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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: J2K9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00893

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245205**

2.STATE VENDOR OR MEDICAID NO.
(L2) **261960100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANOKA REHABILITATION AND LIVING CENTER**
(L4) **3000 4TH AVENUE**
(L5) **ANOKA, MN** (L6) **55303**

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) **11/01/2012**

6. DATE OF SURVEY **02/11/2016** (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 **120** (L18)

13.Total Certified Beds **120** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(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 :
Austin Fry, HFE NE II — 02/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/07/1976
(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.
00320
(L31)

30. REMARKS
Posted 04/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/05/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245205
February 29, 2016

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation and Living Center
3000 Fourth Avenue
Anoka, Minnesota 55303

Dear Mr. Dolinsky:

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 January 18, 2016 the above facility is certified for or recommended for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 29, 2016

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation and Living Center
3000 Fourth Avenue
Anoka, Minnesota 55303

RE: Project Number S5205026

Dear Mr. Dolinsky:

On December 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 10, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 11, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 1, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 10, 2015, effective January 18, 2016 and therefore remedies outlined in our letter to you dated December 29, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245205 Y1	A. Building B. Wing Y2	2/11/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0205	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.12(b)(1)&(2)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	01/18/2016	LSC	01/18/2016	LSC	01/18/2016
ID Prefix F0309	Correction	ID Prefix F0312	Correction	ID Prefix F0314	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed
LSC	01/18/2016	LSC	01/18/2016	LSC	01/18/2016
ID Prefix F0315	Correction	ID Prefix F0318	Correction	ID Prefix F0329	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(l)	Completed
LSC	01/18/2016	LSC	01/18/2016	LSC	01/18/2016
ID Prefix F0356	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	01/18/2016	LSC	01/18/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) JS/KJ	DATE 02/29/2016	SIGNATURE OF SURVEYOR 33925	DATE 02/11/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/10/2015	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245205	A. Building 02 - ANOKA CARE & REHAB CENTER B. Wing	2/1/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 01/18/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 01/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 02/29/2016	SIGNATURE OF SURVEYOR 19251	DATE 02/01/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/9/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 29, 2016

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation and Living Center
3000 Fourth Avenue
Anoka, Minnesota 55303

Re: Reinspection Results - Project Number S5205026

Dear Mr. Dolinsky:

On February 11, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 10, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00893 Y1	A. Building B. Wing Y2	2/11/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20560	Correction	ID Prefix 20565	Correction	ID Prefix 20830	Correction
Reg. # MN Rule 4658.0405 Subp. 2	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed
LSC	01/18/2016	LSC	01/18/2016	LSC	01/18/2016
ID Prefix 20895	Correction	ID Prefix 20900	Correction	ID Prefix 20910	Correction
Reg. # MN Rule 4658.0525 Subp. 2.B	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.0525 Subp. 5 A.B	Completed
LSC	01/18/2016	LSC	01/18/2016	LSC	01/18/2016
ID Prefix 20920	Correction	ID Prefix 21390	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.0525 Subp. 6 B	Completed	Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed	Reg. #	Completed
LSC	01/18/2016	LSC	01/18/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	JS/KJ	02/29/2016	33925	02/11/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/10/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J2K9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00893

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245205**
2.STATE VENDOR OR MEDICAID NO.
(L2) **261960100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANOKA REHABILITATION AND LIVING CENTER**
(L4) **3000 4TH AVENUE**
(L5) **ANOKA, MN** (L6) **55303**

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) **11/01/2012**

6. DATE OF SURVEY **12/10/2015** (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 **120** (L18)
13.Total Certified Beds **120** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(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 :
Austin Fry, HFE NE II 01/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 02/04/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/07/1976
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Electronically delivered
December 29, 2015

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation and Living Center
3000 Fourth Avenue
Anoka, Minnesota 55303

RE: Project Number S5205026

Dear Mr. Dolinsky:

On December 10, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
Licensing & Certification
Health Regulation Division
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

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 January 19, 2016, 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 January 19, 2016 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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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 March 10, 2016 (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 June 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(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 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.	F 205		1/18/16

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

Electronically Signed | 01/07/2016

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F 205	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident or legal representative written notification of the facility's bed hold policy at the time of hospitalization for 1 of 1 residents (R53) reviewed for admission, transfer, discharge. Findings include: R53 medical record indicated the resident was hospitalized from 11/6/15 - 11/9/15. The medical record lacked documentation that written notification regarding the bed hold policy was provided to the resident, family or legal representative. When interviewed on 12/8/15, at 12:20 p.m. family member (FM)-A stated no notice of the bed hold policy was received when R53 was hospitalized. When interviewed on 12/10/15, at 11:40 a.m. social services (SS)-A stated no notification was provided to FM-A when R53 was transferred to the hospital, and verified there was nothing in writing related to the bed hold when R53 was hospitalized. During interview on 12/10/15, at 2:18 p.m. director of nursing (DON) stated the social worker should ask the resident or their legal representative if they want their bed held if they are admitted to the hospital, and they should also be informed of the bed hold policy on admission. DON stated the bed hold information was provided in the admission packet, however, a resident should also be provided information in	F 205	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. It is the policy of Anoka Rehabilitation and Living Center to provide notice to the resident and/or designated decision maker before transfer to the hospital or therapeutic leave. All residents receive bedhold policy information upon admission. All resident and or their designated or legal representative will be given a bed hold form for signature upon transfer to the hospital or go on leave of absence per state guidelines. Bedhold policy per state guidelines has been reviewed by the interdisciplinary team on 12/31/15 to ensure that bed hold and readmission notice information is provided to all residents who transfer and or leave facility (hospital, Leave of absence). The policy and procedure for bed hold and readmission notification was reviewed by the interdisciplinary team on 12/31/15. Staff members were trained as it relates to their respective roles and responsibilities regarding the bedhold policy on January 4th, 5th and 6th 2016. Audits will be completed weekly x3,	

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F 205	Continued From page 2 writing on the bed hold upon transfer to a hospital. When interviewed on 12/10/15, at 2:26 p.m. assistant executive director (AED) stated social service staff are responsible for reviewing the bed hold policy with the resident and/ or legal representative. AED stated any time a resident is transferred to the hospital, the form is discussed and signed by the resident or designee, and AED stated this was to be done in writing and not just verbally. The facility policy titled Minnesota Bed Hold Policy dated 8/2011, identified the assigned social work or designee will contact the resident or the responsible party within one business day after a hospitalization to ask if they wish to have a bed held.	F 205	monthly x3 and quarterly x2. Upon review staff education will be implemented if indicated by a prescribed corrective action plan. The Director of Nursing/Clinical Services/Finance Director/Business Office Manager or designee will be responsible for compliance.	
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		1/18/16

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F 279	Continued From page 3 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 develop a comprehensive plan of care to include fistula precautions for 1 of 1 residents (R132) reviewed for dialysis, and for behavioral symptoms and interventions for 1 of 2 residents (R210) reviewed for emotional well-being. Findings include: R132's admission Minimum Data Set (MDS) dated 11/5/15, identified R132 had moderate cognitive impairment, and had recieved dialysis at an outside facility. R132's care plan dated 10/30/15, identified R132 was a new admission to the facility, had a dialysis port, and was currently receiving dialysis. However, the care lacked where R132's port was located, any ongoing care instructions for the shunt site, or any restrictions for blood pressure monitoring resulted from R132's shunt site. During observation on 12/8/15, at 4:42 p.m. R132 was seated at the dining room table. R132 had a dialysis shunt visible in his right upper arm, and stated he goes to dialysis three times a week. When interviewed on 12/8/15, at 5:46 p.m. nursing assistant (NA)-C stated the NA staff check resident blood pressures on bath days.	F 279	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. It is the policy of Anoka Rehabilitation and living center to provide care and services by qualified persons in accordance with each resident's written plan of care. For Resident(s) # 210 the care plan was reviewed and revised by the interdisciplinary team on 12/31/2015. Corresponding updates have been made to kardex and care plan. Notification of changes have been made to resident, family and physician. Resident # 132 discharged 12/9/15For other residents who may be affected by this practice, review and revise careplan upon admission, significant change and quarterly. Individualized careplan will reflect resident's current status, licensed staff will update the careplan per facility policy. The policy for comprehensive care plans	

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F 279	Continued From page 4 NA-C stated she was unaware of any restrictions for obtaining blood pressures on R132. When interviewed on 12/8/15, at 6:05 p.m. registered nurse (RN)-D stated the resident care plan was used to direct the care and needs of residents, and the NA care guides were created from the resident care plan and was to be a reference for the NA staff . RN-D stated blood pressures were not to be obtained using R132's right arm because of his dialysis shunt, and that information should be identified on R132's care plan and NA care guide. R132's undated NA care guide was reviewed and indicated R132 recieved dialysis, but the care guide did not identify the location of R132's dialysis shunt, any care instructions or monitoring required, or not to collect blood pressures in his right arm. When observed and interviewed about his care on 12/8/15, at 6:27 p.m. R132 was seated in his wheelchair in his room. R132's room did not have any signage displayed to alert staff to his dialysis shunt, or any instructions on how to obtain R132's blood pressure. R132 stated several staff, including NA's, had attempted to obtain blood pressures in his right arm (with his shunt). During interview on 12/9/15, at 1:30 p.m. RN-E stated the care plan is used to, "Individually care for that particular patient." RN-E stated information about not collecting blood pressures on R132's right arm was identified on the nurses treatment records, but the NA staff did not have access to those adding, "It should have been on the care plan."	F 279	was reviewed by the interdisciplinary team on 12/31/15. Staff members were trained as it relates to their respective roles and responsibilities regarding the careplan policy and procedures on January 4th, 5th & 6th 2016. The Director of Nursing or designee will be responsible for compliance. Care plan audits will be completed weekly for 3 weeks, monthly for 3 months, then quarterly. Staff education will be provided if indicated by audits.	

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F 279	Continued From page 5 R210's significant change MDS dated 11/18/15, identified her cognition was moderately impaired and required extensive assistance for most activities of daily living (ADLs). The MDS identified R210 demonstrated wandering behaviors. The care plan dated 11/25/15, identified R210 had Lewy Body dementia. The care plan directed the following interventions for communication, dementia care, behaviors and elopement: Anticipate needs; encourage socialization; listen carefully; observe her facial expressions and body language; observe for sad/anxious mood related to sensory loss; provide opportunity for her to express feelings regarding her inability to make her wants and needs known; speak clearly, use short and direct phrases; communicate at eye level; introduce yourself at each interaction; explain activities/ care prior to beginning them; provide one directive at a time; validate her feelings when appropriate; allow time for her to respond, bring her to activities to promote her psychosocial well being; approach her in a calm manner; avoid arguing with her; redirect her for safety and re-approach as needed; praise her for finding her own room; distract her from wandering by offering pleasant diversions of activity, food, fluids or conversation; involve her in activities as much as possible; and ensure her Wanderguard was in place. The care plan did not address R210's wandering into other resident rooms. The care plan also lacked direction for the increased staff supervision that was required for R210. In addition, the care plan lacked specification of R210's individualized interests and successful interventions identified through the facility's behavior rounds process.	F 279		

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During observations on 12/9/15, at 12:27 p.m., another resident approached registered nurse (RN)-J and reported she needed help in her room. RN-J and nursing assistant (NA)-K entered the room and R210 was observed lying in this other resident's bed (this was not R210's room). R210 was alert, but not oriented and required weight bearing assistance from both RN-J and NA-K to stand and transfer back to her wheelchair. R210 was resistive to the transfer and did not appear to understand what was happening to her. Most of R210's body was limp during the transfer and/or R210 was leaning back toward the bed. R210 stated, "I'm scared of some of these things," and grabbed NA-K's forearm area tightly and held it. R210 was also noted to comment, "That hurts," as they assisted her to transfer back to her wheelchair. NA-K replied to R210 stating, "Well that's hurting me, with my arm,,, [will you] let go please?" R210 did let go of NA-K's arm and then they completed the transfer to her wheelchair. As NA-K left the room, rubbing her forearm. She reported R210 did hurt her arm during the transfer, specifically, she pinched her arm. NA-K stated, "Yeah, she pinches." At 12:36 p.m., R210 was observed wandering into a different resident's room (again, not her own room). RN-J alerted NA-K and NA-K assisted R210 out of the room and brought her down another hallway where she began to propel in the direction of her own resident room. At 12:42 p.m., R210 was observed in her own resident room, seated on the toilet in her bathroom. RN-J confirmed NA-K had checked in on R210 and found she had self-transferred to her toilet. R210 had a medium bowel movement and a small void of urine. RN-J commented that perhaps R210 had been trying to communicate

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her need to use the bathroom by her wandering and anxious-like behavior.

During interview on 12/9/15, at 12:09 a.m. RN-J stated R210 had lived on that unit for approximately one month. RN-J reported R210 demonstrated multiple behavior concerns including pinching, tugging at others' clothing, wandering into other resident rooms and planting her feet into the floor when someone is propelling her in her wheelchair. RN-J reported the following interventions she found as successful in her work with R210: Providing her with snacks, using a warm blanket over her shoulders, toileting her right after each meal, providing 1:1's ensuring her pain was well managed, encouraging her to attend activities. RN-J added, there were a couple of other residents on the unit, who were not tolerant of R210's wandering into their room. RN-J stated, "That's why we have to keep such a close eye on her." She stated R210 wandered into other resident rooms one, to two times during each shift. She identified that it was important for all of the staff to be cognizant of where she was at all times and to make every effort to keep other resident's doors closed, to minimize her likelihood of entering their rooms. RN-J stated interventions found to be successful, were to be communicated to staff through shift reports and once weekly behavior rounds. She also believed R210's nursing progress notes should have included specific behavior concerns identified by staff. RN-J stated interventions were to be identified during these reports and rounds, with the care plans being updated by the leaders of the behavior rounds group. Other interventions RN-J identified were keeping her busy, offering her a cup of coffee, sitting next to her. RN-J stated, "I don't think she likes to be alone... I

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should add that warm blanket in there [the care plan]."

During interview on 12/9/15, at 12:49 p.m. NA-K stated behavior interventions for R210 included offering coffee, a warm banked, or a marker to draw on paper with. She added R210's current interventions were effective approximately 50% of the time. NA-K stated the NAs routinely took part in the behavior rounds, where they were given the opportunity to share interventions which each other had found to be effective. NA-K stated this was the time of day when R210 typically became more fidgety. She added, other interventions of waiting and re-approaching R210 were somewhat effective. She reported R210's behaviors were likely a result of her attempting to communicate something to the staff. NA-K reported R210 did not routinely wander into other resident's rooms.

During interview on 12/9/15, at 2:27 p.m. licensed social worker (LSW)-C, stated the facility's behavior rounds took place at least once monthly, but often more frequently than this. He stated the NAs and other staff discussed any new behaviors observed since the prior meeting and shared successful interventions implemented and/or suggested interventions to attempt with R210. LSW-C reported that between himself and activities director (AD)-A, meeting minutes were recorded and successful interventions should have been added to the care plan. LSW-C reported he was not aware that R210 had been wandering into other resident rooms and did not recall the staff discussing this subject during the behavior rounds.

During interview on 12/10/15, at 4:15 p.m. AD-A stated that he had just been informed of R210's

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behavior of wandering into other resident rooms, earlier that day. He stated, "We try to have her engaged as much as possible." AD-A identified interventions of engaging her in activities and providing 1:1 assistance with them three to four times weekly and as needed. AD-A reported that he tried to have R210 participate in three to four activities per week. He added, R210 did not always participate in activities, but would sit parallel with the other residents, if given a cup of coffee to drink. AD-A confirmed he routinely led the behavior rounds on R210's unit. He stated that he took notes of the discussion at the meetings, but thought that any suggested interventions should have been added to the care plan by the facility's nursing department. He confirmed he did not typically enter the findings of the behavior rounds into a resident's written plan of care. AD-A stated the interventions shared at the behavior rounds were communicated to all other staff via a communication book and/or via the nurses updates to the care plan.

During interview on 12/10/15, at 4:31 p.m. the director of nursing (DON) stated, any behavior that was consistently observed by staff, should have been included on the care plan, with a plan for how to address the behavior.

Review of the facility's Care Plan Policy and Procedure dated 3/12/15, directed individualized interventions be written to help residents meet their goals. The care plan was to be updated or changed as care needs changed and any temporary problems were to be added to the comprehensive care plan if no resolution was met within 30 days. The interdisciplinary team was to be involved in development of the care plan, in order to promote autonomy, dignity,

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F 279	Continued From page 10 self-determination and participation.	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 ensure the plan of care was followed for 2 of 2 residents (R208, R19) reviewed for pressure ulcers, 2 of 2 residents (R211, R208)) reviewed for urinary incontinence, and for 1 of 3 residents (R208) reviewed for range of motion services. Findings include: R208's Medication Review Report (physician orders) dated 12/2/15, identified diagnoses including dementia, depression, anxiety, lung cancer, chronic obstructive pulmonary disease and acute and chronic respiratory failure. Physician orders directed interventions to minimize R208's risk for further progression of her current pressure ulcers and the development of new pressure ulcers. These orders included daily Tefla dressings to both heel sores, wrapping in Kerlix; Elevating her bilateral heels and Achilles off bed at all times using a Heel Lift Manager, with no pressure on her heels while up in her wheelchair and no shoes to be worn; and Placing gripper socks only half-way onto her feet and not covering her heels due to wounds.	F 282	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance. It is the policy of Anoka Rehabilitation and living center to provide care and services by qualified persons in accordance with each resident□s written plan of care. Resident # 208 a comprehensive reassessment was conducted to include; ADLs, range of motion, bowel and bladder assessment, positioning, transfers, pain, skin/body audit assessment, hospice plan, pharmacy consultant medication management review, MD/NP consult	1/18/16

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F 282	Continued From page 11 R208's care plan dated 10/2/15, directed the following interventions to minimize the risk for pressure ulcers: Staff to keep heels elevated on pillows at all times, assuring her heels were not touching anything. R208 required two staff to boost up in bed or with any major repositioning. R208 required multiple pressure relieving devices including an alternating pressure mattress for her bed, a pressure reducing device for her chair and a cushion to float her heels. The care plan noted, "Resident does have a tendency to remove her heels from the heel manager or off the pillows that elevate her heels when up in the Broda chair. Needs reminders and assistance to keep heels elevated." R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified severe cognitive impairment, required extensive to total assistance for activities of daily living, had developed one-stage two pressure ulcer, and two- unstageable pressure ulcers since the prior assessment. Observations of R208 included the following: On 12/8/15, at 7:00 p.m. R208 was seated in her Broda wheelchair in the hallway, near the nurse's station. She had white socks and black, canvas shoes on both feet. A gauze dressing was observed around her right lower ankle/ heel area. However, no gauze or dressing was observed to her left foot. On 12/9/15, at 7:14 a.m. to 8:55 a.m., R208 was lying in her bed, on her left side, with pillows propped on either side of her torso. There were	F 282	The careplan was reviewed and revised by the interdisciplinary team on 12/31/15. The corresponding updates have been made to Kardex and careplan. Dietician reviewed resident nutritional supplement for skin integrity. The notifications have been to resident family and physician. 1/5/16 met with family & hospice team to review concerns, the bowel and bladder assessment was revised and updated again on 1/5/16 to reflect residents current elimination status which will be to check and change upon rising, after meals, at bedtime, as needed during the night and upon request. For resident #211 personalized toileting careplan was revised to reflect current toileting plan of toilet after meals, check and change as need at night. The careplan and Kardex have been reviewed and revised by the Quality Assessment team Resident #19 was reassessed during weekly wound rounds on 12/14/2015 and wound on right buttock healed. Dr. Fairbaim observed area on 12/14/15, Nurse Practitioner Melissa Sorenson, NP and family notified. R19 was reassessed by Nurse Manager on 12/24/15 and 01/05/16 and skin remains intact. A Comprehensive reassessment was conducted to include; ADLs, Braden, bowel and bladder assessment, positioning, transfers, pain, skin/body audit assessment. For other residents who may be affected	

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F 282	Continued From page 12 no pillows or devices in place to float her heels and both heels were observed resting on the bed. She wore regular, white socks to her bilateral feet. Her right, lower ankle area was wrapped with gauze, but the left was not. NA-I confirmed R208's bilateral heels were resting on the mattress. On 12/10/15, at 8:05 a.m. to 9:40 a.m., R208 was lying in her bed in her resident room. No pillows or devices were in place to float her heels. She was wearing regular, white socks to both feet and white gauze was observed around only her right lower ankle/ heel area. A black heel floating cushion was observed, tucked between the nightstand and the wall to R208's right side. NA-H entered R208's room to assist her with eating her breakfast. NA-H raised the head of the bed to approximately 60 degrees. R208 remained lying flat on her back, with her shoulder blades resting at the crease from the raised head of her bed and both knees bent. The balls of her bilateral feet and toes were pressed against the footboard of her bed, with her bilateral heels pressed into the mattress. No pillows or devices were in place to float her heels. On 12/10/15, at 9:50 a.m. NA-H and NA-I completed R208's morning cares and placed shoes and socks on the resident, although the care plan directed the resident not to wear shoes. During interview on 12/10/15, at 2:15 p.m. RN-A confirmed she was R208's nurse manager and was responsible for the development of her care plan interventions. RN-A stated R208's heels were to be floated with a heel lift manager whenever she was lying in bed. RN-A stated R208's bilateral heels were to be wrapped with a	F 282	by this practice, the nurse managers and MDS coordinator reviewed and revised careplans and updated as needed. Other residents whose clinical conditions are at risk for impaired skin integrity Licensed staff to implement preventative measures such as Braden assessments in order to provide appropriate treatment modalities for wounds according to industry standards of care. After review updates will be made as appropriate for each resident identified. All residents will have a plan of care and Kardex that reflects individual care needs based on assessments. These assessments will be conducted and reviewed upon admission, significant change and quarterly. Individualized careplan and Kardex will reflect resident□s current status. Licensed staff will update the careplan per facility policy. Each resident will have an individualized careplan that reflects their care needs based on assessment. The nurse managers will review periodically to ensure that the careplan and Kardex are up to date. The policy for comprehensive care plans was reviewed by the interdisciplinary team on 12/31/15. Staff members were trained as it relates to their respective roles and responsibilities regarding the careplan policy and procedures on January 4th, 5th & 6th 2016. The Director of Nursing or designee will	

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F 282	Continued From page 13 dressing, and stated it may had fallen off. During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated staff should implement each resident's care plan and to follow physician orders. R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified R208's cognition was severely impaired and she required extensive to total assistance for activities of daily living, including extensive assistance for toileting. The MDS identified R208 was not on a toileting program and was always incontinent of both bowel and bladder. The care plan dated 10/2/15, directed staff to offer toileting to R208 upon rising, after meals, at bedtime, as needed during the night, and upon request. The care plan directed staff to either assist R208 with the bed pan or to have two staff provide her with assistance to transfer to the toilet. R208 was to receive hands-on assistance from two staff with the use of a mechanical lift for transfers and assistance with clothing management and pericare. During observations on 12/8/15, from 5:30 p.m. to 7:00 p.m. R208 was assisted to the dining room for the supper meal and then brought back to the nurse's station area, where she remained in the hallway throughout the evening. R208 was not offered the use of a bedpan or toileting assistance according to her care plan. During observation on 12/10/15, at 9:50 a.m. nursing assistant (NA)-H and NA-I completed morning cares with R208, during which her incontinence product was changed. NA-I	F 282	be responsible for compliance.	

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confirmed R208 had been incontinent, with a medium bowel movement and a small void of urine. R208 was not offered the use of a bedpan or toileting assistance.

During interview on 12/10/15, at 1:45 p.m. NA-H confirmed she was R208's primary NA on the day shift. NA-H reported R208 was to be checked and changed on a routine basis, approximately every three hours. NA-H confirmed earlier this morning, she did not check and change R208 until her morning cares at 9:50 a.m. and she was unaware of when she was changed prior to that, but confirmed it was prior to 6:30 a.m. (approximately three and a half hours prior).

During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated staff should be implementing each resident's care plan.

R208's significant change MDS dated 9/30/15, identified R208's cognition was severely impaired and she required extensive to total assistance for activities of daily living. The MDS identified R208 had a functional limitation in ROM to one side of her upper extremity. The Care Area Assessment (CAA) dated 9/30/15, noted, "Resident on hospice, expected to decline over time. Have resident participate [in activities of daily living] as able... Requires lift for transfers; not able to weight bear with right arm..." The CAA did not address PROM or exercises.

R208's care plan dated 10/2/15, directed PROM to both upper extremities (UE) and lower extremities (LE), with three repetitions each, during morning cares. The care plan also directed, "ROM program for both UB [upper body] and LB [lower body] once per day following

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worksheets in her closet..." The worksheets in R208's closet, as referenced in the care plan included the following:
-An Upper Extremity ROM Program form (undated) directed PROM exercises to R208's fingers, wrists, elbows, and shoulders, with 20 repetitions to each area, one to two times daily. This form was signed by certified occupational therapy assistant, licensed (COTA/L)-A.
The Lower Extremity ROM Program form dated 8/4/15, directed PROM exercises to R208's ankles, knees, legs and hips, with five to 10 repetitions, one time daily. This exercise program was directed by physical therapy assistant (PTA)-A.

During a telephone interview on 12/8/15, at 8:54 p.m. family member (FM)-B stated she had concerns of her mother not receiving PROM as had been ordered by therapy.

R208's Documentation Survey Report from 9/1/15, through 12/9/15, detailed the following regarding provision of her ROM services.
In 9/15, R208 received PROM to her upper and lower extremities during 21 out of 30 days, with no PROM noted on six days and no data for the remaining three days.
In 10/15, R208 received PROM during eight out of 31 days, with no PROM noted on 22 days and no data for the one remaining day.
In 11/15, R208 received PROM during five out of 30 days (17% of opportunities), with no PROM noted on 23 days and no data for the remaining two days.
In 12/15, R208 received PROM during one out of nine days, with no PROM noted on eight days.

During observation on 12/10/15, at 9:50 a.m.

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F 282	Continued From page 16 R208's morning cares were observed with NA-H and NA-I. As the NAs turned R208 side-to-side during cares, holding her hips and shoulders to push and/or pull her to either side, she was observed to moan and say, "Owe, owe, owe." NA-H and NA-I confirmed this was typical and historical for R208 to made such vocalizations during cares. R208 also demonstrated indications of pain and discomfort with dressing of both her UE and LE. During application of her sweatshirt, while assisting her with putting her arms into each sleeve, she held her hand over her face and moaned. She also vocalized "owe" with lifting each leg into her pants. No PROM or any other exercises were provided to R208 during her morning cares. During interview on 12/10/15, at 1:45 p.m. NA-H stated R208 was supposed to receive ROM, "but she is so painful, you move her arm and then she's 'owe, owe.'" NA-H added, R208 demonstrated these indications of pain/ discomfort whenever she moved her feet, arms legs and when turning her side-to-side in bed. NA-H reiterated she did not do ROM exercises with R208 because of the pain/ discomfort which seemed to result. NA-H denied having reported these observations of pain with movements of her extremities to her supervisors and/or reporting that she was not providing ROM exercises because of this pain. During interview on 12/10/15, at 2:15 p.m. registered nurse (RN)-A confirmed she was R208's nurse manager and was responsible for developing care plans and monitoring implementation. Upon inquiry, RN-A was unsure whether R208 was supposed to receive ROM services. She briefly reviewed R208's physician	F 282		

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orders and stated she was not seeing anything to direct ROM. She added, any ROM programs that were in place, were typically placed inside each resident's closet door and NAs were prompted to document the exercises in the facility's electronic medical record system. RN-A denied having been informed of any pain concerns and/or any concerns of care planned exercises not being implemented for R208.

During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) reported that it was his expectation for staff to implement each resident's care plan.

R19's quarterly MDS dated 10/29/15, indicated R19 had moderate cognitive impairment, required extensive assistance for bed mobility, was frequently incontinent, was at risk for developing pressure ulcer, but did not have any current pressure ulcers, and had a pressure reducing mattress and wheelchair cushion. The MDS included diagnoses of heart failure, cerebral vascular accident (CVA) and depression, and indicated R19 was receiving hospice care.

R19's care plan was observed electronically on 12/8/15, the care plan included R19 was at risk for alteration of skin integrity due to bladder incontinence and periods of lethargy where she needed more assistance with mobility. Interventions included: alternating pressure mattress on bed, pressure relieving device in chair, inspect skin daily with cares, and turn every two hours and check brief.

On 12/9/15, at 7:10 a.m. through 9:09 a.m. R19 was observed sleeping on her back in bed, with her upper body tilted slightly to the left, staff were

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not observed repositioning R19, nor did R19 make any changes in her position by herself during this period of time.

On 12/9/15, at 9:16 a.m. NA-A entered R19's room with a breakfast tray for R19 and raised R19's head of the bed, however, pressure was not relieved from R19's buttocks. NA-A placed the tray table with R19's breakfast in front of R19. NA-A set up R19's breakfast tray and left the room without providing any repositioning assistance. R19 was observed in the same position eating breakfast until 9:54 a.m.

During interview on 12/9/15, at 9:57 a.m. NA-A stated she was assigned to care for R19 for the shift and the resident was to be repositioned every two hours, however, NA-A stated she had not repositioned R19 since the beginning of her shift at 7:00 a.m. because she had, "Forgot."

When interviewed on 12/10/15, at 9:55 a.m. RN-B stated R19 needed help being repositioned and the aids are to help her every two hours, regardless if she is sleeping.

When interviewed on 12/10/15, at 2:02 p.m. RN-A stated that the care plan on 12/9/15 indicated R19 had a two hour repositioning schedule to relieve pressure.

When interviewed on 12/10/15, at 3:01 p.m. the DON stated his expectation was staff should be following the residents individualized care plan for turning and repositioning.

R211's admission MDS dated 11/25/15, identified R211 had intact cognition, required extensive assistance with toileting, and was frequently

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F 282	Continued From page 19 incontinent of bladder. R211's care plan dated 12/7/15, identified R211 was incontinent of bladder, and directed staff to, "Toilet upon rising, before and after meals, HS [hour of sleep and prn [as needed]." R211's undated nursing assistant (NA) care guide identified, "Toilet upon rising [,] before after meals [sic], HS and prn..." During observation of morning care on 12/9/15, at 7:05 a.m. nursing assistant (NA)-E helped R211 get dressed in bed, and transferred him into his wheelchair. NA-E assisted him into the restroom, and helped him brush his teeth and comb his hair, then assisted him to the dining room table for breakfast. R211 was not offered or provided toileting after rising as directed by his plan of care. When interviewed on 12/9/15, at 7:47 a.m. NA-E stated R211 should be assisted with toileting, "Like every two hours," and added R211's bed was saturated with urine this morning when they woke him up. NA-E stated she did not offer toileting to R211 that morning upon rising, despite his care planning directing staff to, because she thought R211 would say he didn't have to use it because his bedding was wet with urine. During interview on 12/9/15, at 12:47 p.m. registered nurse (RN)-F stated R211's care plan should be used as, "An individualized plan of care," and staff were expected, "To follow the plan of care." Further, R211 was on a scheduled toileting program and should have been assisted to the toilet upon rising as directed by his care plan.	F 282		

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F 282	Continued From page 20 The facility's Care Plan Policy and Procedure dated 3/12, indicated, "The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible." Furthermore, the policy directed the care plan would serve to direct necessary care for residents, including measurable goals to determine progress.	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 all nursing staff were aware of specialized care required for 1 of 1 residents (R132) reviewed who was receiving dialysis. In addition, the facility failed to ensure individualized dementia care interventions were provided for 1 of 1 residents (R210) reviewed for behavioral and emotional status. Findings include: R132's admission Minimum Data Set (MDS) dated 11/5/15, identified R132 had moderate cognitive impairment, and had received dialysis at an outside facility while a resident in the facility.	F 309	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance. It is the policy of Anoka rehabilitation and living Center to provide each resident the necessary care and services to attain or maintain the highest practicable physical,	1/18/16

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F 309	Continued From page 21 R132's care plan dated 10/30/15, identified R132 was a new admission to the facility, had a dialysis port, and was currently receiving dialysis at an outside facility. However, the care plan lacked where R132's dialysis port was located, any ongoing care instructions for the shunt site, or any restrictions for blood pressure monitoring related to R132's shunt site. During observation on 12/8/15, at 4:42 p.m. R132 was seated at the dining room table. R132 had a dialysis shunt visible in his right upper arm, and stated he goes to dialysis three times a week. When interviewed on 12/8/15, at 5:46 p.m. nursing assistant (NA)-C stated the nurses checked R132's vital signs, "Most of the time," however, NA staff check them as well on bath days. NA-C stated she was unaware of any restrictions for collecting blood pressures on R132, and was not aware blood pressures could not be taken on the arm with the dialysis access. During interview on 12/8/15, at 5:55 p.m. NA-D stated the NA staff will check R132's vital signs when he receives his baths. NA-D stated she believed blood pressure should not be checked in his arm with his dialysis shunt, but added she did not receive any training from the facility in the care of a dialysis patient only from, "The test," she took to become a nursing assistant. When interviewed on 12/8/15, at 6:05 p.m. registered nurse (RN)-D stated a care plan was used to direct the care and needs of the resident, and the NA care guides were created from the care plan to be a reference for the NA staff to know about specialized individual resident cares.	F 309	mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. For Resident # 210 the interdisciplinary team reassessed the interest needs and individualized the plan of careplan and Kardex to reflect interest and interventions. These updates include; offer a cup of coffee, 1:1 visit, escort to an activity to observe and suggestions to assist staff in understanding behavior and possible needs. Resident # 132 discharged on 12/9/15. Specifically for dialysis a template has been developed and implemented including: coordination of dialysis care which include shunt site location, days of dialysis, and location of dialysis unit/phone number. Interventions include what days resident receive dialysis, transportation and phone number, no blood draws from central line dialysis port, no blood pressure or blood draws from specific arm of graft. Emergency protocol with specific protocol for the staff to notify doctor/nurse practitioner if no thrill or bruit, applying direct pressure if there is a bleed and calling 911 All other residents have been reviewed to ensure that individualized behavior and planning has been developed. Staff education had been provided for each individual resident requiring behavior programming. The policy for Dementia Care and dialysis	

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F 309	Continued From page 22 RN-D stated blood pressures should not be collected in R132's right arm because of his dialysis shunt and that information should be identified on R132's care plan and the NA care guide. RN-D stated if float staff were to assist R132 and didn't know him, they use the information on the care plan and NA care guide as a reference to provide resident cares. R132's undated NA care guide identified the resident was receiving dialysis, however, the care guide did not identify the location of R132's dialysis shunt, any care instructions or monitoring required, or not to collect blood pressures in his right arm. When observed and interviewed on 12/8/15, at 6:27 p.m. R132 was seated in his wheelchair in his room. R132's room did not have any sign displayed to alert staff to his dialysis shunt, or any instructions on how to obtain R132's blood pressure. R132 stated several staff, including NA's, had attempted to obtain blood pressures in his right arm (with his shunt) before, and he has had to stop them. During interview on 12/9/15, at 1:30 p.m. RN-E stated the care plan is used to, "Individually care for that particular patient." RN-E stated information about not collecting blood pressures on R132's right arm was identified on the nurses treatment records, but the NA staff did not have access to those and stated this information should have been on the care plan. A facility policy on dialysis care was requested, but none was provided. R210's significant change MDS dated 11/18/15,	F 309	care was reviewed by the interdisciplinary team on 12/31/2015. Staff members were trained as it relates to their respective roles and responsibilities regarding the Dementia care and Dialysis care plan policy and procedures on January 4th, 5th, and 6th of 2016. On admission the nurse managers will review any new resident for specialized care needs including behavior programming and dialysis. Dementia care plan audits will be completed weekly x 3 weeks, monthly x 3 months, then quarterly for 2 quarters to ensure compliance with results reported to the QA/QI Committee for review and further recommendations. Dialysis Care Plan audits will be completed weekly x 3 weeks, monthly x3 months, and quarterly for 2 quarters to ensure compliance with results reported to the Quality Assurance Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance.	

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F 309	Continued From page 23 identified diagnoses including aphasia and dementia. R210 had moderately impaired cognition, required extensive assistance for most activities of daily living (ADLs), demonstrated physical behavioral symptoms, other behavioral symptoms directed toward others, and wandering behaviors. R210's care plan dated 11/25/15, identified R210 had Lewy Body dementia. The care plan directed the following interventions for communication, dementia care, behaviors and elopement: Anticipate needs; encourage socialization; listen carefully; observe her facial expressions and body language; observe for sad/anxious mood related to sensory loss; provide opportunity for her to express feelings regarding her inability to make her wants and needs known; speak clearly, use short and direct phrases; communicate at eye level; introduce yourself at each interaction; explain activities/ care prior to beginning them; provide one directive at a time; validate her feelings when appropriate; allow time for her to respond, bring her to activities to promote her psychosocial well being; approach her in a calm manner; avoid arguing with her; redirect her for safety and re-approach as needed; praise her for finding her own room; distract her from wandering by offering pleasant diversions of activity, food, fluids or conversation; involve her in activities as much as possible; and ensure her Wanderguard was in place. The care plan did not address R210's wandering into other resident rooms, and it also lacked direction for the increased staff supervision that was required for R210. In addition, the care plan lacked specification of R210's individualized interests and successful interventions identified through the facility's behavior rounds process.	F 309		

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During observations on 12/9/15, at 12:04 p.m. R210 was seated in her wheel chair at the dining room table eating her lunch meal. R210 had eaten less than 10% of her meal, when she began to self propel away from the table. RN-J encouraged R210 to continue eating, and referred to the resident using pet names of honey, sweetie, and dear. R210 was not responsive to RN-J's attempts and continued wheeling away from the table. At 12:27 p.m., another resident approached RN-J and stated she needed help in her room. RN-J and NA-K entered the room and R210 was observed lying in the other resident's bed (this was not R210's room). R210 was alert, but not oriented and required weight bearing assistance from both RN-J and NA-K to stand and transfer back to her wheelchair. R210 was resistive to the transfer and appeared confused. Most of R210's body was limp during the transfer and/or R210 was leaning back toward the bed. R210 stated, "I'm scared of some of these things," and grabbed NA-K's forearm area tightly and held it. NA-K replied to R210 stating, "Well that's hurting me, with my arm,,, [will you] let go please?" R210 did let go of NA-K's arm and then they completed the transfer to her wheelchair. As NA-K left the room, rubbing her forearm, she stated R210 did hurt her arm during the transfer, specifically, she pinched her arm. NA-K stated, "Yeah, she [R210] pinches." At 12:36 p.m., R210 was observed wandering into a different resident's room (again, not her own room). RN-J alerted NA-K, and NA-K assisted R210 out of the room and brought her down another hallway where she began to propel in the direction of her own resident room. At 12:42 p.m., R210 was observed in her own resident room, seated on the toilet in her

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bathroom. RN-J confirmed NA-K had checked in on R210 and found she had self-transferred to her toilet. R210 had a medium bowel movement and a small void of urine. RN-J stated perhaps R210 had been trying to communicate her need to use the bathroom by her wandering and anxious-like behavior.

During interview on 12/9/15, at 12:09 a.m. RN-J stated R210 had lived on that unit for approximately one month, and stated R210 demonstrated multiple behavior concerns including pinching, tugging at others' clothing, wandering into other resident rooms, and planting her feet onto the floor when someone was propelling her in the wheelchair. RN-J stated R210 seemed to be generally suspicious of people and was always on guard when approached by other staff and residents. RN-J stated the following interventions she found were successful in her work with R210 during behaviors: Providing her with snacks, using a warm blanket over her shoulders, toileting her right after each meal, providing 1:1's, ensuring her pain was well managed, and encouraging her to attend activities. RN-J stated there were a couple of other residents on the unit who were not tolerant of R210's wandering into their room and stated, "That's why we have to keep such a close eye on her." She stated R210 wandered into other resident rooms one to two times during each shift, and it was important for all of the staff to be cognizant of where she was at all times, and to make every effort to keep other resident's doors closed to minimize her likelihood of entering their rooms. RN-J stated R210 did not typically lie down or take a nap in the afternoon, and if she were to lie down in her room, the staff would need to check on her every few minutes.

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RN-J stated interventions found to be successful by staff were to be communicated to staff through shift reports and during once weekly behavior rounds, and should than be added to the residents care plan. RN-J stated she also believed R210's nursing progress notes should have included specific behavior concerns identified by staff, and other interventions RN-J identified were to keep R210 busy, offering her a cup of coffee, and sitting next to her. RN-J stated, "I don't think she likes to be alone... I should add that warm blanket in there [the care plan]."

During interview on 12/9/15, at 12:49 p.m. NA-K stated behavior interventions for R210 included offering coffee, a warm blanket, or a marker to draw on paper. NA-K stated R210's current interventions were effective approximately 50% of the time. NA-K stated the NAs routinely took part in the behavior rounds and they were given the opportunity to share interventions which each other had found to be effective. NA-K stated the afternoon was the time of day when R210 typically became more fidgety, and R210's behaviors were likely a result of her attempting to communicate something to the staff.

During interview on 12/9/15, at 2:27 p.m. licensed social worker (LSW)-C, stated the facility's behavior rounds took place at least once monthly but could be more often to meet resident needs. LSW-C stated the NAs and other staff discussed any new resident behaviors observed since the prior meeting and shared successful interventions implemented and/or suggested interventions to attempt with R210. LSW-C stated between himself and activities director (AD)-A, meeting minutes were recorded and successful

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interventions should have been added to the care plan. LSW-C stated he was not aware R210 had been wandering into other resident rooms and did not recall the staff discussing this subject during the behavior rounds.

During interview on 12/10/15, at 4:15 p.m. AD-A stated he had just been informed of R210's behavior of wandering into other resident rooms earlier that day. He stated staff try to engaged R210 in activities as much as possible. AD-A stated he tried to have R210 participate in three to four activities per week, and although R210 did not always participate in activities, staff would have the resident sit parallel with the other residents and would give her a cup of coffee to drink. AD-A stated he led the behavior round meeting, however, nursing was responsible to update the resident's written plan of care with any new behaviors/ interventions discussed. AD-A stated the interventions shared at the behavior rounds were communicated to all other staff via a communication book and/or via the nurses updates to the care plan.

During interview on 12/10/15, at 4:20 p.m. NA-J stated he was a primary staff on the unit and he routinely worked with R210. NA-J stated R210 often went into other resident's rooms and had just done so about 10 minutes prior. He stated, "She went into that room and stood up... so [we] have to watch her... she really need[s] one-to-one attention." NA-J stated R210's locked unit had 20 residents, but had only two aides. NA-J stated R210 was actually a one to one resident but the facility did not do that type of care. NA-J stated other residents often became annoyed with R210's wandering into their rooms and she routinely wandered into any room with an open

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F 309	Continued From page 28 door. During interview on 12/10/15, at 4:31 p.m. DON stated any behavior consistently observed by staff should be included on the care plan including the intervention on how to address the behavior. The DON stated all resident's on that unit wandered, however, he was not aware R210 wandering into other resident rooms any more than any other resident on that unit. Review of the facility's Guidelines for Memory Support Programs and Services dated 2/15, directed the program operate under a person-centered model, with emphasis on the whole person, including their physical, social, emotional, intellectual, occupational and spiritual needs, regardless of their level of cognitive function. Review of the facility's Care Plan Policy and Procedure dated 3/12/15, directed individualized interventions be written to help residents meet their goals. The care plan was to be updated or changed as care needs changed and any temporary problems were to be added to the comprehensive care plan if no resolution was met within 30 days. The interdisciplinary team was to be involved in development of the care plan, in order to promote autonomy, dignity, self-determination and participation.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		1/18/16

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F 312	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services related to incontinece care as directed by the plan of care for 1 of 4 residents (R208) reviewed who required staff assistance with toileting. Findings include: R208's Medication Review Report signed 12/2/15, identified diagnoses including dementia, lung cancer, respiratory failure and chronic pain. R208's significant change Minimum Data Set (MDS) dated 9/30/15, indicated R208's cognition was severely impaired and she required extensive to total assistance for activities of daily living including extensive assistance for toileting. The MDS identified R208 was not on a toileting program, but was always incontinent of both bowel and bladder. R208's Care Area Assessment (CAA) dated 9/30/15, identified R208 had diagnoses which included end stage congestive heart failure, restricted mobility, was always incontinent of urine, urgency and needed assistance with toileting. The CAA also noted, "Continue to offer toileting/or to be checked and changed. Continue to provide pericare after each incontency [incontinence]. Has functional incontinency [incontinence]." Although the cooresponding MDS assessment dated 9/30/15, indicated R208 was not on a toileting program, the CAA directed	F 312	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance. It is the policy of Anoka Rehabilitation and Living Center to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident # 208 a comprehensive reassessment was conducted to include; ADLs, range of motion, bowel and bladder assessment, positioning, transfers, pain, skin/body audit assessment, hospice plan, pharmacy consultant medication management review, MD/NP consult The careplan was reviewed and revised by the interdisciplinary team on 12/31/15. The corresponding updates have been made to Kardex and careplan. Dietician reviewed resident nutritional supplement for skin integrity. Reviewed and in place; low air loss mattress, broada chair, nutritional supplements intervention for	

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F 312	Continued From page 30 the resident was to be offered toileting. Any additional bowel and bladder assessments completed on R208 were requested, but none were provided. R208's care plan dated 10/2/15, directed staff to offer toileting to R208 upon rising, after meals, at bedtime, as needed during the night and upon request. The care plan directed staff to either assist R208 with the bed pan or to have two staff provide her with assistance to transfer to the toilet. During observations on 12/8/15, from 5:30 p.m. to 7:00 p.m. R208 was assisted to the dining room for the supper meal and then brought back to the nurse's station area, where she remained in the hallway throughout the evening. R208 was not provided check and change services nor did staff offer use of a bedpan or toileting assistance as R208's care plan and CAA directed. During continuous observation on 12/9/15, from 7:14 a.m. through 8:55 a.m. R208 was lying in bed in her room. R208 continued to lie in bed, until 8:34 a.m., when a facility nursing assistant briefly entered her room, and assisted with moving her legs in bed and immediately exited R208's room. Check and change services were not observed to be offered or provided. R208 was not offered the use of a bedpan or toileting assistance. At 8:55 a.m., R208 remained in bed, alone in her room. R208 had not been checked/changed nor offered toileting for the entire observation. NA-H confirmed earlier this morning, she did not check and change R208 until her morning cares	F 312	appropriateness. 1/5/16 met with family & hospice team to review concerns, the bowel and bladder assessment was revised and updated again on 1/5/16 to reflect residents current elimination status which will be to check and change upon rising, after meals, at bedtime, as needed during the night and upon request. It was determined by the interdisciplinary team the resident skin integrity issue was unavoidable due to decline in health status and quality of life choice to wear shoes. For other residents who may be affected by this practice, nurse manager and MDS coordinator revised care plans and updated as needed. All residents will have a care plan and kardex that reflects individualized care needs based on bowel and bladder assessment. Bowel and bladder assessments are reviewed upon admission, during significant change, annually and as needed if a change in elimination is noted. Bowel and bladders assessment will be communicated to nurses and nursing assistants via careplan, and kardex . Upon this review, care plan staff education will be implemented if indicated on January 4th, 5th, & 6th 2016. The policy for Activities of Daily Living dependent care was reviewed by the interdisciplinary team on 12/31/15. Staff members were informed to follow the individualized comprehensive careplan and Kardex.	

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F 312	Continued From page 31 at 9:50 a.m. and was unaware of when she was changed prior to that, but confirmed it was prior to 6:30 a.m. (approximately three and a half hours prior). During interview on 12/10/15, at 2:15 p.m. registered nurse (RN)-A stated R208 was to be offered the bed pan and utilized an incontinence brief. RN-A was unsure as to whether R208 was on a toileting program, but confirmed the bed pan should have been offered to her on a regular basis and with cares. During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) reported it was his expectation for staff to implement each resident's care plan. A facility policy addressing toileting assistance or urinary incontinence was requested, but none was provided.	F 312	Staff members will be trained as it relates to their respective roles and responsibilities regarding the policy and procedures on January 4th, 5th, & 6th 2016. Six Random focus Bowel and Bladder audits will be completed by Nurse manager or designee weekly x three weeks, monthly for three months and quarterly for 2 quarters to ensure continued compliance with results reported to the Quality Assurance Committee for review and further recommendation. The Director of Nursing or designee will be responsible for compliance.	
F 314 SS=G	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	F 314	Preparation, submission and	1/18/16

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F 314	Continued From page 32 review, the facility failed to assess the resident's skin for an appropriate turning/ repositioning schedule, and failed to implement interventions which had been assessed to prevent further pressure ulcers from developing and/ or to promote healing of current pressure ulcers for 2 of 3 residents (R208 and R19) reviewed who were identified with current pressure ulcers. This resulted in actual harm for R208, who developed an unstageable pressure ulcer to the second toe of her right foot. Findings include: R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified severe cognitive impairment, required extensive to total assistance for activities of daily living, had developed one-stage two pressure ulcer (defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough), and two- unstageable pressure ulcers (unable to measure depth of pressure ulcer due to eschar or scabbing) since the prior assessment. R208's Care Area Assessment (CAA) dated 9/30/15, identified R208's overall condition was declining and that the resident had been admitted to hospice services. Risk factors identified included severe cognitive deficit, poor nutrition, incontinence, immobility, and the use of antidepressant medication. The CAA indicated, "Does have capability of turning side to side in bed." Although the CAA indicated R208 was capabale of turning in bed, there was no individualized comprehensive assessment completed which identified the resident was able to turn without staff assistance.	F 314	implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance. It is the policy of Anoka Rehabilitation and Living Center to ensure that based on the comprehensive Assessment of a resident, a resident who enters our 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. Resident # 208 a comprehensive reassessment was conducted to include; ADLs, Range of motion, bowel and bladder assessment, positioning, transfers, pain, skin/body audit assessment, hospice plan, pharmacy consultant medication management review, MD/NP consult, nutrition assessment. The careplan was reviewed and revised by the interdisciplinary team on 12/31/15. The corresponding updates have been made to Kardex and careplan. Dietician	

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F 314	Continued From page 33 R208's Medication Review Report (physician orders) signed 12/2/15, identified diagnoses including: dementia, lung cancer, chronic obstructive pulmonary disease, and acute and chronic respiratory failure. The report noted R208 was admitted to hospice services on 9/21/15, with a terminal diagnosis of diastolic heart failure. Physician orders directed interventions to minimize R208's risk for further progression of current pressure ulcers and to prevent the development of new pressure ulcers which included: Alternating pressure reduction mattress; Daily Tefla dressings to both heel pressure ulcers and wrapping them in Kerlix; Barrier cream post episodes of incontinence, as needed; Pressure relief with pillows when up in chair; Twice daily skin checks to heels and Achilles, contacting the nurse practitioner (NP) with any concerns identified; Elevating both heels and Achilles off bed at all times using a Heel Lift Manager, with no pressure on her heels while up in her wheelchair and no shoes to be worn; Keeping the necrotic areas on her left and right Achilles open to air to keeping them dry; Placing gripper socks only half-way onto her feet and not covering her heels due to the pressure ulcers. R208's care plan dated 10/2/15, directed staff to keep heels elevated on pillows at all times, assuring heels were not touching anything, two staff to boost up in bed or with any major repositioning, R208 required multiple pressure relieving devices including an alternating pressure mattress for her bed, a pressure reducing device for her chair and a cushion to float her heels. The care plan indicated, "Resident does have a tendency to remove her heels from the heel manager or off the pillows that elevate her heels	F 314	reviewed resident nutritional supplement for skin integrity. The notifications have been to resident, family, and physician. 1/5/16 met with family & hospice team to review concerns, the bowel and bladder assessment was revised and updated again on 1/5/16 to reflect residents current elimination status which will be to check and change upon rising, after meals, at bedtime, as needed during the night, and upon request. Initiated low airloss mattress, broda chair, and nutritional supplements. It was determined by the interdisciplinary team the resident skin integrity issue was unavoidable due to decline in health status and quality of life choice to wear shoes. Resident #19 was reassessed during weekly wound rounds on 12/14/2015 and wound on right buttock healed. Dr. Fairbaim observed area on 12/14/15, Nurse Practitioner Melissa Sorenson, NP and family notified. R19 was reassessed by Nurse Manager on 12/24/15 and 01/05/16 and skin remains intact. A Comprehensive reassessment was conducted to include; ADLs, Braden, bowel and bladder assessment, positioning, transfers, pain, skin/body audit assessment. For other residents whose clinical conditions are at risk for impaired skin integrity Licensed staff to implement preventative measures such as Braden	

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F 314	Continued From page 34 when up in the Broda chair. Needs reminders and assistance to keep heels elevated." Review of R208's Weekly Wound Documentation from 9/1/15, through 12/10/15, revealed the following description of the pressure ulcers: Site #1: Left heel pressure ulcer acquired in-house on 9/30/15, measuring 1.8 cm by 1.5 cm superficial, but open area, with 100% granulation. The area was not staged, but was decreasing in size and showed no signs of infection. Site #2: Left Achilles pressure ulcer acquired in-house on 9/11/15, measuring 1.5 cm by 2 cm, with 100% eschar. The area was not staged, but was decreasing in size and showed no signs of infection. Site #3: Right Achilles pressure ulcer acquired in-house on 9/11/15, measuring 1.0 cm by 1.0 cm, with 100% eschar. The area was not staged, but was decreasing in size and showed no signs of infection. During observation on 12/8/15, at 7:00 p.m. R208 was seated in her Broda wheelchair in the hallway, near the nurse's station. She had on white socks and black canvas shoes on both feet. The foot pedals to her wheelchair were in place, however, R208 was observed resting her feet on the floor out in front of the foot pedals, self-propelling her wheelchair. R208 stretched her feet out in front of her, placing her bilateral heels to the floor and then pulling herself forward, and the backs of her heels were observed bumping the foot pedals as she propelled. A gauze dressing was observed around her right lower ankle/ heel area, however, there was no gauze or dressing observed to her left foot/ ankle. During a telephone interview on 12/8/15, at 8:54	F 314	assessments in order to provide appropriate treatment modalities for wounds according to industry standards of care. After review updates will be made as appropriate for each resident identified. The policy and procedure for pressure Ulcer was reviewed by the interdisciplinary team on 12/30/15. Upon admit, significant change, quarterly and as needed if a new pressure area/wound has been identified a skin/body audit assessment is completed by a Licensed nurse. Nursing assistants are educated on skin care with all resident daily cares. Nursing assistant is required to report any noted skin changes to the nurse who reviews skin changes and will implement appropriate wound treatment per the skin protocol policy of the facility. Staff members were trained as it relates to their respective roles and responsibilities regarding the pressure Ulcer policy and procedure on January 4th, 5th and 6th 2016. Resident who have been identified with pressure ulcers audits will be completed weekly for 3 weeks, monthly for 3 months, and quarterly for 2 quarters. The results reported to the Quality Assurance Committee for review for further recommendation. The Director of Nursing or designee will be responsible for compliance.	

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F 314	Continued From page 35 p.m. family member (FM)-B stated she was concerned about R208's pressure ulcers and felt the facility should have done more to minimize this risk for developing further pressure ulcers, and to promote healing of the current pressure ulcers. FM-B stated she felt R208 needed turning and repositioning at least every two hours, which the facility was not currently doing. During observation on 12/9/15, at 7:14 a.m. R208 was lying on her left side in bed with pillows propped on both sides of her torso. There were no pillows or devices in place to float her heels and both heels were observed resting on the bed. At 8:22 a.m., R208 remained asleep in her bed, and her right leg was draped over the edge of the left side of the bed. Her left heel remained flat against the bed with no pillows or devices in place to float her heels. At 8:35 a.m., nursing assistant (NA)-I entered R208's room and boosted her up in bed. NA-I stated R208's legs were hanging over the side of the bed so they repositioned her so she was lying flat on her back. No pillows or devices were put into place to float R208's heels, and they were laying directly on the bed. R208 had regular white socks on both feet, and her right, lower ankle area was wrapped with gauze, however, there was no dressing in place on the left foot/ ankle. NA-I stated R208's bilateral heels were resting on the mattress, and R208 typically ate breakfast in bed and did not receive morning cares until after she ate. However, NA-I left R208's room and did not attempt to float the residents heels off the bed. At 8:55 a.m., R208 was awake and remained lying flat in her bed with no pillows or devices in place to float her heels, and both heels were still resting on the mattress of her bed.	F 314		

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During observation on 12/10/15, at 8:05 a.m. R208 was lying in her bed on her back, and there were no pillows or devices in place to float her heels. At 8:17 a.m., R208 continued to lay flat on her back with both knees bent and her feet were observed resting directly on the bed. She was wearing regular white socks to both feet and white gauze was observed around only her right lower ankle/ heel area, and there was none on the left. A black heel floating cushion was observed tucked between the nightstand and the wall to R208's right side in her room. At 9:40 a.m., NA-H entered R208's room to assist her with eating her breakfast. NA-H raised the head of the bed to approximately 60 degrees and R208 remained on her back with both knees bent and the balls of her feet and toes were pressed against the footboard of her bed, with her heels pressed into the mattress. There were no pillows or devices in place to float her heels.

During observation on 12/10/15, at 9:50 a.m. NA-H and NA-I completed R208's morning cares. While providing cares, R208 required extensive assistance from both NA-H and NA-I to turn from side-to-side while in bed, with NA-H standing on one side of the bed and NA-I stood to the opposite side. They each braced R208's shoulder and hip areas to pull her toward them and/or push her away from them as they proceeded to provide cares. NA-H and NA-I stated they were not aware R208 had any current pressure ulcers. Both NAs proceeded to change R208's white socks, and R208 had gauze wrapped around her right foot rested below an exposed, dark brown/ black scab to her right Achilles tendon area. A scabbed area, with deep red skin surrounding the area was observed to the top of her second toe. On her left Achilles

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tendon area, a dime-sized open area was observed, and there was also a small, flaky scabbed area to the edge of her left heel, and the top of the second toe was reddened. NA-H carefully applied the right sock over the gauze wrapped around R208's right lower ankle/ heel area, however, she did not appear to take the same precautions with the left ankle/ heel area and at one point, one of her fingers was observed directly over the open area to R208's left Achilles tendon. Once dressed, NA-I asked NA-H, "Does she need her shoes?" NA-H replied that R208 sometimes wore the shoes and other times did not, however, NA-H proceeded to apply black canvas shoes.

On 12/10/15, at approximately 10:45 a.m. licensed practical nurse (LPN)-A entered R208's room and stated he was not very familiar with R208, however, he reviewed the residents electronic treatment record and stated R208 was not due for any treatments at this time but the resident had an in-grown toe nail to her left great toe, which required a topical antibacterial ointment. LPN-A removed R208's left sock and applied ointment to that area. As he proceeded to re-apply the sock, he was asked whether there were any other open areas or skin breakdown on the left foot. LPN-A examined the foot running his gloved hand over the back of her foot when he noticed the opening on her Achilles area. Upon referencing R208's electronic treatment record, he stated R208 had a stage 2 pressure ulcer on her left heel, and R208 was supposed to have a "heel lift manager," at all times when in bed to prevent further pressure, which he confirmed was the black heel floating cushion tucked between R208's nightstand and the wall. LPN-A stated the cushion was to be in place at all times while R208

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was in bed and stated the residents pressure ulcers, "would definitely get worse," if her heels were not being floated from the bed. He stated the nurses were expected to check the cushion was in place every time R208 was in bed, and the residents electronic treatment record prompted the nurses to sign off this was being implemented during every shift. LPN-A stated R208's treatment record also directed the evening shift nurse to apply dressings to both R208's heels, however, he was not sure why only the right heel had a wrap on. During this observation, R208 repeatedly crossed one foot over the other, and while crossing her feet, the Achilles area of the top foot was observed resting on the top of the opposite ankle area. LPN-A inspected both R208's feet/ heels and stated the area to her right toe was possibly a new area as he did not see it documented in the residents treatment record, however, LPN-A stated he would have an RN come into the residents room to assess the pressure ulcers.

On 12/10/15, at 11:21 a.m. RN-A (nurse manager) and RN-H (wound nurse) entered R208's room to assess the residents pressure ulcers. RN-A and RN-H assessed all pressure ulcers both R208's feet/ heels and reported the following results:
Site #1: Left heel, dry scabbed area measuring 0.3 centimeters (cm) by 0.4 cm, unstageable.
Site #2: Left Achilles, was a scabbed area upon last assessment but the scab had since fallen off and was now an open area measuring 0.8 cm by 0.8 cm, with granulation noted around edges, stage 2.
Site #3: Right Achilles, dry scabbed area measuring 0.8 cm by 1.0 cm, unstageable.
Site #4: Right second toe, newly identified

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scabbed area measuring 0.2 cm by 0.2 cm, with reddened surrounding tissue measuring 0.3 cm, unstageable.

RN-A stated sites #1, #2 and #3 were improving from past assessments, but stated the pressure ulcer to R208's right second toe (site #4) was new. RN-A stated R208's family had recently brought new shoes in for the resident, and she had just, "had the nurse practitioner change the order" for no shoes on 12/9/15, so R208 could wear the shoes the family had brought in. RN-A placed the black canvas shoe next to R208's right foot and compared the newly identified pressure ulcer to the shoe and stated it appeared the shoes were the cause of the new pressure ulcer. RN-A stated she was going to clean the area, wrap it with Kerlix, and have the NP look at it on 12/11/15, and R208 had slippers she could wear in the meantime. RN-A stated on 12/9/15, she had the NP remove the physician order that directed the resident was not to wear shoes because family had brought in the new black canvas shoes about a week prior for R208. RN-A stated the facility nurses were to observe all of R208's pressure areas during each evening shift. RN-A stated R208's foot pedals should have been turned away and/or removed any time the resident was self-propelling in the wheelchair as the foot pedals could resulted in bumping the pressure ulcers on her bilateral Achilles. RN-A stated R208 did not require a turning or repositioning schedule and the resident was able to independently make significant, prolonged changes to her positioning.

Review of R208's treatment administration record (TAR) from 9/1/15, through 12/10/15, identified the following:

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F 314	Continued From page 40 Starting on 10/16/15, the TAR directed, "Apply Tefla/ non-adherent dressing to both heels sores and wrap with Kerlix. Change daily." The TAR indicated this treatment was administered routinely as ordered, and no refusals were noted. Starting on 9/11/15, the TAR directed, "Elevate Bil [bilateral] heels off bed at all times no pressure on heels when up in w/c [wheelchair] daily checks until resolved to Bil Achilles one time a day; Call if opens or any concerns." The TAR indicated this treatment was administered routinely as ordered and no refusals were noted. Starting on 9/17/15, the TAR directed, "Bid [twice daily] skin checks to heels and Achilles. Call NP with any concerns every day and evening shift for prevention." The TAR indicated this treatment was administered routinely as ordered and no refusals were noted. Starting on 9/17/15, and ending on 12/9/15, the TAR directed, "Heel lift Manager on at all times to elevated heels and Achilles off bed. NO SHOES. Every shift." The TAR indicated this treatment was administered routinely as ordered and no refusals were noted. Starting on 10/2/15, and ending on 12/9/15, the TAR directed, "Place gripper socks 1/2 way onto feet only- do not cover heels due to wounds. Every shift." The TAR noted a few, sporadic refusals, however, overall this treatment was administered routinely as ordered. Review of R208's nursing progress notes from 9/1/15, through 12/10/15, identified the following: The progress notes lacked evidence of R208 routinely refusing cares or treatments of the pressure ulcers. The progress notes lacked evidence of R208 and/or her legal representative being provided	F 314		

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F 314	Continued From page 41 education on the risks of skin breakdown with wearing the black canvas shoes provided by the family. The progress notes lacked any assessment to determine if R208 could wear shoes to prevent further pressure ulcers from developing. The progress notes lacked any notation of FM-B's request for R208 to have a two hour turning and repositioning schedule. The progress notes lacked assessment of an appropriate turning and repositioning schedule for R208. During interview on 12/10/15, at 1:45 p.m. NA-H stated R208 required two staff to reposition and turn her from side-to-side while lying in bed, however, if she was lying on a draw sheet, one staff could turn her. NA-H stated R208 was not able to turn her bottom side-to-side to offload pressure independently. NA-H stated she was not aware of any current pressure ulcers for R208. NA-H stated she typically repositioned R208, but stated she was not directed to do this, but just felt it was something that should be done. NA-H stated she typically repositioned R208 one time between 6:30 a.m. when her shift started, and 10:30 a.m., when staff typically assisted R208 to get dressed and up in her wheelchair. However, NA-H stated she had not repositioned R208 that morning, and she boosted R208 up in bed and raised the head of the bed for her to eat breakfast, but did not turn her to a different position. NA-H was not sure whether R208 was repositioned throughout the night, so she was unable to state how long she had been lying on her back, but confirmed it was at least three hours, from 6:30 a.m. to 9:40 a.m. NA-H was not sure how long R208 had her been wearing the	F 314		

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black canvas shoes, but stated she knew it had been more than a week.

During interview on 12/10/15, at 2:15 p.m. RN-A stated she was R208's nurse manager and was responsible for completion of her assessments and the development of her care plan interventions. RN-A stated the newly identified pressure ulcer to R208's second toe of her right foot was an unstageable, scabbed-over area which had developed after wearing a new pair of shoes brought in by her family. RN-A stated R208 had not been assessed to determine whether the shoes were appropriate, given her risk for skin breakdown and the order for no shoes. RN-A stated R208's family wanted her to wear the shoes so she had the NP discontinue the order. RN-A stated she was unsure of when the areas to R208's bilateral Achilles' developed, but knew they had developed prior to her arrival on this unit in 9/15. RN-A stated the scabbed area to her left heel was originally identified on 9/30/15, and stated R208's heels were to be floated with a heel lift manager whenever she was lying in bed. RN-A was not aware the heel lift manager was not being used by the NAs when they laid R208 down in bed. RN-A stated R208's bilateral heels were to be wrapped with a dressing, however, she stated R208 moved her feet around a lot and the dressing to her left heel area could have fallen off throughout the night. RN-A stated R208 was not on a turning and repositioning schedule, and she felt R208 moved around independently and did not require a turning and repositioning schedule. RN-A stated she would need to review R208's assessments to determine how it was determined the resident did not require a turning and repositioning schedule. RN-A stated she was unaware R208 required one

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person with a draw sheet, or two persons to assist, with turning side-to-side in bed during incontinence cares. RN-A stated, "I guess I really don't know. She moves a lot herself... They do get her up and they offload her and reposition her in the Broda chair." RN-A stated her reference to "offload" was referred to the time during transfers when R208 was not seated or lying, which did not necessarily provide sufficient pressure relief. RN-A stated the facility was still working on developing a timeline of R208's pressure ulcers, and would provide it once it was completed. However, at the time of survey exit on 12/10/15, no assessment of R208's turning and repositioning schedule or pressure ulcer timeline was provided.

During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated staff should implement each resident's care plan and to follow physician orders. DON stated he was made aware of R208's new unstageable pressure ulcer to her toe, and he stated it was R208 and her legal guardian's wish for her to wear the shoes. However, the DON stated he would expected his staff to educate R208's legal representative on the risks and document the education and refusal to abide by the physician's order in the medical record, however, he stated R208's medical record did not show any education on wearing the shoes were provided.

During interview on 12/10/15, at approximately 5:45 p.m. the MDS coordinator reported the facility did not do tissue tolerance testing (an assessment used to individualy assess the skins ability to withstand pressure) as this was no longer the standard of practice and research suggested tests such as this were not effective in

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determination of a resident's need for frequency of turning and repositioning. MDS coordinator stated the facility assessed residents for an appropriate turning or repositioning schedule by adjusting the schedule as concerns arose, and resident skin was checked with all cares on an on-going basis, and any concerns were reported to the nurse for further assessment. She stated the RN's adjusted the turning and repositioning schedule as needed. MDS coordinator stated there was no assessment R208's skin was evaluated for an appropriate turning and repositioning schedule.

A facility policy regarding pressure ulcers was requested, but not provided.

R19's quarterly MDS dated 10/29/15, indicated R19 had moderate cognitive impairment, needed extensive assistance for bed mobility, was frequently incontinent, was receiving hospice care, and was at risk for developing pressure ulcers, but did not have any current pressure ulcers. The MDS indicated the resident had a pressure reducing mattress and wheelchair cushion used to prevent pressure ulcers.

R19's Nurse Quarterly Data Collection dated 10/28/15, included a Tissue Tolerance and Braden and Skin Risk Data Collection. The Tissue Tolerance assessment lacked direction on how often R19 should be repositioned lying or sitting, and the assessment indicated R19 was able to make frequent and minor changes in bodily positions independently, but required staff assistance with major changes. The Braden and Skin Risk Data Collection indicated R19 was at risk for developing pressure ulcers due to being frequently incontinent, chairfast, slightly limited in

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mobility, friction, and shearing.

R19's Nurse Monthly Documentation dated 11/18/15, indicated R19 needed extensive assistance with bed mobility.

R19's electronic care plan was reviewed on 12/8/15, and the care plan included R19 was at risk for alteration of skin integrity due to bladder incontinence and periods of lethargy where she needed more assistance from staff with mobility. Interventions included: Alternating pressure mattress on bed, pressure relieving device in chair, inspect skin daily with cares, turn and reposition every two hours, and check brief for incontinence.

During constant observation on 12/9/15, at 7:10 a.m. through 9:09 a.m. R19 was observed sleeping on her back in bed, with her upper body tilted slightly to the left with no changes in repositioning by staff, nor did R19 make any changes in position by herself during this period of time.

On 12/9/15, at 9:16 a.m. NA-A entered R19's room with a breakfast tray for R19. NA-A raised the head of R19's bed, however pressure was not relieved from R19's buttocks. NA-A placed the tray table with R19's breakfast in front of R19, set up R19's breakfast tray, and left the room without providing any repositioning for R19 at this time.

During interview on 12/9/15, at 9:36 a.m. R19 stated her butt was sore and needed to move a little, however, R19 did not attempt to reposition herself and continued to eat her breakfast. R19 was continuously observed eating breakfast in

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the same position until 9:54 a.m. with no repositioning.

During interview on 12/9/15, at 9:57 a.m. NA-A stated she was assigned to care for R19. NA-A stated R19 was to be repositioned every two hours, however, she had not been repositioned since the beginning of her shift at 7:00 a.m. because NA-A, "Forgot." NA-A than lowered R19's head of the bed, unfastened her incontinent product, and asked R19 to role to her left side. R19 grabbed the left grab bar and tried to roll but could not move herself to her side. NA-A used the the draw sheet on the bed and assisted R19 to her left side. NA-A stated R19 needed help with repositioning. R19's buttocks were observed at this time and was covered in a white cream. NA-A washed the white cream off of R19's buttocks, and R19 had two small open areas about the size of a dime on her right inner buttocks, and a quarter size blanchable red area to her left inner buttock.

On 12/9/15, at 10:07 a.m. licensed practical nurse (LPN)-A entered R19's room and stated he wasn't aware R19 had any open areas and reviewed the medical record and could not find documentation of the open areas. LPN-A looked at R19's treatment record in the order section dated 12/7/15, which instructed staff to cleanse the right buttock pressure ulcer, and cover with a foam dressing as needed and every evening. LPN-A stated R10 had no foam dressing in place to the right buttock, and R19's pressure ulcer(s) were not communicated.

On 12/9/15, at 10:17 a.m. RN-A entered R19's room with a measuring tool and stated she was not aware R19 had any pressure ulcers. RN-A

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stated the residents hospice nurse was in the facility on 12/7/15, but she had not reviewed the hospice notes yet. RN-A measured the pressure ulcers and the upper area measured at 0.6 centimeters (cm) x 0.5 cm, and the lower open area measured 0.5 cm x 0.6 cm. RN-A stated both area's were superficial and had no drainage, and the red area on the left buttock was not measurable as it had completely faded.

When interviewed via telephone on 12/9/15, at 1:17 p.m. RN-B hospice nurse stated she observed a 1 cm pressure ulcer on R19's right buttocks on 12/7/15. RN-B stated she cleansed the pressure ulcer and applied a foam dressing during her visit, and then she updated the facility nurse, RN-C, prior to leaving the facility and wrote an order to cleanse the pressure ulcer and apply a foam dressing daily.

A review of the hospice notes included a note dated 12/7/15, which indicated there was a 1 cm open area on R19's right buttock, which was a recurrent pressure ulcer, and directed facility staff to cover the pressure ulcer with an adhesive foam dressing.

R19's Braden and Skin Risk Assessment updated on 12/9/15, indicated R19 was at risk for developing pressure ulcers, however, had demonstrated she could turn herself side to side independently. Although staff indicated R19 was unable to turn independently, the nurse assessment continued to identify the resident was able to relieve pressure by moving independently.

R19's Nurse Weekly Wound Documentation dated 12/9/15, included the open area's observed with RN-A were in house acquired on 12/7/15,

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F 314	Continued From page 48 and were both superficial stage 2 pressure ulcers. R19's medical record lacked an updated Tissue Tolerance and and analysis of the newly developed pressure ulcer discovered on 12/7/15. R19's care plan was updated on 12/9/15, and indicated R19 had an alteration in skin integrity as evidenced by two superficial open areas on right buttocks. The care plan indicated R19 did not want to be awakened to be turned/ repositioned, R19 was able to turn from side to side using grab bars adequately for pressure relief, and R19 just needed assistance with boosting up in bed When interviewed on 12/10/15, at 8:20 a.m. RN-A stated she had spoken to hospice RN-B and had learned RN-B reported the pressure ulcer to RN-C following the visit on 12/7/15. RN-A stated she had updated the family and the physician regarding the pressure ulcer, however, she had not notified any other facility staff about the pressure ulcer. RN-A stated she observed R19 and felt that she had repositioned herself with the use of the grab bar on her bed, and she had also updated R19's Braden Scale and care plan on 12/9/15, as R19 told her she did not want to be awakened to be be repositioned. RN-A stated she was aware R19 does not always reposition herself as she was weak and forgets. RN-A stated she did not reassess R19's Tissue Tolerance, and stated she should have. RN-A stated she discussed risk vs benefits with R19 regarding not being woke up to be repositioned, however, she did not discuss it with family nor did she document the risk vs benefits were reviewed. During interview on 12/10/15, at 9:55 a.m. RN-C stated RN-B from hospice had reported R19 had	F 314		

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F 314	Continued From page 49 developed a pressure ulcer on her right buttocks and gave a hospice order to cleanse and apply a foam dressing daily and as needed. RN-C stated she processed the order, but failed to document or notify RN-A regarding the pressure ulcer development. RN-B stated R19 needed help with repositioning to relieve pressure, which should be done at least every two hours, regardless if she is sleeping. During follow up interviewed on 12/10/15, at 2:02 p.m. RN-A stated the 10/28/15, Tissue Tolerance assessment lacked direction on how often R19 should be repositioned while sitting and/ or lying. RN-A further stated she could be doing the assessment incorrectly and would check with the MDS nurses to determine the correct way to complete the assessment. RN-A stated the Tissue Tolerance assessment should have indicated two hours for repositioning for R19, as the care plan previously read before it was updated on 12/9/15. A policy on pressure ulcers was requested, and was not received.	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.	F 315		1/18/16

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F 315	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement care plan interventions to promote continence for 1 of 1 residents (R211) reviewed for urinary incontinence. Findings include: R211's admission Minimum Data Set (MDS) dated 11/25/15, identified R211 had intact cognition, required extensive assistance with toileting, was not on a scheduled toileting program, and was frequently incontinent of bladder. R211's Nur Day 4 Post Admission assessment dated 11/21/15, identified R211 to be, "Always incontinent," of bladder and required extensive assistance to use the toilet. The assessment provided a section to document, "Comments on urinary patterns," and check mark boxes to identify interventions to help R211 manage his incontinence which included the following options: "Scheduled/Habit Toileting Plan," "Check and Change Program," "Training to return to previous pattern/retraining" and; "Prompted Voiding." However, none of these fields were completed, and were left blank on the assessment. An analysis of the assessment was only documented as, "Patient [R211] is incontinent of bladder and occasionally incontinent of bowel." The assessment did not identify any potentially reversible causes of R211's urinary incontinence,	F 315	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. It is the policy of Anoka Rehabilitation and Living Center that based on the resident's comprehensive assessment, 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. For Resident # 211 a new assessment for Bowel and urinary incontinence, care plan was review and revised on 12/12/2015 which includes the identification of the type of incontinence. Corresponding updates have been made to the kardex and care plan that address individualized programming and interventions. All staff members responsible for incontinence management were re- educated on policies and procedures on January 4th,	

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F 315	Continued From page 51 any collected patterns of voiding, or any interventions to promote continence for R211. R211's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 12/1/15, identified, "Res [resident] is incontinent of b & b [bowel and bladder] ... unknown if his function will return." Further, the CAA provided a space to include resident and family input on R211's toileting needs, however this space just identified, "Per review." The CAA identified R211's care plan would be developed to slow or minimize his declines, avoid complications, and minimize his risks of urinary incontinence. The CAA did not identify any collected patterns of voiding, or any interventions to promote continence for R211. R211's care plan dated 12/7/15, identified R211 to be incontinent of bladder, and identified an intervention of, "Toilet upon rising, before and after meals, HS [hour of sleep] and prn [as needed]." During observation of morning care on 12/9/15, at 7:05 a.m. R211 was lying in bed, while nursing assistant (NA)-E prepared a wash basin in the restroom. R211 had on an incontinence pad which was soiled with urine and stool. NA-E and NA-F assisted R211 to his wheelchair, and NA-E then assisted him into the restroom, placing him in front of the vanity to brush his teeth. R211 finished his morning cares, and was assisted to the dining room table for breakfast. No offer or attempt to toilet R211 was provided by staff as directed by his care plan. When interviewed on 12/9/15, at 7:47 a.m. NA-E stated R211 was typically incontinent of urine, and	F 315	5th and 6th 2016. For other residents who may be affected by this practice, comprehensive record review of bowel and bladder will completed per facility policy. Staff members were trained as it relates to their respective roles and responsibilities regarding Bowel and Bladder policy and procedures on January 4th, 5th and 6th 2016. Six Random focus Bowel and Bladder audits will be completed by Nurse manager or designee weekly x three weeks, monthly for three months and quarterly for 2 quarters to ensure continued compliance with results reported to the Quality Assurance Committee for review and further recommendation. The Director of Nursing or designee will be responsible for compliance.	

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is usually saturated with urine in the morning, "Normally wet in the morning, every morning." NA-E stated R211's incontinence pad and bedding were saturated with urine this morning when she helped him with morning cares. NA-E stated she helps R211 to the bathroom, Every two hours," and did not offer toileting to R211 that morning upon rising, despite his care plan directing staff to, because she thought R211 would say he didn't have to use it.

During interview on 12/9/15, at 9:28 a.m. NA-G stated she had helped get R211 up for the day just a few days prior, and he had been, "Wet [incontinent] when we got him up." NA-G stated the NA staff do not assist R211 to use the toilet for his voiding, but rather place him on a bed pan adding, at times, R211 would void after being placed on it.

When interviewed on 12/9/15, at 12:33 p.m. registered nurse (RN)-G stated there was no reason R211 could not be placed on the toilet to void, but was unaware if R211 would void after being assisted with toileting. RN-G reviewed the charting the NA staff completed and stated there were several recorded episodes of continent voids for R211. RN-G reviewed R211's Nur Day 4 bladder assessment and stated there was no further documentation she could locate supporting an assessment of R211 had been finished (referencing the blank areas identified), "I don't know what to tell you."

During interview on 12/9/15, at 12:47 p.m. RN-F stated R211 was, "Frequently incontinent of bladder," and at times could verbalize his need to use the restroom. R211 was physically able to use the toilet if given assistance, and was on a

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F 315	Continued From page 53 scheduled toileting plan which included being assisted upon rising in the morning, before and after meals, at bedtime and as needed. R211's comprehensive assessment should have included a summary of his recorded voiding to, "Identify a pattern if there was one." Further, RN-F stated R211 was placed on his current toileting schedule, "To be proactive," and staff should be physically helping R211 to the bathroom during the times identified on the care plan because R211 was a post stroke patient, and it would attempt to retrain his bladder, "So he doesn't lose his ability." A facility policy on bladder incontinence and scheduled toileting was requested, but none was provided.	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 implement passive range of motion (PROM) and upper extremity exercises as directed upon discharge from therapies, for 1 of 1 residents (R208) reviewed for range of motion (ROM).	F 318	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the	1/18/16

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F 318	Continued From page 54 Findings include: R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified R208's cognition was severely impaired, required extensive to total assistance for activities of daily living, and had a functional limitation in ROM to one side of her upper extremity. R208's Care Area Assessment (CAA) dated 9/30/15, indicated, "Resident on hospice, expected to decline over time. Have resident participate [in activities of daily living] as able... Requires lift for transfers; not able to weight bear with right arm..." The CAA did not address PROM or exercises. R208's Medication Review Report (physician orders) signed 12/2/15, identified diagnoses including dementia, lung cancer, respiratory failure, chronic pain, major depression, anxiety and history of falling. The report noted R208 was receiving hospice services with a terminal diagnosis of diastolic heart failure. The orders directed no weight bearing to her upper right extremity and noted, "PRECAUTIONS FOR RIGHT SHOULDER every shift for PREVENTION no reaching pushing pulling lifting with right arm... may do finger and wrist motion." Review of a physician progress note dated 11/2/15, identified R208 had recent bilateral upper and lower extremity fractures and recurrent urinary tract infections. The note specified, "Closed fracture of left humerus with routine healing. Closed fracture of left hip with routine healing- minimally displaced greater trochanteric avulsion fracture... Closed fracture of right hip with routine healing s/p ORIF [status-post open reduction and internal fixation (surgical procedure)]. Closed fracture of	F 318	quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance. It is the policy of 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. For resident #208. A ROM screen was performed in the presence of the surveyor on 12/10/15. The resident presented with functional range of motion in all planes actively and with active assistance from the therapist. Patient presented as being able to go beyond 100 degrees of shoulder flexion and beyond 90 degrees of bilateral shoulder abduction. ROM is within functional range of motion required to perform and participate in activities of daily living. Patient denied pain throughout all ROM on both upper and lower extremities. The resident was deemed to not require a ROM program and the order was discontinued on that day. A review of all ROM programs for residents were reviewed and completed on 1/8/16. For other residents who may be affected by this practice a comprehensive record review of Activity of Daily Living function and Range of Motion will be completed quarterly and as needed. After review updates will be made as appropriate for	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 55 proximal end of right humerus with routine healing." R208's care plan dated 10/2/15, directed PROM to both upper extremities (UE) and lower extremities (LE), with three repetitions each, during morning cares. The care plan also directed, "ROM program for both UB [upper body] and LB [lower body] once per day following worksheets in her closet..." The worksheets in R208's closet, as referenced in the care plan included the following: An Upper Extremity ROM Program form (undated) directed PROM exercises to R208's fingers, wrists, elbows, and shoulders, with 20 repetitions to each area, one to two times daily. This form was signed by certified occupational therapy assistant, licensed (COTA/L)-A. The Lower Extremity ROM Program form dated 8/4/15, directed PROM exercises to R208's ankles, knees, legs and hips, with five to 10 repetitions, one time daily. This exercise program was directed by physical therapy assistant (PTA)-A. A letter dated 12/8/15, submitted to the survey team by family member (FM)-B (R208's legal representative) indicated, "[R208] was in rehab for about 6 [six] weeks and then we were told she was not progressing and would have to transition to long term care. We asked for ongoing PROM which has not occurred. We had some concerns about her care in rehab and it had more to do with their commitment to helping my mom improve it felt like they were giving up on her." During a telephone interview on 12/8/15, at 8:54 p.m. FM-B stated she was concerned her mother	F 318	each resident identified. Other residents who may be affected by this deficient practice were identified by the Therapy department. Physical Therapy will screen all residents upon admission, quarterly, with significant change and annually. Therapy will assign range motion program when necessary for specific residents as indicated. Progressively, current ROM programs will be discussed during the weekly Interdisciplinary Team meetings. Need for therapy assessment will also be discussed if changes need to be done to any program or if a resident is identified to need a ROM program started. Referral to therapy will be given as indicated. A monthly review of all ROM programs will be done with Therapy representative present. For other residents who may be affected by this practice a comprehensive record review of Activity of Daily Living function and Range of Motion will be completed quarterly and as needed. After review updates will be made as appropriate for each resident identified. Other residents who may be affected by this deficient practice were identified by the Therapy department. Physical Therapy will screen all residents upon admission, quarterly, with significant	

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F 318	Continued From page 56 not receiving PROM as ordered by therapy, and felt R208 needed this to remain comfortable. R208's Documentation Survey Report (charting of ROM services) from 9/1/15, through 12/9/15, detailed the following regarding her ROM services. In 9/15, R208 received PROM to her upper and lower extremities 21 out of 30 days (70% of opportunities), with no PROM noted on six days, and no data for the remaining three days. In 10/15, R208 received PROM eight out of 31 days, with no PROM noted on 22 days, and no data for the one remaining day. In 11/15, R208 received PROM five out of 30 days, with no PROM noted on 23 days, and no data for the remaining two days. In 12/15, R208 received PROM during one out of nine days, with no PROM noted on eight days. During observation on 12/10/15, at 9:50 a.m. R208's morning cares were observed with NA-H and NA-I. The NAs turned R208 side-to-side during cares, holding her hips and shoulders to push and/or pull her to either side, R208 was observed to moan and say, "Owe, owe, owe." NA-H and NA-I confirmed this was typical for R208 to say this during cares. R208 also demonstrated indications of pain and discomfort with dressing of both her UE and LE. During application of her sweatshirt, while assisting her with putting her arms into each sleeve, she held her hand over her face and moaned. She also vocalized "owe" with lifting each leg into her pants. No PROM or any other exercises were provided to R208 during her morning cares. During interview on 12/10/15, at 1:45 p.m. NA-H	F 318	change and annually Therapy will assign range motion program when necessary for specific residents as indicated. The protocols and practices for assisting residents with range of motion was reviewed and updated by the interdisciplinary team on 12/31/15. Staff members were trained as it relates to their respective roles and responsibilities regarding the Range of Motion policy and procedures on 12/30/15. Range of motion will be communicated to nurses and nursing assistance via careplan, kardex and treatment sheet. Range of Motion audits will be completed monthly x3 and ongoing quarterly. All residents currently receiving range of motion were reviewed on 1/4/16 through 1/8/16 and updated. Resident on range of motion will be reviewed during interdisciplinary team meeting weekly. The Director of Nursing or designee will be responsible for compliance.	

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F 318	Continued From page 57	F 318		

stated R208 was supposed to receive ROM, "But she is so painful, you move her arm and then she's 'owe, owe.'" NA-H stated, R208 demonstrated these indications of pain/ discomfort whenever she moved her feet, arms, legs, and when turning her side-to-side in bed. NA-H stated she had not spoken specifically to the charge nurses about not providing ROM because of R208's pain, however, NA-H stated all staff were aware of R208's pain and ROM exercises were not being implemented as a result.

During interview on 12/10/15, at 2:15 p.m. registered nurse (RN)-A stated she was R208's nurse manager and was responsible for developing care plans and monitoring implementation. RN-A was unsure whether R208 was supposed to receive ROM services, and stated any ROM programs that were in place were typically placed inside each resident's closet door and NAs were prompted to document the exercises in the facility's electronic medical record system. RN-A stated R208's pain levels were evaluated via observation of her non-verbal's. She indicated she watched resident cares routinely and during her observations of turning/ dressing R208, she felt the moans and/or non-verbalizations observed had more to do with being scared than with concerns of pain. RN-A stated NAs were to report to nursing if a resident who was supposed to receive ROM services was not being provided with the services for any reason. RN-A stated she had not been informed R208 was not receiving ROM as directed by therapy.

During observation and interview on 12/10/15, at 3:30 p.m. physical therapist (PT)-A reassessed

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F 318	Continued From page 58 R208's functional range of motion. R208 was seated in her wheelchair with FM-B seated next to her. PT-A manipulated R208's bilateral upper extremities and bilateral lower extremities and confirmed she found no current functional limitations in any extremity. PT-A reported R208 had shown no evidence of declined ROM since her discharge from therapies in 8/15. During this reassessment, R208 demonstrated no sighs or symptoms of pain, and she communicated with the PT-A and FM-A during the assessment and denied any concerns of pain upon inquiry and with movement of each extremity. PT-A stated R208 did not currently require ROM services from staff and stated ROM orders should have been discontinued upon R208's admission to hospice. However, PT-A stated staff had not notified therapy to ensure the resident did not require any PROM services to continue for comfort. During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated it was his expectation for staff to implement each resident's care plan. A facility policy which addressed ROM services was requested, but not provided.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		1/18/16

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F 329	Continued From page 59 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 observation, interview, and document review, the facility failed to clarify indications/ criteria for use for as needed (PRN) anti-anxiety and anti-psychotic medications, failed to ensure specific behaviors observed were documented for each administration of PRN psycho-active medications, and failed to document non-pharmacological interventions attempted prior to administration of the PRN medication, for 1 of 3 residents (R208) reviewed who received PRN psychoactive medications. Findings include: R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified diagnoses including dementia, anxiety, and depression. R208 had severe cognitive impairment, demonstrated verbal behaviors directed toward	F 329	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. It is the policy of Anoka Rehabilitation and Living Center that each resident's drug regimen is free from unnecessary drugs For Resident # 208 a new assessment for psychotherapeutic medication, cognition, gradual dose reduction, AIMS, was completed on 12/23/2015. For Resident #	

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F 329	Continued From page 60 others, and behaviors not directed toward others for one to three days during the assessment period. The MDS identified R208's behaviors did not place her at significant risk for illness or injury, interfere with cares, or interfere with her participation in social activities. The MDS identified R208 received hospice services. R208's Medication Review Report dated 10/2/15, directed the following medication orders and non-pharmacological directives: On 11/5/15, Ativan (an anti-anxiety medication) 0.25 mg/ 0.1 milliliter (ml), 0.25 mg gel was ordered to be applied transdermally to the inner wrist every four hours as needed (PRN) for anxiety/ agitation. This order was discontinued on 11/24/15. On 11/13/15, Ativan solution 2 mg/ml, 0.25 mg was ordered every four hours as needed for agitation/ confusion. On 11/19/15, Seroquel 25 mg was ordered every four hours as needed for restlessness and agitation. On 11/26/15, the indication for this order was changed to delirium. On 11/23/15, the orders directed staff chart R208's behaviors, noting the time of occurrence to help correlate medication dosing with behaviors. On 11/24/15, the orders directed staff to place R208 in a calm/ quiet environment during every shift to promote/ decrease agitation/ anxiety. R208's Medication Review Report did not direct staff on which PRN medication to use first, nor did it give clear indication which behaviors to use what medication for.	F 329	208 pharmacy consultant completed a drug regimen review on 1/4/16 and the recommendations were forwarded to the primary physician/nurse practitioner for review and follow up. Corresponding updates have been made to the care plan, kardex and communicated to the resident designated decision maker on 1/5/16. The primary physician was informed of the assessment results and a review of the current physician orders was completed on 12/23/15. Gradual dose reduction will be reviewed on 1/4/16For other residents who may be affected by this practice, record of psychotropic meds will be generated from the electronic health record will be completed weekly and as needed by the interdisciplinary team. The policy and procedure for psychotropic medications was reviewed by the interdisciplinary team on 12/31/2015. Staff members were trained as it relates to their respective roles and responsibilities regarding the Psychotropic policy and procedures on January 4th, 5th and 6th 2016. Complete a Psychotropic check report of unnecessary medication , pharmacy regimen review, AIMS (for antipsychotic medications) and Gradual Dose Reduction(GRD) audits will be completed weekly, monthly for 3 months, and quarterly per facility policy to ensure continued compliance. The results will be reported to the Quarter Assurance Committee for review and further recommendation.	

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F 329	Continued From page 61 R208's care plan dated 10/2/15, identified target behaviors of trying to get out of her chair repetitively/ self-transfer unassisted, asking to go home repetitively, and resisting essential cares. Care planned interventions for management of R208's mood/ behavior included the following: - As needed follow up visits with her psychology clinic; A warm and friendly approach; Encouraging involvement in unit activities, especially music activities; Hospice involvement and referrals as needed for additional volunteer services; Providing reassurance and tender loving care; One-to-one visits as needed or as requested; Acknowledgement of her feelings and making supportive statements; Allowing her to verbalize frustrations and feelings; Approaching her in a calm and respectful manner; Calling her family and allowing her to talk with them; Discussing her fears or issues regarding her diagnoses or treatments; Hospice visits with chaplain, home health aide, music therapy and massage therapy in the afternoons when R208 tended to experience anxiety/ delirium; Showing her books from a living room bookshelf and assisting her with the computer in the living room for music/ videos; Wheeling her around the household or to other households; Keeping her environmental noise to a minimum; Offering food/ fluids such as ice cream, cookies or ice tea; Offering toileting and repositioning; Reproaching if she was resisting cares; Approaching her in a calm manner from the front and providing assistance as needed; Avoiding arguments with R208; Ensuring her pain was managed, providing alternative comfort measures as needed; Providing emotional support as needed; Providing psychotherapy as needed; Providing supportive listening and validating feelings; Administering her medications as ordered; Monitoring for side	F 329	The Director of Nursing or designee will be responsible for compliance.	

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F 329	Continued From page 62 effects and documenting medication effectiveness. Review of R208's medication administration record (MAR) and nursing progress notes dated 11/1/15, through 12/10/15, included the following: On 11/5/15, at 5:35 a.m. licensed practical nurse (LPN)-B noted, "Resident's behavior continued to be combative, angry, and frustrated. She also had demonstrated confusion." The progress note identified LPN-B contacted R208's hospice provider and received an order for 2 mg (milligrams) of haloperidol (Haldol), to be administered every 30 minutes until R208's behavior improved. If refusing, the order allowed for 5 mg haloperidol to be injected subcutaneous every 30 minutes until the behavior improved. On 11/6/15, at 4:10 a.m. R208 received a PRN dose of Ativan. Licensed practical nurse (LPN)-B indicated R208 had demonstrated "highly agitative behavior." No further description of the behaviors observed and/ or non-pharmacological interventions attempted were identified. The results of this administration were noted as ineffective. At 6:38 p.m., R208 received another PRN dose of Ativan. LPN-D indicated the medication was administered for "anxiety and agitation." No further description of the behaviors observed and/ or non-pharmacological interventions were identified. The results of this administration were noted as effective. On 11/7/15, at 12:41 p.m. R208 received a PRN dose of Ativan. The MAR and progress notes lacked any description of behaviors observed which preceded this administration and no notation of non-pharmacological interventions	F 329		

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were identified. The results of this administration were noted as effective. At 5:45 p.m., R208 received another PRN dose of Ativan. The MAR and progress notes lacked any description regarding the reasoning for this administration and/ or non-pharmacological interventions attempted prior to administration. The results of this administration were noted as effective.

On 11/8/15, at 12:12 a.m. R 208 received a PRN dose of Ativan. The results of this administration were noted as effective. On 11/8/15, at 1:08 p.m. employee-A noted, "Writer had been updated by NOCs [overnight staff] that resident had been up all noc [night] trying to get out of bed. Resident behaviors has continued on this a.m. shift as well, where resident kept trying to get out of bed as well as her broda chair. Resident was yelling in the hallways, demanding and then laughung [sic] and then talking about someone coming to get her. Resident denies pain. No observations noted regarding pain. PRN [as needed] Ativan [an anti-anxiety medication] administered with moderate relief. Writer then placed resident by nursing station with nurse and played Christmas music, as well as allowing the time for conversation. Resident appeared to settle. Then thereafter family came, she ate lunch and then was placed by nursing station for supervision and interaction... Call placed to hospice to update. New orders given for Haldol PRN. Signed protocol orders to be faxed over." At 5:45 p.m. LPN-C noted she administered an as needed dose of Haldol solution for agitation and confusion. No further description of the behaviors observed and/ or non-pharmacological interventions tried, were identified. The results of this administration were noted as ineffective. At 9:45 p.m. LPN-C noted she administered an as

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needed dose of Haldol solution for "confusion/ agitation." No further description of the behaviors observed and/or non-pharmacological interventions attempted were identified. The results of this administration were noted as ineffective.

On 11/9/15, at 2:59 p.m. LPN-C noted administration of PRN dose of Haldol solution for "confusion/agitation." The progress note identified this administration was effective, but lacked any further details of behaviors observed or interventions attempted prior to administration of this antipsychotic medication.

On 11/10/15, at 3:41 a.m. R208 received a PRN dose of Seroquel for restlessness and agitation. Progress notes and the MAR lacked any description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration were unknown.

On 11/11/15, at 3:41 p.m. R208 received a PRN dose of Ativan. Progress notes and the MAR lacked any description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration were noted as ineffective.

On 11/12/15, at 10:29 a.m. R208 received a PRN dose of Seroquel for agitation and restlessness. Progress notes and the MAR lacked any further description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration were noted as effective. At 2:45 p.m., R208 received a PRN dose of Ativan for agitation and restlessness. Progress notes and the MAR

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F 329	Continued From page 65 lacked any further description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration were noted as ineffective. On 11/13/15, at 3:41 p.m. R208 received a PRN dose of Ativan. Prior to this administration, social services (SS)-A noted R208 had been continuously calling out wanting to find a way out of the unit. SS-A noted staff spoke with resident, validated her feelings and brought her to a different environment. However, these non-pharmacological approaches were unsuccessful. The results of this medication administration were also noted as ineffective, adding, "Resident remained agitated and inconsolable. Continuously attempted to get out of chair, requiring 1:1 [one-to-one] supervision at all times during this shift." On 11/15/15, at 4:41 p.m. R208 received a PRN dose of Seroquel. Progress notes and the MAR lacked any description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration were noted as effective. On 11/17/15, at 6:41 p.m. R208 received a PRN dose of Ativan. Progress notes and the MAR lacked any description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration were noted as ineffective. At 10:05 p.m., R208 received a PRN dose of Ativan. Progress notes and the MAR lacked any description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration was noted as effective.	F 329		

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F 329	Continued From page 66 On 11/18/15, at 4:52 a.m. R208 received a PRN dose of Ativan for being restless with her legs out of bed, twice within 90 minutes. The results of this administration were noted as unknown, adding R208 continued with infrequent placing of her legs off the bed, but then re-settled into sleep upon repositioning and receiving water to drink. At 11:20 p.m., R208 received a PRN dose of Ativan. Progress notes and the MAR lacked any description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration were noted as effective. On 11/19/15, at 3:41 p.m. R208 received a PRN dose of Ativan. Registered nurse (RN)-A noted, "Resident has been holling [sic] out that she wants to go home." The notes identified non-pharmacological interventions of assisting her to speak with her daughter over the telephone, spending some 1:1 time with her, taking and wheeling her around the household, "which helped calm her a bit." The results of this administration were noted as effective. On 11/21/15, at 6:46 p.m. R208 received a PRN dose of Ativan for agitation and confusion, described as continuous rambling, being non-coherent, yelling/ spitting at staff and/or physically hitting staff. The progress notes and MAR lacked notation of non-pharmacological interventions that had been attempted prior to administration of this PRN medication. The results of this administration were noted as effective. On 11/22/15, at 9:21 p.m. R208 received a PRN dose of Ativan for agitation and confusion	F 329		

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ANOKA REHABILITATION AND LIVING CENTER	**3000 4TH AVENUE ANOKA, MN 55303**

(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 329	Continued From page 67 described as wanting to leave the building. No further details were included to identify attempted interventions. The results of this administration was noted as ineffective. On 11/23/15, at 7:00 p.m. R208 received a PRN dose of Ativan for agitation and confusion. Progress notes and the MAR lacked any description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration were noted as effective. On 11/24/15, at 2:24 p.m. R208 received a PRN dose of Ativan for anxiety, exit seeking behavior, trying to pack, swearing at staff. SS-A noted, the facility staff visited with R208 and attended to her needs. However, "Resident continually asking for assistance from staff to 'get to her truck and go home.'" The results of this administration were noted as ineffective. On 11/25/15, at 5:00 p.m. R208 received a PRN dose of Ativan for agitation/ confusion. SS-A noted R208 was continually calling out to leave the building and go home to her family. Interventions included offering food, fluids, talking with her and then administration of her PRN medication. The results of this administration was noted as ineffective. On 11/28/15, at 4:16 p.m. R208 received a PRN dose of Seroquel for agitation. RN-I noted R208 continually called out for help. Despite staff attending to her and providing 1:1 attention, R208 returned to the continual calling out as soon as the 1:1 visit ceased. The results of this administration were noted as effective.	F 329		

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F 329	Continued From page 68 On 11/29/15, at 7:02 p.m. R208 received a PRN dose of Ativan for agitation/ confusion, noting she was yelling and screaming without cause. The MAR and progress notes lacked identification of non-pharmacological interventions attempted and the results of the medication administration. On 12/5/15, at 1:51 a.m. R208 received a PRN dose of Ativan. Progress notes and the MAR lacked any description of behaviors observed and/or interventions attempted prior to administration of this medication. The results of this administration was noted as effective. At 1:54 p.m., R208 received a PRN dose of Ativan for agitation/ confusion, noting, "Resident calling out trying to take apart hoyer [mechanical lift] sling. The MAR and progress notes lacked identification of interventions attempted prior to administration of this PRN medication. The results of this administration was noted as ineffective. On 12/9/15, at 10:27 p.m. R208 received a PRN dose of Ativan for agitation/ confusion. LPN-C noted R208 was yelling out to staff to help her. No further description of the behaviors observed or interventions attempted were included in the MAR or progress notes. The results of this administration were noted as effective. Review of a letter dated 12/8/15, submitted to the survey team by family member (FM)-B (R208's legal representative) indicated multiple concerns including staff had approached her and other family members many times expressing how difficult her mother was and insinuating there was nothing more they could do, and perhaps the family could come in to be with her. FM-B stated staff at the facility were good, but she did not feel	F 329		

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F 329	Continued From page 69	F 329		

there was enough staff to meet her mother's needs. She added, "The staff changes so much no relationships are made and the residents don't have any sense of security nor does the family."

During a telephone interview on 12/8/15, at 8:54 p.m. FM-B stated she felt the Seroquel medication had been effective for her mother, however, FM-B stated she did not feel the facility's responsiveness and timeliness to her mother's needs was acceptable and indicated this correlated with her mother's level of agitation, confusion and restlessness. She stated, "They put her by the nurse's station and/or put her in someone's office if she has been acting out," and FM-B stated she did not feel staff were utilizing the appropriate non pharmalogical interventions. FM-B stated she was asked to sign a consent form to administer Haldol (an antipsychotic medication), but declined to authorize this medication because she was fearful the staff were going to use it as an alternative to staffing or supervision.

During observation on 12/8/15, at 5:00 p.m. R208 was seated in her wheelchair in her resident room in front of the television. She was calling out for help and making non-sensical comments that were easily audible from down the hall. No staff were observed to interact with R208 until she was transported to the dining room around 5:30 p.m. Once in the dining room, R208 did not call out or demonstrate any behaviors. After supper, R208 was brought to the hallway, near the nurse's station area. She propelled herself around in her wheelchair until after 7:00 p.m. Aside from noted confusion, no behaviors and/ or agitation were observed.

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F 329	Continued From page 70	F 329		

During observation on 12/10/15, at 9:40 a.m. R208's morning cares were observed being completed by nursing assistant (NA)-H and NA-I. R208 was alert and somewhat oriented, with no behaviors observed.

During interview on 12/10/15, at 1:45 p.m. NA-H stated R208's behaviors were confusion which escalated around 2:00 p.m. to 3:00 p.m., and anxious behaviors of wanting to go home or outside. NA-H stated interventions of redirecting her, bringing her out in the hallway, or if wanting to go outside telling her it was too cold or raining. NA-H stated redirections were not really effective for R208, and she would just self-propel in her wheelchair in another direction, but the statements of wanting to go home continued. NA-H stated she had never observed R208 physically or verbally abuse anyone and she did not typically reject cares. Aside from verbal or physical redirections, NA-H was not familiar with any other behavior interventions used for R208.

During interview on 12/10/15, at 2:15 p.m. RN-A (R208's nurse manager) stated, "She [R208] likes to ramp up at two to three in the afternoon [2:00 p.m. to 3:00 p.m.]." RN-A described many non-pharmacological interventions for R208, including music therapy, massage therapy, reading, use of the computer/ movies, inviting her to activities, taking her for rides/ giving her tours of the facility, or having NAs sit with her in the lounge area. RN-A stated, "We try to keep her in a common area if she is real anxious." RN-A was unable to provide details of which medication was given, when it was given, why it was given, and what non-pharmacological interventions were attempted prior to the PRN administrations. She stated that she was not familiar with where this

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F 329	Continued From page 71 information was to be documented within the facility's electronic medical record system, and she was unable to locate any further information. The facility's Psychoactive Medication Use and Gradual Dose Reduction policy dated 8/13, indicated, "It is the policy of Volunteers of America that a resident will not receive unnecessary medications including psychoactive medications, unless non-pharmacological interventions have failed to sufficiently modify a resident's target behavioral, mood or sleep disturbance." The policy directed each psychoactive medication be given to treat a clearly defined targeted condition.	F 329		
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.	F 356		1/18/16

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F 356	Continued From page 72 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 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 observation, interview, and document review, the facility failed to ensure the daily staff posting was updated on a daily basis to reflect the actual employees working for each shift. This had the potential to affect all 118 residents in the facility, staff, and visitors who wished to review the information. Findings include: During observation on 12/7/15, at 9:13 a.m. the Nursing Staffing posting was displayed directly inside the front entrance in a shadow box frame and was dated 12/5/15, 2 days prior. The posting identified the census of 118 and identified the following staff working: Morning shift Five registered nurses (RN) from 6:30 a.m. - 3:00 p.m. One RN from 10:00 a.m. - 6:30 p.m. Four licensed practical nurses (LPN) from 6:30 a.m. - 3:00 p.m. One nursing assistant (NA) from 7:00 a.m. - 1:00 p.m. 12- NA from 6:30 a.m. - 3:00 p.m. Evening shift	F 356	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. It is the policy of Anoka Rehabilitation and Living center to publicly post nurse staffing information at the beginning of each shift and include the minimum data and allow public access to posted nurse staffing data. The policy and practice of posting hours was reviewed 12/ 30 /2015 to include posting nursing staffing upon receiving current daily resident census in the morning. This will be communicated to staffing and clinical leadership meeting on 12/31/15 For other residents who may be affected by this practice, the hours posting will be	

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F 356	Continued From page 73 Three RN from 2:30 p.m. - 11:00 p.m. Three LPN from 2:30 p.m. - 11:00 p.m. One NA from 6:00 p.m. - 9:00 p.m. Six NA from 3:00 p.m. - 10:30 p.m. Six NA from 3:00 p.m. - 11:30 p.m. Night shift Four RN from 10:30 p.m. - 7:00 a.m. Two LPN from 10:30 p.m. - 7:00 a.m. Six NA from 10:30 p.m. - 7:00 a.m. When interviewed on 12/7/15, at 10:13 a.m. staffing coordinator (SC)-A stated she is in charge of changing the staffing posting and does this during the week and everyother weekend when she works, however, the opposite weekend she is just on call and does not come in to the facility to change the staffing posting. Therefore, the staffing posting is not updated every other weekend. SC-A stated there was no staff posting available for 12/6/15, and updated the posting for 12/7/15, to post during this time. When interviewed on 12/7/15, at 5:35 p.m. director of nursing (DON) stated there was no policy related to staff posting, and the posting should be updated and posted every morning, including the weekends. DON stated the SM is responsible for ensuring the staff posting was posted daily and up to date, and he was not aware the posting was not being updated every other weekend.	F 356	reviewed by the Director of Nursing or designee each day before posting to ensure proper listing of Nursing hours including facility name, date, number hours worked in each category (RN, LPN, nursing assistant and census is on the posting to ensure compliance. The policy and procedure for nursing staffing, scheduling coordination, hours posting was reviewed by the interdisciplinary team on (12/30/15). Staffing members were re-educated as it relates to their respective roles and responsibilities regarding posting hours and procedures on January 4th,5th and 6th 2016. Audits of the hours posting will be completed 3 times weekly x 3 weeks, monthly for 3 months, and then quarterly for 2 quarters to ensure continued compliance. The results will be reported to the Quality Assurance Committee for review and further recommendation. The Director of Nursing or designee will be responsible for compliance.	
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	F 441		1/18/16

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F 441	Continued From page 74 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 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 implement an infection control program which included consistent monitoring,	F 441	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or	

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F 441	Continued From page 75 trending, and analysis of infections to reduce the transmission to other residents in the facility. This had the potential to affect all 118 residents residing in the facility, staff, and visitors. Findings include: Review of the facility's Monthly Infection Control Log dated 2010, identified a flowsheet for staff development (SD) to record resident infections. One sheet was available for each household, with the following columns: - Resident name - Admit date - Room # - Unit - Infection type - Body site (catheter?) - Date of onset - Date culture taken - Organism(s) - Antibiotic resistant (Y/N) - Antibiotic type - Start date - Infection definition met (Y/N) - Resident for 48 hours or greater (Y/N) - Classification not infected - Classification community - Classification healthcare associated infection - Date resolved - Isolated (type)? Review of the infection control flowsheets dated May 2015, through October 2015, typically identified the resident name, admit date, infection type, antibiotic, and if the infection was present on admit. However, it lacked consistent documentation of room number, body site, date of onset, date culture taken, organism	F 441	agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. It is the policy of Anoka rehabilitation and Living Center to 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. The infection surveillance program was reviewed and revised on 12/31/15 by the interdisciplinary team. A new infection summary sheet will be implemented for each household with a more comprehensive analysis of data and preventative measures taken starting January 8th 2016. For other residents who may be affected by this practice a record review will be completed upon admission and notification from Licensed staff of current resident(s) with infection. Staff members were trained as it relates to their respective roles and responsibilities regarding the policy and procedures on infection control on January 4th, 5th and 6th 2016 Audits will be completed weekly for x3 weeks, monthly for x3 months, and quarterly x2 to ensure continued compliance with results reported to the	

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F 441	Continued From page 76 identification, antibiotic resistant, date resolved, and whether or not it was isolated as directed to be filled out by the flowsheet to ensure accurate tracking and trending of resident infections. When interviewed on 12/10/15, at 4:36 p.m. staff development (SD)-A, who was also infection control nurse, stated cultures are not typically ordered by the physician, and the organism is not identified when a resident is admitted from the hospital with an infection. She also stated the facility does not attempt to receive this information from the hospital after admission. Infections are tracked for each household, and compiled on the above mentioned form to bring to quality assurance (QA) meetings. SD-A stated she looks at the type of infection, the location of the infection, is the resident receiving treatment for it, is there an intervention, was it acquired at the facility or present on admission, and is it resolved. Further, SD-A stated the symptoms are not tracked on the log, but available in the resident's progress notes in the chart, which she has access to. An infection control policy was requested from the facility, but not received.	F 441	Quality Assurance Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance.	

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on December 09,2015. At the time of this survey Anoka Rehabilitation & Living Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/07/2016

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

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K 000	Continued From page 1 prevent a reoccurrence of the deficiency. Anoka Care-Rehabilitation Center was constructed in 2012 and opened in 2013. It is a two story building with a basement. The construction type is determined to be Type II (111). The building is separated from the rest of the complex by 2 hour fire rated construction. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 120 beds and 118 were occupied at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to provide proper protection from a hazardous area in the facility. This deficient practice could affect 40 residents, as smoke from a fire in this room could enter the	K 029	The two 20 minute doors on room B008 (Kitchen Storage) will be changed to meet or exceed the 45 minute requirement stated during inspection. Bill Barth, Environmental Services Director will	1/18/16

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K 029	Continued From page 2 corridor making it untenable. Findings include: On facility tour between 9:00 AM and 12:30 PM on 12/09/2015, it was observed that the basement kitchen dry storage room(which is over 100 sq.ft.) had a 20-minute fire rated door and not a 45-minute fire rated door. This deficient practice was verified by the Maintenance Director at the time of inspection.	K 029	ensure compliance.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to vary the times of the fire drills in the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include:	K 050	It is the policy of Anoka Rehabilitation and Living Center to conduct fire drills at unexpected times under varying conditions, at least quarterly on each shift. Fire drills that occur on the same shift will vary at least 1 ½ hours in time. One fire drill per quarter per shift will be conducted and documented as required per MSFC. Bill Barth, Environmental Services	1/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING **02 - ANOKA CARE & REHAB CENTER** B. WING _____	**12/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	**3000 4TH AVENUE ANOKA, MN 55303**

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K 050	Continued From page 3 On facility tour between between 9:00 AM and 12:30 PM on 12/09/2015, a record review revealed that the facility conducted the Evening-Shift fire drills in 2015 between the hours of 3:49 PM, 8:12 PM, 3:10 PM, 3:26 PM not varied times as required. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 050	Director will ensure compliance.	

MDH
Minnesota
Department
of Health

Electronically submitted
December 29, 2015

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation and Living Center
3000 Fourth Avenue
Anoka, Minnesota 55303

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5205026

Dear Mr. Dolinsky:

The above facility was surveyed on December 7, 2015 through December 10, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner, Unit Supervisor at (320)223-7343.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 7-10th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 560	Continued From page 2	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care to include fistula precautions for 1 of 1 residents (R132) reviewed for dialysis, and for behavioral symptoms and interventions for 1 of 2 residents (R210) reviewed for emotional well-being. Findings include: R132's admission Minimum Data Set (MDS) dated 11/5/15, identified R132 had moderate cognitive impairment, and had recieved dialysis at an outside facility. R132's care plan dated 10/30/15, identified R132 was a new admission to the facility, had a dialysis port, and was currently receiving dialysis. However, the care lacked where R132's port was located, any ongoing care instructions for the shunt site, or any restrictions for blood pressure monitoring resulted from R132's shunt site. During observation on 12/8/15, at 4:42 p.m. R132	2 560	Corrected	1/18/16

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2 560	Continued From page 3 was seated at the dining room table. R132 had a dialysis shunt visible in his right upper arm, and stated he goes to dialysis three times a week. When interviewed on 12/8/15, at 5:46 p.m. nursing assistant (NA)-C stated the NA staff check resident blood pressures on bath days. NA-C stated she was unaware of any restrictions for obtaining blood pressures on R132. When interviewed on 12/8/15, at 6:05 p.m. registered nurse (RN)-D stated the resident care plan was used to direct the care and needs of residents, and the NA care guides were created from the resident care plan and was to be a reference for the NA staff . RN-D stated blood pressures were not to be obtained using R132's right arm because of his dialysis shunt, and that information should be identified on R132's care plan and NA care guide. R132's undated NA care guide was reviewed and indicated R132 recieved dialysis, but the care guide did not identify the location of R132's dialysis shunt, any care instructions or monitoring required, or not to collect blood pressures in his right arm. When observed and interviewed about his care on 12/8/15, at 6:27 p.m. R132 was seated in his wheelchair in his room. R132's room did not have any signage displayed to alert staff to his dialysis shunt, or any instructions on how to obtain R132's blood pressure. R132 stated several staff, including NA's, had attempted to obtain blood pressures in his right arm (with his shunt). During interview on 12/9/15, at 1:30 p.m. RN-E stated the care plan is used to, "Individually care	2 560		

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2 560	Continued From page 4 for that particular patient." RN-E stated information about not collecting blood pressures on R132's right arm was identified on the nurses treatment records, but the NA staff did not have access to those adding, "It should have been on the care plan." R210's significant change MDS dated 11/18/15, identified her cognition was moderately impaired and required extensive assistance for most activities of daily living (ADLs). The MDS identified R210 demonstrated wandering behaviors. The care plan dated 11/25/15, identified R210 had Lewy Body dementia. The care plan directed the following interventions for communication, dementia care, behaviors and elopement: Anticipate needs; encourage socialization; listen carefully; observe her facial expressions and body language; observe for sad/anxious mood related to sensory loss; provide opportunity for her to express feelings regarding her inability to make her wants and needs known; speak clearly, use short and direct phrases; communicate at eye level; introduce yourself at each interaction; explain activities/ care prior to beginning them; provide one directive at a time; validate her feelings when appropriate; allow time for her to respond, bring her to activities to promote her psychosocial well being; approach her in a calm manner; avoid arguing with her; redirect her for safety and re-approach as needed; praise her for finding her own room; distract her from wandering by offering pleasant diversions of activity, food, fluids or conversation; involve her in activities as much as possible; and ensure her Wanderguard was in place. The care plan did not address R210's wandering into other resident rooms. The care plan also lacked direction for the increased	2 560		

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2 560	Continued From page 5	2 560		

staff supervision that was required for R210. In addition, the care plan lacked specification of R210's individualized interests and successful interventions identified through the facility's behavior rounds process.

During observations on 12/9/15, at 12:27 p.m., another resident approached registered nurse (RN)-J and reported she needed help in her room. RN-J and nursing assistant (NA)-K entered the room and R210 was observed lying in this other resident's bed (this was not R210's room). R210 was alert, but not oriented and required weight bearing assistance from both RN-J and NA-K to stand and transfer back to her wheelchair. R210 was resistive to the transfer and did not appear to understand what was happening to her. Most of R210's body was limp during the transfer and/or R210 was leaning back toward the bed. R210 stated, "I'm scared of some of these things," and grabbed NA-K's forearm area tightly and held it. R210 was also noted to comment, "That hurts," as they assisted her to transfer back to her wheelchair. NA-K replied to R210 stating, "Well that's hurting me, with my arm,,, [will you] let go please?" R210 did let go of NA-K's arm and then they completed the transfer to her wheelchair. As NA-K left the room, rubbing her forearm. She reported R210 did hurt her arm during the transfer, specifically, she pinched her arm. NA-K stated, "Yeah, she pinches." At 12:36 p.m., R210 was observed wandering into a different resident's room (again, not her own room). RN-J alerted NA-K and NA-K assisted R210 out of the room and brought her down another hallway where she began to propel in the direction of her own resident room. At 12:42 p.m., R210 was observed in her own resident room, seated on the toilet in her bathroom. RN-J confirmed NA-K had checked in

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2 560	Continued From page 6 on R210 and found she had self-transferred to her toilet. R210 had a medium bowel movement and a small void of urine. RN-J commented that perhaps R210 had been trying to communicate her need to use the bathroom by her wandering and anxious-like behavior. During interview on 12/9/15, at 12:09 a.m. RN-J stated R210 had lived on that unit for approximately one month. RN-J reported R210 demonstrated multiple behavior concerns including pinching, tugging at others' clothing, wandering into other resident rooms and planting her feet into the floor when someone is propelling her in her wheelchair. RN-J reported the following interventions she found as successful in her work with R210: Providing her with snacks, using a warm blanket over her shoulders, toileting her right after each meal, providing 1:1's ensuring her pain was well managed, encouraging her to attend activities. RN-J added, there were a couple of other residents on the unit, who were not tolerant of R210's wandering into their room. RN-J stated, "That's why we have to keep such a close eye on her." She stated R210 wandered into other resident rooms one, to two times during each shift. She identified that it was important for all of the staff to be cognizant of where she was at all times and to make every effort to keep other resident's doors closed, to minimize her likelihood of entering their rooms. RN-J stated interventions found to be successful, were to be communicated to staff through shift reports and once weekly behavior rounds. She also believed R210's nursing progress notes should have included specific behavior concerns identified by staff. RN-J stated interventions were to be identified during these reports and rounds, with the care plans being updated by the leaders of the behavior rounds group. Other interventions	2 560		

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2 560	Continued From page 7 RN-J identified were keeping her busy, offering her a cup of coffee, sitting next to her. RN-J stated, "I don't think she likes to be alone... I should add that warm blanket in there [the care plan]." During interview on 12/9/15, at 12:49 p.m. NA-K stated behavior interventions for R210 included offering coffee, a warm banked, or a marker to draw on paper with. She added R210's current interventions were effective approximately 50% of the time. NA-K stated the NAs routinely took part in the behavior rounds, where they were given the opportunity to share interventions which each other had found to be effective. NA-K stated this was the time of day when R210 typically became more fidgety. She added, other interventions of waiting and re-approaching R210 were somewhat effective. She reported R210's behaviors were likely a result of her attempting to communicate something to the staff. NA-K reported R210 did not routinely wander into other resident's rooms. During interview on 12/9/15, at 2:27 p.m. licensed social worker (LSW)-C, stated the facility's behavior rounds took place at least once monthly, but often more frequently than this. He stated the NAs and other staff discussed any new behaviors observed since the prior meeting and shared successful interventions implemented and/or suggested interventions to attempt with R210. LSW-C reported that between himself and activities director (AD)-A, meeting minutes were recorded and successful interventions should have been added to the care plan. LSW-C reported he was not aware that R210 had been wandering into other resident rooms and did not recall the staff discussing this subject during the behavior rounds.	2 560		

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2 560	Continued From page 8 During interview on 12/10/15, at 4:15 p.m. AD-A stated that he had just been informed of R210's behavior of wandering into other resident rooms, earlier that day. He stated, "We try to have her engaged as much as possible." AD-A identified interventions of engaging her in activities and providing 1:1 assistance with them three to four times weekly and as needed. AD-A reported that he tried to have R210 participate in three to four activities per week. He added, R210 did not always participate in activities, but would sit parallel with the other residents, if given a cup of coffee to drink. AD-A confirmed he routinely led the behavior rounds on R210's unit. He stated that he took notes of the discussion at the meetings, but thought that any suggested interventions should have been added to the care plan by the facility's nursing department. He confirmed he did not typically enter the findings of the behavior rounds into a resident's written plan of care. AD-A stated the interventions shared at the behavior rounds were communicated to all other staff via a communication book and/or via the nurses updates to the care plan. During interview on 12/10/15, at 4:31 p.m. the director of nursing (DON) stated, any behavior that was consistently observed by staff, should have been included on the care plan, with a plan for how to address the behavior. Review of the facility's Care Plan Policy and Procedure dated 3/12/15, directed individualized interventions be written to help residents meet their goals. The care plan was to be updated or changed as care needs changed and any temporary problems were to be added to the comprehensive care plan if no resolution was met within 30 days. The interdisciplinary team was to be involved in development of the care plan, in	2 560		

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2 560	Continued From page 9 order to promote autonomy, dignity, self-determination and participation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff to the development of a comprehensive care plan, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was followed for 2 of 2 residents (R208, R19) reviewed for pressure ulcers, 2 of 2 residents (R211, R208)) reviewed for urinary incontinence, and for 1 of 3 residents (R208) reviewed for range of motion services. Findings include: R208's Medication Review Report (physician orders) dated 12/2/15, identified diagnoses including dementia, depression, anxiety, lung	2 565	corrected	1/18/16

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2 565	Continued From page 10 cancer, chronic obstructive pulmonary disease and acute and chronic respiratory failure. Physician orders directed interventions to minimize R208's risk for further progression of her current pressure ulcers and the development of new pressure ulcers. These orders included daily Tefla dressings to both heel sores, wrapping in Kerlix; Elevating her bilateral heels and Achilles off bed at all times using a Heel Lift Manager, with no pressure on her heels while up in her wheelchair and no shoes to be worn; and Placing gripper socks only half-way onto her feet and not covering her heels due to wounds. R208's care plan dated 10/2/15, directed the following interventions to minimize the risk for pressure ulcers: Staff to keep heels elevated on pillows at all times, assuring her heels were not touching anything. R208 required two staff to boost up in bed or with any major repositioning. R208 required multiple pressure relieving devices including an alternating pressure mattress for her bed, a pressure reducing device for her chair and a cushion to float her heels. The care plan noted, "Resident does have a tendency to remove her heels from the heel manager or off the pillows that elevate her heels when up in the Broda chair. Needs reminders and assistance to keep heels elevated." R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified severe cognitive impairment, required extensive to total assistance for activities of daily living, had developed one-stage two pressure ulcer, and two- unstageable pressure ulcers since the prior assessment. Observations of R208 included the following:	2 565		

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2 565	Continued From page 11 On 12/8/15, at 7:00 p.m. R208 was seated in her Broda wheelchair in the hallway, near the nurse's station. She had white socks and black, canvas shoes on both feet. A gauze dressing was observed around her right lower ankle/ heel area. However, no gauze or dressing was observed to her left foot. On 12/9/15, at 7:14 a.m. to 8:55 a.m., R208 was lying in her bed, on her left side, with pillows propped on either side of her torso. There were no pillows or devices in place to float her heels and both heels were observed resting on the bed. She wore regular, white socks to her bilateral feet. Her right, lower ankle area was wrapped with gauze, but the left was not. NA-I confirmed R208's bilateral heels were resting on the mattress. On 12/10/15, at 8:05 a.m. to 9:40 a.m., R208 was lying in her bed in her resident room. No pillows or devices were in place to float her heels. She was wearing regular, white socks to both feet and white gauze was observed around only her right lower ankle/ heel area. A black heel floating cushion was observed, tucked between the nightstand and the wall to R208's right side. NA-H entered R208's room to assist her with eating her breakfast. NA-H raised the head of the bed to approximately 60 degrees. R208 remained lying flat on her back, with her shoulder blades resting at the crease from the raised head of her bed and both knees bent. The balls of her bilateral feet and toes were pressed against the footboard of her bed, with her bilateral heels pressed into the mattress. No pillows or devices were in place to float her heels. On 12/10/15, at 9:50 a.m. NA-H and NA-I	2 565		

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2 565	Continued From page 12 completed R208's morning cares and placed shoes and socks on the resident, although the care plan directed the resident not to wear shoes. During interview on 12/10/15, at 2:15 p.m. RN-A confirmed she was R208's nurse manager and was responsible for the development of her care plan interventions. RN-A stated R208's heels were to be floated with a heel lift manager whenever she was lying in bed. RN-A stated R208's bilateral heels were to be wrapped with a dressing, and stated it may had fallen off. During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated staff should implement each resident's care plan and to follow physician orders. R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified R208's cognition was severely impaired and she required extensive to total assistance for activities of daily living, including extensive assistance for toileting. The MDS identified R208 was not on a toileting program and was always incontinent of both bowel and bladder. The care plan dated 10/2/15, directed staff to offer toileting to R208 upon rising, after meals, at bedtime, as needed during the night, and upon request. The care plan directed staff to either assist R208 with the bed pan or to have two staff provide her with assistance to transfer to the toilet. R208 was to receive hands-on assistance from two staff with the use of a mechanical lift for transfers and assistance with clothing management and pericare. During observations on 12/8/15, from 5:30 p.m. to 7:00 p.m. R208 was assisted to the dining room	2 565		

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2 565	Continued From page 13	2 565		

for the supper meal and then brought back to the nurse's station area, where she remained in the hallway throughout the evening. R208 was not offered the use of a bedpan or toileting assistance according to her care plan.

During observation on 12/10/15, at 9:50 a.m. nursing assistant (NA)-H and NA-I completed morning cares with R208, during which her incontinence product was changed. NA-I confirmed R208 had been incontinent, with a medium bowel movement and a small void of urine. R208 was not offered the use of a bedpan or toileting assistance.

During interview on 12/10/15, at 1:45 p.m. NA-H confirmed she was R208's primary NA on the day shift. NA-H reported R208 was to be checked and changed on a routine basis, approximately every three hours. NA-H confirmed earlier this morning, she did not check and change R208 until her morning cares at 9:50 a.m. and she was unaware of when she was changed prior to that, but confirmed it was prior to 6:30 a.m. (approximately three and a half hours prior).

During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated staff should be implementing each resident's care plan.

R208's significant change MDS dated 9/30/15, identified R208's cognition was severely impaired and she required extensive to total assistance for activities of daily living. The MDS identified R208 had a functional limitation in ROM to one side of her upper extremity. The Care Area Assessment (CAA) dated 9/30/15, noted, "Resident on hospice, expected to decline over time. Have resident participate [in activities of daily living] as able... Requires lift for transfers; not able to

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2 565	Continued From page 14 weight bear with right arm..." The CAA did not address PROM or exercises. R208's care plan dated 10/2/15, directed PROM to both upper extremities (UE) and lower extremities (LE), with three repetitions each, during morning cares. The care plan also directed, "ROM program for both UB [upper body] and LB [lower body] once per day following worksheets in her closet..." The worksheets in R208's closet, as referenced in the care plan included the following: -An Upper Extremity ROM Program form (undated) directed PROM exercises to R208's fingers, wrists, elbows, and shoulders, with 20 repetitions to each area, one to two times daily. This form was signed by certified occupational therapy assistant, licensed (COTA/L)-A. The Lower Extremity ROM Program form dated 8/4/15, directed PROM exercises to R208's ankles, knees, legs and hips, with five to 10 repetitions, one time daily. This exercise program was directed by physical therapy assistant (PTA)-A. During a telephone interview on 12/8/15, at 8:54 p.m. family member (FM)-B stated she had concerns of her mother not receiving PROM as had been ordered by therapy. R208's Documentation Survey Report from 9/1/15, through 12/9/15, detailed the following regarding provision of her ROM services. In 9/15, R208 received PROM to her upper and lower extremities during 21 out of 30 days, with no PROM noted on six days and no data for the remaining three days. In 10/15, R208 received PROM during eight out of 31 days, with no PROM noted on 22 days and no data for the one remaining day.	2 565		

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2 565	Continued From page 15 In 11/15, R208 received PROM during five out of 30 days (17% of opportunities), with no PROM noted on 23 days and no data for the remaining two days. In 12/15, R208 received PROM during one out of nine days, with no PROM noted on eight days. During observation on 12/10/15, at 9:50 a.m. R208's morning cares were observed with NA-H and NA-I. As the NAs turned R208 side-to-side during cares, holding her hips and shoulders to push and/or pull her to either side, she was observed to moan and say, "Owe, owe, owe." NA-H and NA-I confirmed this was typical and historical for R208 to made such vocalizations during cares. R208 also demonstrated indications of pain and discomfort with dressing of both her UE and LE. During application of her sweatshirt, while assisting her with putting her arms into each sleeve, she held her hand over her face and moaned. She also vocalized "owe" with lifting each leg into her pants. No PROM or any other exercises were provided to R208 during her morning cares. During interview on 12/10/15, at 1:45 p.m. NA-H stated R208 was supposed to receive ROM, "but she is so painful, you move her arm and then she's 'owe, owe.'" NA-H added, R208 demonstrated these indications of pain/ discomfort whenever she moved her feet, arms legs and when turning her side-to-side in bed. NA-H reiterated she did not do ROM exercises with R208 because of the pain/ discomfort which seemed to result. NA-H denied having reported these observations of pain with movements of her extremities to her supervisors and/or reporting that she was not providing ROM exercises because of this pain.	2 565		

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2 565	Continued From page 16 During interview on 12/10/15, at 2:15 p.m. registered nurse (RN)-A confirmed she was R208's nurse manager and was responsible for developing care plans and monitoring implementation. Upon inquiry, RN-A was unsure whether R208 was supposed to receive ROM services. She briefly reviewed R208's physician orders and stated she was not seeing anything to direct ROM. She added, any ROM programs that were in place, were typically placed inside each resident's closet door and NAs were prompted to document the exercises in the facility's electronic medical record system. RN-A denied having been informed of any pain concerns and/or any concerns of care planned exercises not being implemented for R208. During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) reported that it was his expectation for staff to implement each resident's care plan. R19's quarterly MDS dated 10/29/15, indicated R19 had moderate cognitive impairment, required extensive assistance for bed mobility, was frequently incontinent, was at risk for developing pressure ulcer, but did not have any current pressure ulcers, and had a pressure reducing mattress and wheelchair cushion. The MDS included diagnoses of heart failure, cerebral vascular accident (CVA) and depression, and indicated R19 was receiving hospice care. R19's care plan was observed electronically on 12/8/15, the care plan included R19 was at risk for alteration of skin integrity due to bladder incontinence and periods of lethargy where she needed more assistance with mobility. Interventions included: alternating pressure mattress on bed, pressure relieving device in	2 565		

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2 565	Continued From page 17 chair, inspect skin daily with cares, and turn every two hours and check brief. On 12/9/15, at 7:10 a.m. through 9:09 a.m. R19 was observed sleeping on her back in bed, with her upper body tilted slightly to the left, staff were not observed repositioning R19, nor did R19 make any changes in her position by herself during this period of time. On 12/9/15, at 9:16 a.m. NA-A entered R19's room with a breakfast tray for R19 and raised R19's head of the bed, however, pressure was not relieved from R19's buttocks. NA-A placed the tray table with R19's breakfast in front of R19. NA-A set up R19's breakfast tray and left the room without providing any repositioning assistance. R19 was observed in the same position eating breakfast until 9:54 a.m. During interview on 12/9/15, at 9:57 a.m. NA-A stated she was assigned to care for R19 for the shift and the resident was to be repositioned every two hours, however, NA-A stated she had not repositioned R19 since the beginning of her shift at 7:00 a.m. because she had, "Forgot." When interviewed on 12/10/15, at 9:55 a.m. RN-B stated R19 needed help being repositioned and the aids are to help her every two hours, regardless if she is sleeping. When interviewed on 12/10/15, at 2:02 p.m. RN-A stated that the care plan on 12/9/15 indicated R19 had a two hour repositioning schedule to relieve pressure. When interviewed on 12/10/15, at 3:01 p.m. the DON stated his expectation was staff should be following the residents individualized care plan for	2 565		

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2 565	Continued From page 18 turning and repositioning. R211's admission MDS dated 11/25/15, identified R211 had intact cognition, required extensive assistance with toileting, and was frequently incontinent of bladder. R211's care plan dated 12/7/15, identified R211 was incontinent of bladder, and directed staff to, "Toilet upon rising, before and after meals, HS [hour of sleep and prn [as needed]." R211's undated nursing assistant (NA) care guide identified, "Toilet upon rising [,] before after meals [sic], HS and prn..." During observation of morning care on 12/9/15, at 7:05 a.m. nursing assistant (NA)-E helped R211 get dressed in bed, and transferred him into his wheelchair. NA-E assisted him into the restroom, and helped him brush his teeth and comb his hair, then assisted him to the dining room table for breakfast. R211 was not offered or provided toileting after rising as directed by his plan of care. When interviewed on 12/9/15, at 7:47 a.m. NA-E stated R211 should be assisted with toileting, "Like every two hours," and added R211's bed was saturated with urine this morning when they woke him up. NA-E stated she did not offer toileting to R211 that morning upon rising, despite his care planning directing staff to, because she thought R211 would say he didn't have to use it because his bedding was wet with urine. During interview on 12/9/15, at 12:47 p.m. registered nurse (RN)-F stated R211's care plan should be used as, "An individualized plan of care," and staff were expected, "To follow the	2 565		

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2 565	Continued From page 19 plan of care." Further, R211 was on a scheduled toileting program and should have been assisted to the toilet upon rising as directed by his care plan. The facility's Care Plan Policy and Procedure dated 3/12, indicated, "The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible." Furthermore, the policy directed the care plan would serve to direct necessary care for residents, including measurable goals to determine progress. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding implementation of a residents care plan, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		1/18/16

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2 830	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure all nursing staff were aware of specialized care required for 1 of 1 residents (R132) reviewed who was receiving dialysis. In addition, the facility failed to ensure individualized dementia care interventions were provided for 1 of 1 residents (R210) reviewed for behavioral and emotional status. Findings include: R132's admission Minimum Data Set (MDS) dated 11/5/15, identified R132 had moderate cognitive impairment, and had received dialysis at an outside facility while a resident in the facility. R132's care plan dated 10/30/15, identified R132 was a new admission to the facility, had a dialysis port, and was currently receiving dialysis at an outside facility. However, the care plan lacked where R132's dialysis port was located, any ongoing care instructions for the shunt site, or any restrictions for blood pressure monitoring related to R132's shunt site. During observation on 12/8/15, at 4:42 p.m. R132 was seated at the dining room table. R132 had a dialysis shunt visible in his right upper arm, and stated he goes to dialysis three times a week. When interviewed on 12/8/15, at 5:46 p.m. nursing assistant (NA)-C stated the nurses checked R132's vital signs, "Most of the time," however, NA staff check them as well on bath	2 830	corrected	

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2 830	Continued From page 21 days. NA-C stated she was unaware of any restrictions for collecting blood pressures on R132, and was not aware blood pressures could not be taken on the arm with the dialysis access. During interview on 12/8/15, at 5:55 p.m. NA-D stated the NA staff will check R132's vital signs when he receives his baths. NA-D stated she believed blood pressure should not be checked in his arm with his dialysis shunt, but added she did not receive any training from the facility in the care of a dialysis patient only from, "The test," she took to become a nursing assistant. When interviewed on 12/8/15, at 6:05 p.m. registered nurse (RN)-D stated a care plan was used to direct the care and needs of the resident, and the NA care guides were created from the care plan to be a reference for the NA staff to know about specialized individual resident cares. RN-D stated blood pressures should not be collected in R132's right arm because of his dialysis shunt and that information should be identified on R132's care plan and the NA care guide. RN-D stated if float staff were to assist R132 and didn't know him, they use the information on the care plan and NA care guide as a reference to provide resident cares. R132's undated NA care guide identified the resident was receiving dialysis, however, the care guide did not identify the location of R132's dialysis shunt, any care instructions or monitoring required, or not to collect blood pressures in his right arm. When observed and interviewed on 12/8/15, at 6:27 p.m. R132 was seated in his wheelchair in his room. R132's room did not have any sign displayed to alert staff to his dialysis shunt, or any	2 830		

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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) COMPLETE DATE
2 830	Continued From page 22 instructions on how to obtain R132's blood pressure. R132 stated several staff, including NA's, had attempted to obtain blood pressures in his right arm (with his shunt) before, and he has had to stop them. During interview on 12/9/15, at 1:30 p.m. RN-E stated the care plan is used to, "Individually care for that particular patient." RN-E stated information about not collecting blood pressures on R132's right arm was identified on the nurses treatment records, but the NA staff did not have access to those and stated this information should have been on the care plan. A facility policy on dialysis care was requested, but none was provided. R210's significant change MDS dated 11/18/15, identified diagnoses including aphasia and dementia. R210 had moderately impaired cognition, required extensive assistance for most activities of daily living (ADLs), demonstrated physical behavioral symptoms, other behavioral symptoms directed toward others, and wandering behaviors. R210's care plan dated 11/25/15, identified R210 had Lewy Body dementia. The care plan directed the following interventions for communication, dementia care, behaviors and elopement: Anticipate needs; encourage socialization; listen carefully; observe her facial expressions and body language; observe for sad/anxious mood related to sensory loss; provide opportunity for her to express feelings regarding her inability to make her wants and needs known; speak clearly, use short and direct phrases; communicate at eye level; introduce yourself at each interaction; explain activities/ care prior to beginning them;	2 830		

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2 830	Continued From page 23	2 830		

provide one directive at a time; validate her feelings when appropriate; allow time for her to respond, bring her to activities to promote her psychosocial well being; approach her in a calm manner; avoid arguing with her; redirect her for safety and re-approach as needed; praise her for finding her own room; distract her from wandering by offering pleasant diversions of activity, food, fluids or conversation; involve her in activities as much as possible; and ensure her Wanderguard was in place. The care plan did not address R210's wandering into other resident rooms, and it also lacked direction for the increased staff supervision that was required for R210. In addition, the care plan lacked specification of R210's individualized interests and successful interventions identified through the facility's behavior rounds process.

During observations on 12/9/15, at 12:04 p.m. R210 was seated in her wheel chair at the dining room table eating her lunch meal. R210 had eaten less than 10% of her meal, when she began to self propel away from the table. RN-J encouraged R210 to continue eating, and referred to the resident using pet names of honey, sweetie, and dear. R210 was not responsive to RN-J's attempts and continued wheeling away from the table. At 12:27 p.m., another resident approached RN-J and stated she needed help in her room. RN-J and NA-K entered the room and R210 was observed lying in the other resident's bed (this was not R210's room). R210 was alert, but not oriented and required weight bearing assistance from both RN-J and NA-K to stand and transfer back to her wheelchair. R210 was resistive to the transfer and appeared confused. Most of R210's body was limp during the transfer and/or R210 was leaning back toward the bed. R210 stated, "I'm

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2 830	Continued From page 24 scared of some of these things," and grabbed NA-K's forearm area tightly and held it. NA-K replied to R210 stating, "Well that's hurting me, with my arm,,, [will you] let go please?" R210 did let go of NA-K's arm and then they completed the transfer to her wheelchair. As NA-K left the room, rubbing her forearm, she stated R210 did hurt her arm during the transfer, specifically, she pinched her arm. NA-K stated, "Yeah, she [R210] pinches." At 12:36 p.m., R210 was observed wandering into a different resident's room (again, not her own room). RN-J alerted NA-K, and NA-K assisted R210 out of the room and brought her down another hallway where she began to propel in the direction of her own resident room. At 12:42 p.m., R210 was observed in her own resident room, seated on the toilet in her bathroom. RN-J confirmed NA-K had checked in on R210 and found she had self-transferred to her toilet. R210 had a medium bowel movement and a small void of urine. RN-J stated perhaps R210 had been trying to communicate her need to use the bathroom by her wandering and anxious-like behavior. During interview on 12/9/15, at 12:09 a.m. RN-J stated R210 had lived on that unit for approximately one month, and stated R210 demonstrated multiple behavior concerns including pinching, tugging at others' clothing, wandering into other resident rooms, and planting her feet onto the floor when someone was propelling her in the wheelchair. RN-J stated R210 seemed to be generally suspicious of people and was always on guard when approached by other staff and residents. RN-J stated the following interventions she found were successful in her work with R210 during behaviors: Providing her with snacks, using a warm blanket over her shoulders, toileting her	2 830		

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2 830	Continued From page 25 right after each meal, providing 1:1's, ensuring her pain was well managed, and encouraging her to attend activities. RN-J stated there were a couple of other residents on the unit who were not tolerant of R210's wandering into their room and stated, "That's why we have to keep such a close eye on her." She stated R210 wandered into other resident rooms one to two times during each shift, and it was important for all of the staff to be cognizant of where she was at all times, and to make every effort to keep other resident's doors closed to minimize her likelihood of entering their rooms. RN-J stated R210 did not typically lie down or take a nap in the afternoon, and if she were to lie down in her room, the staff would need to check on her every few minutes. RN-J stated interventions found to be successful by staff were to be communicated to staff through shift reports and during once weekly behavior rounds, and should than be added to the residents care plan. RN-J stated she also believed R210's nursing progress notes should have included specific behavior concerns identified by staff, and other interventions RN-J identified were to keep R210 busy, offering her a cup of coffee, and sitting next to her. RN-J stated, "I don't think she likes to be alone... I should add that warm blanket in there [the care plan]." During interview on 12/9/15, at 12:49 p.m. NA-K stated behavior interventions for R210 included offering coffee, a warm blanket, or a marker to draw on paper. NA-K stated R210's current interventions were effective approximately 50% of the time. NA-K stated the NAs routinely took part in the behavior rounds and they were given the opportunity to share interventions which each other had found to be effective. NA-K stated the afternoon was the time of day when R210	2 830		

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2 830	Continued From page 26 typically became more fidgety, and R210's behaviors were likely a result of her attempting to communicate something to the staff. During interview on 12/9/15, at 2:27 p.m. licensed social worker (LSW)-C, stated the facility's behavior rounds took place at least once monthly but could be more often to meet resident needs. LSW-C stated the NAs and other staff discussed any new resident behaviors observed since the prior meeting and shared successful interventions implemented and/or suggested interventions to attempt with R210. LSW-C stated between himself and activities director (AD)-A, meeting minutes were recorded and successful interventions should have been added to the care plan. LSW-C stated he was not aware R210 had been wandering into other resident rooms and did not recall the staff discussing this subject during the behavior rounds. During interview on 12/10/15, at 4:15 p.m. AD-A stated he had just been informed of R210's behavior of wandering into other resident rooms earlier that day. He stated staff try to engaged R210 in activities as much as possible. AD-A stated he tried to have R210 participate in three to four activities per week, and although R210 did not always participate in activities, staff would have the resident sit parallel with the other residents and would give her a cup of coffee to drink. AD-A stated he led the behavior round meeting, however, nursing was responsible to update the resident's written plan of care with any new behaviors/ interventions discussed. AD-A stated the interventions shared at the behavior rounds were communicated to all other staff via a communication book and/or via the nurses updates to the care plan.	2 830		

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2 830	Continued From page 27 During interview on 12/10/15, at 4:20 p.m. NA-J stated he was a primary staff on the unit and he routinely worked with R210. NA-J stated R210 often went into other resident's rooms and had just done so about 10 minutes prior. He stated, "She went into that room and stood up... so [we] have to watch her... she really need[s] one-to-one attention." NA-J stated R210's locked unit had 20 residents, but had only two aides. NA-J stated R210 was actually a one to one resident but the facility did not do that type of care. NA-J stated other residents often became annoyed with R210's wandering into their rooms and she routinely wandered into any room with an open door. During interview on 12/10/15, at 4:31 p.m. DON stated any behavior consistently observed by staff should be included on the care plan including the intervention on how to address the behavior. The DON stated all resident's on that unit wandered, however, he was not aware R210 wandering into other resident rooms any more than any other resident on that unit. Review of the facility's Guidelines for Memory Support Programs and Services dated 2/15, directed the program operate under a person-centered model, with emphasis on the whole person, including their physical, social, emotional, intellectual, occupational and spiritual needs, regardless of their level of cognitive function. Review of the facility's Care Plan Policy and Procedure dated 3/12/15, directed individualized interventions be written to help residents meet their goals. The care plan was to be updated or changed as care needs changed and any temporary problems were to be added to the	2 830		

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2 830	Continued From page 28 comprehensive care plan if no resolution was met within 30 days. The interdisciplinary team was to be involved in development of the care plan, in order to promote autonomy, dignity, self-determination and participation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding the current standards of practice for care of a dialysis, and cogntively impaired residents, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by:	2 895		1/18/16

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2 895	Continued From page 29 Based on observation, interview, and document review, the facility failed to implement passive range of motion (PROM) and upper extremity exercises as directed upon discharge from therapies, for 1 of 1 residents (R208) reviewed for range of motion (ROM). Findings include: R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified R208's cognition was severely impaired, required extensive to total assistance for activities of daily living, and had a functional limitation in ROM to one side of her upper extremity. R208's Care Area Assessment (CAA) dated 9/30/15, indicated, "Resident on hospice, expected to decline over time. Have resident participate [in activities of daily living] as able... Requires lift for transfers; not able to weight bear with right arm..." The CAA did not address PROM or exercises. R208's Medication Review Report (physician orders) signed 12/2/15, identified diagnoses including dementia, lung cancer, respiratory failure, chronic pain, major depression, anxiety and history of falling. The report noted R208 was receiving hospice services with a terminal diagnosis of diastolic heart failure. The orders directed no weight bearing to her upper right extremity and noted, "PRECAUTIONS FOR RIGHT SHOULDER every shift for PREVENTION no reaching pushing pulling lifting with right arm... may do finger and wrist motion." Review of a physician progress note dated 11/2/15, identified R208 had recent bilateral upper and lower extremity fractures and recurrent urinary tract infections. The note specified, "Closed fracture of	2 895	corrected	

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2 895	Continued From page 30 left humerus with routine healing. Closed fracture of left hip with routine healing- minimally displaced greater trochanteric avulsion fracture... Closed fracture of right hip with routine healing s/p ORIF [status-post open reduction and internal fixation (surgical procedure)]. Closed fracture of proximal end of right humerus with routine healing." R208's care plan dated 10/2/15, directed PROM to both upper extremities (UE) and lower extremities (LE), with three repetitions each, during morning cares. The care plan also directed, "ROM program for both UB [upper body] and LB [lower body] once per day following worksheets in her closet..." The worksheets in R208's closet, as referenced in the care plan included the following: An Upper Extremity ROM Program form (undated) directed PROM exercises to R208's fingers, wrists, elbows, and shoulders, with 20 repetitions to each area, one to two times daily. This form was signed by certified occupational therapy assistant, licensed (COTA/L)-A. The Lower Extremity ROM Program form dated 8/4/15, directed PROM exercises to R208's ankles, knees, legs and hips, with five to 10 repetitions, one time daily. This exercise program was directed by physical therapy assistant (PTA)-A. A letter dated 12/8/15, submitted to the survey team by family member (FM)-B (R208's legal representative) indicated, "[R208] was in rehab for about 6 [six] weeks and then we were told she was not progressing and would have to transition to long term care. We asked for ongoing PROM which has not occurred. We had some concerns about her care in rehab and it had more to do	2 895		

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2 895	Continued From page 31 with their commitment to helping my mom improve it felt like they were giving up on her." During a telephone interview on 12/8/15, at 8:54 p.m. FM-B stated she was concerned her mother not receiving PROM as ordered by therapy, and felt R208 needed this to remain comfortable. R208's Documentation Survey Report (charting of ROM services) from 9/1/15, through 12/9/15, detailed the following regarding her ROM services. In 9/15, R208 received PROM to her upper and lower extremities 21 out of 30 days (70% of opportunities), with no PROM noted on six days, and no data for the remaining three days. In 10/15, R208 received PROM eight out of 31 days, with no PROM noted on 22 days, and no data for the one remaining day. In 11/15, R208 received PROM five out of 30 days, with no PROM noted on 23 days, and no data for the remaining two days. In 12/15, R208 received PROM during one out of nine days, with no PROM noted on eight days. During observation on 12/10/15, at 9:50 a.m. R208's morning cares were observed with NA-H and NA-I. The NAs turned R208 side-to-side during cares, holding her hips and shoulders to push and/or pull her to either side, R208 was observed to moan and say, "Owe, owe, owe." NA-H and NA-I confirmed this was typical for R208 to say this during cares. R208 also demonstrated indications of pain and discomfort with dressing of both her UE and LE. During application of her sweatshirt, while assisting her with putting her arms into each sleeve, she held her hand over her face and moaned. She also vocalized "owe" with lifting each leg into her	2 895		

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2 895	Continued From page 32 pants. No PROM or any other exercises were provided to R208 during her morning cares. During interview on 12/10/15, at 1:45 p.m. NA-H stated R208 was supposed to receive ROM, "But she is so painful, you move her arm and then she's 'owe, owe.'" NA-H stated, R208 demonstrated these indications of pain/ discomfort whenever she moved her feet, arms, legs, and when turning her side-to-side in bed. NA-H stated she had not spoken specifically to the charge nurses about not providing ROM because of R208's pain, however, NA-H stated all staff were aware of R208's pain and ROM exercises were not being implemented as a result. During interview on 12/10/15, at 2:15 p.m. registered nurse (RN)-A stated she was R208's nurse manager and was responsible for developing care plans and monitoring implementation. RN-A was unsure whether R208 was supposed to receive ROM services, and stated any ROM programs that were in place were typically placed inside each resident's closet door and NAs were prompted to document the exercises in the facility's electronic medical record system. RN-A stated R208's pain levels were evaluated via observation of her non-verbal's. She indicated she watched resident cares routinely and during her observations of turning/ dressing R208, she felt the moans and/or non-verbalizations observed had more to do with being scared than with concerns of pain. RN-A stated NAs were to report to nursing if a resident who was supposed to receive ROM services was not being provided with the services for any reason. RN-A stated she had not been informed R208 was not receiving ROM as directed by therapy.	2 895		

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2 895	Continued From page 33 During observation and interview on 12/10/15, at 3:30 p.m. physical therapist (PT)-A reassessed R208's functional range of motion. R208 was seated in her wheelchair with FM-B seated next to her. PT-A manipulated R208's bilateral upper extremities and bilateral lower extremities and confirmed she found no current functional limitations in any extremity. PT-A reported R208 had shown no evidence of declined ROM since her discharge from therapies in 8/15. During this reassessment, R208 demonstrated no sighs or symptoms of pain, and she communicated with the PT-A and FM-A during the assessment and denied any concerns of pain upon inquiry and with movement of each extremity. PT-A stated R208 did not currently require ROM services from staff and stated ROM orders should have been discontinued upon R208's admission to hospice. However, PT-A stated staff had not notified therapy to ensure the resident did not require any PROM services to continue for comfort. During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated it was his expectation for staff to implement each resident's care plan. A facility policy which addressed ROM services was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding implementation of the care plan to include completing range of motion as directed, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the resident's skin for an appropriate turning/ repositioning schedule, and failed to implement interventions which had been assessed to prevent further pressure ulcers from developing and/ or to promote healing of current pressure ulcers for 2 of 3 residents (R208 and R19) reviewed who were identified with current pressure ulcers. This resulted in actual harm for R208, who developed an unstageable pressure ulcer to the second toe of her right foot. Findings include: R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified severe cognitive	2 900	corrected	1/18/16

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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) COMPLETE DATE
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impairment, required extensive to total assistance for activities of daily living, had developed one-stage two pressure ulcer (defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough), and two- unstageable pressure ulcers (unable to measure depth of pressure ulcer due to eschar or scabbing) since the prior assessment.

R208's Care Area Assessment (CAA) dated 9/30/15, identified R208's overall condition was declining and that the resident had been admitted to hospice services. Risk factors identified included severe cognitive deficit, poor nutrition, incontinence, immobility, and the use of antidepressant medication. The CAA indicated, "Does have capability of turning side to side in bed." Although the CAA indicated R208 was capabale of turning in bed, there was no individualized comprehensive assessment completed which identified the resident was able to turn without staff assistance.

R208's Medication Review Report (physician orders) signed 12/2/15, identified diagnoses including: dementia, lung cancer, chronic obstructive pulmonary disease, and acute and chronic respiratory failure. The report noted R208 was admitted to hospice services on 9/21/15, with a terminal diagnosis of diastolic heart failure. Physician orders directed interventions to minimize R208's risk for further progression of current pressure ulcers and to prevent the development of new pressure ulcers which included: Alternating pressure reduction mattress; Daily Tefla dressings to both heel pressure ulcers and wrapping them in Kerlix; Barrier cream post episodes of incontinence, as needed; Pressure relief with pillows when up in

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2 900	Continued From page 36 chair; Twice daily skin checks to heels and Achilles, contacting the nurse practitioner (NP) with any concerns identified; Elevating both heels and Achilles off bed at all times using a Heel Lift Manager, with no pressure on her heels while up in her wheelchair and no shoes to be worn; Keeping the necrotic areas on her left and right Achilles open to air to keeping them dry; Placing gripper socks only half-way onto her feet and not covering her heels due to the pressure ulcers. R208's care plan dated 10/2/15, directed staff to keep heels elevated on pillows at all times, assuring heels were not touching anything, two staff to boost up in bed or with any major repositioning, R208 required multiple pressure relieving devices including an alternating pressure mattress for her bed, a pressure reducing device for her chair and a cushion to float her heels. The care plan indicated, "Resident does have a tendency to remove her heels from the heel manager or off the pillows that elevate her heels when up in the Broda chair. Needs reminders and assistance to keep heels elevated." Review of R208's Weekly Wound Documentation from 9/1/15, through 12/10/15, revealed the following description of the pressure ulcers: Site #1: Left heel pressure ulcer acquired in-house on 9/30/15, measuring 1.8 cm by 1.5 cm superficial, but open area, with 100% granulation. The area was not staged, but was decreasing in size and showed no signs of infection. Site #2: Left Achilles pressure ulcer acquired in-house on 9/11/15, measuring 1.5 cm by 2 cm, with 100% eschar. The area was not staged, but was decreasing in size and showed no signs of infection. Site #3: Right Achilles pressure ulcer acquired in-house on 9/11/15, measuring 1.0 cm by 1.0	2 900		

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cm, with 100% eschar. The area was not staged, but was decreasing in size and showed no signs of infection.

During observation on 12/8/15, at 7:00 p.m. R208 was seated in her Broda wheelchair in the hallway, near the nurse's station. She had on white socks and black canvas shoes on both feet. The foot pedals to her wheelchair were in place, however, R208 was observed resting her feet on the floor out in front of the foot pedals, self-propelling her wheelchair. R208 stretched her feet out in front of her, placing her bilateral heels to the floor and then pulling herself forward, and the backs of her heels were observed bumping the foot pedals as she propelled. A gauze dressing was observed around her right lower ankle/ heel area, however, there was no gauze or dressing observed to her left foot/ ankle.

During a telephone interview on 12/8/15, at 8:54 p.m. family member (FM)-B stated she was concerned about R208's pressure ulcers and felt the facility should have done more to minimize this risk for developing further pressure ulcers, and to promote healing of the current pressure ulcers. FM-B stated she felt R208 needed turning and repositioning at least every two hours, which the facility was not currently doing.

During observation on 12/9/15, at 7:14 a.m. R208 was lying on her left side in bed with pillows propped on both sides of her torso. There were no pillows or devices in place to float her heels and both heels were observed resting on the bed. At 8:22 a.m., R208 remained asleep in her bed, and her right leg was draped over the edge of the left side of the bed. Her left heel remained flat against the bed with no pillows or devices in place to float her heels. At 8:35 a.m., nursing assistant

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2 900	Continued From page 38 (NA)-I entered R208's room and boosted her up in bed. NA-I stated R208's legs were hanging over the side of the bed so they repositioned her so she was lying flat on her back. No pillows or devices were put into place to float R208's heels, and they were laying directly on the bed. R208 had regular white socks on both feet, and her right, lower ankle area was wrapped with gauze, however, there was no dressing in place on the left foot/ ankle. NA-I stated R208's bilateral heels were resting on the mattress, and R208 typically ate breakfast in bed and did not receive morning cares until after she ate. However, NA-I left R208's room and did not attempt to float the residents heels off the bed. At 8:55 a.m., R208 was awake and remained lying flat in her bed with no pillows or devices in place to float her heels, and both heels were still resting on the mattress of her bed. During observation on 12/10/15, at 8:05 a.m. R208 was lying in her bed on her back, and there were no pillows or devices in place to float her heels. At 8:17 a.m., R208 continued to lay flat on her back with both knees bent and her feet were observed resting directly on the bed. She was wearing regular white socks to both feet and white gauze was observed around only her right lower ankle/ heel area, and there was none on the left. A black heel floating cushion was observed tucked between the nightstand and the wall to R208's right side in her room. At 9:40 a.m., NA-H entered R208's room to assist her with eating her breakfast. NA-H raised the head of the bed to approximately 60 degrees and R208 remained on her back with both knees bent and the balls of her feet and toes were pressed against the footboard of her bed, with her heels pressed into the mattress. There were no pillows or devices in place to float her heels.	2 900		

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2 900	Continued From page 39 During observation on 12/10/15, at 9:50 a.m. NA-H and NA-I completed R208's morning cares. While providing cares, R208 required extensive assistance from both NA-H and NA-I to turn from side-to-side while in bed, with NA-H standing on one side of the bed and NA-I stood to the opposite side. They each braced R208's shoulder and hip areas to pull her toward them and/or push her away from them as they proceeded to provide cares. NA-H and NA-I stated they were not aware R208 had any current pressure ulcers. Both NAs proceeded to change R208's white socks, and R208 had gauze wrapped around her right foot rested below an exposed, dark brown/ black scab to her right Achilles tendon area. A scabbed area, with deep red skin surrounding the area was observed to the top of her second toe. On her left Achilles tendon area, a dime-sized open area was observed, and there was also a small, flaky scabbed area to the edge of her left heel, and the top of the second toe was reddened. NA-H carefully applied the right sock over the gauze wrapped around R208's right lower ankle/ heel area, however, she did not appear to take the same precautions with the left ankle/ heel area and at one point, one of her fingers was observed directly over the open area to R208's left Achilles tendon. Once dressed, NA-I asked NA-H, "Does she need her shoes?" NA-H replied that R208 sometimes wore the shoes and other times did not, however, NA-H proceeded to apply black canvas shoes. On 12/10/15, at approximately 10:45 a.m. licensed practical nurse (LPN)-A entered R208's room and stated he was not very familiar with R208, however, he reviewed the residents electronic treatment record and stated R208 was	2 900		

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2 900	Continued From page 40 not due for any treatments at this time but the resident had an in-grown toe nail to her left great toe, which required a topical antibacterial ointment. LPN-A removed R208's left sock and applied ointment to that area. As he proceeded to re-apply the sock, he was asked whether there were any other open areas or skin breakdown on the left foot. LPN-A examined the foot running his gloved hand over the back of her foot when he noticed the opening on her Achilles area. Upon referencing R208's electronic treatment record, he stated R208 had a stage 2 pressure ulcer on her left heel, and R208 was supposed to have a "heel lift manager," at all times when in bed to prevent further pressure, which he confirmed was the black heel floating cushion tucked between R208's nightstand and the wall. LPN-A stated the cushion was to be in place at all times while R208 was in bed and stated the residents pressure ulcers, "would definitely get worse," if her heels were not being floated from the bed. He stated the nurses were expected to check the cushion was in place every time R208 was in bed, and the residents electronic treatment record prompted the nurses to sign off this was being implemented during every shift. LPN-A stated R208's treatment record also directed the evening shift nurse to apply dressings to both R208's heels, however, he was not sure why only the right heel had a wrap on. During this observation, R208 repeatedly crossed one foot over the other, and while crossing her feet, the Achilles area of the top foot was observed resting on the top of the opposite ankle area. LPN-A inspected both R208's feet/ heels and stated the area to her right toe was possibly a new area as he did not see it documented in the residents treatment record, however, LPN-A stated he would have an RN come into the residents room to assess the pressure ulcers.	2 900		

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2 900	Continued From page 41 On 12/10/15, at 11:21 a.m. RN-A (nurse manager) and RN-H (wound nurse) entered R208's room to assess the residents pressure ulcers. RN-A and RN-H assessed all pressure ulcers both R208's feet/ heels and reported the following results: Site #1: Left heel, dry scabbed area measuring 0.3 centimeters (cm) by 0.4 cm, unstageable. Site #2: Left Achilles, was a scabbed area upon last assessment but the scab had since fallen off and was now an open area measuring 0.8 cm by 0.8 cm, with granulation noted around edges, stage 2. Site #3: Right Achilles, dry scabbed area measuring 0.8 cm by 1.0 cm, unstageable. Site #4: Right second toe, newly identified scabbed area measuring 0.2 cm by 0.2 cm, with reddened surrounding tissue measuring 0.3 cm, unstageable. RN-A stated sites #1, #2 and #3 were improving from past assessments, but stated the pressure ulcer to R208's right second toe (site #4) was new. RN-A stated R208's family had recently brought new shoes in for the resident, and she had just, "had the nurse practitioner change the order" for no shoes on 12/9/15, so R208 could wear the shoes the family had brought in. RN-A placed the black canvas shoe next to R208's right foot and compared the newly identified pressure ulcer to the shoe and stated it appeared the shoes were the cause of the new pressure ulcer. RN-A stated she was going to clean the area, wrap it with Kerlix, and have the NP look at it on 12/11/15, and R208 had slippers she could wear in the meantime. RN-A stated on 12/9/15, she had the NP remove the physician order that directed the resident was not to wear shoes because family had brought in the new black	2 900		

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2 900	Continued From page 42 canvas shoes about a week prior for R208. RN-A stated the facility nurses were to observe all of R208's pressure areas during each evening shift. RN-A stated R208's foot pedals should have been turned away and/or removed any time the resident was self-propelling in the wheelchair as the foot pedals could resulted in bumping the pressure ulcers on her bilateral Achilles. RN-A stated R208 did not require a turning or repositioning schedule and the resident was able to independently make significant, prolonged changes to her positioning. Review of R208's treatment administration record (TAR) from 9/1/15, through 12/10/15, identified the following: Starting on 10/16/15, the TAR directed, "Apply Tefla/ non-adherent dressing to both heels sores and wrap with Kerlix. Change daily." The TAR indicated this treatment was administered routinely as ordered, and no refusals were noted. Starting on 9/11/15, the TAR directed, "Elevate Bil [bilateral] heels off bed at all times no pressure on heels when up in w/c [wheelchair] daily checks until resolved to Bil Achilles one time a day; Call if opens or any concerns." The TAR indicated this treatment was administered routinely as ordered and no refusals were noted. Starting on 9/17/15, the TAR directed, "Bid [twice daily] skin checks to heels and Achilles. Call NP with any concerns every day and evening shift for prevention." The TAR indicated this treatment was administered routinely as ordered and no refusals were noted. Starting on 9/17/15, and ending on 12/9/15, the TAR directed, "Heel lift Manager on at all times to elevated heels and Achilles off bed. NO SHOES. Every shift." The TAR indicated this treatment was administered routinely as ordered and no	2 900		

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refusals were noted.
Starting on 10/2/15, and ending on 12/9/15, the TAR directed, "Place gripper socks 1/2 way onto feet only- do not cover heels due to wounds. Every shift." The TAR noted a few, sporadic refusals, however, overall this treatment was administered routinely as ordered.

Review of R208's nursing progress notes from 9/1/15, through 12/10/15, identified the following:
The progress notes lacked evidence of R208 routinely refusing cares or treatments of the pressure ulcers.
The progress notes lacked evidence of R208 and/or her legal representative being provided education on the risks of skin breakdown with wearing the black canvas shoes provided by the family.
The progress notes lacked any assessment to determine if R208 could wear shoes to prevent further pressure ulcers from developing.
The progress notes lacked any notation of FM-B's request for R208 to have a two hour turning and repositioning schedule.
The progress notes lacked assessment of an appropriate turning and repositioning schedule for R208.

During interview on 12/10/15, at 1:45 p.m. NA-H stated R208 required two staff to reposition and turn her from side-to-side while lying in bed, however, if she was lying on a draw sheet, one staff could turn her. NA-H stated R208 was not able to turn her bottom side-to-side to offload pressure independently. NA-H stated she was not aware of any current pressure ulcers for R208. NA-H stated she typically repositioned R208, but stated she was not directed to do this, but just felt it was something that should be done. NA-H

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2 900	Continued From page 44 stated she typically repositioned R208 one time between 6:30 a.m. when her shift started, and 10:30 a.m., when staff typically assisted R208 to get dressed and up in her wheelchair. However, NA-H stated she had not repositioned R208 that morning, and she boosted R208 up in bed and raised the head of the bed for her to eat breakfast, but did not turn her to a different position. NA-H was not sure whether R208 was repositioned throughout the night, so she was unable to state how long she had been lying on her back, but confirmed it was at least three hours, from 6:30 a.m. to 9:40 a.m. NA-H was not sure how long R208 had her been wearing the black canvas shoes, but stated she knew it had been more than a week. During interview on 12/10/15, at 2:15 p.m. RN-A stated she was R208's nurse manager and was responsible for completion of her assessments and the development of her care plan interventions. RN-A stated the newly identified pressure ulcer to R208's second toe of her right foot was an unstageable, scabbed-over area which had developed after wearing a new pair of shoes brought in by her family. RN-A stated R208 had not been assessed to determine whether the shoes were appropriate, given her risk for skin breakdown and the order for no shoes. RN-A stated R208's family wanted her to wear the shoes so she had the NP discontinue the order. RN-A stated she was unsure of when the areas to R208's bilateral Achilles' developed, but knew they had developed prior to her arrival on this unit in 9/15. RN-A stated the scabbed area to her left heel was originally identified on 9/30/15, and stated R208's heels were to be floated with a heel lift manager whenever she was lying in bed. RN-A was not aware the heel lift manager was not being used by the NAs when	2 900		

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they laid R208 down in bed. RN-A stated R208's bilateral heels were to be wrapped with a dressing, however, she stated R208 moved her feet around a lot and the dressing to her left heel area could have fallen off throughout the night. RN-A stated R208 was not on a turning and repositioning schedule, and she felt R208 moved around independently and did not require a turning and repositioning schedule. RN-A stated she would need to review R208's assessments to determine how it was determined the resident did not require a turning and repositioning schedule. RN-A stated she was unaware R208 required one person with a draw sheet, or two persons to assist, with turning side-to-side in bed during incontinence cares. RN-A stated, "I guess I really don't know. She moves a lot herself... They do get her up and they offload her and reposition her in the Broda chair." RN-A stated her reference to "offload" was referred to the time during transfers when R208 was not seated or lying, which did not necessarily provide sufficient pressure relief. RN-A stated the facility was still working on developing a timeline of R208's pressure ulcers, and would provide it once it was completed. However, at the time of survey exit on 12/10/15, no assessment of R208's turning and repositioning schedule or pressure ulcer timeline was provided.

During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated staff should implement each resident's care plan and to follow physician orders. DON stated he was made aware of R208's new unstageable pressure ulcer to her toe, and he stated it was R208 and her legal guardian's wish for her to wear the shoes. However, the DON stated he would expected his staff to educate R208's legal representative on the risks and document the education and refusal

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to abide by the physician's order in the medical record, however, he stated R208's medical record did not show any education on wearing the shoes were provided.

During interview on 12/10/15, at approximately 5:45 p.m. the MDS coordinator reported the facility did not do tissue tolerance testing (an assessment used to individualy assess the skins ability to withstand pressure) as this was no longer the standard of practice and research suggested tests such as this were not effective in determination of a resident's need for frequency of turning and repositioning. MDS coordinator stated the facility assessed residents for an appropriate turning or repositioning schedule by adjusting the schedule as concerns arose, and resident skin was checked with all cares on an on-going basis, and any concerns were reported to the nurse for further assessment. She stated the RN's adjusted the turning and repositioning schedule as needed. MDS coordinator stated there was no assessment R208's skin was evaluated for an appropriate turning and repositioning schedule.

R19's quarterly MDS dated 10/29/15, indicated R19 had moderate cognitive impairment, needed extensive assistance for bed mobility, was frequently incontinent, was receiving hospice care, and was at risk for developing pressure ulcers, but did not have any current pressure ulcers. The MDS indicated the resident had a pressure reducing mattress and wheelchair cushion used to prevent pressure ulcers.

R19's Nurse Quarterly Data Collection dated 10/28/15, included a Tissue Tolerance and Braden and Skin Risk Data Collection. The Tissue Tolerance assessment lacked direction on

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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) COMPLETE DATE
2 900	Continued From page 47 how often R19 should be repositioned lying or sitting, and the assessment indicated R19 was able to make frequent and minor changes in bodily positions independently, but required staff assistance with major changes. The Braden and Skin Risk Data Collection indicated R19 was at risk for developing pressure ulcers due to being frequently incontinent, chairfast, slightly limited in mobility, friction, and shearing. R19's Nurse Monthly Documentation dated 11/18/15, indicated R19 needed extensive assistance with bed mobility. R19's electronic care plan was reviewed on 12/8/15, and the care plan included R19 was at risk for alteration of skin integrity due to bladder incontinence and periods of lethargy where she needed more assistance from staff with mobility. Interventions included: Alternating pressure mattress on bed, pressure relieving device in chair, inspect skin daily with cares, turn and reposition every two hours, and check brief for incontinence. During constant observation on 12/9/15, at 7:10 a.m. through 9:09 a.m. R19 was observed sleeping on her back in bed, with her upper body tilted slightly to the left with no changes in repositioning by staff, nor did R19 make any changes in position by herself during this period of time. On 12/9/15, at 9:16 a.m. NA-A entered R19's room with a breakfast tray for R19. NA-A raised the head of R19's bed, however pressure was not relieved from R19's buttocks. NA-A placed the tray table with R19's breakfast in front of R19, set up R19's breakfast tray, and left the room without providing any repositioning for R19 at this	2 900		

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2 900	Continued From page 48 time. During interview on 12/9/15, at 9:36 a.m. R19 stated her butt was sore and needed to move a little, however, R19 did not attempt to reposition herself and continued to eat her breakfast. R19 was continuously observed eating breakfast in the same position until 9:54 a.m. with no repositioning. During interview on 12/9/15, at 9:57 a.m. NA-A stated she was assigned to care for R19. NA-A stated R19 was to be repositioned every two hours, however, she had not been repositioned since the beginning of her shift at 7:00 a.m. because NA-A, "Forgot." NA-A than lowered R19's head of the bed, unfastened her incontinent product, and asked R19 to role to her left side. R19 grabbed the left grab bar and tried to roll but could not move herself to her side. NA-A used the the draw sheet on the bed and assisted R19 to her left side. NA-A stated R19 needed help with repositioning. R19's buttocks were observed at this time and was covered in a white cream. NA-A washed the white cream off of R19's buttocks, and R19 had two small open areas about the size of a dime on her right inner buttocks, and a quarter size blanchable red area to her left inner buttock. On 12/9/15, at 10:07 a.m. licensed practical nurse (LPN)-A entered R19's room and stated he wasn't aware R19 had any open areas and reviewed the medical record and could not find documentation of the open areas. LPN-A looked at R19's treatment record in the order section dated 12/7/15, which instructed staff to cleanse the right buttock pressure ulcer, and cover with a foam dressing as needed and every evening. LPN-A stated R19 had no foam dressing in place	2 900		

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2 900	Continued From page 49	2 900		

to the right buttock, and R19's pressure ulcer(s) were not communicated.

On 12/9/15, at 10:17 a.m. RN-A entered R19's room with a measuring tool and stated she was not aware R19 had any pressure ulcers. RN-A stated the residents hospice nurse was in the facility on 12/7/15, but she had not reviewed the hospice notes yet. RN-A measured the pressure ulcers and the upper area measured at 0.6 centimeters (cm) x 0.5 cm, and the lower open area measured 0.5 cm x 0.6 cm. RN-A stated both area's were superficial and had no drainage, and the red area on the left buttock was not measurable as it had completely faded.

When interviewed via telephone on 12/9/15, at 1:17 p.m. RN-B hospice nurse stated she observed a 1 cm pressure ulcer on R19's right buttocks on 12/7/15. RN-B stated she cleansed the pressure ulcer and applied a foam dressing during her visit, and then she updated the facility nurse, RN-C, prior to leaving the facility and wrote an order to cleanse the pressure ulcer and apply a foam dressing daily.

A review of the hospice notes included a note dated 12/7/15, which indicated there was a 1 cm open area on R19's right buttock, which was a recurrent pressure ulcer, and directed facility staff to cover the pressure ulcer with an adhesive foam dressing.

R19's Braden and Skin Risk Assessment updated on 12/9/15, indicated R19 was at risk for developing pressure ulcers, however, had demonstrated she could turn herself side to side independently. Although staff indicated R19 was unable to turn independently, the nurse assessment continued to identify the resident was

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2 900	Continued From page 50 able to relieve pressure by moving independently. R19's Nurse Weekly Wound Documentation dated 12/9/15, included the open area's observed with RN-A were in house acquired on 12/7/15, and were both superficial stage 2 pressure ulcers. R19's medical record lacked an updated Tissue Tolerance and and analysis of the newly developed pressure ulcer discovered on 12/7/15. R19's care plan was updated on 12/9/15, and indicated R19 had an alteration in skin integrity as evidenced by two superficial open areas on right buttocks. The care plan indicated R19 did not want to be awakened to be turned/ repositioned, R19 was able to turn from side to side using grab bars adequately for pressure relief, and R19 just needed assistance with boosting up in bed When interviewed on 12/10/15, at 8:20 a.m. RN-A stated she had spoken to hospice RN-B and had learned RN-B reported the pressure ulcer to RN-C following the visit on 12/7/15. RN-A stated she had updated the family and the physician regarding the pressure ulcer, however, she had not notified any other facility staff about the pressure ulcer. RN-A stated she observed R19 and felt that she had repositioned herself with the use of the grab bar on her bed, and she had also updated R19's Braden Scale and care plan on 12/9/15, as R19 told her she did not want to be awakened to be be repositioned. RN-A stated she was aware R19 does not always reposition herself as she was weak and forgets. RN-A stated she did not reassess R19's Tissue Tolerance, and stated she should have. RN-A stated she discussed risk vs benefits with R19 regarding not being woke up to be repositioned, however, she did not discuss it with family nor did	2 900		

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2 900	Continued From page 51 she document the risk vs benefits were reviewed. During interview on 12/10/15, at 9:55 a.m. RN-C stated RN-B from hospice had reported R19 had developed a pressure ulcer on her right buttocks and gave a hospice order to cleanse and apply a foam dressing daily and as needed. RN-C stated she processed the order, but failed to document or notify RN-A regarding the pressure ulcer development. RN-B stated R19 needed help with repositioning to relieve pressure, which should be done at least every two hours, regardless if she is sleeping. During follow up interviewed on 12/10/15, at 2:02 p.m. RN-A stated the 10/28/15, Tissue Tolerance assessment lacked direction on how often R19 should be repositioned while sitting and/ or lying. RN-A further stated she could be doing the assessment incorrectly and would check with the MDS nurses to determine the correct way to complete the assessment. RN-A stated the Tissue Tolerance assessment should have indicated two hours for repositioning for R19, as the care plan previously read before it was updated on 12/9/15. A policy on pressure ulcers was requested, and was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding implementation of a care plan to ensure appropriate treatment of pressure ulcers, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement care plan interventions to promote continence for 1 of 1 residents (R211) reviewed for urinary incontinence. Findings include: R211's admission Minimum Data Set (MDS) dated 11/25/15, identified R211 had intact cognition, required extensive assistance with toileting, was not on a scheduled toileting program, and was frequently incontinent of bladder. R211's Nur Day 4 Post Admission assessment dated 11/21/15, identified R211 to be, "Always	2 910	corrected	1/18/16

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2 910	Continued From page 53	2 910		

incontinent," of bladder and required extensive assistance to use the toilet. The assessment provided a section to document, "Comments on urinary patterns," and check mark boxes to identify interventions to help R211 manage his incontinence which included the following options:
"Scheduled/Habit Toileting Plan,"
"Check and Change Program,"
"Training to return to previous pattern/retraining" and;
"Prompted Voiding."
However, none of these fields were completed, and were left blank on the assessment. An analysis of the assessment was only documented as, "Patient [R211] is incontinent of bladder and occasionally incontinent of bowel." The assessment did not identify any potentially reversible causes of R211's urinary incontinence, any collected patterns of voiding, or any interventions to promote continence for R211.

R211's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 12/1/15, identified, "Res [resident] is incontinent of b & b [bowel and bladder] ... unknown if his function will return." Further, the CAA provided a space to include resident and family input on R211's toileting needs, however this space just identified, "Per review." The CAA identified R211's care plan would be developed to slow or minimize his declines, avoid complications, and minimize his risks of urinary incontinence. The CAA did not identify any collected patterns of voiding, or any interventions to promote continence for R211.

R211's care plan dated 12/7/15, identified R211 to be incontinent of bladder, and identified an intervention of, "Toilet upon rising, before and after meals, HS [hour of sleep] and prn [as

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2 910	Continued From page 54 needed]." During observation of morning care on 12/9/15, at 7:05 a.m. R211 was lying in bed, while nursing assistant (NA)-E prepared a wash basin in the restroom. R211 had on an incontinence pad which was soiled with urine and stool. NA-E and NA-F assisted R211 to his wheelchair, and NA-E then assisted him into the restroom, placing him in front of the vanity to brush his teeth. R211 finished his morning cares, and was assisted to the dining room table for breakfast. No offer or attempt to toilet R211 was provided by staff as directed by his care plan. When interviewed on 12/9/15, at 7:47 a.m. NA-E stated R211 was typically incontinent of urine, and is usually saturated with urine in the morning, "Normally wet in the morning, every morning." NA-E stated R211's incontinence pad and bedding were saturated with urine this morning when she helped him with morning cares. NA-E stated she helps R211 to the bathroom, Every two hours," and did not offer toileting to R211 that morning upon rising, despite his care plan directing staff to, because she thought R211 would say he didn't have to use it. During interview on 12/9/15, at 9:28 a.m. NA-G stated she had helped get R211 up for the day just a few days prior, and he had been, "Wet [incontinent] when we got him up." NA-G stated the NA staff do not assist R211 to use the toilet for his voiding, but rather place him on a bed pan adding, at times, R211 would void after being placed on it. When interviewed on 12/9/15, at 12:33 p.m. registered nurse (RN)-G stated there was no reason R211 could not be placed on the toilet to	2 910		

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2 910	Continued From page 55 void, but was unaware if R211 would void after being assisted with toileting. RN-G reviewed the charting the NA staff completed and stated there were several recorded episodes of continent voids for R211. RN-G reviewed R211's Nur Day 4 bladder assessment and stated there was no further documentation she could locate supporting an assessment of R211 had been finished (referencing the blank areas identified), "I don't know what to tell you." During interview on 12/9/15, at 12:47 p.m. RN-F stated R211 was, "Frequently incontinent of bladder," and at times could verbalize his need to use the restroom. R211 was physically able to use the toilet if given assistance, and was on a scheduled toileting plan which included being assisted upon rising in the morning, before and after meals, at bedtime and as needed. R211's comprehensive assessment should have included a summary of his recorded voiding to, "Identify a pattern if there was one." Further, RN-F stated R211 was placed on his current toileting schedule, "To be proactive," and staff should be physically helping R211 to the bathroom during the times identified on the care plan because R211 was a post stroke patient, and it would attempt to retrain his bladder, "So he doesn't lose his ability." A facility policy on bladder incontinence and scheduled toileting was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding how to comprehesnively assess and develop interventions to reduce incontinence, and then audit to ensure compliance.	2 910		

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2 910	Continued From page 56 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services related to incontinece care as directed by the plan of care for 1 of 4 residents (R208) reviewed who required staff assistance with toileting. Findings include: R208's Medication Review Report signed 12/2/15, identified diagnoses including dementia, lung cancer, respiratory failure and chronic pain. R208's significant change Minimum Data Set (MDS) dated 9/30/15, indicated R208's cognition was severely impaired and she required extensive to total assistance for activities of daily living including extensive assistance for toileting. The MDS identified R208 was not on a toileting program, but was always incontinent of both bowel and bladder.	2 920	corrected	1/18/16

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2 920	Continued From page 57 R208's Care Area Assessment (CAA) dated 9/30/15, identified R208 had diagnoses which included end stage congestive heart failure, restricted mobility, was always incontinent of urine, urgency and needed assistance with toileting. The CAA also noted, "Continue to offer toileting/or to be checked and changed. Continue to provide pericare after each incontency [incontinence]. Has functional incontinency [incontinence]." Although the cooresponding MDS assessment dated 9/30/15, indicated R208 was not on a toileting program, the CAA directed the resident was to be offered toileting. Any additional bowel and bladder assessments completed on R208 were requested, but none were provided. R208's care plan dated 10/2/15, directed staff to offer toileting to R208 upon rising, after meals, at bedtime, as needed during the night and upon request. The care plan directed staff to either assist R208 with the bed pan or to have two staff provide her with assistance to transfer to the toilet. During observations on 12/8/15, from 5:30 p.m. to 7:00 p.m. R208 was assisted to the dining room for the supper meal and then brought back to the nurse's station area, where she remained in the hallway throughout the evening. R208 was not provided check and change services nor did staff offer use of a bedpan or toileting assistance as R208's care plan and CAA directed. During continuous observation on 12/9/15, from 7:14 a.m. through 8:55 a.m. R208 was lying in bed in her room. R208 continued to lie in bed, until 8:34 a.m., when a facility nursing assistant briefly entered her room, and assisted with	2 920		

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2 920	Continued From page 58 moving her legs in bed and immediately exited R208's room. Check and change services were not observed to be offered or provided. R208 was not offered the use of a bedpan or toileting assistance. At 8:55 a.m., R208 remained in bed, alone in her room. R208 had not been checked/changed nor offered toileting for the entire observation. NA-H confirmed earlier this morning, she did not check and change R208 until her morning cares at 9:50 a.m. and was unaware of when she was changed prior to that, but confirmed it was prior to 6:30 a.m. (approximately three and a half hours prior). During interview on 12/10/15, at 2:15 p.m. registered nurse (RN)-A stated R208 was to be offered the bed pan and utilized an incontinence brief. RN-A was unsure as to whether R208 was on a toileting program, but confirmed the bed pan should have been offered to her on a regular basis and with cares. During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) reported it was his expectation for staff to implement each resident's care plan. A facility policy addressing toileting assistance or urinary incontinence was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding implementation of a residents care plan to ensure assistance with toileting is provided, and then audit to ensure compliance.	2 920		

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2 920	Continued From page 59 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control	21390	corrected	1/18/16

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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) COMPLETE DATE
21390	Continued From page 60	21390		

program which included consistent monitoring, trending, and analysis of infections to reduce the transmission to other residents in the facility. This had the potential to affect all 118 residents residing in the facility, staff, and visitors.

Findings include:

Review of the facility's Monthly Infection Control Log dated 2010, identified a flowsheet for staff development (SD) to record resident infections. One sheet was available for each household, with the following columns:
- Resident name
- Admit date
- Room #
- Unit
- Infection type
- Body site (catheter?)
- Date of onset
- Date culture taken
- Organism(s)
- Antibiotic resistant (Y/N)
- Antibiotic type
- Start date
- Infection definition met (Y/N)
- Resident for 48 hours or greater (Y/N)
- Classification not infected
- Classification community
- Classification healthcare associated infection
- Date resolved
- Isolated (type)?

Review of the infection control flowsheets dated May 2015, through October 2015, typically identified the resident name, admit date, infection type, antibiotic, and if the infection was present on admit. However, it lacked consistent documentation of room number, body site, date of onset, date culture taken, organism

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	12/10/2015

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21390	Continued From page 61 identification, antibiotic resistant, date resolved, and whether or not it was isolated as directed to be filled out by the flowsheet to ensure accurate tracking and trending of resident infections. When interviewed on 12/10/15, at 4:36 p.m. staff development (SD)-A, who was also infection control nurse, stated cultures are not typically ordered by the physician, and the organism is not identified when a resident is admitted from the hospital with an infection. She also stated the facility does not attempt to receive this information from the hospital after admission. Infections are tracked for each household, and compiled on the above mentioned form to bring to quality assurance (QA) meetings. SD-A stated she looks at the type of infection, the location of the infection, is the resident receiving treatment for it, is there an intervention, was it acquired at the facility or present on admission, and is it resolved. Further, SD-A stated the symptoms are not tracked on the log, but available in the resident's progress notes in the chart, which she has access to. An infection control policy was requested from the facility, but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the infection control policies, procedures and program, to ensure adequate monitoring of illness, and analysis to reduce potential transmission to other residents. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		