, at 3:34 p.m. RN-A confirmed R17 was admitted from another facility with hospice services. RN-A stated the catheter was placed at the previous facility for R17's comfort. RN-A stated the catheter was changed monthly and confirmed there had been no attempts to remove it since admission. At 3:46 p.m. RN-A confirmed the facility did not have justification for the use of the catheter.

On 5/22/14, at 4:06 p.m. the director of nursing (DON) stated she believed the original rationale for the catheter was to produce accurate urinary output readings due to R17's diagnoses of ascites and edema. The DON confirmed R17 was no longer receiving active treatment for the edema as she was on palliative care. When asked if it was still necessary to have an accurate measurement when R17 was not being actively treated, DON responded "that is a good point." The DON confirmed R17's medical record lacked documentation of the justification for the use of the catheter.

The facility's Urinary Incontinence - Clinical Protocol revised October 2010, indicated the treatment / management of urinary incontinence to include; "If a resident is admitted from the hospital with a newly placed indwelling catheter, the attending physician and staff will evaluate the potential for removing it, depending on the current condition and the rationale for its original placement" and "The physician will identify situations where an indwelling urethral or suprapubic catheter are indicated, and will

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F 315	Continued From page 31 document why other alternatives are not feasible."	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the application of a splint device in order to prevent further contractures (a condition of fixed high resistance to passive stretch of a muscle) for 1 of 1 resident (R7) reviewed for limitations in range of motion. Findings include: R7's undated Diseases Index Report indicated R7 was diagnosed with hemiplegia (total paralysis of the arm, leg and trunk on one side of the body). R7's quarterly Minimum Data Set (MDS) dated 2/16/14, indicated R7 had severe cognitive impairment and required extensive assistance of two plus staff for bed mobility, transfer, dressing and toileting and required extensive assist of one person for personal hygiene. The MDS further identified R7 to have functional limitation in range of motion with upper and lower extremity	F 318	Jourdain Perpich will increase/prevent decrease in range of motion. A. R7 orders for application of splint were clarified by Physical Therapy. R7 now wears left hand splint at all times except during cares. Care plan updated. B. All residents with orders for splints will have care plan reviewed and updated. All residents with splints will have slints applied as per care plan. C. Policy and procedure for the application of splints will be reviewed and updated as needed. Staff education will be conducted on June 24th at a meeting. D. Plan of correction will be monitored by the Director of Nursing or designee. Report will be made to QAPI at least quarterly.	7/1/14

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F 318	Continued From page 32 impairment on one side. R7's physician orders dated 5/5/14, directed staff to apply R7's left hand splint for 4 hours twice a day and throughout the night. The Splint Wear & Care instructions dated 9/16/13, indicated R7's splint was to be worn 2 hours 4 times a day for 2 weeks followed by 4 hours twice a day and at night and directed staff to asses for skin redness. R7's care plan dated 5/20/14, directed staff to apply R7's left hand splint for contractures as ordered. On 5/21/14, during continuous observations from 7:03 a.m. through 9:29 a.m. R7 was observed not to be wearing the left hand splint. The splint was observed stored on a hamper in R7's room. -At 11:20 a.m. R7 was observed seated at a dining room table. R7's left hand splint was not applied. -At 1:25 p.m. R7 observed in bed. The left hand splint was observed stored on a hamper next to R7's bed. -At 2:28 p.m. R7 was observed in bed, awake. The left hand splint remained on the hamper next to R7's bed. -At 3:08 p.m. R7 remained in bed and the splint remained on the bedside hamper. On 5/22/14, at 10:18 a.m. nursing assistant (NA)-C stated the NAs were responsible to apply R7's left hand splint every day. NA-A indicated the	F 318		

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F 318	Continued From page 33 splint was to be worn all day. NA-C and NA-A both indicated the application of the splint and times to be worn were not documented. -At 10:21 a.m. NA-B confirmed she had taken care of R7 on 5/21/14, and verified she had not applied R7's splint at any time throughout the day. NA-B stated the splint was to be worn for 2 hours at a time. -At 3:17 p.m. the director of nursing (DON) confirmed R7's orders indicated the left hand splint was to be worn 4 hours twice per day and throughout the night and also confirmed the NA assignment sheet which informed the staff of the residents needs and care directives lacked direction as to how long the splint should be worn. The DON stated she expected R7's splint to be applied as ordered. A policy on the use of splints was requested but none was provided.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 assess the risk of	F 323	Jourdain Perpich has a plan in place to ensure the safety of all residents.	7/1/14

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F 323	Continued From page 34 entrapment related to the use of side rails for 1 of 1 resident (R3) in the facility who was reviewed for side rail use. In addition, the facility failed to complete an assessment after falls for 1 of 3 residents (R23) reviewed for accidents. Findings include: R3 was observed to have bilateral side rails and the facility failed to complete a safety assessment related to the safe use of the rails. R3s quarterly Minimum Data Set (MDS) dated 3/5/14, indicated R3 had severe cognitive impairment and was diagnosed with quadriplegia (paralysis of all 4 limbs below the neck). The MDS also indicated R3 required extensive staff assistance with bed mobility and was totally dependent on staff for transfers with a mechanical lift. R3's Fall Risk assessments dated 12/7/13, 2/7/14, 3/5/14, 3/26/14, and 4/2/14, all indicated R3 was at high risk for falls. The side rail assessment dated 9/3/13, indicated R3 used bilateral side rails (SRs). The assessment was reviewed on 3/5/14, by registered nurse (RN)-B and the security section of the assessment failed to identify R3's history of rolling out of bed. R3's current care plan dated 9/16/13, and reviewed by staff on 3/5/14, indicated R3 had a potential for falls related to quadriplegia and directed staff to assist R3 with transfers via a mechanical lift. The care plan also indicated R3 utilized a hi-lo bed in lowest position, concave mattress, wheelchair and bed clip alarms, mats on the floor and directed staff to not leave R3	F 323	A. R3 was reassessed for use of half side rails. Side rails have been discontinued and removed from bed. Care plan and NAR assignment sheets updated. B. All side rails were reviewed as appropriate. Policy and Procedure for comprehensive assessments will be reviewed and updated as needed. The comprehensive assessment includes both falls and side rails. C. Policy for comprehensive assessments was reviewed by Interdisciplinary team and updated. Side rail and fall assessments will be done at within 7 days of admission, quarterly and yearly on all residents. Fall assessments are completed after each fall and reported to the QAPI team monthly. Staff will be reeducated on procedures on completing assessments at the June 24th meeting. D. Plan of correction will be monitored by Director of nursing or designee and results will be reported to QAPI team at least quarterly	

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unattended in his room while in the wheelchair and to provide every 1 hour visual safety checks. However, the care plan did not address the use of the bilateral half SRs.

The Incident Report Forms were reviewed from 9/16/13, and 9/20/13. The Fall Scene Investigation (FSI) Reports were reviewed from 11/14/13, through 5/11/14 and the following was revealed:

-9/16/13, at 10:20 p.m. R3 was found lying half on the mat and half on the floor, bed in lowest position. R3 did not sustain an injury. The concave mattress was added as a fall intervention.

-9/20/13, at 11:00 p.m. R3 was found on the floor, bed in lowest position, floor mats on the floor, clip alarm was on and working. R3 did not sustain an injury. All the current care plan interventions had been implemented at this time.

-11/14/13, at 7:30 p.m. R3 was found on the floor, prior to being found on the floor R3 was watching boxing on TV and was very excited and was "air boxing," which caused him to fall out of bed. R3 did not sustain an injury.

-2/7/14, at 1:15 p.m. R3 had an unwitnessed roll out of the bed. R3 did not sustain an injury.

-3/3/14, at 12:00 a.m. R3's roommate alerted staff that R3 had rolled out of bed and was on the floor. The floor mat was in place and the alarm was on and working. R3 did not sustain an injury.

-3/24/14, at 2:05 p.m. R3's roommate alerted staff that R3 was on the floor, wrapped in

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blankets laughing and smiling. R3 did not sustain an injury.

-4/12/14, at 6:00 a.m. R3 was found on the floor next to his bed. R3 was smiling. R3 did not sustain an injury.

-4/28/14, at 6:40 a.m. R3's room call light was on and the alarm could be heard through the closed door. When entered room, R3 was found on the mat by the bedside. R3 did not sustain an injury.

-5/11/14, at 10:20 p.m. R3 was found on the floor in his room on his stomach and was leaning on his elbows in the crawling motion. At 10:50 p.m. R3 was again found on the mat next to his bed by staff. R3 did not sustain an injury.

On 5/20/14, at 1:08 p.m. R3 was observed in bed on his right side, asleep. The bed was up against the wall with a mat on the floor. The bed clip alarm was attached to R3's shirt. There were bilateral half SRs raised on the bed.

On 5/21/14, at 7:03 a.m. R3 was observed in bed on his left side, asleep. The bed clip alarm was attached to the bottom of his shirt. The mat was on the floor.

-At 7:10 a.m. nursing assistant (NA)-A and NA-E were observed to turn R3 from side to side in the bed to check his brief for incontinence. R3 was not observed to use either SR to assist with the repositioning. NA-A stated R3's bed was in the lowest position it would go. She stated there were beds in the facility that did go all the way to the floor.

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-At 7:15 a.m. NA-A and NA-E were observed to assist R3 into the wheelchair via the mechanical lift. The wheelchair clip alarm was attached.

-At 10:00 a.m. NA-E and NA-F were observed to assist R3 into bed via the mechanical lift. R3 was rolled from side to side to have his brief checked. R3 was no observed to use either side rail to assist with repositioning. The bed clip alarm was attached to R3.

On 5/21/14, at 3:25 p.m. NA-H stated when R3 was admitted the facility, staff was told R3 had lived at home with family and had slept on the floor without a pillow. NA-H stated R3 would only use the SRs with turning. NA-H also stated the bed alarm notified staff that R3 was already on the mat. NA-H stated the NAs checked on R3 hourly and so did the staff person administering medications.

On 5/22/14, at 8:26 a.m. the director of nursing (DON) and RN-A were interviewed. The DON stated the SR assessment should be reviewed quarterly at a minimum. The DON and RN-A both stated when RN-B reviewed the SR assessment on 3/5/14, R3 had a history of rolling out of bed, therefore, the assessment was not correct. The DON and RN-A stated R3 had lived with family and slept on a floor mat.

-At 8:41 a.m. RN-B confirmed she had "missed" R3's quarterly SR assessment review in December and stated R3 used the SRs for turning.

-At 8:55 a.m. the trained medication aide (TMA)-B stated she checked R3 every hour and documented those checks on R3's medication

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administration record (MAR).

-At 9:00 a.m. the DON confirmed R3 was at high risk for falls and stated R3 was on hourly safety checks. The DON added, it would not hurt for the NAs to do the second step and just check R3's brief at that time. The DON verified this intervention had not been care planned. The DON added the night shift provided morning cares between 5:30 a.m. and 6:30 a.m. at which time she wanted R3 assisted into the wheelchair after those cares were completed by the night shift staff. The DON stated this intervention had also not been included on R3's care plan.

-At 9:46 a.m. the DON stated she had been the "lone ranger" on facility falls and at the last fall risk committee she opened the meeting to everyone.

On 5/22/14, at 10:00 a.m. NA-F and NA-G were observed to transfer R3 into bed via the mechanical lift. R3 was rolled side to side for a brief change, and R3 was not observed to use either SR.

On 5/22/14, at 1:02 p.m. the DON stated she did not have a policy regarding SR assessments. R23 had a history of falls and the facility failed to complete a post fall analysis to determine root causes and interventions to prevent further falls.

R23's significant change MDS dated 4/25/14, indicated R23 had cognitive impairment and was diagnosed with a stroke with right sided hemiparesis (weakness to one side of the body), dementia, Parkinson's disease and diabetes mellitus. The MDS further indicated R23 required extensive assistance with mobility, toileting and

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had occasional bladder incontinence. The MDS also indicated since the last assessment completed on 1/26/14, R23 had two falls without injury, one fall with injury, and no falls with major injury.

R23's Activity of Daily Living / Rehabilitation CAA and Fall Potential CAA both dated 5/2/14, indicated R23 was unsteady and unable to stabilize without staff assistance for transitions and ambulation and was at very high risk for falls.

R23's current care plan dated 5/2/14, indicated R23 had decreased mobility with potential for falls related to dementia, diabetes, a stroke with hemiparesis and Parkinson's disease. The care plan indicated R23 required extensive staff assistance to sit up, lie down and to get feet and legs into bed. Staff were to directed to provide extensive assist for pivot transfers. Fall interventions included wheelchair locked, bed brakes locked, fall mat on floor (left side), call light within reach, non-skid footwear, non-skid strips at bedside, offer regular toileting and sensor alarm on bed at all times to alert staff of attempts to self transfer. The care plan indicated R23 would ambulate 280 feet over 15 minutes 3 times per week x 90 days and also directed staff to ambulate R23 to and from meals. However, the care plan did not address the every one hour visual checks, hi-low bed in lowest position, and that staff were not to leave him unattended in his room while in the wheelchair.

On 5/22/14, at 10:00 a.m. R23 was observed to ambulate 200 feet with a front wheeled walker (FWW), with the rehab aide's assistance. The rehab aide stated R23's ability to ambulate varied from day to day due to his Parkinson's disease

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and refusals to ambulate.

The Nurse Notes and Observation, Incident Report and Fall Scene Investigation Report forms were reviewed from 1/23/14, and 5/18/14, and revealed the following information:

- 1/23/14, at 5:30 a.m. the Nursing Notes and Observation form indicated R23 was found on the floor by the end of his bed with a small cut above right eye with small amount of blood. R23 was going to the bathroom and lost his balance, and was unsure where got cut.

-The 1/23/14, at 5:30 a.m. Fall Scene Investigation Report form indicated R23 lost balance, was found on floor, in his room, was ambulating, going to the bathroom and was wearing socks. No new fall interventions were added.
The Falls Scene Investigation Report lacked documentation regarding if alarms were being used, last time toileted, root cause of fall, interventions to prevent future falls, care plan updated, nurse aide assignment updated, Fall Team Meeting Notes and conclusion.

- 2/6/14, (no time) nursing notes and observation indicated R23 had a fall in his room, right side of head and right forearm hurt. Noted a small abrasion on R23's right forearm. At 1:10 p.m. R23 returned from the emergency room.
The 2/6/14, ER/Clinic Referral form indicated R23 fell off the bed and hit the right side of his face and his right forearm.
The 2/6/14, at 11:48 a.m. Fall Scene Investigation Report indicated R23 tried to self transfer from chair to bed, he had shoes on. The report indicated alarm was not being used and root

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cause of fall was the alarm not sounding.
The Falls Scene Investigation Report lacked documentation regarding last time toileted, interventions to prevent future falls, care plan updated, nurse aide assignment sheet updated, Fall Team Meeting Notes, and conclusion.
No new interventions put into place.

- 3/13/14, at 1:40 a.m. the Vital Sign Report sheet indicated R23 was found on the floor, by his bed facing face first. R23 stated he was going to the bathroom, brakes were noted not to be locked on wheelchair. No injury.
On 5/21/14, at 1:45 p.m. RN-A stated an incident report should have been completed.
At 3:05 p.m. the DON stated a staff direction to not leave R23 unattended in his room while seated in the wheelchair and to offer R23 bathroom assistance after meals were put into place after the fall. However, the interventions were not added to R23's care plan.

- 3/17/14, p.m. (no time) Nursing Notes and Observation flow sheet indicated R23 slipped from his chair while transferring to the toilet. R23 stated "my hand slipped off chair arm rest. No noted bruises or injuries. No new interventions put in place.
The 3/17/14, Fall Scene Investigation Report form lacked documentation regarding last time toileted, root cause of fall, interventions to prevent future falls, care plan updated, nurse aide assignment updated, Fall Team Meeting Notes, and conclusion.

-5/18/14, at 6:50 p.m. R23 was found by the side of his bed, he had hit head on the corner of his foot rest while coming back from bathroom.
The 5/18/14, Clinic Referral form indicated R23

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fell, going from bathroom to bed, hit his head, and complained of forearm pain. An x-ray of forearm was completed with no findings, no new orders and R23 returned back to the facility.
No new interventions put into place.
The 5/18/14, Fall Scene Investigation Report lacked documentation regarding last time toileted, root cause of fall, interventions to prevent future falls, care plan updated, nurse aide assignment updated, Fall Team Meeting Notes and conclusion.

On 5/21/14, at 2:55 p.m. the DON stated a full Fall Assessment should be completed after every fall. The DON stated the facility had been having some issues with staff completing the required needed information after residents had a fall. The DON stated staff were having issues in complying with filling out incident reports completely.

RN-A stated the facility recently had meetings with the licensed staff regarding the need to complete incident forms and instructed them to perform a thorough assessment after each fall occurrence and staff were currently continuing to work on the issue.

On 5/22/14, TMA-A stated R23 was on hourly visual checks and it was documented on R23's medication administration record (MAR). TMA-A stated it was the responsibility of all staff to assist with completing the one hour checks.

On 5/23/14, at 7:00 a.m. licensed practical nurse (LPN)-B (night staff) stated R23 usually yelled when he needed something. She stated she felt the one hour visual checks were very beneficial.

On 5/23/14, at 2:00 p.m. RN-A verified complete

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F 323	Continued From page 43 fall assessments were lacking on R23 falls and R23's care plan was lacking fall interventions that had been put in place. The facility policy, Assessing Falls and Their Causes, dated 4/24/13, indicated the purpose of the procedure was to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy directed staff to take steps in the procedure of, what to do after the fall, the need to define the details of the fall, identifying causes of a fall or fall risk, performing a post-fall evaluation and identifying complications of falls.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ongoing weight loss was comprehensively assessed and interventions implemented to minimize further weight loss for 1 of 3 residents (R4) in the facility that were reviewed for nutrition.	F 325	Jourdain Perpich will ensure that all residents maintain acceptable parameters of nutritional status unless medically explainable and receive a therapeutic diet when there is a nutritional problem. A. R4 was reevaluated on 5-28-14,	7/1/14

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F 325	Continued From page 44 The findings include: R4's ADMISSIONS FACE SHEET identified R4 was admitted to the facility with diagnoses that include, but were not limited to: type II diabetes mellitus, anemia, blindness of both eyes, pressure ulcer, venous stasis ulcer and esophageal reflux. R4's significant change Minimum Data Set (MDS) dated 4/17/14, indicated R4 had severe cognitive impairment, was independent with eating after tray set up and had a weight loss of 5% or more in the past month or a loss of 10% or more in the past 6 months. Review of the weight record for R4 revealed that on 1/8/14, R4 weighed 232.6 pounds. On 2/10/14, R4 weighed 201. On 3/10/14, R4 weighed 186. On 4/14/13, R4 weighed 187 pounds, and on 5/12/14, R4 weighed 178 pounds. The record indicated R4 had lost 54 pounds since 1/1/14. R4 was observed seated up on the edge of the bed on 5/21/14, at 7:57 a.m. when breakfast was ready and served. R4 received the meal but refused to eat and demanded to be assisted back into bed. R4 did not eat the breakfast meal. R4 was not provided any further nutrition until the noon meal at 11:37 a.m. during which time R4 was served a breaded chicken patty, egg noodles, corn, bread, a bowl of tomato soup and ice cream for dessert. R4 stated to nursing assistant (NA)-D that he did not like the meal served but was not observed to be offered an alternate food choice. R4 was observed to consume 75% of the breaded chicken patty, 25% of the corn, 20% of the tomato soup, 0% ice	F 325	recommendations were made. Care plan was reviewed and updated. Improved fluid status with a significant decrease in edema contributed to the weight loss. Protein needs were calculated by dietitian on January 2, 2014 and the same needs continue to hold for current weight. B. All residents will be monitored for significant weight loss by the registered dietitian on a quarterly basis unless there is a significant weight loss noted then on at least a monthly basis. Nursing staff will notify registered dietitian of all residents noted to have significant weight loss. The bath CNA will reweigh if there is a plus or minus 5 pound weight change. C. Policy and procedure was reviewed and updated to include a nutritional intervention program utilizing real food first, then the addition of high calorie, high protein foods. Staff education will be provided June 24th, 2014 at the nursing staff meeting D. Plan of correction will be monitored the DON or designee on a weekly basis x4 weeks, then monthly thereafter. QAPI will be updated on at least quarterly.	

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	245535	A. BUILDING _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN/PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 325	Continued From page 45	F 325		

cream, 0% bread and 0% milk. R4 was not observed to be encouraged to eat any more of the meal and the meal tray was removed for R4's room at 12:23 p.m.

R4's care plan for nutrition dated 4/6/11, indicated R4 had a goal to have weight stability with a goal weight of 195# (+ /- 10 pounds) the next 90 days. The care plan directed staff to provide R4 a regular diet, set up tray, open and pour liquids, arrange food to enhance independent eating, provide built-up silverware, offer alternatives, offer healthy snacks twice a day, encourage intake of high protein food, document meal intake percentages and to provide consultation with the dietician at least quarterly and as needed. The care plan also directed staff to obtain R4's weight, labs and vital signs as ordered.

Review of the last documented registered dietician progress notes dated 3/27/14, indicated R4 had a significant weight loss of 6% in 30 days and 17% in 180 days. The note also indicated R4's weight fluctuation was greater than normal and R4 was still in the over weight range. Additionally, the note indicated R4 received a consistent carbohydrate cardiac low potassium diet and consumed 25-75% of most meals with the occasional 100% consumption. The note indicated R4 was independent with eating after tray set up with the use of built up silverware. R4's usual weight was 215. The RD indicated it was hard to assess R4's diabetic status as R4 refused all blood sugar checks, insulin and oral medications. The RD noted R4 had upper and lower extremity edema bilaterally with nursing reporting R4 had some improvement in edema and had a decline in cognition. The RD indicated staff would monitor R4's labs, oral intake and

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F 325	Continued From page 46 weight. The RD assessment had not identified what nutritional interventions were going to be implemented to minimize further weight loss. Additionally, the RD had not identified R4's protein needs for wound healing and had not initiated a nutritional supplement despite the massive weight loss in 5 month's time nor issues related to impaired skin integrity. The RD was interviewed via telephone on 5/22/14, at 1:13 p.m. during which she stated she was not aware that R4 continued to have weight loss after she had assessed R4 on 3/27/14. The RD stated she consulted at the facility twice a month and monitored all of the residents weights monthly. The RD confirmed nutritional interventions had not been implemented to minimize ongoing weight loss for R4. The director of nursing was interviewed on 5/22/14, at 1:27 p.m. and confirmed she was not aware R4 had a 54 pound weight loss since 1/1/14, and stated R4 should have been comprehensively assessed and nutrition interventions should have been implemented to minimize further weight loss.	F 325		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334		7/1/14

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F 334	Continued From page 47 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of	F 334		

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F 334	Continued From page 48 pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that prior to receiving the influenza immunization 4 of 4 (R18, R43, R3, R39) residents or their legal representative received the required education regarding the benefits and potential side effects of the immunization. Findings include: R18's family member gave verbal consent for the influenza immunization via phone on 9/12/13. The Influenza Immunization form, which documented this information did not address all the benefits and risks of a influenza immunization. R18 received his influenza immunization on 9/26/13. R43's family member gave verbal consent for the influenza immunization via phone on 9/12/13. The Influenza Immunization form, which documented this information did not address all the benefits	F 334	Jourdain Perpich will provide education on benefits and side effects of the influenza and pneumococcal vaccination, prior to the administration. A. Facility will utilize the information sheet obtained from the CDC to educate all residents and/or responsible party. B. Consent and refusal form for the influenza and pneumococcal vaccination has been updated to include that education was provided. If verbal consent is obtained, infection control nurse will mail the educational information sheet. C. Policy and Procedure has been developed and approved by the Administator and Medical Director. D. Plan of correction will be monitored by the Director of Nursing or designee. Results will be reported to QAPI at least quarterly.	

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F 334	Continued From page 49	F 334		

and risks of a influenza immunization. R43 received his influenza immunization on 9/26/13.

R3's family member gave verbal consent for the influenza immunization via phone on 9/12/13. The Influenza Immunization form, which documented this information did not address all the benefits and risks of a influenza immunization. R3 received his influenza immunization on 9/26/13.

R39 gave written consent for the influenza immunization on 9/13/13. The Influenza Immunization form, which documented this information did not address all the benefits and risks of a influenza immunization. R39 received his influenza immunization on 1/25/14.

On 5/22/14, at 7:52 a.m. registered nurse (RN)-B stated she knew the alert residents received the vaccination information sheet (VIS). However, there was no documentation that R39 had received the VIS sheet prior to the influenza immunizations.

-At 7:55 a.m. licensed practical nurse (LPN)-A stated if the family member was present at the time of the immunization then they would have received the education, and stated if the family member was not present, then they did not receive the information. There was no documentation that indicated if the family members had received the education.

At 8:47 a.m. the director of nursing (DON) stated she thought the influenza immunization consent form was up to date and that RN-B was following up on it.

-At 2:43 p.m. RN-B stated the influenza

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F 334	Continued From page 50 immunization policy indicated the Centers for Disease Control (CDC) VIS sheet would be given to the resident/family. RN-B verified there was no documentation that residents / legal representative had received it. The Influenza Vaccine policy revised 12/12, indicated prior to the vaccination, the resident or resident's legal representative would be provided information and education regarding the benefits and potential side effects of the influenza vaccine from the CDC. This education would be documented in the resident's medical record.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F 356		7/1/14

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F 356	Continued From page 51 make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the actual hours worked and the total number of hours worked for each category of staff were reflected on the nurse staff posting as required. This had the potential to affect all 43 residents who resided in the facility as well as any visitors who wished to view this information Findings Include: On 5/22/14 at 3:05 p.m. the Report of Nursing Staff Directly Responsible for Resident Care forms dated 5/19/14, 5/20/14, 5/21/14, and 5/22/14, were reviewed with director of nursing (DON) and ward clerk (WC). The reports included fields for date and census. It also included columns for shift (including day, evening and night), licensed nursing staff (including RN and LPN columns) and certified nursing staff (including TMA and NA). The form lacked actual hours worked for each individual shift and the total number of hours worked for each category of staff. The WC verified the report did not include the rehabilitative aid hours worked nor did it contain the nurse manager hours in the registered nurse (RN) column. The DON confirmed the required information was lacking.	F 356	Jourdain Perpich will post accurate nurse staffing information. A. Staff information data sheet was revised to reflect facility name, current date, and total number of staffing hours and actual hours worked and resident census. B. Staff information will be posted by the ward clerk and/or charge nurse daily. Staff information will be kept for a minimum of 18 months. C. Policy and procedure will be reviewed and updated as needed. Staff education regarding posting will be provided in staff meeting June 24, 2014. D. Plan of correction will be monitored by Director of Nursing or designee and reported to QAPI at least quarterly.	

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F 356	Continued From page 52 A policy regarding nurse staffing posting was requested but none was provided.	F 356		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		7/1/14

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F 441	Continued From page 53 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to analyze patterns and trends of infections for both staff and residents. In addition, the facility was lacking current infection control policies and procedures. This had the potential to affect all 43 residents who resided in the facility. Findings include: The facility's infection control program lacked a surveillance program with ongoing analysis of patterns and trends of infection risks. The Monthly Infection Control (IC) Logs were reviewed from November 2013, through May 2014. The IC logs revealed only infections with prescribed antibiotics were tracked. The facility's tracking system lacked trending of infections without antibiotics. In addition, a tracking system for employee infections and comparison surveillance between resident and employee illnesses had not been established. On 5/21/14, at 1:35 p.m. registered nurse (RN)-C who functioned as the infection control RN was interviewed. RN-C stated she became the IC nurse on 3/7/14. RN-C stated she had not performed any handwashing audits since she became the IC nurse. In addition, the last documented handwashing audits were done in 2012. RN-C stated prior to her becoming the IC nurse, RN-B had been the designated IC nurse. She stated the IC program had not received the	F 441	Jourdain Perpich will establish and maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A. Resident infections and staff illnesses will be investigated, controlled and the spread of infection prevented. B. An infection control policy and procedure has been developed and implemented. All resident and staff illness will be monitored and tracked, appropriate measures will be taken to prevent the spread of illness. C. Policy and procedures will be reviewed and updated on a yearly basis. The infection control nurse will track and log all illnesses and implement the necessary measures to prevent the spread of illness and infection. D. The plan of correction will be monitored by the Director of Nurses. QAPI will continue to be updated monthly by the Infection Control Nurse or Director of Nursing.	

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F 441	Continued From page 54	F 441		

attention that it deserved. RN-C stated she also worked on the floor as a RN, and there was no time for extra duties. RN-C stated she did feel that RN-B had been given the time to do adequate IC surveillance.

The undated Clostridium Difficile (C-DIFF) (a spore which causes watery diarrhea) policy was reviewed with RN-C. The C-DIFF isolation procedures indicated any visible fecal contamination and items would be disinfected. However, the C-DIFF policy failed to indicate how the disinfection would be done. RN-C stated the C-DIFF policy indicated to disinfect but did not state how.

RN-C stated stated when employees call in ill they were to ask for the charge nurse. RN-C stated there were forms to be filled out when the employee was sick which would include their symptoms. RN-C stated the completed forms were given to the director of nursing (DON). RN-C stated she had not been receiving the employee illness forms from the DON. RN-C stated the employee illnesses were not tracked like they should be. RN-C stated the policy indicated an employee's temperature was to be rechecked when the employee returned to work. RN-C stated this was not occurring and she was trying to get "on top of things." RN-C stated she was not sure if there was an actual employee illness policy.

In addition, RN-C stated she did not have the list of communicable diseases that needed to be reported to the MN Department of Health. RN-C stated there were several IC policies that were lacking, RN-C stated she did not currently track and trend resident and employee illnesses. RN-C

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F 441	Continued From page 55 added, she did not track resident illnesses without antibiotics. RN-C stated she had not logged the resident infections for the months of April and May. According to the November 2013, through March 2014 IC logs, the organism had not been identified related to the infection. In addition, the IC logs failed to identify if a culture had been obtained. RN-C verified the findings, and stated she was not the IC nurse at that time. RN-C stated she had never tracked resident illnesses without antibiotics. RN-C stated there was not a policy regarding how to track employee and resident illnesses.	F 441		

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	245535	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/20/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey The Jourdain/ Perpich Extended Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Jourdain/ Perpich Extended Care Center is a 1-story building without a basement. The building was constructed in 1989 and is of Type II(000) construction. An assisted living apartment building, constructed in 2006 is separated from the building with a 2-hour fire barrier to the west and a hospital building, built prior to the extended care building is separated with a 2-hour fire barrier is to the east. The building is divided into 3 smoke compartments with 1-hour fire rated barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with corridor smoke detection, smoke detection in all common areas and automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and has automatic fire detection in all areas required by the Minnesota State Fire Code 2007 edition. The facility was surveyed as one building.	K 000		

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

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

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JOURDAIN/PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The facility has a capacity of 47 beds. At the time of the survey the census was 43 residents. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		