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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JM4C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00593

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245483**

2.STATE VENDOR OR MEDICAID NO.
(L2) **940220900**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE NORTH SHORE ESTATES LLC**
(L4) **7700 GRAND AVENUE**
(L5) **DULUTH, MN** (L6) **55807**

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) **07/14/2016**

6. DATE OF SURVEY **01/21/2020** (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 **70** (L18)
13.Total Certified Beds **70** (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
	70			
(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 :
Kimberly Settergren, HFE NE II 01/21/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/21/2020 (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
05/01/1987
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/14/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 21, 2020

CMS Certification Number (CCN): 245483

Administrator
The North Shore Estates LLC
7700 Grand Avenue
Duluth, MN 55807

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 3, 2020 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 21, 2020

Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

RE: CCN: 245483
Cycle Start Date: November 21, 2019

Dear Administrator:

On January 21, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JM4C

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(L5) **DULUTH, MN** (L6) **55807**

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
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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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 :
Kimberly Settergren, HFE - NE II 12/26/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/13/2020 (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
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05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
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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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 11, 2019

Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

RE: CCN: 245483
Cycle Start Date: November 21, 2019

Dear Administrator:

On November 21, 2019, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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

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

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

If substantial compliance with the regulations is not verified by February 21, 2020 (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).

In addition, if substantial compliance with the regulations is not verified by May 21, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was conducted on 11/17/19, through 11/21/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/17/19, through 11/21/19, a standard survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5483040C 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		1/3/20

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

Electronically Signed | 12/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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 550	Continued From page 1 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 550	Immediate Corrective Action:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 550	Continued From page 2 review, the facility failed to conceal a urinary drainage bag and incontinence products from public view for 1 of 3 residents (R27) reviewed for dignity. In addition, the facility failed to ensure a resident was offered the use of a toilet for voiding upon request for 1 of 3 residents (R53) reviewed for dignity. Findings include: R27's Face Sheet printed 11/20/19, indicated diagnoses included chronic kidney disease, and history of urinary tract infection. R27's annual Minimum Data Set (MDS) dated 9/19/19, indicated R27 was cognitively intact, and required extensive assist with mobility, transfers, dressing and toileting. R27's care plan dated 11/4/19, indicated R27 was at risk for complications such as urinary tract infection (UTI) related to altercation in elimination. On 11/19/19, at 7:31 a.m. R27 was observed laying in her bed with door open. R27's Foley catheter bag was exposed and visible from the hallway. R27's catheter bag had bright clear yellow urine in the tubing and bag. On 11/20/19, at 3:46 p.m. R27 was observed laying in her bed with door open. R27's Foley catheter bag was hanging from her bed frame, visible from the hallway. R27's catheter bag had bright clear yellow urine in the tubing and bag. On 11/20/19, at 3:30 p.m. nursing assistant (NA)-E confirmed R27's Foley catheter bag was not in a privacy bag, and was clearly visible from the hallway. NA-E stated Foley catheter bags	F 550	Resident #27 was provided a urinary drainage bag cover to utilized when in bed and wheelchair. Resident #53□s NAR who was caring for him received education regarding proper process to follow when a resident asks to use the bathroom. Corrective Action as it applies to others: The Policy and Procedure for Quality of Life-Dignity remains current. The nurses and NARs will be re-educated on the Quality of Life-Dignity Policy with regards to need to keep urinary drainage bags covered per resident□s preference and to provide toileting assistance when a resident states that they need to use the bathroom by 1/3/2019. All residents who have urinary drainage bags will be reviewed to ensure that they have a urinary drainage bag cover if that is their preference. All others will be care planned that they don□t wish to have drainage bag covered. Date of Compliance 1/3/2019 Recurrence will be prevented by: Audits of 5 residents who have urinary drainage bags will be conducted weekly x 4 and then monthly x 2 months to assure that bags are covered to provide for resident privacy. Audits of 5 residents receiving toileting cares will be conducted weekly x4 and the monthly x 2 months. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 3 should be in privacy bags to ensure the resident's dignity and privacy. NA-E further stated this would be especially important for R27, since R27 preferred to have her door open at all times. On 11/20/19, at 3:52 p.m. licensed practical nurse (LPN)-E confirmed R27's Foley catheter bag was not in a privacy bag and was visible from the hallway. LPN-E indicated Foley catheter bags were to be in privacy bags for dignity purposes. On 11/20/19, at 4:39 p.m. the director of nursing (DON) was interviewed and verified R27's catheter bag was to be placed in a privacy bag in order to maintain her dignity. The facility policy Quality of Life-Dignity revised 8/09, indicated staff are to promote, maintain and protect resident's privacy. R53's Admission Record printed 11/20/19, indicated R53's diagnoses included Parkinson's disease. R53's quarterly MDS dated 11/5/19, indicated R53 was cognitively intact, required extensive assistance with toileting, and was not on a toileting program. R53's Care Area Assessment (CAA) dated 8/19/19, indicated R53 was frequently incontinent of urine. The CAA indicated toileting needs would be care planned for R53 to continue to offer toileting, check, and change every two hours.	F 550	Corrections will be monitored by: DON/ADON/Nurse Managers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 4	F 550		

R53's care plan dated 8/26/19, indicated R53 had alteration in elimination related to a history of urinary tract infections (UTI), urinary retention, impaired mobility, and was incontinent of bowel and bladder. R53's goal was to remain clean, dry, odor free, and to be free from signs and symptoms of UTI. R53 interventions included assistance of two and a Hoyer (mechanical lift) with toileting needs including pericare, pad, and clothing adjustments.

R53's nursing assistant care guide dated 11/17/19, indicated R53 was incontinent, and required two assist and a Hoyer with toileting.

R53's Bladder Evaluation dated 9/20/19, indicated R53 was incontinent of bowel and bladder, did not inform staff of need to void, and occasionally would ask staff for a urinal, but R53 had already voided and did not void in a urinal. R53 required assistance with toileting including a Hoyer for transfers, clothing and pad management, and peri care. Staff was to offer toileting, check, and change every two hours. R53 was able to make needs known and understand others.

On 11/17/19, at 1:16 p.m. R53 stated he urinated in his pants because he is unable to use the bathroom, and would be unable to use the urinal on his own.

During observation on 11/19/19, at 10:07 a.m. R53 had verbalized he had to urinate during morning cares. Nursing assistant (NA)-A instructed R53 to "pee" in his pants because he was wearing an incontinent brief. NA-B asked NA-A if R53 had a urinal. NA-A stated R53 did not have urinal, and told R53 that NA-A would

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change his brief and get him cleaned up when he was done.

On 11/19/19, 11:24 a.m. licensed practical nurse (LPN)-B confirmed she overheard R53 state he had to urinate, and heard NA-A instruct R53 to go ahead and pee in his pants because he was wearing an incontinent brief. LPN- B stated she had planned to talk with NA-A about that comment because it was not acceptable to tell a resident to urinate in their pants, it would be a dignity concern for that resident. LPN-B stated that was the first time she had heard R53 say he had to go to the bathroom, and had known R53 to be incontinent of bowel and bladder. LPN-B further stated R53 was getting stronger, and maybe would be able to use a urinal with assistance. LPN-B stated R53 should have been offered to use the urinal or to be toileted. LPN-B verified R53 did not have a urinal in his room.

On 11/19/19, at 12:50 p.m. R53 stated he would prefer to use the bathroom and not urinate in his pants. R53 stated staff don't offer to take him to the bathroom or offer a urinal. R53 stated when staff came into his room, R53 would say he had to "pee," and the staff would often tell him to just go in his pants.

On 11/20/19, at 2:10 p.m. the ADON stated residents should be offered to be toileted and not instructed to go in their pants, and that it would be a dignity issue for that resident.

On 11/20/19, at 4:39 p.m. the DON stated if a resident was able to verbalize they had to urinate, the resident should be on a bowel and bladder program. A toileting log would be initiated to assess the resident's urinary patterns to promote

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F 550	Continued From page 6 highest bladder functioning. The facility policy Behavioral Programs and Toileting Plans for Urinary Incontinence dated 10/10, directed a review of the resident's care plan to assess for any special needs of the resident. Conduct a thorough assessment of the resident and his or her environment to determine factors that may have contributed to any recent decline in urinary incontinence. Monitor, record, and evaluate information about the resident's bladder habits, and continence or incontinence. Assess the resident for appropriateness of behavioral programs which promote urinary incontinence.	F 550		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		1/3/20

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§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident

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F 585	Continued From page 8 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written response to a grievance for 1 of 1 residents (R12) reviewed for grievances. Findings include:	F 585	Resident #12 had a grievance form filled out with regards to missing shorts. Replacement shorts were ordered on 12/19/19.Grievance form was put in file. Action as it applies to others:	

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F 585	Continued From page 9 R12's Admission Record printed 11/20/19, indicated R12's diagnoses included unspecified intellectual disabilities, and unspecified convulsions (seizures). R12's quarterly Minimum Data Set (MDS) dated 9/10/19, indicated R12 had a moderate cognitive deficit, was able to speak clearly, was understood, and understood others. R12's MDS indicated R12 displayed no behaviors, no signs or symptoms of delirium or psychosis, and had no mood symptoms. R12's care plan initiated 4/20/17, indicated R12 was cognitively intact, was able to understand others, was able to be understood by others, and was able to communicate needs effectively. R12's progress notes dated 10/23/19 through 11/19/19, lacked documentation regarding missing clothing. On 11/17/19, at 2:17 p.m. R12 was interviewed and stated she had three to four pairs of missing purple shorts. R12 stated the facility looked for the shorts, and she was told after she asked, the facility was unable to find them. R12 stated she had reported it to the lady who did the laundry. R12 denied getting a written response in regards to the missing clothing. On 11/19/19, at 7:40 a.m. laundry aide (LA)-A stated R12 had been missing two purple shorts for 3 to 4 months. LA-A stated she has looked through everything and was unable to find them. LA-A stated R12's family knew about it. On 11/20/19, at 2:40 p.m. social services director	F 585	The Grievance Policy and Procedure was reviewed and remains current. Grievance/Concern Form has been updated to reflect facility□s offer of a copy of the written resolution. All staff will be educated on the Grievance Policy and Procedure by 1/3/2019. Resident Counsel meeting on 12/18/2019 was held and Grievance Procedure reviewed. Date of completion: 1/3/2019 Recurrence will be prevented by: 3 resident interviews regarding any grievances will be held weekly x4, then monthly x2 months, on various units to assure concerns are documented and followed through with resolutions and that they were aware who to contact. The results of these interview audits will be reviewed monthly at the facility QAPI committee meeting for input on the need to increase, decrease or discontinue the audits. Grievances will continue to be discussed at the monthly Resident Counsel meetings and will be reported monthly on an ongoing basis to the facility QAPI committee. The correction will be monitored by: Administrator/Social Services Director/Designee	

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(SS)-A stated she had not heard about R12's missing clothing. SS-A stated the resident or family gets updated with the results of the grievance investigation, but they do not provide a written response.

On 11/20/19, at 2:43 p.m. social services regional director (SS)-B stated R12's missing shorts occurred some time ago. SS-B stated the administrator was supposed to purchase new shorts, but the re was a problem finding the appropriate size. SS-B confirmed the facility did not provide a written response to R12 or the resident representative. SS-B stated they would keep the grievance form on file.

R12's grievance form was requested and not provided.

The facility policy Complaints and Grievance Procedure dated 9/01, directed a grievance form to be completed, and turned into the administrator as soon as reasonable possible when the verbal complaint had been voiced. The administrator would provide a verbal summary, unless a written summary was required, to the complainant no later than 5 business days after the receipt of the grievance. If the grievance was not resolved, the grievance form was to be sent to the corporate Grievance Office, and within 7 days, the grievance officer would attempt to resolve the grievance and notify the complainant in writing of the proposed action. If the grievance was not resolved, it would be submitted to the Board of Directors and the Board would issue a written summary to the complainant of proposed action no later than 30 days after receipt of the grievance. All completed grievance forms would be kept on record at the facility for no less than 3

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F 585	Continued From page 11 years.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report bruises of unknown origin to the State Agency within 2 hours for 1 of 3 residents (R21) reviewed for abuse.	F 609	Immediate Corrective Action: Resident #21□s bruising to right and left thumb have resolved. The nurse who did not report the incident to the administrator	1/3/20

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F 609	Continued From page 12 Findings include: R21's Admission Record printed 11/20/19, indicated R21's diagnoses included vascular dementia with behavioral disturbance, and cerebral infarction (stroke). R21's quarterly Minimum Data Set (MDS) dated 9/19/19, indicated R21 had a severe cognitive impairment, displayed no symptoms of delirium or psychosis, no behaviors during the assessment period, and required extensive assistance with all activities of daily living (ADLs). R21's care plan initiated 4/24/17, indicated R21 was unable to remove self from harmful situations due to physical and cognitive deficits, and directed staff to observe for and report any changes in vulnerability. R21's care plan directed staff to provide physical assistance with all ADLs and mobility, indicated R21 could be resistive to assistance with cares, and directed staff to re-approach as R21 allowed. R21's care plan further indicated R21 was forgetful and confused, had a modified independence with decision making and required some assistance in new situations, and had an impaired short term memory and moderately impaired long term memory. R21's nursing assistant care guide sheet directed staff to give space, and re-approach when demonstrating agitated behaviors, and Tubigrips (stockinette) from knuckles to elbows as she allows. R21's Order Summary Report with active orders as of 11/20/19, included a chewable 81 milligram	F 609	was provided one to one education on 11/22/2019 regarding timely reporting of injuries of unknown origin. Corrective Action as it applies to others: The Abuse Prevention Plan remains current. Re-education on the Abuse Prevention Plan with an emphasis on timely notification of administrator for injuries of unknown origin will be completed by 1/3/2019 for all nurses and NARs. All resident□s risk assessments for last month will be reviewed to check for any areas that may not have been followed up on appropriately including possible VA reporting. Date of Compliance:1/3/2019 Recurrence will be prevented by: Audits of all resident skin incident reports will occur weekly x 4 and then monthly x2 to assure the Abuse Prevention Plan has been followed to include timely reporting. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/DON/ADON/Nurse Managers	

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(mg) aspirin daily. R21's orders did not include any orders for anticoagulant or steroid medications.

R21's progress notes dated 10/31/19, at 12:19 a.m. indicated staff had reported bruises to both of R21's hands at the base of the thumbs, with the right thumb bruise measuring 2.0 centimeters (cm) by 1.0 cm, and the left thumb measuring 3.8 cm x 4.0 cm. The bruises were documented as being black and blue. R21 did not respond to questions of how she got the bruises, or if she were being hurt. The oncoming licensed nurse was updated on the bruises.

R21's progress notes dated 11/1/19, at 9:55 a.m. indicated the interdisciplinary team (IDT) met on 10/31/19, to review R21's bruises noted on 10/30/19. The IDT noted R21 would frequently grab at staff and strike out with her hands, and refuse medications and treatments. IDT decided to place Tubigrips to both arms from knuckles to elbows for protection as R21 allowed.

R21's progress notes lacked indication of a specific event that led to R21's bruises, and lacked indication that R21's bruises were reported to the State Agency.

R21's physician visit note dated 11/4/19, indicated R21 resisted examination, and was seen for increased behaviors and refusal behaviors the previous month. R21's physician note lacked notation of bruises on bilateral thumbs.

On 11/20/19, at 4:12 p.m. the director of nursing (DON) stated staff should have been asked at the time of the incident for possible causes of bruising, and if no one knew how it could have

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F 609	Continued From page 14 happened, it should have been reported to the state agency within 2 hours, as a potential abuse. The facility policy for Abuse Prevention/Vulnerable Adult Plan dated 12/18, directed staff to immediately notify the unit nurse, who was then to attempt to determine the cause of the injury of unknown origin, immediately notify the administrator of an injury of unknown origin, and suspected abuse would be reported to the state agency no later than 2 hours after forming the suspicion.	F 609		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		12/19/19

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F 623	Continued From page 15 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623		

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F 623	Continued From page 16 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notification of reason for transfer to a hospital was provided for 2 of 5 residents (R19, R50) reviewed for transfer/discharge. Findings include:	F 623	Resident #19 and Resident #50 both had completed bed-holds, including name of resident, transfer location/hospital name, date of transfer, and reason for transfer. Resident #19 signed her own bed hold. Resident #50 left from an appointment straight to the ER and thus a phone call to	

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F 623	Continued From page 17 R19's Admission Record printed 11/20/19, indicated R19's diagnoses included anemia, chronic kidney disease, and congestive heart failure. R19's hospital discharge paperwork dated 9/25/19, indicated R19 was admitted to the hospital on 9/23/19, for evaluation after a fall. R19's medical record lacked evidence a written notice for transfer was obtained and provided in writing to R19 and/or R19's representative. R19's progress note dated 10/20/19, indicated R19 had a fall and was sent to the emergency room for evaluation and returned back to the facility on 10/20/19. R19's medical record lacked evidence a written notice for transfer was provided in writing to R19 and/or R19's representative. R50's Admission Record printed 11/20/19, indicated R50's diagnoses included chronic kidney disease, diabetes type 2, and had a mild cognitive impairment. R50's progress note dated 5/1/19, at 2:31 p.m. indicated R50 was admitted to the hospital on 5/1/19, for Influenza. R50's medical record lacked evidence a written notice of transfer was provided in writing to R50 and/or R50's representative. R50's Interagency Referral Form dated 8/16/19, indicated R50 was hospitalized 8/12/16, for swollen leg, fatigue and poor appetite. R50's medical record lacked evidence a written notice for transfer was provided in writing to R50 and/or R50's representative.	F 623	the residents representative was completed and documented on the form. Considering the above information, the facility is going to copmlete an IDR as it does not appear there is defient practice. The facility does have a current policy on written notice of transfers/bedholds which remains current. Policy remains current, facility will educated all nurses on completing notice of transfer/bedhold when resident is being sent to hospital/ER/going on a leave. All nurses will be trained by 1//2019	

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F 623	Continued From page 18 On 11/20/19, at 1:38 p.m. director of social services stated when a resident goes into the hospital from the facility, the nurses will obtain a signed bed hold and a written notification of transfer from the resident to sign if the resident is able to sign for themselves, and if not will obtain a verbal from the residents representative. A written Bed-Hold Notice for Hospital Transfer and Therapeutic Leave form given to the resident or representative, and best practice would be to document in the resident's medical record that a written was provided to the resident and/or resident representative. On 11/20/19, at 2:00 p.m. licensed practical nurse (LPN)-A stated if a resident goes into the hospital from the facility, the resident would sign a bed hold form including reason for transfer, and if the resident was unable to sign, a verbal consent would be obtained from the resident's representative over the phone and documented in the resident's medical record. LPN-A stated the completed form was put into the resident's chart, and the director of nursing (DON) was notified in person or by email of the hospitalization. On 11/20/19, at 4:39 p.m. the DON verified the facility was not providing a written notice of transfer to residents and/or resident representatives only upon request. The facility was unable to provide a policy on written notice of transfer.	F 623		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		1/3/20

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F 677	Continued From page 19 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 4 dependent residents (R41) reviewed for activities of daily living (ADLs). Findings include: R41's Face Sheet printed 11/20/19, indicated R41's diagnoses included Parkinson's disease, anxiety, schizoaffective disorder, and bipolar. R41's annual Minimum Data Set (MDS) dated 10/14/19, indicated R41 was cognitively intact, and required extensive assistance for ADLs, which included grooming. R41's Care Area Assessment (CAA) Summary dated 10/15/19, indicated R41 required extensive assistance with grooming. R41's nursing assistant care guide dated 11/17/19, indicated R41 required assistance with grooming, and preferred to have facial hair shaved. On 11/17/19, at 2:06 p.m. R41 was observed lying in her bed in a hospital gown. R41 had dark stubble of facial hair on her upper lip and chin. On 11/18/19, at 9:25 a.m. R41 was observed and the facial hair remained on her upper lip and chin. R41 stated she was supposed to have a shower twice a week, which did not always occur. R41 stated she was unable to remove the facial hair	F 677	Immediate Corrective Action: Resident #41 received assistance with removal of her facial hair. Corrective Action as it applies to others: The Policy and Procedure on ADL assistance was reviewed and remains current. All nurses and NARs will be re-educated by 1/3/2019 on the ADL assistance Policy which includes assistance with facial hair. All residents will be reviewed and their preference for removal of facial hair will be reflected on the care plan and NAR care sheets. Date of Compliance: 1/3/2019 Recurrence will be prevented by: Audits of 5 random residents will be completed weekly x 4 then monthly x 2 months to assure timely assistance is provided for removal of facial hair. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Designee	

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F 677	Continued From page 20	F 677		

herself, and depended on staff to assist with shaving. R41 further stated having facial hair bothered her, and she preferred to have her facial hair removed.

On 11/19/19, at 1:10 p.m. R41's facial hair remained. R41 stated staff did not offer to assistance with shaving during morning cares.

On 11/19/19, at 1:26 p.m. nursing assistant (NA)-A stated R41 was dependent on staff for all ADLs including shaving. NA-A stated grooming assistance was provided for R41 during morning cares, but did not offer to assist R41 with shaving. NA-A further stated facial hair was noted that morning, and it appeared R41 facial hair had been present for several days. NA-A verified R41's nursing care guide indicated R41 was dependent on staff for grooming, and preferred to have facial hair removed.

On 11/20/19, at 4:39 p.m. the director of nursing (DON) stated she would expect a resident that required assistance with shaving to be shaved if that was the resident's desire. DON stated if a resident's plan of care included a resident preferred to have facial hair removed, she would expect staff to follow the resident preferences. The DON futher stated the lack of grooming for a resident that preferred to have facial hair removed was a dignity issue.

The facility policy Shaving the Resident dated 2/18, indicated the purpose was to promote cleanliness and to provide skin cares to the resident. The policy directed staff to review the residents' care plan to assess for any special needs of the resident, and to notify the supervisor if the resident refuses the procedure.

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure monitoring of weights as ordered by a physician regarding a medical condition for 1 of 6 residents (R29) reviewed for unnecessary medications. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure (CHF), and edema. R29's care plan initiated 8/24/18, indicated R29 was at risk for falls related to medical conditions, including CHF, edema, and vascular dementia. R29's care plan indicated R29 was taking psychotropic medications, and directed nursing to obtain a monthly orthostatic blood pressure. R29's care plan identified R29's cardiovascular diagnoses and conditions, including CHF and bilateral leg edema with medications that included Lasix (diuretic), but lacked direction for daily weights and notification of provider of increase of	F 684	Immediate Corrective Action: Resident #29 continues to have orders to check daily weights and has specific parameters on when to call Heart Center to update. Resident□s diagnosis of CHF remains stable. Corrective Action as it applies to others: The Heart Failure-Clinical Protocol Policy remains current. All nurses will be re-educated by 1/3/2019 on the Heart Failure-Clinical Protocol Policy with regards to the need to follow physician recommendations/parameters on when to notify physician for further direction. All residents with multiple day of week weights will be reviewed to ensure that they have specific parameters on when to notify MD. Date of Compliance: 1/3/2019 Recurrence will be prevented by: Audits of 5 residents with multiple day of week weights will be completed weekly x 4 then monthly x 2 months to assure	1/3/20

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F 684	Continued From page 22 3 pounds overnight or 5 pounds weekly. R29's care guide lacked direction to obtain daily weights and weight gain guidelines for notification of the physician. R29's Order Summary Report with Active Orders as of 11/19/19, included orders for: -check vital signs daily. Order 9/17/19. -daily weights every day shift, call Heart Center if weight gain of 3 pounds overnight or 5 pounds in one week. Call heart center of shortness of breath, orthopnea, edema or bloating. Order date 9/30/19. -Monthly orthostatic blood pressure (lying, sitting, and standing) the 24th of every month. Nursing order date 8/26/18. -Lasix (diuretic) 40 milligrams (mg) twice daily for CHF. Order start date 10/23/19. -Melatonin 3 mg at bedtime for difficulty sleeping manifestations. -Metoprolol succinate (for blood pressure) extended release 24 hour; 25 mg in the a.m. -Sertraline HCL (antidepressant) 50 mg at bedtime. Order start date 9/17/19. -Olanzapine (antipsychotic) 5 mg every evening for bipolar disorder. Order start dated 9/17/19. R29's nurse practitioner (NP) visit note dated 9/27/19, indicated R29 had been hospitalized from 9/5/19, through 9/17/19, with CHF, potential intestinal bleed, encphalopathy (brain disease, damage, or malfunction). R29's NP visit note further indicated R29 was discharged from the hospital with orders for Lasix and daily weights, and referral to the heart clinic. R29's Treatment Administration Record (TAR) for September 2019, indicated R29 had daily weights	F 684	weights are being done per physician parameters. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Designee	

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F 684	Continued From page 23	F 684		

completed only on 9/18/19, and 9/19/19, then weekly weights.

R29's Physician Visit Record dated 9/30/19, included signed NP orders for daily weights, and to call the heart center if weight gain of 3 pounds overnight or 5 pounds in one week, and if symptoms of shortness of breath, orthopnea, edema or bloating.

R29's NP visit notes dated 10/11/19, indicated R29 had been hospitalized 9/5/19 through 9/17/19, with a GI bleed, acute encephalopathy, and CHF. R29 was discharged with orders for daily weights, Lasix and a referral to the heart failure clinic.

R29's TAR for 10/1/19, through 10/31/19, indicated R29's daily weight was to be obtained daily starting 10/1/19, and R29's daily weights were not obtained 10/1/19, 10/2/19, 10/10/19, 10/17/19, and 10/22/19. R29's TAR for October 2019 indicated R29's weight on 10/3/19, was 180 pounds. R29's TAR for September 2019, indicated R29's previous weight was 171.5 on 9/25/19.

R29's TAR for 11/1/19, through 11/20/19, indicated R29's daily weight was not obtained on 11/3/19, or 11/14/19. R29's TAR indicated R29 had more than a 3 pound weight gain from 11/11/19, to 11/12/19, and it increased slightly again on 11/13/19. R29's progress notes dated 11/12/19, and 11/13/19, lacked documentation of notification of the physician regarding the weight increase of greater than 3 pounds, and lacked documentation of monitoring of symptoms of CHF, edema or respiratory status.

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R29's Weights and Vitals summary for 9/21/19, through 11/20/19, indicated R29 had missed daily weights from 10/1/19, through 10/3/19, 10/10/19, 10/17/19, 10/18/19, 10/22/19, 11/3/19, and 11/14/19.
-R29's weight record indicated R29 had a weight gain of 8.5 pounds from 9/25,/19 to 10/3/19. No weights were recorded in R29's medical record between 9/25/19, and 10/3/19. R29's progress notes dated 10/4/19, indicated the weight gain was reported to the physician, though lacked evidence of monitoring for symptoms of CHF, increased edema and respiratory status.
-R29's weight record indicated R29 had a weight gain of 4 pounds from 10/5/19, to 10/6/19. R29's Progress notes lacked documentation of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain.
- R29's weight record indicated R29 had a weight gain of 4 pounds from 10/9/19, through 10/11/19, with no weight recorded on 10/10/19. Progress notes lacked documentation of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain.
-R29's weight record indicated R29 had a weight gain of 3.7 pounds from 10/16/19, to 10/19/19, but had not obtained a weight on 10/17/19, or 10/18/19. Progress notes lacked documentation of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain. R29's progress notes dated 10/23/19, indicated NP increased R29's Lasix for 3 days, following a visit.
-R29's weight record indicated R29 had a weight gain of 12.9 pounds from 10/29/19, to 10/30/19. R29's medical record indicated R29 went to the

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F 684	Continued From page 25	F 684		

CHF clinic that day and daily weights were ordered. R29's medical record lacked documentation of monitoring for symptoms of CHF, increased edema and respiratory status.
-R29's weight record indicated R29 had a weight gain of 3.2 pounds from 11/11/19, to 11/12/19. R29's medical record lacked evidence of notification of the physician or heart clinic of weight gain and lacked documentation of monitoring for symptoms of CHF, increased edema and respiratory status.
-R29's weight record indicated R29 had a weight gain of 7.5 pounds from 11/17/19, to 11/18/19, though had a weight loss of 6.5 pounds the previous day.

R29's nurse practitioner (NP) visit notes dated 10/30/19, indicated R29's Lasix had been increased a week prior, and R29's weight was down 5 pounds, along with decreased edema, though the NP visit was prior to R29's weight that same day.

On 11/18/19, at 9:47 a.m. R29's resident representative (RR)-F expressed concern that R29's weight is not checked daily.

On 11/20/19, at 4:28 p.m. director of nursing (DON) verified missing weights and lack of notification to the physician. DON stated nursing should monitor for symptoms of CHF with increased weight. DON verified nursing should have notified the heart center and monitored R29 with the increased weight. DON also verified orthostatic BP's should be obtained for monitoring of psychotropic medications and should be documented.

The facility policy Heart Failure-Clinical Protocol

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F 684	Continued From page 26 revised 11/18, lacked direction for monitoring for symptoms of CHF, following physician orders for monitoring and management of CHF, and notification of physician of symptoms.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure consistent wound assessment to prevent worsening of pressure ulcers and evaluate the effectiveness of treatment for 2 of 4 residents (R5, R50) reviewed for pressure ulcers. Findings include: National Pressure Injury Advisory Panel staging definitions for pressure injuries (pressure ulcers) Pressure Injury: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may	F 686	Immediate Corrective Action: Resident #5□s pressure ulcer was reassessed by ADON. Area continues to be stable and wound continues to be followed by wound clinic on a routine basis. Resident #50□s pressure ulcer was reassessed by ADON. Area continues to be followed by wound clinic on a routine basis. ADON was educated on need to complete a weekly assessment of pressure ulcers. Corrective Action as it applies to others: The Policy and Procedure on Skin Assessment and Wound Management	1/3/20

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F 686	Continued From page 27 appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole	F 686	was reviewed and remains current. All nursing staff will be re-educated by 1/3/2019 on the Skin Assessment and Wound Management Policy including the need to document on pressure ulcers weekly. All residents with pressure ulcers will be reviewed to ensure that they have weekly skin assessments documented. Date of Compliance: 1/3/2019 Recurrence will be prevented by: Audits of all residents with pressure ulcers will be completed weekly x 4 then monthly x 2 months to assure pressure ulcers are being documented on weekly. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Designee	

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(rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed

R5's Admission Record printed 11/20/19, indicated R20's diagnoses included diabetes with neuropathy, pressure ulcer of right heel, non-pressure related chronic ulcer of left foot, anemia, edema, and encephalopathy (brain damage, disorder, or disease).

R5's annual Minimum Data Set (MDS) dated 8/27/19, indicated R5 had a severe cognitive impairment, had no rejection of cares during the assessment period, required extensive assistance of two staff for bed mobility, total assistance of two staff for transfers, and was nonambulatory.
R5's MDS further indicated R5 was at risk for pressure ulcers, and had an unstageable pressure ulcer with slough (dead yellow/creamy/greyish tissue in a wound bed) or eschar (dead thick, leathery, black tissue in a wound bed) present.

R5's Care Area Assessment for Pressure Ulcer/Injury dated 8/27/19, indicated weekly skin check would be completed by a licensed nurse as

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R5 allowed.

R5's physician appointment dated 9/4/19, indicated R5 had a large pressure ulcer at the base of the right heel with dark tissue overlying the wound, and tender to touch. Physician documentation indicated R5's pressure ulcer did not appear to be acutely infected at that time.

R5's care plan initiated 10/3/18, indicated R5 had a mobility impairment, and directed staff to reposition every 2 hours, and noted R5 frequently refused repositioning. R5's care plan further indicated R5 had a history of skin breakdown, including pressure ulcers to bilateral heels, and directed nursing to offer repositioning every 2 hours. Interventions dated 11/14/19, indicated R5 was followed by hospital wound care.

R5's Weekly Skin Inspections dated 9/10/19, indicated there were no new areas of concern, and R5 continued to have an unstageable pressure area to the right heel.

R5's Weekly Pressure Ulcer Wound Evaluation dated 9/11/19, indicated R5's left heel pressure ulcer measured 3.8 centimeters (cm) x 4.0 cm and was unstageable with 100% eschar. R5's pressure ulcer was documented as ongoing and unchanged.

R5's Weekly Pressure Ulcer Wound Evaluation dated 9/17/19, indicated R5's left heel pressure ulcer measured 3.4 cm x 5.0 cm and was unstageable with 20% eschar, 70% slough and 10% granulation (new connective tissue) tissue, and moderate serosanguineous (clear liquid mixed with the blood) drainage with odor. R5's pressure ulcer was documented as ongoing and

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improved.

R5's Weekly Skin Inspection dated 9/24/19, indicated there were no new areas of concern, and continued to have an unstageable pressure area to the right heel. R5 had not had a Weekly Skin inspection since 9/11/19.

R5's Weekly Skin Inspection dated 10/1/19, indicated R5 had no new areas of concern, and continued unstageable pressure area to right heel.

R5's Weekly Pressure Wound Evaluation dated 10/3/19, indicated R5's left heel pressure ulcer measured 3.2 cm x 4.5 cm, and was unstageable with 25% granulation, 75% slough, and moderate amount of serosanguineous drainage with an odor. R5's pressure area was documented as ongoing and declined. R5 had not had a registered nurse assess the wound between 9/17/19, and 10/3/19, and the wound had worsened during that time.

R5's Weekly Pressure Wound Evaluation dated 10/8/19, indicated R5's right heel pressure ulcer measured 4.0 cm x 4.5 cm and was unstageable, was 10% granulation and 90% slough, with moderate brownish, green drainage and no odor. R5's pressure ulcer was documented as ongoing and improved, though measurements and slough had increased with decreased granulation tissue. In addition, the right heel pressure ulcer had previously been documented on the Weekly Pressure Wound Evaluations as the left heel.

R5's progress notes dated 10/14/19, indicated R5 went to wound clinic

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R5's Weekly Skin Inspection dated 10/15/19, indicated R5 continued to have an unstageable pressure area to the right heel, outer aspect of right great toe and top of right second toe. R5 had not had a weekly skin inspection since 10/1/19.

R5's Weekly Pressure Wound Evaluation dated 10/17/19, indicated R5's right heel pressure ulcer measured 3.5 cm x 3.0 cm and was unstageable with 75% granulation, and 25% slough, and moderate serosanguineous drainage with no odor. R5's pressure ulcer was documented as improved. In addition, R5's wound evaluation indicted R5 had a stage one pressure area on his left toe that had healed.

R5's progress notes dated 10/22/19, indicated a physician called with orders for an antibiotic, a wound culture, and follow up appointment for a worsening heel ulcer with possible infection.

R5's progress notes dated 10/23/19, indicated an antibiotic was ordered for a wound infection.

R5's progress notes indicated R5 had a wound culture result with a moderate amount of pseudomonas aurginosa (bacteria organism).

R5's progress notes dated 10/26/19, indicated R5 had a new order for a change in antibiotic to treat a wound infection with pseudomonas until 11/1/19. R5's progress notes, the same day indicated R5 had gone to wound dare and treatment orders had changed to right heel and left medial fifth toe, including cleansing with soap and water and a vinegar solution.

R5's Weekly Skin Inspection dated 10/29/19,

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indicated R5 continued to have unstageable pressure ulcer to the right heel, outer aspect of right great toe, and top of right second toe, along with a superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/15/19.

R5's Braden Scale Assessment (a tool to assist in determining risk for skin breakdown), dated 11/7/19, indicated R5 was at risk for skin breakdown.

R5's progress notes dated 11/8/19, indicated R5 refused to go to wound care appointment and appointment was rescheduled for 11/22/19.

R5's Weekly Skin Inspection dated 11/12/19, indicated R5 continued to have a right heel pressure ulcer, along with the outer aspect of the right great toe and tope of right second toe, and superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/29/19.

R5's Weekly Pressure Wound Evaluation dated 11/14/19, indicated R5's right heel pressure ulcer measured 3.3 cm x 5.2 cm and was unstageable with 25% granulation and 75% slough with a moderate amount of serosanguineous drainage with no odor. R5's pressure ulcer was documented as improved, though measurements had increased, the granulation tissue had decreased and slough had increased. R5 had not had an RN assessment of the pressure ulcer at the facility since 10/17/19, though R5 had been treated for a worsening pressure ulcer with infection.

R5's Weekly Skin Inspection dated 11/19/19, was

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not completed.

R5's progress notes dated 11/20/19, indicated R5's right heel ulcer measured 5 cm x 3.5 cm x 0.3 cm with a minimal amount of tan drainage.

On 11/19/19, at 10:58 a.m. the assistant director of nursing (ADON) stated R5 had an unstageable pressure ulcer on the right heel. ADON stated R5 goes to wound care, but R5 was non-compliant. ADON stated R5's pressure ulcer was improving and they have a good treatment for it.

On 11/20/19, at 8:44 a.m. licensed practical nurse (LPN)-A looked at R5's right heel wound after he had showered. R5's right heel ulcer had regular edges, light slough, and was unstageable.

On 11/20/19, at 9:45 a.m. LPN-A stated R5's wound looked better, with some slough and some drainage. LPN-A stated R5 had previously had an infection in the right heel ulcer.

On 11/20/19, at 1:51 p.m. LPN-A with registered nurse (RN)-F, soaked right heel and left 5th toe pressure ulcers in vinegar solution as ordered. LPN-A sanitized hands, gloved, and measured the right heel pressure ulcer at 5 cm x 3.5 cm x 0.3 cm. LPN-A used a cotton tip swab to attempt to remove some slough. LPN-A removed gloves, sanitized hands, gloved, and completed treatment as ordered. LPN-A stated R5's wound base had 50% slough. LPN-A stated it had been debrided and was cleaner since starting the vinegar solution.

On 11/20/19, at 4:04 p.m. director of nursing (DON) verified wound assessments were not done weekly, R5 had a wound infection, and

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weekly wound assessments would be done weekly.

The facility policy for Skin Assessment and Wound Management dated 12/18, directed a weekly skin inspection would be completed by licensed staff, document skin condition weekly on the Pressure Wound Evaluation, and review skin conditions with interdisciplinary team at least monthly.

R50's Admission Record printed 11/20/19, indicated diagnoses that included chronic non-pressure right heel and mid foot ulcer, type 2 diabetes, anemia, and chronic kidney disease.

R50's quarterly MDS dated 10/28/19, indicated R50 had a severe cognitive impairment, required extensive assistance with bed mobility, transfers, toileting, and was total dependent on person hygiene. MDS further indicated R50 had an unstageable pressure ulcer.

R50's physician orders directed to wash left heel ulcer with soap and water, dry, smear a small amount of Iososorb on Xeroform (yellow gauze), wrap with kerlix and place surgilast, and change every 2 days. Wear heel boot while in bed, post-op boot while in chair.

R50's care plan updated 3/29/19, indicated R50 had a wound to right heel and interventions included to offload heels by floatation off pillow when R50 was in bed, and treatment per

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F 686	Continued From page 35 physician orders. R50's medical record lacked Weekly Pressure Wound Evaluations from 5/23/19-6/12/19, 6/27/19-9/6/19, and 10/22/19-11/19/19. On 11/20/19, at 2:10 p.m. the ADON stated R50's left heel pressure ulcer was identified on 3/29/19. The ADON verified she did not complete weekly wound assessments for R50 from 10/22/19, to 11/19/19. The ADON stated at that time, R50's dressing was changed every three days, and she did not coordinate with the nurses when the dressing was changed to complete the weekly wound evaluation. The ADON stated it was important to complete weekly wound assessments to monitor the progress of the wound. On 11/20/19, at 4:39 p.m. the DON, stated she would expect wound assessments to be completed weekly.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		1/3/20

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F 690	Continued From page 36 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely toileting to prevent incontinence for 1 of 2 residents (R29) reviewed for incontinence. In addition, the facility failed to assess and develop a toileting program to maintain continence of bowel and bladder for 1 of 2 residents (R53) reviewed for incontinence. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure, and anxiety disorder.	F 690	Immediate Corrective Action: Resident #29 was provided toileting by NAR. Care plan and NAR care sheets were updated to reflect the same information. A toileting log was initiated for resident #53 to reassess for an appropriate toileting program. Corrective Action as it applies to others: The Policy and Procedure for ADL Assistance and was reviewed and remains current as it pertains to assistance with toileting. The Urinary Continence and Incontinence Policy remains current. All residents needing assistance with	

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F 690	Continued From page 37 R29's annual Minimum Data Set (MDS) dated 10/2/19, indicated R29 was cognitively intact with no resistive behaviors, delirium, psychosis or mood symptoms during the assessment period. R29's MDS further indicated R29 was frequently incontinent of bowel and bladder, required extensive assistance of two staff for toileting cares, and received a diuretic on a regular basis. R29's undated Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, completed for annual MDS with the reference date of 9/23/19, indicated R29 required assistance with toileting cares, was frequently incontinent of bladder, and had recently been hospitalized with a urinary tract infection (UTI). R29's CAA indicated R29 was offered toileting every 2 hours and as needed, and was transferred using a stand-aide assist lift. R29 did not always alert staff to the need to use the toilet. R29 received Lasix, which could increase the risk for urgency and frequency. R29's CAA further indicated R29 was able to communicate needs. R29's care plan revised 10/2/19, indicated R29 was able to communicate needs, was understood by others, and could usually understand simple conversation. R29's care plan indicated R29 was frequently incontinent of bowel and bladder, and directed staff to toilet every 2 hours and as necessary. R29's care guide/pocket care plan dated 11/17/19, indicated R29 was incontinent, and directed staff to provide hourly toileting while awake. R29's Order Summary Report for Active Orders as of 11/19/19, included orders for Lasix (diuretic	F 690	toileting will be provided this assistance per care plan/care sheet details. All nurses and NARs will be re-educated on the ADL Assistance Policy by 1/3/2019. The education will include the need for timely toileting per care plan. All residents who are incontinent will be reassessed to determine whether a toileting program is appropriate. All nurses and NARs will be re-educated on the Urinary Continence and Incontinence Policy by 1/3/2019 as it pertains to completion of a toileting log to determine whether a toileting program is appropriate. Date of Compliance: 1/3/2019 Recurrence will be prevented by: Audits of 5 incontinent residents will be completed weekly x 4 then monthly x 2 months to assure toileting needs have been addressed and care planned and that residents are being toileted individual care plan. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Designee	

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medication) 40 milligrams (mg) twice daily.

R29's progress notes dated 10/21/19, through 11/19/19, indicated R29 had not had incidents of refusing toileting cares.

On 11/18/19, at 9:47 a.m. resident representative (RR)-F was interviewed and expressed concern that R29 did not get toileted frequently enough.

On 11/19/19, during observations from 7:25 a.m. through 8:58 a.m., R29 was in her room watching television, received her hearing aide, visited with RR-F, and ate breakfast. Staff had not entered her room since RR-F arrived at 8:05 a.m., and R29 was not offered toilet use since 7:25 a.m.
-At 8:51 a.m. RR-F talked to R29 about going to exercise group, turned on the call light, and told R29 she would be back 10 minutes prior to her appointment, later that morning. Before RR-F left the room, staff entered R29's room and RR-F informed staff R29 would like to go to exercise group and then she would come back before the appointment, and stated R29 would need to be toileted prior to the appointment. Staff did not offer toilet use prior to exercise group.
-At 8:58 a.m. RR-F took R29 downstairs to exercise group.
-At 9:46 a.m. R29 returned from exercise group and the nurse change R29's oxygen.
-At 9:48 a.m. staff brought R29 down to her room.

On 11/19/19, at 9:51 a.m. R29 stated she had not been to the bathroom yet, and had just put on her call light to ask to go. Staff entered the room and R29 told them she had to go to the bathroom.

On 11/19/19, at 9: 55 a.m. nursing assistant (NA)-F entered R29's room with the stand-assist

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lift and transferred her to the commode. R29 voided in the commode. NA-F verified R29's incontinent brief was a little damp. NA-F stated R29 was to be toileted at least every 2 hours, but usually was toileted per her request.

On 11/19/19, at 10:26 a.m. NA-G stated R29 would usually call and tell them when she had to go to the bathroom, and they would answer promptly. At that time, NA-H verified the care guide directed toilet use every hour for R29. NA-H stated she would check on her and R29 would ask, but verified staff should offer.

On 11/19/19, at 11:04 a.m. the assistant director of nursing (ADON) stated nursing assistants should provide care according to the care guide sheets. ADON stated R29's family had wanted her toileted every hour for awhile when R29 was incontinent more frequently, and stated the care plan directed every 2 hours and as needed. ADON verified the care guide sheets were not changed when the care plan was changed.

The facility policy for ADL (activities of daily living) Assistance per Care Plan revised 5/20/19, directed to provide ADL assistance to all residents based on the assessment and care plan. Incontinent residents were to be checked and toileted according to the care plan.

R53's Admission Record printed 11/20/19, indicated R53's diagnoses included Parkinson's disease, morbid obesity, and a gastrostomy tube (a tube inserted through the belly that brings nutrition directly to the stomach).

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R53's quarterly MDS dated 11/5/19, indicated R53 was cognitively intact, and required extensive assistance with toileting, and was not on a toileting program.

R53's CAA dated 8/19/19, indicated R53 was frequently incontinent of urine. The CAA indicated toileting needs would be care planned for R53 to continue to offer toileting, check, and change every two hours, and overall goal was to improve urinary incontinence.

R53's care plan dated 8/26/19, indicated R53 had alteration in elimination related to a history or urinary tract infections (UTI), urinary retention, impaired mobility, and was incontinent of bowel and bladder. R53's goal was to remain clean, dry, odor free, and to be free from signs and symptoms of UTI. R53 interventions included assistance of two and a Hoyer (mechanical lift) with toileting needs including peri care, pad, and clothing adjustments.

R53's Bladder Evaluation dated 9/20/19, indicated R53 was incontinent of bowel and bladder, did not inform staff of need to void, and occasionally would ask staff for a urinal but R53 had already voided and did not void in a urinal. R53 required two assists with toileting including a Hoyer for transfers, clothing and pad management, and peri care. Staff was to offer toileting, check, and change every two hours. R53 was able to make needs known and understand others.

R53's nursing assistant care guide sheet dated 11/17/19, indicated R53 was incontinent and required two assist and a Hoyer with toileting.

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On 11/17/19, at 1:16 p.m. R53 stated he urinated in his pants because he was unable to use the bathroom, and would be unable to use the urinal on his own.

During observation on 11/19/19, at 10:07 a.m. R53 had verbalized he had to "pee" during morning cares. NA-A instructed R53 just to "pee" in his pants because he was wearing an incontinent brief. NA-B asked NA-A if R53 had a urinal. NA-A stated R53 did not have urinal, and told R53 that NA-A would change and get him cleaned up when he was done.

On 11/19/19, 11:24 a.m. licensed practical nurse (LPN)-B confirmed R53 was incontinent of bowel and bladder, and stated R53 was getting stronger and maybe would be able to use a urinal with assistance. LPN-B stated R53 should be assessed for a toileting program, and should be offered to use the urinal or to be toileted.

On 11/19/19, at 12:50 p.m. R53 stated he would prefer to use the bathroom and not "pee" in his pants. R53 stated staff did not offer to take him to the bathroom or offer a urinal. R53 stated when staff would come into his room, R53 would say he had to "pee" and the staff was used to him going in his pants.

On 11/20/19, at 2:10 p.m. the ADON stated bowel and bladder assessments were completed upon admission, annually, and with any resident changes. The ADON stated if a resident showed signs that he/she may be able to be continent of bowel or bladder, the resident would be started on a toileting program.

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F 690	Continued From page 42 On 11/20/19, at 4:39 p.m. the DON stated if a resident was able to verbalize they had to urinate, the resident should be on a bowel and bladder program. A toileting log would be initiated to assess the resident's urinary patterns to promote highest bladder functioning. The facility policy Behavioral Programs and Toileting Plans for Urinary Incontinence dated 10/10, directed a review of the residents care plan to assess for any special needs of the resident. Conduct a thorough assessment of the resident and his or her environment to determine factors that may have contributed to any recent decline in urinary incontinence. Monitor, record, and evaluate information about the resident's bladder habits, and continence or incontinence. Assess the resident for appropriateness of behavioral programs which promote urinary incontinence.	F 690		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		1/3/20

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F 732	Continued From page 43 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. 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. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 65 residents who resided in the facility. Findings include: On 11/17/19, at 11:30 a.m. upon entering the facility for annual survey no staff posting and facility census was visible. Registered nurse (RN)-A confirmed the staff posting was to be located on the first floor on the bulletin board next to the nurse's station. On 11/17/19, at 11:40 a.m. RN-B working on the	F 732	Immediate Corrective Action: Nursing Staffing Information was posted in facility. Corrective Action as it applies to others: The Nursing Hours Posting Policy remains current. Management nurses and Administrator were re-educated on need to ensure that information is posted daily and changed to reflect changes for each shift. Date of Compliance: 1/3/2019 Recurrence will be prevented by: Audits of the nursing staffing information sheet will be completed weekly x 4 then	

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F 732	Continued From page 44 first floor confirmed there was not a posting in place which identified the staffing and facility census. On 11/17/19, at 2:06 p.m. facility staff posting and census was noted to be posted on first floor wall located directly across from the nurse's station. The posting dated 11/17/19, indicated census and staffing. On 11/17/19, at 2:17 p.m. the administrator stated the staff posting was not completed, and was updated and posted after the surveyors entered on 11/17/19, by the director of nursing (DON). On 11/20/19, at 2:44 p.m. the DON was interviewed and stated she was responsible for the staff posting and census forms for the weekend, and staff are to be updating with changes. The DON stated the staff posting was not posted 11/17/19, until after the survey team had entered the facility on 11/17/19. The facility form titled Hours Report of Nursing Staff Directly Responsible for Resident Care dated 11/17/19, directed, "The posting of this information is required for nursing homes participating in Medicare and Medicaid."	F 732	monthly x 2 months to assure information is being posted daily. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/DON/ADON/Nurse Managers/Designee	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		1/3/20

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F 757	Continued From page 45 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure orthostatic blood pressures for monitoring of potential side effects related psychotropic medications were completed for 3 of 6 residents (R29, R39, R3) reviewed for unnecessary medications. In addition, the facility failed to ensure appropriate diagnoses for use of medications for 1 of 6 residents (R39) reviewed for unnecessary medications. In addition, the facility failed to ensure monitoring of weights as ordered by a physician regarding a medical condition for 1 of 6 residents (R29) reviewed for unnecessary medications. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure (CHF), edema, bipolar disorder, and	F 757	Immediate corrective action: Resident # 29s orthostatic BP□s were completed. Residents #39 has discharged from facility. Resident #3□s orthostatic BP□s were completed. Resident□s daily weights continue to be monitored. Action as it applies to others: The Policy and Procedure for Antipsychotic medication use, including orthostatic BP□s, requirements for MD orders on duration of use and need for targeted behaviors remains current. All residents taking psychotropic meds were reviewed to assure that orthostatic BPs are being completed as appropriate and that appropriate diagnosis are being utilized. All residents with multiple day of week weights will be reviewed to ensure that	

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F 757	Continued From page 46 anxiety disorder. R29's care plan initiated 8/24/18, indicated R29 was at risk for falls related to medical conditions, including CHF, edema, bipolar disorder, and vascular dementia. R29's care plan indicated R29 was taking psychotropic medications (mood and behavior altering medications), and directed nursing to obtain a monthly orthostatic blood pressure. R29's Order Summary Report with Active Orders as of 11/19/19, included orders for: -check vital signs daily. Order 9/17/19. -Monthly psychotropic side effect monitoring, if side effects, update physician. Every day shift on the 24th, monthly. -Sertraline HCL (antidepressant) 50 mg at bedtime. Order start date 9/17/19. -Olanzapine (antipsychotic) 5 mg every evening for bipolar disorder. Order start dated 9/17/19. R29's progress notes dated 9/24/19, indicated R29 refused an orthostatic blood pressure. R29's progress notes lacked documentation of any attempts to re-approach R29 for an orthostatic blood pressure. R29's Treatment Administration Record (TAR) indicated R29's orthostatic blood pressure was not completed. R29's Weights and Vitals Summary for 9/24/19, lacked documentation of an orthostatic blood pressure. R29's TAR for October 2019, indicated R29's orthostatic blood pressures for monitoring of psychotropic medications were obtained on	F 757	they have specific parameters on when to notify MD. All nurses will be re-educated on the Antipsychotic Medication Policy, including orthostatic BP□s (if appropriate) and that appropriate diagnoses need to be utilized for antipsychotic meds by 1/3/2019. All nurses will be re-educated by 1/3/2019 on the Heart Failure-Clinical Protocol Policy with regards to the need to follow physician recommendations/parameters on when to notify physician for further direction. Date of completion: 1/3/2019 Recurrence will be prevented by: 3 residents receiving psychotropic medication will be reviewed weekly on various units x4 then monthly x2 to assure orthostatic BPs are being completed as appropriate and that appropriate diagnosis are being utilized. The results of these audits will be reviewed by the facility QAPI Committee monthly for input on the need to increase, decrease or discontinue the audits. Audits of 5 residents with multiple day of week weights will be completed weekly x 4 then monthly x 2 months to assure weights are being done per physician parameters. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/ADON/Nurse Managers/Designee	

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10/24/19, but lacked documentation of orthostatic blood pressure results.

R29's progress notes dated 10/24/19, lacked documentation of R29's orthostatic blood pressure results.

R29's Weights and Vitals Summary for 10/24/19, lacked documentation of an orthostatic blood pressure.

R29's TAR for November 2019, indicated R29's orthostatic blood pressure had not yet been taken, and was scheduled for 11/24/19. R29's TAR indicated R29 was to be monitored monthly for psychotropic side effect monitoring monthly on the 24th.

R29's Weights and Vitals Summary dated 10/3/19, through 11/20/19, indicated no orthostatic blood pressures were obtained or recorded for R29.

On 11/20/19, at 4:28 p.m. director of nursing (DON) verified orthostatic BP's should be obtained for monitoring of psychotropic medications.

R39's Admission Record printed 11/20/19, indicated R39's diagnoses included CHF, mild cognitive impairment, encephalopathy (brain damage, disease, or malfunction), major depressive disorder, and insomnia.

R39's Order Summary Report for active orders as of 11/20/19, included orders for:
-quetiapine (antipsychotic medication) 50 milligrams (mg) at bedtime for primary insomnia, order dated 10/29/19.

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-Sertraline (antidepressant medication) 100 mg tablet; take 2 tabs daily for depression, order dated 10/29/19

In addition, R39's orders included the following medications without diagnoses for use of the medications:
-Pregabalin Capsule (nerve pain medication)
-Slow Mag tablet DR (magnesium supplement)
-Metoprolol Tartrate (for chest pain or high blood pressure)
-Melatonin (hormone used for sleep)
-Lisinopril (for high blood pressure and heart failure)
-Furosemide (diuretic)
-Atorvastatin Calcium (for high cholesterol)
-Diltiazem CD ER 24 hour (high blood pressure and heart failure)
-cholestyramine light packet (for high cholesterol)
-cholecalciferol (vitamin D supplement)
-Budesonide capsule DR (anti-inflammatory for Crohn's or ulcerative colitis)
- Aspirin

R39's order summary lacked direction for monitoring of psychotropic medication side effects, and orthostatic blood pressures for monitoring of psychotropic medications.

R39's care plan initiated 8/29/19, indicated R39 received psychotropic medications and was at risk for adverse side effects. R29's care plan directed nursing to monitor for adverse drug reactions and obtain monthly orthostatic blood pressures.

R39's Consultant Pharmacist's Medication Review dated 7/19/19, recommendations included monitoring of antipsychotics including

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orthostatic blood pressures, side effects, and target behaviors. Nursing signed recommendation as completed on 8/12/19.

R39's Medication Administration Record (MAR) for September 2019, indicated R39 received quetiapine fumarate for insomnia on 9/10/19 through 9/12/19, melatonin daily for insomnia, and sertraline for depression daily. R39's MAR included directives for antipsychotic side effect monitoring monthly and was documented as completed on 9/6/19.

R39's Treatment Administration Record (TAR) for September 2019, directed nursing to obtain a lying and sitting (orthostatic) blood pressure due to antipsychotic medication monthly. R39's orthostatic blood pressure was documented as done, but without results.

R39's progress notes dated 9/619, lacked documentation of orthostatic blood pressure results or attempts to reapproach for the orthostatic blood pressure.

R39's Weights and Vitals Summary report for 9/6/29, lacked documentation of an orthostatic blood pressure.

R39's MAR for October 2019, indicated R39 received quetiapine fumarate for insomnia and depression, and sertraline for depression, and melatonin for insomnia. R39's MAR included directives for antipsychotic side effect monitoring monthly and was documented as completed on 10/6/19.

R39's TAR for October 2019, directed nursing to obtain an orthostatic blood pressure monthly due

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to antipsychotic medication. R39's TAR indicated an orthostatic blood pressure was obtained on 10/6/19, but lacked documentation of results.

R39's Weights and Vitals Summary for 10/6/19, indicated R39's orthostatic blood pressure was completed, and indicated no orthostatic hypotension (drop in blood pressure) with change in position from lying to sitting.

R39's MAR for November 2019, indicated R39 received melatonin, quetiapine fumarate for insomnia, and sertraline for depression. R39's MAR lacked direction to monitor for antipsychotic medication side effects.

R39's TAR for November 2019, lacked direction to obtain orthostatic blood pressures monthly due to psychotropic medications.

R39's Weights and vitals Summary since readmission on 10/29/19, indicated no orthostatic blood pressures had been obtained.

R39's progress notes since readmission on 10/29/19, lacked documentation of orthostatic blood pressures, or clarification of diagnosis for use of quetiapine or other medications.

R39's Psychotropic Medication review dated 10/10/19, was not completed and signed.

R39's Target Behavior Form was not completed 11/14/19.

R39's NP visit note dated 9/4/19, indicated R39 had received quetiapine every night for agitation, nursing reported no agitation since admission, and R39 was unable to indicate when and why

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quetiapine was prescribed. NP discontinued quetiapine and started melatonin every evening.

R39's progress notes dated 9/8/19, indicated R39 had not been sleeping well and was concerned the physician had discontinued the quetiapine that had helped her sleep good previously.

R39's progress notes dated 9/9/19, indicated R39's primary care physician sated insomnia had recurred since quetiapine was discontinued, so reordered quetiapine at bedtime.

R39's progress notes dated 9/12/19, indicated insomnia was not an approved diagnosis for quetiapine.
R39's Consultant Pharmacist's Medication Review dated 9/12/19, identified an irregularity regarding quetiapine. The pharmacist indicated sleep was not an approved indication for quetiapine and recommended a review and assessment of the current use of quetiapine for R39, and if the diagnosis is sleep, to discontinue use of quetiapine. R39's physician responded by changing R39's diagnosis for use of quetiapine to depression.

R39's physician visit notes dated 9/13/19, indicated R39 had seen her primary care physician on 9/9/19, and the physician felt she should restart quetiapine for insomnia, so it had been restarted.

R39's progress notes dated 9/13/19, indicated R39's diagnosis for quetiapine was changed to depression.

R39's Consultant Pharmacist Medication Review dated 9/18/19, identified an irregularity regarding

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use of quetiapine. The pharmacist indicated on 8/30/19, R39 was not showing signs of agitation and quetiapine was discontinued. Resident then complained of not being able to sleep and quetiapine was started with a diagnosis of sleep and then changed to a diagnosis of depression. The consultant pharmacist recommended tapering R39 off the quetiapine and starting a medication that would target sleep, such as trazodone or mirtazapine that would also help with depression. R39's physician addressed the pharmacist's recommendation by ordering trazodone in place of quetiapine.

R39's physician notes dated 11/4/19, indicated R39 had been readmitted from a hospital stay during 10/24/19 to 10/29/19, for heart failure exacerbation. R39's physician visit notes indicated medications were reviewed, but diagnoses were not provided for use of medications, and lacked diagnoses for psychosis or psychotic behaviors. R39's physician visit notes further indicated R39 had not significant behavioral changes.

R39's NP visit notes dated 11/11/19, lacked diagnoses for medications received by R39 per orders. R39's NP visit notes indicated R39's mood was good, and had no significant behavioral changes. R39's NP visit notes further indicated R39 received quetiapine for chronic insomnia, and the plan was to continue the medication as ordered.

R39's nurse practitioner (NP) visit notes dated 11/20/19, indicated orthostatic blood pressures had not been checked between 11/19/19 and 11/21/19, and lacked diagnoses for medications received by R39 per orders.

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On 11/19/19, at 1:22 p.m. R39 stated she felt her medications were helpful and she had not experienced any side effects.

On 11/20/19, at 4:19 p.m. director of nursing (DON) stated she would expect orthostatic blood pressures to be done when a resident is receiving any psychotropic medication. DON verified quetiapine is not an appropriate medication for sleep and verified R39's orthostatic blood pressures were not completed and antipsychotic side effect monitoring was not on the TAR following R39's hospital return and should have been done. DON verified the NP and physician had seen R39 since her return from the hospital and nursing should have put in a request for diagnoses of medications at that time. DON verified R39's Psychotropic Medication review had not been completed as dated for 10/10/19, and Target Behavior Form was not completed for 11/14/19.

The facility policy Antipsychotic Medication Use revised 12/16, directed residents would "only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective." The facility policy and procedure further directed the physician to identify, evaluate and document symptoms that may warrant the use of antipsychotic medications, and the diagnosis of a specific condition for which the antipsychotic medications are necessary to treat would be based on a comprehensive assessment. Antipsychotic mediations would not be used if the only symptoms were one or more of symptoms including restlessness, insomnia, nervousness, or mild anxiety.

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R3's Admission Record dated 11/20/19, indicated R3's diagnoses included major depressive disorder and anxiety disorder.

R3's quarterly MDS dated 8/21/19, identified R3 had moderately impaired cognition. R3's MDS also identified she was administered antidepressant medication for seven days, during the seven day lookback period, and had two or more falls without injury.

R3's Order Summary Report dated 11/20/19, indicated R3 was ordered orthostatic blood pressures monitoring due to psychotropic medication usage on the 10th day of every month. Further, R3 was ordered fluoxetine (antidepressant) 20 mg daily for depression on 8/30/19.

R3's care plan dated 3/14/19, indicated R3 had

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F 757	Continued From page 55 potential for psychotropic adverse drug reactions related to fluoxetine medication usage. Interventions included monitoring for adverse drug reactions. R3's November 2019 TAR lacked indication orthostatic blood pressures were taken. Review of R3's weights and vitals summary dated 12/2/19, lacked indication orthostatic blood pressures were recorded from 8/1/19, to 11/21/19. On 11/20/19, at 10:34 a.m. an interview was conducted with registered nurse (RN)-E. RN-E confirmed she was unable to locate orthostatic blood pressures in R3's medical record. RN-E stated staff were expected to follow the order and a process for leaving a progress notes with results was being put into place. On 11/20/19, at 3:37 p.m. an interview was conducted with the DON. The DON stated she expected staff were to complete full sets of orthostatic blood pressures as indicated, and there should had been a note. The facility policy Antipsychotic Medication Use revised 12/16, directed nursing staff to observe, document, and report adverse consequences to the attending physician such as "orthostatic hypotension."	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		1/3/20

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F 760	Continued From page 56 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a correct dosage of a narcotic pain medication was administered to 1 of 8 residents (R52) reviewed for medication administration. Findings include: R52's Admission Record dated 11/19/19, indicated R52's diagnoses included humerus fracture (fracture of upper arm) and mild cognitive impairment. R52's admission Minimum Data Set (MDS) dated 10/28/19, identified R52 had intact cognition. R52's MDS further identified he received as needed pain medication, had occasional pain, and received opioid pain medication for seven days. R52's Order Summary Report dated 11/19/19, indicated R52 was prescribed Norco (a narcotic pain medication) 10-325 milligrams (mg) every six hours as needed for pain rated six or greater on the numeric pain scale. The order was placed on 11/18/19. R52's care plan dated 11/1/19, indicated R58 did not wish to self-administer medications, and had a mild cognitive impairment. The care plan further indicated R58 would be administered medications per physician orders and by a licensed nurse. R52's November 2018 Medication Administration Record (MAR) printed 11/19/19, indicated R58 was prescribed hydrocodone-acetaminophen	F 760	Immediate Corrective Action: Resident #52□s Narco was discontinued on 11/26/19. The licensed nurses who administered the incorrect doses of Narco to resident #52 were re-educated on completing the appropriate checks including checking medication label to MD order on MAR before administering medication. Corrective Action as it applies to others: The Policy and Procedure regarding Medication Administration remains current. All residents were reviewed to ensure that all medication cards are current with what is on the EMAR and that there are no current medication errors. All nurses will be re-educated the proper procedure for medication administration including checking medication label to MD order on MAR before administering medications by 1/3/2019 Date of Compliance: 1/3/2019 Recurrence will be prevented by: Audits of 3 nurses per week will be completed weekly x 4 then monthly x 2 months to assure medications are being appropriate passed per policy. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Designee	

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(Norco) 5-325 mg. R58 was to take one tablet every four hours as needed for pain rated 4-7, or two tablets as needed for pain rated 8-10 on the numeric pain scale. The MAR further identified R58 was administered Norco 11/12/19, at 4:39 p.m. and 11/14/19, at 1:06 a.m. The order was started on 11/6/19, and discontinued on 11/15/19.

R52's November 2018 MAR printed 11/19/19, indicated R58 was prescribed Norco 5-325 mg. R58 was to take one tablet every six hours, as needed, for pain rated 4-7 or two tablets, as needed, for pain rated 8-10 on the numeric pain scale. The MAR further identified R58 was administered Norco on 11/16/19, at 6:31 a.m., and 11/17/19, at 8:46 a.m. The order was started on 11/15/19, and discontinued on 11/18/19.

On 11/17/19, at 7:17 p.m., licensed practical nurse (LPN)-C and LPN-E were observed administering medications. R58 approached LPN-C and LPN-E and stated he needed pain medication. LPN-C removed a medication card labeled Norco 10-325 mg, belonging to R58, from a locked compartment within the medication cart. LPN-C compared the medication card label to the electronic medication administration record (eMAR) and verbalized the dosage on medication card label did not match the physicians order. LPN-C did not administer the Norco and requested LPN-E to check the physicians order located in R58's paper medical record. LPN-C verified six doses of Norco 10-325 mg had been dispensed from the medication card. Registered nurse (RN)-E walked to the medication cart and informed LPN-C the physician order indicated the correct dosage was Norco 5-325, and stated she would start a medication error form.

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On 11/17/19, at 7:27 p.m., an interview was conducted with RN-E. RN-E audited R58's medical record, and stated R58's Norco order was updated in the eMAR on 11/15/19. RN-E verbalized the Norco frequency was changed from every four hours to every six hours however, the dosage of 5-325 mg remained the same. RN-E stated the order transcription was accurate, according to the written physician order, and the error occurred as staff had failed to verify the medication label against the medication order to ensure accuracy. The medication card was again observed, and RN-E confirmed six doses were incorrectly administered. The medication card was documented as filled on 11/12/19.

A Medication Error Reconciliation Form dated 11/17/19, indicated, "Dose sent from pharmacy 10-325 administered total of 6 times. Escript sent to pharmacy but not facility for updated dose on 11/12/19." The Medication Error Reconciliation Form further indicated the wrong drug/dosage was administered and "an error occurred that reached the patient but did not cause patient harm."

On 11/20/19, at 3:36 p.m. an interview was conducted with the director of nursing (DON). The DON stated the nurses were to check medication labels against the medication orders prior to administration. The DON further stated adverse consequences of receiving double doses of opioid pain medication could include confusion and constipation.

The facility policy Administering Medications revised 4/19, directed, "The individual administering the medication checks the label THREE (3) times to verify the right resident, right

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F 760	Continued From page 59 medication, right dosage, right time and right method (route) of administration before giving the medication."	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at the appropriate temperature to ensure food safety and prevent food borne illness. This had a potential to affect 63 of 65 residents who ate food prepared in the facility kitchen. Findings include: On 11/17/19, at 5:34 p.m. review of the facility food temperature log for November 2019,	F 812	Immediate Corrective Action: Food temps were checked to ensure they were at appropriate temp. Corrective Action as it applies to others: The Food Preparation and Service Policy was reviewed and remains current. All culinary staff will be re-educated on need to take and document food temperatures in the kitchen prior to each meal being served by 1/3/2019 Date of Compliance: 1/3/2019	1/3/20

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F 812	Continued From page 60 revealed temperatures were not taken for the following meals: Breakfast food temperatures for 11/4, 11/5, 11/8, 11/9, 11/13, and 11/14. Lunch food temperatures for 11/4, 11/5, 11/8, 11/9, 11/13, and 11/14. Supper food temperatures for 11/2, 11/3, 11/9, and 11/15. On 11/19/19, at 12:57 p.m. dietary manager (DM)-A was interviewed, and stated she had not reviewed November food temperature logs. DM-A stated this was the responsibility of the assistant dietary manager. DM-A stated she soul have been notified if food temperatures were not being taken so retraining of staff could have occurred. DM-A stated food safety and temperature of food was important to ensure bacterial growth does not occur which could lead to food borne illness for the residents. On 11/20/19, at 3:00 p.m. the director of nursing (DON) stated taking food temperature before serving food was important not only for food safety and preventing food borne illness, but also palpability of food. The facility policy Culinary Department dated 12/16, directed cooking foods at proper temperatures and maintaining proper temperatures are necessary to prevent pathogens (disease producing bacteria). The facility policy Food Re-Heating and Handling undated, directed staff that all potentially hazardous food must be reheated to 165 degrees	F 812	Recurrence will be prevented by: Random audits will be conducted at 4 different meals weekly x 4 then monthly x 2 months to assure that food temperatures are being completed and recorded and are within appropriate limits. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Culinary Director/Administrator/Designee	

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F 812	Continued From page 61 Fahrenheit or above for 15 seconds within two hours, and held above 150 degrees Fahrenheit until served to prevent bacteria from growth. The facility training material Food Preparation undated, directed kitchen staff to check and record food temperatures prior to service.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		1/3/20

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F 880	Continued From page 62 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand	F 880	Immediate corrective action: NAR was re-educated on completing	

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F 880	Continued From page 63 hygiene and glove use during personal cares and toileting cares to prevent cross contamination for 1 of 3 residents (R29) reviewed for bowel and bladder. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure, and anxiety disorder. R29's annual Minimum Data Set (MDS) completed 10/2/19, indicated R29 was cognitively intact with no resistive behaviors, delirium, psychosis or mood symptoms during the assessment period. R29's MDS further indicated R29 was frequently incontinent of bowel and bladder, required extensive assistance of two staff for toileting cares, and received a diuretic on a regular basis. R29's undated Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, completed for annual MDS with the reference date of 9/23/19, indicated R29 required assistance with toileting cares, was frequently incontinent of bladder, and had recently been hospitalized with a urinary tract infection (UTI). R29's CAA indicated R29 was offered toileting every 2 hours and as needed, and was transferred using a stand-aide assist lift. R29 did not always alert staff to the need to use the toilet. R29 received Lasix (diuretic), which could increase the risk for urinary urgency and frequency. R29's CAA further indicated R29 was able to communicate needs.	F 880	appropriate hand hygiene and glove after assisting resident□s with peri-care. Action as it applies to others: The Handwashing/Hand Hygiene Policy was reviewed and remains current. All nursing assistants and nurses will be re-educated on handwashing and glove use after completing resident cares with a focus on not touching other objects in room before handwashing being completed. Date of completion: 1/3/2019 Recurrence will be prevented by: Visual audits of handwashing/glove changing during ADLs will be conducted 3x weekly for 3 residents on various units x 4 weeks then monthly x 2 months and the results shared with QAPI on the need to increase, decrease, or discontinue the audits. The correction will be monitored by: DON/ADON/Designee	

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F 880	Continued From page 64	F 880		

R29's care plan revised 10/2/19, indicated R29 was able to communicate needs, was understood by others, and could usually understand simple conversation. R29's care plan indicated R29 was frequently incontinent of bowel and bladder, and directed staff to toilet every 2 hours and as necessary.

R29's care guide/pocket care plan dated 11/17/19, indicated R29 was incontinent, and directed staff to provide hourly toileting while awake.

On 11/19/19, at 9: 55 a.m. nursing assistant (NA)-F entered R29's room with the stand-assist lift to assist R29 with toileting cares. NA-F washed her hands, donned gloves, closed the curtain and shades, and positioned the stand-assist lift up to R29. NA-F hooked up the canvas and calf straps, and removed her soiled gloves, sanitized her hands and without performing hand hygiene donned clean gloves, and removed R29's oxygen canula. NA-F raised R29 to a standing position in the stand-assist lift, lowered R29's incontinent brief, and lowered R29 to the commode. NA-F stated R29's brief was a little damp with urine. NA-F removed her soiled gloves and sanitized her hands, as R29 voided a moderate amount of yellow urine in the commode. Without performing hand hygiene, NA-F donned clean gloves, raised R29 in the stand-assist lift, wiped R29's peri area with a personal cleansing wipe. NA-F did not remove her soiled gloves and perform hand hygiene, and put on clean gloves. NA-F put a clean incontinent brief on R29, moved the commode out of the way, put the wheelchair in place, lowered R29 into the wheelchair, unbuckled the canvas,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 65 pushed the wheelchair back, and then removed her soiled gloves. NA-F sanitized her hands and donned clean gloves. NA-F placed R29's oxygen canula on R19's face. NA-F moved the stand-assist lift out of R29's room and brought it into the tub room. NA-F stated she thought she had changed gloves and sanitized following peri care, and said she should have. On 11/19/19, at 11:04 a.m. the assistant director of nursing (ADON) stated staff should remove soiled gloves, sanitize or wash hands, and put clean gloves on going from dirty to clean areas and tasks. The facility Handwashing policy dated 1/08, directed handwashing should be completed when hands are visibly soiled, and when hands are not visibly soiled, to use an alcohol based hand rub. The policy further directed hand hygiene should be performed before and after contact with residents, before doing an invasive procedure, after contact with bodily fluids, before moving from contaminated body site to a clean body site during resident cares, after contact with mechanical equipment, after removing gloves.	F 880		
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management	F 947		1/3/20

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F 947	Continued From page 66 training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure abuse, vulnerable adult training, and Alzheimer's/dementia training was provided to staff during orientation and prior to working with residents for 1 of 5 nursing assistants (NA-I) reviewed for staffing. In addition, the facility failed to ensure performance reviews were completed every 12 months for 1 of 9 nursing assistants (NA-B) who had been employed by the facility for over one year. This had the potential to affect all 65 residents residing in the facility. Findings include: A review of staff training records indicated nursing assistant (NA)-I was hired on 6/24/19, and had not received abuse or dementia training prior to working with residents. On 11/18/19, at 3:58 p.m. director of nursing (DON) verified NA-I had not received the required abuse and dementia training. The facility policy Abuse Prevention/Vulnerable Adult Plan revised 7/18, directed staff to receive	F 947	Immediate corrective action: NAR who had not completed abuse, vulnerable adult training, and Alzheimer□s/ Dementia training will complete the missing training sessions before being allowed to work with residents. The NAR□s performance evaluation who had not been completed was reviewed/completed with NAR. Action as it applies to others: The Abuse Prevention/Vulnerable Adult Plan Policy remains current. All staff who have been employed less than 1 year will be reviewed to ensure that they have received abuse, vulnerable adult training, and Alzheimer□s/dementia training and will be removed from the schedule until it is completed. All management team involved in the hiring process were re-educated on need to ensure that abuse, vulnerable adult training, and Alzheimer□s/dementia training are completed by all new hires prior to working with residents.	

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F 947	Continued From page 67 vulnerable adult, resident's rights, and abuse training in new employee orientation and annually. The facility Dementia Training Disclosure policy revised 1/18, and was provided in the resident admission packet, indicated all staff would receive 8.25 hours of training within their first 160 hours worked, and 2 hours of training annually thereafter. The facility disclosure indicated training would include a comprehensive view of Alzheimer's, comprehensive view of dementia, abuse prevention in persons with dementia, and care of the cognitively impaired resident. An undated Employee Roster Report printed on 11/17/19, and personnel record review indicated the following: NA-B's hire date was 6/6/18. No annual performance review had been completed. On 11/20/19, at 4:39 p.m. the facility nurse consultant confirmed NA-B did not have an annual performance review completed. The facility policy Personal Records dated 5/2018, directed performance evaluations were to be completed at least annually.	F 947	The personnel Records Policy remains current. All facility staff records will be reviewed and annual performance evaluations will be completed as needed. Date of completion: 1/3/2019 Recurrence will be prevented by: Administrator will work with Human Resources to assure new hires receive the abuse, vulnerable adult training, and Alzheimer□s/dementia training prior to working with residents and that annual performance evaluations are completed in a timely manner. This will be an ongoing practice reviewed monthly by both. The correction will be monitored by: Administrator/Human Resources/Designee	

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	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	**7700 GRAND AVENUE** **DULUTH, MN 55807**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The North Shore Estates was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2019

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 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The North Shore Estates is a 2-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1971 with an addition in 2005. Both buildings are type II (111) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building, the 2005 building is support services only. The building is fully sprinkler protected, by a complete automatic fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for	K 000		

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	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2019**

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K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 70 beds and had a census of 65 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.6.1.3. This deficient practice could affect 30 of 70 residents. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/19/2019, observations revealed that the smoke detector located in the AED room on the first floor by the nurses stations had a smoke detector that is damaged and has parts of the	K 345	Based on staff interview and a review of the available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.6.1.3. This deficient practice could affect 30 of 70 residents. Smoke detector located near AED on first floor replaced 11-27-19. Monitoring system in TELS in place to alert maintenance Department of need for inspection of Smoke Detector system. Responsible person- Chad Anderson	11/27/19

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	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2019**

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K 345	Continued From page 3 smoke detector broken off of it. This deficient condition was confirmed by a Maintenance Supervisor.	K 345	Maintenance Director	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 70 of	K 353	Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the	12/3/19

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	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2019**

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THE NORTH SHORE ESTATES LLC	**7700 GRAND AVENUE** **DULUTH, MN 55807**

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K 353	Continued From page 4 70 residents. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/19/2019, observations revealed the following deficient conditions affecting the facility's fire sprinkler system: 1. The sprinkler heads in the kitchen around the oven located appeared to be corroded. 2. There is a painted fire sprinkler head located in the employee dining room. 3. There was a 1/4 inch gap around the fire sprinkler head escutcheon ring in the ceiling tile located inside the kitchen by the main entry. This deficient condition was confirmed by a Maintenance Supervisor.	K 353	fire protection system capability in the event of an emergency that could affect 70 of 70 residents. All automatic sprinkler system - all sprinkler heads in Kitchen and Employee dining room have been replaced. Records of system design, maintenance , inspection and testing are completed by maintenance supervisor or Designee Person Responsible- Chad Anderson	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 11, 2019

Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

Re: State Nursing Home Licensing Orders
Event ID: JM4C11

Dear Administrator:

The above facility was surveyed on November 17, 2019 through November 21, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

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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 htttp://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 attached Minnesota 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 11/17/19, through 11/21/19, 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. H Complaint H5483040C was investigated and was substantiated. 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,	2 000		

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2 000	Continued From page 2 "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		
2 280	MN Rule 4658.0100 Subp. 1 Employee Orientation and In-Service Education Subpart 1. Orientation and initial training. All personnel must be instructed in the requirements of the law and the rules pertaining to their respective duties and the instruction must be documented. All personnel must be informed of the policies of the nursing home, and procedure manuals must be readily available to guide them in the performance of their duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure abuse, vulnerable adult training, and Alzheimer's/dementia training was provided to staff during orientation and prior to working with residents for 1 of 5 nursing assistants (NA-I) reviewed for staffing. In addition, the facility failed to ensure performance reviews were completed every 12 months for 1 of 9 nursing assistants (NA-B) who had been employed by the facility for over one year. This had the potential to affect all 65 residents residing in the facility. Findings include: A review of staff training records indicated nursing assistant (NA)-I was hired on 6/24/19, and had	2 280	Corrected	1/3/20

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2 280	Continued From page 3	2 280		

not received abuse or dementia training prior to working with residents.

On 11/18/19, at 3:58 p.m. director of nursing (DON) verified NA-I had not received the required abuse and dementia training.

The facility policy Abuse Prevention/Vulnerable Adult Plan revised 7/18, directed staff to receive vulnerable adult, resident's rights, and abuse training in new employee orientation and annually.

The facility Dementia Training Disclosure policy revised 1/18, and was provided in the resident admission packet, indicated all staff would receive 8.25 hours of training within their first 160 hours worked, and 2 hours of training annually thereafter. The facility disclosure indicated training would include a comprehensive view of Alzheimer's, comprehensive view of dementia, abuse prevention in persons with dementia, and care of the cognitively impaired resident.

An undated Employee Roster Report printed on 11/17/19, and personnel record review indicated the following:

NA-B's hire date was 6/6/18. No annual performance review had been completed.

On 11/20/19, at 4:39 p.m. the facility nurse consultant confirmed NA-B did not have an annual performance review completed.

The facility policy Personal Records dated 5/2018, directed performance evaluations were to be completed at least annually.

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2 280	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and/or revise the current staff training policies and procedures to ensure all staff receive the appropriate abuse and dementia training at orientation and annually. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 280		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees	2 302		1/3/20

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2 302	Continued From page 5 trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Alzheimer's/dementia training containining all the appropriate components was provided and received during orientation, and prior to working with residents for 1 of 5 nursing assistants (NA-I) reviewed for staffing. This had the potential to affect all residents. Findings include: A review of staff training records indicated nursing assistant (NA)-I was hired on 6/24/19, and had not received abuse or dementia training prior to working with residents. On 11/18/19, at 3:58 p.m. director of nursing (DON) verified NA-I had not received the required abuse and dementia training, and NA-I was immediately told she would not be able to work on the units with residents that day, upon reviewing her training records. On 11/20/19, DON stated NA-I was removed from the schedule until appropriate training was received. The facility policy and procedure for Abuse Prevention/Vulnerable Adult Plan revised 7/18, directed staff to receive vulnerable adult, resident's rights, and abuse training in new	2 302	Corrected	

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2 302	Continued From page 6 employee orientation and annually. The facility Dementia Training Disclosure revised 1/18, and was provided in the resident admission packet indicated all staff would receive 8.25 hours of training within their first 160 hours worked and 2 hours of training annually, thereafter. The facility disclosure indicated training would include a comprehensive view of Alzheimer's, comprehensive view of dementia, abuse prevention in persons with dementia, and care of the cognitively impaired resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current Alzheimer's training policies and procedures to ensure all staff receive the appropriate Alzheimer's training. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 680	MN Rule 4658.0465 Subp. 1 Transfer, Discharge, and Death: Dis. Summay Subpart 1. Discharge summary at death. When a resident dies, the nursing home must compile a discharge summary that includes the date, time, and cause of death. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 680	Corrected	1/3/20

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2 680	Continued From page 7	2 680		

facility failed to ensure a recapitulation of stay was completed for 2 of 5 residents (R60, and , R62) reviewed for discharges. In addition, the facility failed to document and reconcile the destruction of medications for 1 of 5 residents (R60) reviewed for discharge.

Findings include:

R60's Admission Record printed 11/19/19, indicated R60 was admitted on 5/9/17, and R60's diagnoses included cancer of the prostate, heart failure, chronic atrial fibrillation, chronic kidney disease, and dementia.

R60's Order Summary Report with active orders at the time of death, indicated R60's medications did not include controlled medications.

R60's progress notes dated 8/22/19, indicated R60 expired at 1:27 p.m.

R60's medical record lacked a discharge summary with a recapitulation of R60's stay at the facility. R60's medical record also lacked documentation of R60's medications dispensed or disposed of following R60's death.

On 11/19/19, at 2:58 p.m. director of nursing (DON) verified they could not find a discharge summary or recapitulation of stay, and could not find a disposition of medication form for R60. DON stated R60's medications came from the veteran's affairs (VA) and R60's spouse wanted the medications, but the facility did not fill out a form, and should have.

The facility policy and procedure for Discharge Summary Recapitulation and Plan revised

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2 680	Continued From page 8 12/3/18, lacked directives for a recapitulation of stay following a death of a resident. The facility policy and procedure for Discharge Medications, revised 12/16, lacked direction for reconciliation and documentation of medications following a death of a resident. The facility policy and procedure did include directions to complete the medication disposition record, including the signature of the person receiving the medications and the nurse releasing the medications for a resident's discharge. R62 Admission Record printed 11/20/19, indicated R62's was admitted to the facility on 9/28/19, and included the following diagnoses of heart failure, atrial fibrillation, and had a pacemaker. R62's progress note dated 9/29/19, at 9:15 a.m. indicated R62 was sent to the emergency room on 9/29/19 for diuresing. R62's progress noted dated 9/29/19, at 9:52 a.m. indicated R62's son declined bed hold due to how long R62 was going to be in the hospital was planned on picking up R62's belongings that day. A review of R62's medical record lacked evidence a recapitulation of stay was completed. On 11/20/19, at 4:39 p.m. DON verified no recapitulation of stay was completed for R62 and should have been completed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures for resident discharges and or transfers.	2 680		

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2 680	Continued From page 9 The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.	2 680		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure monitoring of weights as ordered by a physician regarding a medical condition for 1 of 6 residents (R29) reviewed for unnecessary medications. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure (CHF), and edema.	2 830	Corrected	1/3/20

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2 830	Continued From page 10 R29's care plan initiated 8/24/18, indicated R29 was at risk for falls related to medical conditions, including CHF, edema, and vascular dementia. R29's care plan indicated R29 was taking psychotropic medications, and directed nursing to obtain a monthly orthostatic blood pressure. R29's care plan identified R29's cardiovascular diagnoses and conditions, including CHF and bilateral leg edema with medications that included Lasix (diuretic), but lacked direction for daily weights and notification of provider of increase of 3 pounds overnight or 5 pounds weekly. R29's care guide lacked direction to obtain daily weights and weight gain guidelines for notification of the physician. R29's Order Summary Report with Active Orders as of 11/19/19, included orders for: -check vital signs daily. Order 9/17/19. -daily weights every day shift, call Heart Center if weight gain of 3 pounds overnight or 5 pounds in one week. Call heart center of shortness of breath, orthopnea, edema or bloating. Order date 9/30/19. -Monthly orthostatic blood pressure (lying, sitting, and standing) the 24th of every month. Nursing order date 8/26/18. -Lasix (diuretic) 40 milligrams (mg) twice daily for CHF. Order start date 10/23/19. -Melatonin 3 mg at bedtime for difficulty sleeping manifestations. -Metoprolol succinate (for blood pressure) extended release 24 hour; 25 mg in the a.m. -Sertraline HCL (antidepressant) 50 mg at bedtime. Order start date 9/17/19. -Olanzapine (antipsychotic) 5 mg every evening for bipolar disorder. Order start dated 9/17/19.	2 830		

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2 830	Continued From page 11 R29's nurse practitioner (NP) visit note dated 9/27/19, indicated R29 had been hospitalized from 9/5/19, through 9/17/19, with CHF, potential intestinal bleed, encphalopathy (brain disease, damage, or malfunction). R29's NP visit note further indicated R29 was discharged from the hospital with orders for Lasix and daily weights, and referral to the heart clinic. R29's Treatment Administration Record (TAR) for September 2019, indicated R29 had daily weights completed only on 9/18/19, and 9/19/19, then weekly weights. R29's Physician Visit Record dated 9/30/19, included signed NP orders for daily weights, and to call the heart center if weight gain of 3 pounds overnight or 5 pounds in one week, and if symptoms of shortness of breath, orthopnea, edema or bloating. R29's NP visit notes dated 10/11/19, indicated R29 had been hospitalized 9/5/19 through 9/17/19, with a GI bleed, acute encephalopathy, and CHF. R29 was discharged with orders for daily weights, Lasix and a referral to the heart failure clinic. R29's TAR for 10/1/19, through 10/31/19, indicated R29's daily weight was to be obtained daily starting 10/1/19, and R29's daily weights were not obtained 10/1/19, 10/2/19, 10/10/19, 10/17/19, and 10/22/19. R29's TAR for October 2019 indicated R29's weight on 10/3/19, was 180 pounds. R29's TAR for September 2019, indicated R29's previous weight was 171.5 on 9/25/19. R29's TAR for 11/1/19, through 11/20/19, indicated R29's daily weight was not obtained on	2 830		

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2 830	Continued From page 12 11/3/19, or 11/14/19. R29's TAR indicated R29 had more than a 3 pound weight gain from 11/11/19, to 11/12/19, and it increased slightly again on 11/13/19. R29's progress notes dated 11/12/19, and 11/13/19, lacked documentation of notification of the physician regarding the weight increase of greater than 3 pounds, and lacked documentation of monitoring of symptoms of CHF, edema or respiratory status. R29's Weights and Vitals summary for 9/21/19, through 11/20/19, indicated R29 had missed daily weights from 10/1/19, through 10/3/19, 10/10/19, 10/17/19, 10/18/19, 10/22/19, 11/3/19, and 11/14/19. -R29's weight record indicated R29 had a weight gain of 8.5 pounds from 9/25,/19 to 10/3/19. No weights were recorded in R29's medical record between 9/25/19, and 10/3/19. R29's progress notes dated 10/4/19, indicated the weight gain was reported to the physician, though lacked evidence of monitoring for symptoms of CHF, increased edema and respiratory status. -R29's weight record indicated R29 had a weight gain of 4 pounds from 10/5/19, to 10/6/19. R29's Progress notes lacked documentation of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain. - R29's weight record indicated R29 had a weight gain of 4 pounds from 10/9/19, through 10/11/19, with no weight recorded on 10/10/19. Progress notes lacked documentation of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain. -R29's weight record indicated R29 had a weight gain of 3.7 pounds from 10/16/19, to 10/19/19, but had not obtained a weight on 10/17/19, or 10/18/19. Progress notes lacked documentation	2 830		

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2 830	Continued From page 13	2 830		

of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain. R29's progress notes dated 10/23/19, indicated NP increased R29's Lasix for 3 days, following a visit.
-R29's weight record indicated R29 had a weight gain of 12.9 pounds from 10/29/19, to 10/30/19. R29's medical record indicated R29 went to the CHF clinic that day and daily weights were ordered. R29's medical record lacked documentation of monitoring for symptoms of CHF, increased edema and respiratory status.
-R29's weight record indicated R29 had a weight gain of 3.2 pounds from 11/11/19, to 11/12/19. R29's medical record lacked evidence of notification of the physician or heart clinic of weight gain and lacked documentation of monitoring for symptoms of CHF, increased edema and respiratory status.
-R29's weight record indicated R29 had a weight gain of 7.5 pounds from 11/17/19, to 11/18/19, though had a weight loss of 6.5 pounds the previous day.

R29's nurse practitioner (NP) visit notes dated 10/30/19, indicated R29's Lasix had been increased a week prior, and R29's weight was down 5 pounds, along with decreased edema, though the NP visit was prior to R29's weight that same day.

On 11/18/19, at 9:47 a.m. R29's resident representative (RR)-F expressed concern that R29's weight is not checked daily.

On 11/20/19, at 4:28 p.m. director of nursing (DON) verified missing weights and lack of notification to the physician. DON stated nursing should monitor for symptoms of CHF with

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2 830	Continued From page 14 increased weight. DON verified nursing should have notified the heart center and monitored R29 with the increased weight. DON also verified orthostatic BP's should be obtained for monitoring of psychotropic medications and should be documented. The facility policy Heart Failure-Clinical Protocol revised 11/18, lacked direction for monitoring for symptoms of CHF, following physician orders for monitoring and management of CHF, and notification of physician of symptoms. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current policies and procedures for monitoring medical conditions as ordered and monitoring of symptoms to ensure appropriate treatment. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced	2 850		1/3/20

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2 850	Continued From page 15 by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 4 dependent residents (R41) reviewed for activities of daily living (ADLs). Findings include: R41's Face Sheet printed 11/20/19, indicated R41's diagnoses included Parkinson's disease, anxiety, schizoaffective disorder, and bipolar. R41's annual Minimum Data Set (MDS) dated 10/14/19, indicated R41 was cognitively intact, and required extensive assistance for ADLs, which included grooming. R41's Care Area Assessment (CAA) Summary dated 10/15/19, indicated R41 required extensive assistance with grooming. R41's nursing assistant care guide dated 11/17/19, indicated R41 required assistance with grooming, and preferred to have facial hair shaved. On 11/17/19, at 2:06 p.m. R41 was observed lying in her bed in a hospital gown. R41 had dark stubble of facial hair on her upper lip and chin. On 11/18/19, at 9:25 a.m. R41 was observed and the facial hair remained on her upper lip and chin. R41 stated she was supposed to have a shower twice a week, which did not always occur. R41 stated she was unable to remove the facial hair herself, and depended on staff to assist with shaving. R41 further stated having facial hair bothered her, and she preferred to have her facial hair removed.	2 850	Corrected	

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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
2 850	Continued From page 16 On 11/19/19, at 1:10 p.m. R41's facial hair remained. R41 stated staff did not offer to assistance with shaving during morning cares. On 11/19/19, at 1:26 p.m. nursing assistant (NA)-A stated R41 was dependent on staff for all ADLs including shaving. NA-A stated grooming assistance was provided for R41 during morning cares, but did not offer to assist R41 with shaving. NA-A further stated facial hair was noted that morning, and it appeared R41 facial hair had been present for several days. NA-A verified R41's nursing care guide indicated R41 was dependent on staff for grooming, and preferred to have facial hair removed. On 11/20/19, at 4:39 p.m. the director of nursing (DON) stated she would expect a resident that required assistance with shaving to be shaved if that was the resident's desire. DON stated if a resident's plan of care included a resident preferred to have facial hair removed, she would expect staff to follow the resident preferences. The DON futher stated the lack of grooming for a resident that preferred to have facial hair removed was a dignity issue. The facility policy Shaving the Resident dated 2/18, indicated the purpose was to promote cleanliness and to provide skin cares to the resident. The policy directed staff to review the residents' care plan to assess for any special needs of the resident, and to notify the supervisor if the resident refuses the procedure. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure all residents that were dependent on staff	2 850		

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2 850	Continued From page 17 received assistance with personal hygiene. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to track compliance and report results to the Quality Assurance and Performance Improvement (QAPI) committee. QAPI could conduct audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
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 ensure consistent wound assessment to prevent worsening of pressure ulcers and evaluate the effectiveness of	2 900	Corrected	1/3/20

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2 900	Continued From page 18 treatment for 2 of 4 residents (R5, R50) reviewed for pressure ulcers. Findings include: National Pressure Injury Advisory Panel staging definitions for pressure injuries (pressure ulcers) Pressure Injury: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep	2 900		

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2 900	Continued From page 19	2 900		

wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed

R5's Admission Record printed 11/20/19, indicated R20's diagnoses included diabetes with neuropathy, pressure ulcer of right heel, non-pressure related chronic ulcer of left foot, anemia, edema, and encephalopathy (brain damage, disorder, or disease).

R5's annual Minimum Data Set (MDS) dated 8/27/19, indicated R5 had a severe cognitive impairment, had no rejection of cares during the assessment period, required extensive assistance of two staff for bed mobility, total assistance of two staff for transfers, and was nonambulatory.
R5's MDS further indicated R5 was at risk for

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pressure ulcers, and had an unstageable pressure ulcer with slough (dead yellow/creamy/greyish tissue in a wound bed) or eschar (dead thick, leathery, black tissue in a wound bed) present.

R5's Care Area Assessment for Pressure Ulcer/Injury dated 8/27/19, indicated weekly skin check would be completed by a licensed nurse as R5 allowed.

R5's physician appointment dated 9/4/19, indicated R5 had a large pressure ulcer at the base of the right heel with dark tissue overlying the wound, and tender to touch. Physician documentation indicated R5's pressure ulcer did not appear to be acutely infected at that time.

R5's care plan initiated 10/3/18, indicated R5 had a mobility impairment, and directed staff to reposition every 2 hours, and noted R5 frequently refused repositioning. R5's care plan further indicated R5 had a history of skin breakdown, including pressure ulcers to bilateral heels, and directed nursing to offer repositioning every 2 hours. Interventions dated 11/14/19, indicated R5 was followed by hospital wound care.

R5's Weekly Skin Inspections dated 9/10/19, indicated there were no new areas of concern, and R5 continued to have an unstageable pressure area to the right heel.

R5's Weekly Pressure Ulcer Wound Evaluation dated 9/11/19, indicated R5's left heel pressure ulcer measured 3.8 centimeters (cm) x 4.0 cm and was unstageable with 100% eschar. R5's pressure ulcer was documented as ongoing and unchanged.

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2 900	Continued From page 21 R5's Weekly Pressure Ulcer Wound Evaluation dated 9/17/19, indicated R5's left heel pressure ulcer measured 3.4 cm x 5.0 cm and was unstageable with 20% eschar, 70% slough and 10% granulation (new connective tissue) tissue, and moderate serosanguineous (clear liquid mixed with the blood) drainage with odor. R5's pressure ulcer was documented as ongoing and improved. R5's Weekly Skin Inspection dated 9/24/19, indicated there were no new areas of concern, and continued to have an unstageable pressure area to the right heel. R5 had not had a Weekly Skin inspection since 9/11/19. R5's Weekly Skin Inspection dated 10/1/19, indicated R5 had no new areas of concern, and continued unstageable pressure area to right heel. R5's Weekly Pressure Wound Evaluation dated 10/3/19, indicated R5's left heel pressure ulcer measured 3.2 cm x 4.5 cm, and was unstageable with 25% granulation, 75% slough, and moderate amount of serosanguineous drainage with an odor. R5's pressure area was documented as ongoing and declined. R5 had not had a registered nurse assess the wound between 9/17/19, and 10/3/19, and the wound had worsened during that time. R5's Weekly Pressure Wound Evaluation dated 10/8/19, indicated R5's right heel pressure ulcer measured 4.0 cm x 4.5 cm and was unstageable, was 10% granulation and 90% slough, with moderate brownish, green drainage and no odor. R5's pressure ulcer was documented as ongoing and improved, though measurements and slough had increased with decreased granulation tissue.	2 900		

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2 900	Continued From page 22 In addition, the right heel pressure ulcer had previously been documented on the Weekly Pressure Wound Evaluations as the left heel. R5's progress notes dated 10/14/19, indicated R5 went to wound clinic R5's Weekly Skin Inspection dated 10/15/19, indicated R5 continued to have an unstageable pressure area to the right heel, outer aspect of right great toe and top of right second toe. R5 had not had a weekly skin inspection since 10/1/19. R5's Weekly Pressure Wound Evaluation dated 10/17/19, indicated R5's right heel pressure ulcer measured 3.5 cm x 3.0 cm and was unstageable with 75% granulation, and 25% slough, and moderate serosanguineous drainage with no odor. R5's pressure ulcer was documented as improved. In addition, R5's wound evaluation indicted R5 had a stage one pressure area on his left toe that had healed. R5's progress notes dated 10/22/19, indicated a physician called with orders for an antibiotic, a wound culture, and follow up appointment for a worsening heel ulcer with possible infection. R5's progress notes dated 10/23/19, indicated an antibiotic was ordered for a wound infection. R5's progress notes indicated R5 had a wound culture result with a moderate amount of pseudomonas aurginosa (bacteria organism). R5's progress notes dated 10/26/19, indicated R5 had a new order for a change in antibiotic to treat a wound infection with pseudomonas until 11/1/19. R5's progress notes, the same day	2 900		

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2 900	Continued From page 23	2 900		

indicated R5 had gone to wound dare and treatment orders had changed to right heel and left medial fifth toe, including cleansing with soap and water and a vinegar solution.

R5's Weekly Skin Inspection dated 10/29/19, indicated R5 continued to have unstageable pressure ulcer to the right heel, outer aspect of right great toe, and top of right second toe, along with a superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/15/19.

R5's Braden Scale Assessment (a tool to assist in determining risk for skin breakdown), dated 11/7/19, indicated R5 was at risk for skin breakdown.

R5's progress notes dated 11/8/19, indicated R5 refused to go to wound care appointment and appointment was rescheduled for 11/22/19.

R5's Weekly Skin Inspection dated 11/12/19, indicated R5 continued to have a right heel pressure ulcer, along with the outer aspect of the right great toe and tope of right second toe, and superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/29/19.

R5's Weekly Pressure Wound Evaluation dated 11/14/19, indicated R5's right heel pressure ulcer measured 3.3 cm x 5.2 cm and was unstageable with 25% granulation and 75% slough with a moderate amount of serosanguineous drainage with no odor. R5's pressure ulcer was documented as improved, though measurements had increased, the granulation tissue had decreased and slough had increased. R5 had not had an RN assessment of the pressure ulcer

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2 900	Continued From page 24 at the facility since 10/17/19, though R5 had been treated for a worsening pressure ulcer with infection. R5's Weekly Skin Inspection dated 11/19/19, was not completed. R5's progress notes dated 11/20/19, indicated R5's right heel ulcer measured 5 cm x 3.5 cm x 0.3 cm with a minimal amount of tan drainage. On 11/19/19, at 10:58 a.m. the assistant director of nursing (ADON) stated R5 had an unstageable pressure ulcer on the right heel. ADON stated R5 goes to wound care, but R5 was non-compliant. ADON stated R5's pressure ulcer was improving and they have a good treatment for it. On 11/20/19, at 8:44 a.m. licensed practical nurse (LPN)-A looked at R5's right heel wound after he had showered. R5's right heel ulcer had regular edges, light slough, and was unstageable. On 11/20/19, at 9:45 a.m. LPN-A stated R5's wound looked better, with some slough and some drainage. LPN-A stated R5 had previously had an infection in the right heel ulcer. On 11/20/19, at 1:51 p.m. LPN-A with registered nurse (RN)-F, soaked right heel and left 5th toe pressure ulcers in vinegar solution as ordered. LPN-A sanitized hands, gloved, and measured the right heel pressure ulcer at 5 cm x 3.5 cm x 0.3 cm. LPN-A used a cotton tip swab to attempt to remove some slough. LPN-A removed gloves, sanitized hands, gloved, and completed treatment as ordered. LPN-A stated R5's wound base had 50% slough. LPN-A stated it had been debrided and was cleaner since starting the vinegar solution.	2 900		

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2 900	Continued From page 25 On 11/20/19, at 4:04 p.m. director of nursing (DON) verified wound assessments were not done weekly, R5 had a wound infection, and weekly wound assessments would be done weekly. The facility policy for Skin Assessment and Wound Management dated 12/18, directed a weekly skin inspection would be completed by licensed staff, document skin condition weekly on the Pressure Wound Evaluation, and review skin conditions with interdisciplinary team at least monthly. R50's Admission Record printed 11/20/19, indicated diagnoses that included chronic non-pressure right heel and mid foot ulcer, type 2 diabetes, anemia, and chronic kidney disease. R50's quarterly MDS dated 10/28/19, indicated R50 had a severe cognitive impairment, required extensive assistance with bed mobility, transfers, toileting, and was total dependent on person hygiene. MDS further indicated R50 had an unstageable pressure ulcer. R50's physician orders directed to wash left heel ulcer with soap and water, dry, smear a small amount of Iososorb on Xeroform (yellow gauze), wrap with kerlix and place surgilast, and change every 2 days. Wear heel boot while in bed, post-op boot while in chair. R50's care plan updated 3/29/19, indicated R50 had a wound to right heel and interventions included to offload heels by floatation off pillow when R50 was in bed, and treatment per physician orders. R50's medical record lacked Weekly Pressure	2 900		

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2 900	Continued From page 26 Wound Evaluations from 5/23/19-6/12/19, 6/27/19-9/6/19, and 10/22/19-11/19/19. On 11/20/19, at 2:10 p.m. the ADON stated R50's left heel pressure ulcer was identified on 3/29/19. The ADON verified she did not complete weekly wound assessments for R50 from 10/22/19, to 11/19/19. The ADON stated at that time, R50's dressing was changed every three days, and she did not coordinate with the nurses when the dressing was changed to complete the weekly wound evaluation. The ADON stated it was important to complete weekly wound assessments to monitor the progress of the wound. On 11/20/19, at 4:39 p.m. the DON, stated she would expect wound assessments to be completed weekly. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents that have pressure ulcers are assessed weekly for monitoring progress and to prevent worsening of pressure ulcers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		1/3/20

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2 910	Continued From page 27 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 ensure timely toileting to prevent incontinence for 1 of 2 residents (R29) reviewed for incontinence. In addition, the facility failed to assess and develop a toileting program to maintain continence of bowel and bladder for 1 of 2 residents (R53) reviewed for incontinence. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure, and anxiety disorder. R29's annual Minimum Data Set (MDS) dated 10/2/19, indicated R29 was cognitively intact with	2 910	Corrected	

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2 910	Continued From page 28	2 910		

no resistive behaviors, delirium, psychosis or mood symptoms during the assessment period. R29's MDS further indicated R29 was frequently incontinent of bowel and bladder, required extensive assistance of two staff for toileting cares, and received a diuretic on a regular basis.

R29's undated Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, completed for annual MDS with the reference date of 9/23/19, indicated R29 required assistance with toileting cares, was frequently incontinent of bladder, and had recently been hospitalized with a urinary tract infection (UTI). R29's CAA indicated R29 was offered toileting every 2 hours and as needed, and was transferred using a stand-aide assist lift. R29 did not always alert staff to the need to use the toilet. R29 received Lasix, which could increase the risk for urgency and frequency. R29's CAA further indicated R29 was able to communicate needs.

R29's care plan revised 10/2/19, indicated R29 was able to communicate needs, was understood by others, and could usually understand simple conversation. R29's care plan indicated R29 was frequently incontinent of bowel and bladder, and directed staff to toilet every 2 hours and as necessary.

R29's care guide/pocket care plan dated 11/17/19, indicated R29 was incontinent, and directed staff to provide hourly toileting while awake.

R29's Order Summary Report for Active Orders as of 11/19/19, included orders for Lasix (diuretic medication) 40 milligrams (mg) twice daily.

R29's progress notes dated 10/21/19, through

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2 910	Continued From page 29 11/19/19, indicated R29 had not had incidents of refusing toileting cares. On 11/18/19, at 9:47 a.m. resident representative (RR)-F was interviewed and expressed concern that R29 did not get toileted frequently enough. On 11/19/19, during observations from 7:25 a.m. through 8:58 a.m., R29 was in her room watching television, received her hearing aide, visited with RR-F, and ate breakfast. Staff had not entered her room since RR-F arrived at 8:05 a.m., and R29 was not offered toilet use since 7:25 a.m. -At 8:51 a.m. RR-F talked to R29 about going to exercise group, turned on the call light, and told R29 she would be back 10 minutes prior to her appointment, later that morning. Before RR-F left the room, staff entered R29's room and RR-F informed staff R29 would like to go to exercise group and then she would come back before the appointment, and stated R29 would need to be toileted prior to the appointment. Staff did not offer toilet use prior to exercise group. -At 8:58 a.m. RR-F took R29 downstairs to exercise group. -At 9:46 a.m. R29 returned from exercise group and the nurse change R29's oxygen. -At 9:48 a.m. staff brought R29 down to her room. On 11/19/19, at 9:51 a.m. R29 stated she had not been to the bathroom yet, and had just put on her call light to ask to go. Staff entered the room and R29 told them she had to go to the bathroom. On 11/19/19, at 9: 55 a.m. nursing assistant (NA)-F entered R29's room with the stand-assist lift and transferred her to the commode. R29 voided in the commode. NA-F verified R29's incontinent brief was a little damp. NA-F stated R29 was to be toileted at least every 2 hours, but	2 910		

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2 910	Continued From page 30 usually was toileted per her request. On 11/19/19, at 10:26 a.m. NA-G stated R29 would usually call and tell them when she had to go to the bathroom, and they would answer promptly. At that time, NA-H verified the care guide directed toilet use every hour for R29. NA-H stated she would check on her and R29 would ask, but verified staff should offer. On 11/19/19, at 11:04 a.m. the assistant director of nursing (ADON) stated nursing assistants should provide care according to the care guide sheets. ADON stated R29's family had wanted her toileted every hour for awhile when R29 was incontinent more frequently, and stated the care plan directed every 2 hours and as needed. ADON verified the care guide sheets were not changed when the care plan was changed. The facility policy for ADL (activities of daily living) Assistance per Care Plan revised 5/20/19, directed to provide ADL assistance to all residents based on the assessment and care plan. Incontinent residents were to be checked and toileted according to the care plan. R53's Admission Record printed 11/20/19, indicated R53's diagnoses included Parkinson's disease, morbid obesity, and a gastrostomy tube (a tube inserted through the belly that brings nutrition directly to the stomach). R53's quarterly MDS dated 11/5/19, indicated R53 was cognitively intact, and required extensive assistance with toileting, and was not on a toileting program. R53's CAA dated 8/19/19, indicated R53 was	2 910		

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2 910	Continued From page 31	2 910		

frequently incontinent of urine. The CAA indicated toileting needs would be care planned for R53 to continue to offer toileting, check, and change every two hours, and overall goal was to improve urinary incontinence.

R53's care plan dated 8/26/19, indicated R53 had alteration in elimination related to a history or urinary tract infections (UTI), urinary retention, impaired mobility, and was incontinent of bowel and bladder. R53's goal was to remain clean, dry, odor free, and to be free from signs and symptoms of UTI. R53 interventions included assistance of two and a Hoyer (mechanical lift) with toileting needs including peri care, pad, and clothing adjustments.

R53's Bladder Evaluation dated 9/20/19, indicated R53 was incontinent of bowel and bladder, did not inform staff of need to void, and occasionally would ask staff for a urinal but R53 had already voided and did not void in a urinal. R53 required two assists with toileting including a Hoyer for transfers, clothing and pad management, and peri care. Staff was to offer toileting, check, and change every two hours. R53 was able to make needs known and understand others.

R53's nursing assistant care guide sheet dated 11/17/19, indicated R53 was incontinent and required two assist and a Hoyer with toileting.

On 11/17/19, at 1:16 p.m. R53 stated he urinated in his pants because he was unable to use the bathroom, and would be unable to use the urinal on his own.

During observation on 11/19/19, at 10:07 a.m. R53 had verbalized he had to "pee" during

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morning cares. NA-A instructed R53 just to "pee" in his pants because he was wearing an incontinent brief. NA-B asked NA-A if R53 had a urinal. NA-A stated R53 did not have urinal, and told R53 that NA-A would change and get him cleaned up when he was done.

On 11/19/19, 11:24 a.m. licensed practical nurse (LPN)-B confirmed R53 was incontinent of bowel and bladder, and stated R53 was getting stronger and maybe would be able to use a urinal with assistance. LPN-B stated R53 should be assessed for a toileting program, and should be offered to use the urinal or to be toileted.

On 11/19/19, at 12:50 p.m. R53 stated he would prefer to use the bathroom and not "pee" in his pants. R53 stated staff did not offer to take him to the bathroom or offer a urinal. R53 stated when staff would come into his room, R53 would say he had to "pee" and the staff was used to him going in his pants.

On 11/20/19, at 2:10 p.m. the ADON stated bowel and bladder assessments were completed upon admission, annually, and with any resident changes. The ADON stated if a resident showed signs that he/she may be able to be continent of bowel or bladder, the resident would be started on a toileting program.

On 11/20/19, at 4:39 p.m. the DON stated if a resident was able to verbalize they had to urinate, the resident should be on a bowel and bladder program. A toileting log would be initiated to assess the resident's urinary patterns to promote highest bladder functioning.

The facility policy Behavioral Programs and Toileting Plans for Urinary Incontinence dated

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2 910	Continued From page 33 10/10, directed a review of the residents care plan to assess for any special needs of the resident. Conduct a thorough assessment of the resident and his or her environment to determine factors that may have contributed to any recent decline in urinary incontinence. Monitor, record, and evaluate information about the resident's bladder habits, and continence or incontinence. Assess the resident for appropriateness of behavioral programs which promote urinary incontinence. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are assisted with toileting as determined necessary by their individualized assessment. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 910		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms.	21025		1/3/20

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21025	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at the appropriate temperature to ensure food safety and prevent food borne illness. This had a potential to affect 63 of 65 residents who ate food prepared in the facility kitchen. Findings include: On 11/17/19, at 5:34 p.m. review of the facility food temperature log for November 2019, revealed temperatures were not taken for the following meals: Breakfast food temperatures for 11/4, 11/5, 11/8, 11/9, 11/13, and 11/14. Lunch food temperatures for 11/4, 11/5, 11/8, 11/9, 11/13, and 11/14. Supper food temperatures for 11/2, 11/3, 11/9, and 11/15. On 11/19/19, at 12:57 p.m. dietary manager (DM)-A was interviewed, and stated she had not reviewed November food temperature logs. DM-A stated this was the responsibility of the assistant dietary manager. DM-A stated she soul have been notified if food temperatures were not being taken so retraining of staff could have occurred. DM-A stated food safety and temperature of food was important to ensure bacterial growth does not occur which could lead to food borne illness for the residents. On 11/20/19, at 3:00 p.m. the director of nursing (DON) stated taking food temperature before serving food was important not only for food	21025	Corrected	

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21025	Continued From page 35 safety and preventing food borne illness, but also palpability of food. The facility policy Culinary Department dated 12/16, directed cooking foods at proper temperatures and maintaining proper temperatures are necessary to prevent pathogens (disease producing bacteria). The facility policy Food Re-Heating and Handling undated, directed staff that all potentially hazardous food must be reheated to 165 degrees Fahrenheit or above for 15 seconds within two hours, and held above 150 degrees Fahrenheit until served to prevent bacteria from growth. The facility training material Food Preparation undated, directed kitchen staff to check and record food temperatures prior to service. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could review and/or revise the current food temperature policies and procedures to ensure food is cooked and held to appropriate temperatures to prevent food-borne illnesses. The dietary manager or designee could educate the appropriate staff on the policies/procedures. The dietary manager or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the	21385		1/3/20

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21385	Continued From page 36 infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use during personal cares and toileting cares to prevent cross contamination for 1 of 3 residents (R29) reviewed for bowel and bladder. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure, and anxiety disorder. R29's annual Minimum Data Set (MDS) completed 10/2/19, indicated R29 was cognitively intact with no resistive behaviors, delirium, psychosis or mood symptoms during the assessment period. R29's MDS further indicated R29 was frequently incontinent of bowel and bladder, required extensive assistance of two staff for toileting cares, and received a diuretic on a regular basis. R29's undated Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, completed for annual MDS with the reference date of 9/23/19, indicated R29 required assistance with toileting cares, was frequently incontinent of bladder, and had recently been	21385	Corrected	

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hospitalized with a urinary tract infection (UTI). R29's CAA indicated R29 was offered toileting every 2 hours and as needed, and was transferred using a stand-aide assist lift. R29 did not always alert staff to the need to use the toilet. R29 received Lasix (diuretic), which could increase the risk for urinary urgency and frequency. R29's CAA further indicated R29 was able to communicate needs.

R29's care plan revised 10/2/19, indicated R29 was able to communicate needs, was understood by others, and could usually understand simple conversation. R29's care plan indicated R29 was frequently incontinent of bowel and bladder, and directed staff to toilet every 2 hours and as necessary.

R29's care guide/pocket care plan dated 11/17/19, indicated R29 was incontinent, and directed staff to provide hourly toileting while awake.

On 11/19/19, at 9: 55 a.m. nursing assistant (NA)-F entered R29's room with the stand-assist lift to assist R29 with toileting cares. NA-F washed her hands, donned gloves, closed the curtain and shades, and positioned the stand-assist lift up to R29. NA-F hooked up the canvas and calf straps, and removed her soiled gloves, sanitized her hands and without performing hand hygiene donned clean gloves, and removed R29's oxygen canula. NA-F raised R29 to a standing position in the stand-assist lift, lowered R29's incontinent brief, and lowered R29 to the commode. NA-F stated R29's brief was a little damp with urine. NA-F removed her soiled gloves and sanitized her hands, as R29 voided a moderate amount of yellow urine in the commode. Without performing hand hygiene,

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NA-F donned clean gloves, raised R29 in the stand-assist lift, wiped R29's peri area with a personal cleansing wipe. NA-F did not remove her soiled gloves and perform hand hygiene, and put on clean gloves. NA-F put a clean incontinent brief on R29, moved the commode out of the way, put the wheelchair in place, lowered R29 into the wheelchair, unbuckled the canvas, pushed the wheelchair back, and then removed her soiled gloves. NA-F sanitized her hands and donned clean gloves. NA-F placed R29's oxygen canula on R19's face. NA-F moved the stand-assist lift out of R29's room and brought it into the tub room. NA-F stated she thought she had changed gloves and sanitized following peri care, and said she should have.

On 11/19/19, at 11:04 a.m. the assistant director of nursing (ADON) stated staff should remove soiled gloves, sanitize or wash hands, and put clean gloves on going from dirty to clean areas and tasks.

The facility Handwashing policy dated 1/08, directed handwashing should be completed when hands are visibly soiled, and when hands are not visibly soiled, to use an alcohol based hand rub. The policy further directed hand hygiene should be performed before and after contact with residents, before doing an invasive procedure, after contact with bodily fluids, before moving from contaminated body site to a clean body site during resident cares, after contact with mechanical equipment, after removing gloves.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and/or revise the current hand hygiene and cleaning of medical equipment policies and

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21385	Continued From page 39 procedures to ensure prevention of cross-contamination. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	Corrected	1/3/20

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21426	Continued From page 40	21426		

facility failed to ensure resident's second step Tuberculin skin test (TST, a skin test used to check for tuberculosis infection) was completed for 1 of 5 residents (R2) reviewed for TST.

Findings include:

R2's Face Sheet printed 11/20/19, indicated R2's diagnoses included asthma.

R2's Baseline Tuberculin (TB) Screening form indicated R2 received his first step TST on 5/24/19, but lacked information indicating the date, time, and interpretation of the TST. R2's TB screening form had provided space to record a second TST however, it was left blank. R2's medical record lacked documentation R2 received a second step TST.

On 11/20/19, at 2:34 p.m. the assistant director of nursing (ADON) verified R2's TB Screening form did not indicate results from the first step TST, and also lacked evidence that R2 received the required second step TST. The ADON stated documentation of the TST results should include a positive or negative reading, along with the millimeters (mm) of induration, date, and time the TST was read.

On 11/21/19, at 4:37 p.m. the director of nursing (DON) verified R2 did not receive the required second TST, and would expect the second step TST to be completed. The DON further stated if the second step TST was not administered, she would expect the TST to be repeated.

The facility policy Resident Baseline Tuberculosis Screening of Resident dated 11/10, directed qualified nurses interpret the TST 48 to 72 hours after administration of the TST. All test results

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21426	Continued From page 41 must be read in millimeter. Document the time of interpretation. Time of interpretation must not be greater than 72 hours after time of administration. The policy further indicated residents whose first step TST is negative will receive a second step TST one to three weeks after the initial TST was administered. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the facility's process to ensure TB testing for resident is completed and documented as required. The DON or designee could re-educate nursing staff on the process and TB policy. The DON or designee could review current monitoring or audit system to ensure compliance of TB screening and documentation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending	21540		1/3/20

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21540	Continued From page 42 physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure orthostatic blood pressures for monitoring of potential side effects related psychotropic medications were completed for 3 of 6 residents (R29, R39, R3) reviewed for unnecessary medications. In addition, the facility failed to ensure appropriate diagnoses for use of medications for 1 of 6 residents (R39) reviewed for unnecessary medications. In addition, the facility failed to ensure monitoring of weights as ordered by a physician regarding a medical condition for 1 of 6 residents (R29) reviewed for unnecessary medications. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure (CHF), edema, bipolar disorder, and anxiety disorder. R29's care plan initiated 8/24/18, indicated R29 was at risk for falls related to medical conditions, including CHF, edema, bipolar disorder, and vascular dementia. R29's care plan indicated	21540	Corrected	

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21540	Continued From page 43 R29 was taking psychotropic medications (mood and behavior altering medications), and directed nursing to obtain a monthly orthostatic blood pressure. R29's Order Summary Report with Active Orders as of 11/19/19, included orders for: -check vital signs daily. Order 9/17/19. -Monthly psychotropic side effect monitoring, if side effects, update physician. Every day shift on the 24th, monthly. -Sertraline HCL (antidepressant) 50 mg at bedtime. Order start date 9/17/19. -Olanzapine (antipsychotic) 5 mg every evening for bipolar disorder. Order start dated 9/17/19. R29's progress notes dated 9/24/19, indicated R29 refused an orthostatic blood pressure. R29's progress notes lacked documentation of any attempts to re-approach R29 for an orthostatic blood pressure. R29's Treatment Administration Record (TAR) indicated R29's orthostatic blood pressure was not completed. R29's Weights and Vitals Summary for 9/24/19, lacked documentation of an orthostatic blood pressure. R29's TAR for October 2019, indicated R29's orthostatic blood pressures for monitoring of psychotropic medications were obtained on 10/24/19, but lacked documentation of orthostatic blood pressure results. R29's progress notes dated 10/24/19, lacked documentation of R29's orthostatic blood pressure results.	21540		

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21540	Continued From page 44 R29's Weights and Vitals Summary for 10/24/19, lacked documentation of an orthostatic blood pressure. R29's TAR for November 2019, indicated R29's orthostatic blood pressure had not yet been taken, and was scheduled for 11/24/19. R29's TAR indicated R29 was to be monitored monthly for psychotropic side effect monitoring monthly on the 24th. R29's Weights and Vitals Summary dated 10/3/19, through 11/20/19, indicated no orthostatic blood pressures were obtained or recorded for R29. On 11/20/19, at 4:28 p.m. director of nursing (DON) verified orthostatic BP's should be obtained for monitoring of psychotropic medications. R39's Admission Record printed 11/20/19, indicated R39's diagnoses included CHF, mild cognitive impairment, encephalopathy (brain damage, disease, or malfunction), major depressive disorder, and insomnia. R39's Order Summary Report for active orders as of 11/20/19, included orders for: -quetiapine (antipsychotic medication) 50 milligrams (mg) at bedtime for primary insomnia, order dated 10/29/19. -Sertraline (antidepressant medication) 100 mg tablet; take 2 tabs daily for depression, order dated 10/29/19 In addition, R39's orders included the following medications without diagnoses for use of the medications: -Pregabalin Capsule (nerve pain medication)	21540		

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21540	Continued From page 45 -Slow Mag tablet DR (magnesium supplement) -Metoprolol Tartrate (for chest pain or high blood pressure) -Melatonin (hormone used for sleep) -Lisinopril (for high blood pressure and heart failure) -Furosemide (diuretic) -Atorvastatin Calcium (for high cholesterol) -Diltiazem CD ER 24 hour (high blood pressure and heart failure) -cholestyramine light packet (for high cholesterol) -cholecalciferol (vitamin D supplement) -Budesonide capsule DR (anti-inflammatory for Crohn's or ulcerative colitis) - Aspirin R39's order summary lacked direction for monitoring of psychotropic medication side effects, and orthostatic blood pressures for monitoring of psychotropic medications. R39's care plan initiated 8/29/19, indicated R39 received psychotropic medications and was at risk for adverse side effects. R29's care plan directed nursing to monitor for adverse drug reactions and obtain monthly orthostatic blood pressures. R39's Consultant Pharmacist's Medication Review dated 7/19/19, recommendations included monitoring of antipsychotics including orthostatic blood pressures, side effects, and target behaviors. Nursing signed recommendation as completed on 8/12/19. R39's Medication Administration Record (MAR) for September 2019, indicated R39 received quetiapine fumarate for insomnia on 9/10/19 through 9/12/19, melatonin daily for insomnia, and sertraline for depression daily. R39's MAR	21540		

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21540	Continued From page 46 included directives for antipsychotic side effect monitoring monthly and was documented as completed on 9/6/19. R39's Treatment Administration Record (TAR) for September 2019, directed nursing to obtain a lying and sitting (orthostatic) blood pressure due to antipsychotic medication monthly. R39's orthostatic blood pressure was documented as done, but without results. R39's progress notes dated 9/619, lacked documentation of orthostatic blood pressure results or attempts to reapproach for the orthostatic blood pressure. R39's Weights and Vitals Summary report for 9/6/29, lacked documentation of an orthostatic blood pressure. R39's MAR for October 2019, indicated R39 received quetiapine fumarate for insomnia and depression, and sertraline for depression, and melatonin for insomnia. R39's MAR included directives for antipsychotic side effect monitoring monthly and was documented as completed on 10/6/19. R39's TAR for October 2019, directed nursing to obtain an orthostatic blood pressure monthly due to antipsychotic medication. R39's TAR indicated an orthostatic blood pressure was obtained on 10/6/19, but lacked documentation of results. R39's Weights and Vitals Summary for 10/6/19, indicated R39's orthostatic blood pressure was completed, and indicated no orthostatic hypotension (drop in blood pressure) with change in position from lying to sitting.	21540		

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21540	Continued From page 47 R39's MAR for November 2019, indicated R39 received melatonin, quetiapine fumarate for insomnia, and sertraline for depression. R39's MAR lacked direction to monitor for antipsychotic medication side effects. R39's TAR for November 2019, lacked direction to obtain orthostatic blood pressures monthly due to psychotropic medications. R39's Weights and vitals Summary since readmission on 10/29/19, indicated no orthostatic blood pressures had been obtained. R39's progress notes since readmission on 10/29/19, lacked documentation of orthostatic blood pressures, or clarification of diagnosis for use of quetiapine or other medications. R39's Psychotropic Medication review dated 10/10/19, was not completed and signed. R39's Target Behavior Form was not completed 11/14/19. R39's NP visit note dated 9/4/19, indicated R39 had received quetiapine every night for agitation, nursing reported no agitation since admission, and R39 was unable to indicate when and why quetiapine was prescribed. NP discontinued quetiapine and started melatonin every evening. R39's progress notes dated 9/8/19, indicated R39 had not been sleeping well and was concerned the physician had discontinued the quetiapine that had helped her sleep good previously. R39's progress notes dated 9/9/19, indicated R39's primary care physician sated insomnia had recurred since quetiapine was discontinued, so	21540		

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21540	Continued From page 48 reordered quetiapine at bedtime. R39's progress notes dated 9/12/19, indicated insomnia was not an approved diagnosis for quetiapine. R39's Consultant Pharmacist's Medication Review dated 9/12/19, identified an irregularity regarding quetiapine. The pharmacist indicated sleep was not an approved indication for quetiapine and recommended a review and assessment of the current use of quetiapine for R39, and if the diagnosis is sleep, to discontinue use of quetiapine. R39's physician responded by changing R39's diagnosis for use of quetiapine to depression. R39's physician visit notes dated 9/13/19, indicated R39 had seen her primary care physician on 9/9/19, and the physician felt she should restart quetiapine for insomnia, so it had been restarted. R39's progress notes dated 9/13/19, indicated R39's diagnosis for quetiapine was changed to depression. R39's Consultant Pharmacist Medication Review dated 9/18/19, identified an irregularity regarding use of quetiapine. The pharmacist indicated on 8/30/19, R39 was not showing signs of agitation and quetiapine was discontinued. Resident then complained of not being able to sleep and quetiapine was started with a diagnosis of sleep and then changed to a diagnosis of depression. The consultant pharmacist recommended tapering R39 off the quetiapine and starting a medication that would target sleep, such as trazodone or mirtazapine that would also help with depression. R39's physician addressed the pharmacist's recommendation by ordering	21540		

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21540	Continued From page 49 trazodone in place of quetiapine. R39's physician notes dated 11/4/19, indicated R39 had been readmitted from a hospital stay during 10/24/19 to 10/29/19, for heart failure exacerbation. R39's physician visit notes indicated medications were reviewed, but diagnoses were not provided for use of medications, and lacked diagnoses for psychosis or psychotic behaviors. R39's physician visit notes further indicated R39 had not significant behavioral changes. R39's NP visit notes dated 11/11/19, lacked diagnoses for medications received by R39 per orders. R39's NP visit notes indicated R39's mood was good, and had no significant behavioral changes. R39's NP visit notes further indicated R39 received quetiapine for chronic insomnia, and the plan was to continue the medication as ordered. R39's nurse practitioner (NP) visit notes dated 11/20/19, indicated orthostatic blood pressures had not been checked between 11/19/19 and 11/21/19, and lacked diagnoses for medications received by R39 per orders. On 11/19/19, at 1:22 p.m. R39 stated she felt her medications were helpful and she had not experienced any side effects. On 11/20/19, at 4:19 p.m. director of nursing (DON) stated she would expect orthostatic blood pressures to be done when a resident is receiving any psychotropic medication. DON verified quetiapine is not an appropriate medication for sleep and verified R39's orthostatic blood pressures were not completed and antipsychotic side effect monitoring was not on the TAR	21540		

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21540	Continued From page 50	21540		

following R39's hospital return and should have been done. DON verified the NP and physician had seen R39 since her return from the hospital and nursing should have put in a request for diagnoses of medications at that time. DON verified R39's Psychotropic Medication review had not been completed as dated for 10/10/19, and Target Behavior Form was not completed for 11/14/19.

The facility policy Antipsychotic Medication Use revised 12/16, directed residents would "only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective." The facility policy and procedure further directed the physician to identify, evaluate and document symptoms that may warrant the use of antipsychotic medications, and the diagnosis of a specific condition for which the antipsychotic medications are necessary to treat would be based on a comprehensive assessment. Antipsychotic mediations would not be used if the only symptoms were one or more of symptoms including restlessness, insomnia, nervousness, or mild anxiety.

R3's Admission Record dated 11/20/19, indicated R3's diagnoses included major depressive disorder and anxiety disorder.

R3's quarterly MDS dated 8/21/19, identified R3 had moderately impaired cognition. R3's MDS also identified she was administered antidepressant medication for seven days, during the seven day lookback period, and had two or more falls without injury.

R3's Order Summary Report dated 11/20/19, indicated R3 was ordered orthostatic blood

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21540	Continued From page 51	21540		

pressures monitoring due to psychotropic medication usage on the 10th day of every month. Further, R3 was ordered fluoxetine (antidepressant) 20 mg daily for depression on 8/30/19.

R3's care plan dated 3/14/19, indicated R3 had potential for psychotropic adverse drug reactions related to fluoxetine medication usage. Interventions included monitoring for adverse drug reactions.

R3's November 2019 TAR lacked indication orthostatic blood pressures were taken.

Review of R3's weights and vitals summary dated 12/2/19, lacked indication orthostatic blood pressures were recorded from 8/1/19, to 11/21/19.

On 11/20/19, at 10:34 a.m. an interview was conducted with registered nurse (RN)-E. RN-E confirmed she was unable to locate orthostatic blood pressures in R3's medical record. RN-E stated staff were expected to follow the order and a process for leaving a progress notes with results was being put into place.

On 11/20/19, at 3:37 p.m. an interview was conducted with the DON. The DON stated she expected staff were to complete full sets of orthostatic blood pressures as indicated, and there should had been a note.

The facility policy Antipsychotic Medication Use revised 12/16, directed nursing staff to observe, document, and report adverse consequences to the attending physician such as "orthostatic hypotension."

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21540	Continued From page 52 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current monitoring of psychotropic medication policies and procedures to ensure potential side effects are identified and managed. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single	21545		1/3/20

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21545	Continued From page 53 medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a correct dosage of a narcotic pain medication was administered to 1 of 8 residents (R52) reviewed for medication administration. Findings include: R52's Admission Record dated 11/19/19, indicated R52's diagnoses included humerus fracture (fracture of upper arm) and mild cognitive impairment. R52's admission Minimum Data Set (MDS) dated 10/28/19, identified R52 had intact cognition.	21545	Corrected	

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21545	Continued From page 54 R52's MDS further identified he received as needed pain medication, had occasional pain, and received opioid pain medication for seven days. R52's Order Summary Report dated 11/19/19, indicated R52 was prescribed Norco (a narcotic pain medication) 10-325 milligrams (mg) every six hours as needed for pain rated six or greater on the numeric pain scale. The order was placed on 11/18/19. R52's care plan dated 11/1/19, indicated R58 did not wish to self-administer medications, and had a mild cognitive impairment. The care plan further indicated R58 would be administered medications per physician orders and by a licensed nurse. R52's November 2018 Medication Administration Record (MAR) printed 11/19/19, indicated R58 was prescribed hydrocodone-acetaminophen (Norco) 5-325 mg. R58 was to take one tablet every four hours as needed for pain rated 4-7, or two tablets as needed for pain rated 8-10 on the numeric pain scale. The MAR further identified R58 was administered Norco 11/12/19, at 4:39 p.m. and 11/14/19, at 1:06 a.m. The order was started on 11/6/19, and discontinued on 11/15/19. R52's November 2018 MAR printed 11/19/19, indicated R58 was prescribed Norco 5-325 mg. R58 was to take one tablet every six hours, as needed, for pain rated 4-7 or two tablets, as needed, for pain rated 8-10 on the numeric pain scale. The MAR further identified R58 was administered Norco on 11/16/19, at 6:31 a.m., and 11/17/19, at 8:46 a.m. The order was started on 11/15/19, and discontinued on 11/18/19.	21545		

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21545	Continued From page 55 On 11/17/19, at 7:17 p.m., licensed practical nurse (LPN)-C and LPN-E were observed administering medications. R58 approached LPN-C and LPN-E and stated he needed pain medication. LPN-C removed a medication card labeled Norco 10-325 mg, belonging to R58, from a locked compartment within the medication cart. LPN-C compared the medication card label to the electronic medication administration record (eMAR) and verbalized the dosage on medication card label did not match the physicians order. LPN-C did not administer the Norco and requested LPN-E to check the physicians order located in R58's paper medical record. LPN-C verified six doses of Norco 10-325 mg had been dispensed from the medication card. Registered nurse (RN)-E walked to the medication cart and informed LPN-C the physician order indicated the correct dosage was Norco 5-325, and stated she would start a medication error form. On 11/17/19, at 7:27 p.m., an interview was conducted with RN-E. RN-E audited R58's medical record, and stated R58's Norco order was updated in the eMAR on 11/15/19. RN-E verbalized the Norco frequency was changed from every four hours to every six hours however, the dosage of 5-325 mg remained the same. RN-E stated the order transcription was accurate, according to the written physician order, and the error occurred as staff had failed to verify the medication label against the medication order to ensure accuracy. The medication card was again observed, and RN-E confirmed six doses were incorrectly administered. The medication card was documented as filled on 11/12/19. A Medication Error Reconciliation Form dated 11/17/19, indicated, "Dose sent from pharmacy 10-325 administered total of 6 times. Escript sent	21545		

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21545	Continued From page 56	21545		

to pharmacy but not facility for updated dose on 11/12/19." The Medication Error Reconciliation Form further indicated the wrong drug/dosage was administered and "an error occurred that reached the patient but did not cause patient harm."

On 11/20/19, at 3:36 p.m. an interview was conducted with the director of nursing (DON). The DON stated the nurses were to check medication labels against the medication orders prior to administration. The DON further stated adverse consequences of receiving double doses of opioid pain medication could include confusion and constipation.

The facility policy Administering Medications revised 4/19, directed, "The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and/or revise the current medication administration and medication error policies and procedures to prevent significant medication errors.
The DON or designee could educate the appropriate staff on the policies/procedures.
The DON or designee could develop a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21880	Continued From page 57	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		1/3/20

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21880	Continued From page 58 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written response to a grievance for 1 of 1 residents (R12) reviewed for grievances. Findings include: R12's Admission Record printed 11/20/19, indicated R12's diagnoses included unspecified intellectual disabilities, and unspecified convulsions (seizures). R12's quarterly Minimum Data Set (MDS) dated 9/10/19, indicated R12 had a moderate cognitive deficit, was able to speak clearly, was understood, and understood others. R12's MDS indicated R12 displayed no behaviors, no signs or symptoms of delirium or psychosis, and had no mood symptoms. R12's care plan initiated 4/20/17, indicated R12 was cognitively intact, was able to understand others, was able to be understood by others, and was able to communicate needs effectively. R12's progress notes dated 10/23/19 through 11/19/19, lacked documentation regarding missing clothing. On 11/17/19, at 2:17 p.m. R12 was interviewed and stated she had three to four pairs of missing	21880	Corrected	

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purple shorts. R12 stated the facility looked for the shorts, and she was told after she asked, the facility was unable to find them. R12 stated she had reported it to the lady who did the laundry. R12 denied getting a written response in regards to the missing clothing.

On 11/19/19, at 7:40 a.m. laundry aide (LA)-A stated R12 had been missing two purple shorts for 3 to 4 months. LA-A stated she has looked through everything and was unable to find them. LA-A stated R12's family knew about it.

On 11/20/19, at 2:40 p.m. social services director (SS)-A stated she had not heard about R12's missing clothing. SS-A stated the resident or family gets updated with the results of the grievance investigation, but they do not provide a written response.

On 11/20/19, at 2:43 p.m. social services regional director (SS)-B stated R12's missing shorts occurred some time ago. SS-B stated the administrator was supposed to purchase new shorts, but the re was a problem finding the appropriate size. SS-B confirmed the facility did not provide a written response to R12 or the resident representative. SS-B stated they would keep the grievance form on file.

R12's grievance form was requested and not provided.

The facility policy Complaints and Grievance Procedure dated 9/01, directed a grievance form to be completed, and turned into the administrator as soon as reasonable possible when the verbal complaint had been voiced. The administrator would provide a verbal summary, unless a written summary was required, to the complainant no

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21880	Continued From page 60 later than 5 business days after the receipt of the grievance. If the grievance was not resolved, the grievance form was to be sent to the corporate Grievance Office, and within 7 days, the grievance officer would attempt to resolve the grievance and notify the complainant in writing of the proposed action. If the grievance was not resolved, it would be submitted to the Board of Directors and the Board would issue a written summary to the complainant of proposed action no later than 30 days after receipt of the grievance. All completed grievance forms would be kept on record at the facility for no less than 3 years. SUGGESTED METHOD OF CORRECTION: The administrator, social services director or designee could review and/or revise the current grievances policies and procedures to ensure a written response/resolution to a grievance is provided. The administrator, social services director, or designee could educate the appropriate staff on the policies/procedures. The administrator, social services director, or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its	21925		1/3/20

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21925	Continued From page 61 justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notification of reason for transfer to a hospital was provided for 2 of 5 residents (R19, R50) reviewed for transfer/discharge. Findings include: R19's Admission Record printed 11/20/19, indicated R19's diagnoses included anemia, chronic kidney disease, and congestive heart failure. R19's hospital discharge paperwork dated 9/25/19, indicated R19 was admitted to the hospital on 9/23/19, for evaluation after a fall.	21925	Corrected	

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R19's medical record lacked evidence a written notice for transfer was obtained and provided in writing to R19 and/or R19's representative.

R19's progress note dated 10/20/19, indicated R19 had a fall and was sent to the emergency room for evaluation and returned back to the facility on 10/20/19. R19's medical record lacked evidence a written notice for transfer was provided in writing to R19 and/or R19's representative.

R50's Admission Record printed 11/20/19, indicated R50's diagnoses included chronic kidney disease, diabetes type 2, and had a mild cognitive impairment.

R50's progress note dated 5/1/19, at 2:31 p.m. indicated R50 was admitted to the hospital on 5/1/19, for Influenza. R50's medical record lacked evidence a written notice of transfer was provided in writing to R50 and/or R50's representative.

R50's Interagency Referral Form dated 8/16/19, indicated R50 was hospitalized 8/12/16, for swollen leg, fatigue and poor appetite. R50's medical record lacked evidence a written notice for transfer was provided in writing to R50 and/or R50's representative.

On 11/20/19, at 1:38 p.m. director of social services stated when a resident goes into the hospital from the facility, the nurses will obtain a signed bed hold and a written notification of transfer from the resident to sign if the resident is able to sign for themselves, and if not will obtain a verbal from the residents representative. A written Bed-Hold Notice for Hospital Transfer and Therapeutic Leave form given to the resident or

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21925	Continued From page 63 representative, and best practice would be to document in the resident's medical record that a written was provided to the resident and/or resident representative. On 11/20/19, at 2:00 p.m. licensed practical nurse (LPN)-A stated if a resident goes into the hospital from the facility, the resident would sign a bed hold form including reason for transfer, and if the resident was unable to sign, a verbal consent would be obtained from the resident's representative over the phone and documented in the resident's medical record. LPN-A stated the completed form was put into the resident's chart, and the director of nursing (DON) was notified in person or by email of the hospitalization. On 11/20/19, at 4:39 p.m. the DON verified the facility was not providing a written notice of transfer to residents and/or resident representatives only upon request. The facility was unable to provide a policy on written notice of transfer. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures on discharges and/or transfers to ensure a written notification of reason for transfer is provided. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.	21925		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults	21995		1/3/20

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21995	Continued From page 64 Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report bruises of unknown origin to the State Agency within 2 hours for 1 of 3 residents (R21) reviewed for abuse. Findings include: R21's Admission Record printed 11/20/19, indicated R21's diagnoses included vascular dementia with behavioral disturbance, and cerebral infarction (stroke). R21's quarterly Minimum Data Set (MDS) dated 9/19/19, indicated R21 had a severe cognitive impairment, displayed no symptoms of delirium or psychosis, no behaviors during the assessment period, and required extensive assistance with all activities of daily living (ADLs). R21's care plan initiated 4/24/17, indicated R21 was unable to remove self from harmful situations due to physical and cognitive deficits, and directed staff to observe for and report any changes in vulnerability. R21's care plan directed staff to provide physical assistance with all ADLs and mobility, indicated R21 could be resistive to	21995	Corrected	

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assistance with cares, and directed staff to re-approach as R21 allowed. R21's care plan further indicated R21 was forgetful and confused, had a modified independence with decision making and required some assistance in new situations, and had an impaired short term memory and moderately impaired long term memory.

R21's nursing assistant care guide sheet directed staff to give space, and re-approach when demonstrating agitated behaviors, and Tubigrips (stockinette) from knuckles to elbows as she allows.

R21's Order Summary Report with active orders as of 11/20/19, included a chewable 81 milligram (mg) aspirin daily. R21's orders did not include any orders for anticoagulant or steroid medications.

R21's progress notes dated 10/31/19, at 12:19 a.m. indicated staff had reported bruises to both of R21's hands at the base of the thumbs, with the right thumb bruise measuring 2.0 centimeters (cm) by 1.0 cm, and the left thumb measuring 3.8 cm x 4.0 cm. The bruises were documented as being black and blue. R21 did not respond to questions of how she got the bruises, or if she were being hurt. The oncoming licensed nurse was updated on the bruises.

R21's progress notes dated 11/1/19, at 9:55 a.m. indicated the interdisciplinary team (IDT) met on 10/31/19, to review R21's bruises noted on 10/30/19. The IDT noted R21 would frequently grab at staff and strike out with her hands, and refuse medications and treatments. IDT decided to place Tubigrips to both arms from knuckles to elbows for protection as R21 allowed.

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21995	Continued From page 66	21995		

R21's progress notes lacked indication of a specific event that led to R21's bruises, and lacked indication that R21's bruises were reported to the State Agency.

R21's physician visit note dated 11/4/19, indicated R21 resisted examination, and was seen for increased behaviors and refusal behaviors the previous month. R21's physician note lacked notation of bruises on bilateral thumbs.

On 11/20/19, at 4:12 p.m. the director of nursing (DON) stated staff should have been asked at the time of the incident for possible causes of bruising, and if no one knew how it could have happened, it should have been reported to the state agency within 2 hours, as a potential abuse.

The facility policy for Abuse Prevention/Vulnerable Adult Plan dated 12/18, directed staff to immediately notify the unit nurse, who was then to attempt to determine the cause of the injury of unknown origin, immediately notify the administrator of an injury of unknown origin, and suspected abuse would be reported to the state agency no later than 2 hours after forming the suspicion.

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON), social services director, or designee could review and/or revise the current vulnerable adult and abuse policies and procedures to ensure timely reporting of potential abuse allegations.
The administrator, director of nursing (DON), social services director or designee could educate the appropriate staff on the policies/procedures.
The administrator, director of nursing (DON),

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21995	Continued From page 67 social services director or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		

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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 htttp://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the	2 000		

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2 000	Continued From page 1 attached Minnesota 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 11/17/19, through 11/21/19, 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. H Complaint H5483040C was investigated and was substantiated. 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,	2 000		

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2 000	Continued From page 2 "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		
2 280	MN Rule 4658.0100 Subp. 1 Employee Orientation and In-Service Education Subpart 1. Orientation and initial training. All personnel must be instructed in the requirements of the law and the rules pertaining to their respective duties and the instruction must be documented. All personnel must be informed of the policies of the nursing home, and procedure manuals must be readily available to guide them in the performance of their duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure abuse, vulnerable adult training, and Alzheimer's/dementia training was provided to staff during orientation and prior to working with residents for 1 of 5 nursing assistants (NA-I) reviewed for staffing. In addition, the facility failed to ensure performance reviews were completed every 12 months for 1 of 9 nursing assistants (NA-B) who had been employed by the facility for over one year. This had the potential to affect all 65 residents residing in the facility. Findings include: A review of staff training records indicated nursing assistant (NA)-I was hired on 6/24/19, and had	2 280	Corrected	1/3/20

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2 280	Continued From page 3	2 280		

not received abuse or dementia training prior to working with residents.

On 11/18/19, at 3:58 p.m. director of nursing (DON) verified NA-I had not received the required abuse and dementia training.

The facility policy Abuse Prevention/Vulnerable Adult Plan revised 7/18, directed staff to receive vulnerable adult, resident's rights, and abuse training in new employee orientation and annually.

The facility Dementia Training Disclosure policy revised 1/18, and was provided in the resident admission packet, indicated all staff would receive 8.25 hours of training within their first 160 hours worked, and 2 hours of training annually thereafter. The facility disclosure indicated training would include a comprehensive view of Alzheimer's, comprehensive view of dementia, abuse prevention in persons with dementia, and care of the cognitively impaired resident.

An undated Employee Roster Report printed on 11/17/19, and personnel record review indicated the following:

NA-B's hire date was 6/6/18. No annual performance review had been completed.

On 11/20/19, at 4:39 p.m. the facility nurse consultant confirmed NA-B did not have an annual performance review completed.

The facility policy Personal Records dated 5/2018, directed performance evaluations were to be completed at least annually.

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2 280	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and/or revise the current staff training policies and procedures to ensure all staff receive the appropriate abuse and dementia training at orientation and annually. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 280		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees	2 302		1/3/20

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2 302	Continued From page 5 trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Alzheimer's/dementia training containining all the appropriate components was provided and received during orientation, and prior to working with residents for 1 of 5 nursing assistants (NA-I) reviewed for staffing. This had the potential to affect all residents. Findings include: A review of staff training records indicated nursing assistant (NA)-I was hired on 6/24/19, and had not received abuse or dementia training prior to working with residents. On 11/18/19, at 3:58 p.m. director of nursing (DON) verified NA-I had not received the required abuse and dementia training, and NA-I was immediately told she would not be able to work on the units with residents that day, upon reviewing her training records. On 11/20/19, DON stated NA-I was removed from the schedule until appropriate training was received. The facility policy and procedure for Abuse Prevention/Vulnerable Adult Plan revised 7/18, directed staff to receive vulnerable adult, resident's rights, and abuse training in new	2 302	Corrected	

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2 302	Continued From page 6 employee orientation and annually. The facility Dementia Training Disclosure revised 1/18, and was provided in the resident admission packet indicated all staff would receive 8.25 hours of training within their first 160 hours worked and 2 hours of training annually, thereafter. The facility disclosure indicated training would include a comprehensive view of Alzheimer's, comprehensive view of dementia, abuse prevention in persons with dementia, and care of the cognitively impaired resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current Alzheimer's training policies and procedures to ensure all staff receive the appropriate Alzheimer's training. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 680	MN Rule 4658.0465 Subp. 1 Transfer, Discharge, and Death: Dis. Summay Subpart 1. Discharge summary at death. When a resident dies, the nursing home must compile a discharge summary that includes the date, time, and cause of death. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 680	Corrected	1/3/20

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2 680	Continued From page 7	2 680		

facility failed to ensure a recapitulation of stay was completed for 2 of 5 residents (R60, and , R62) reviewed for discharges. In addition, the facility failed to document and reconcile the destruction of medications for 1 of 5 residents (R60) reviewed for discharge.

Findings include:

R60's Admission Record printed 11/19/19, indicated R60 was admitted on 5/9/17, and R60's diagnoses included cancer of the prostate, heart failure, chronic atrial fibrillation, chronic kidney disease, and dementia.

R60's Order Summary Report with active orders at the time of death, indicated R60's medications did not include controlled medications.

R60's progress notes dated 8/22/19, indicated R60 expired at 1:27 p.m.

R60's medical record lacked a discharge summary with a recapitulation of R60's stay at the facility. R60's medical record also lacked documentation of R60's medications dispensed or disposed of following R60's death.

On 11/19/19, at 2:58 p.m. director of nursing (DON) verified they could not find a discharge summary or recapitulation of stay, and could not find a disposition of medication form for R60. DON stated R60's medications came from the veteran's affairs (VA) and R60's spouse wanted the medications, but the facility did not fill out a form, and should have.

The facility policy and procedure for Discharge Summary Recapitulation and Plan revised

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2 680	Continued From page 8 12/3/18, lacked directives for a recapitulation of stay following a death of a resident. The facility policy and procedure for Discharge Medications, revised 12/16, lacked direction for reconciliation and documentation of medications following a death of a resident. The facility policy and procedure did include directions to complete the medication disposition record, including the signature of the person receiving the medications and the nurse releasing the medications for a resident's discharge. R62 Admission Record printed 11/20/19, indicated R62's was admitted to the facility on 9/28/19, and included the following diagnoses of heart failure, atrial fibrillation, and had a pacemaker. R62's progress note dated 9/29/19, at 9:15 a.m. indicated R62 was sent to the emergency room on 9/29/19 for diuresing. R62's progress noted dated 9/29/19, at 9:52 a.m. indicated R62's son declined bed hold due to how long R62 was going to be in the hospital was planned on picking up R62's belongings that day. A review of R62's medical record lacked evidence a recapitulation of stay was completed. On 11/20/19, at 4:39 p.m. DON verified no recapitulation of stay was completed for R62 and should have been completed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures for resident discharges and or transfers.	2 680		

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2 680	Continued From page 9 The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.	2 680		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure monitoring of weights as ordered by a physician regarding a medical condition for 1 of 6 residents (R29) reviewed for unnecessary medications. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure (CHF), and edema.	2 830	Corrected	1/3/20

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2 830	Continued From page 10 R29's care plan initiated 8/24/18, indicated R29 was at risk for falls related to medical conditions, including CHF, edema, and vascular dementia. R29's care plan indicated R29 was taking psychotropic medications, and directed nursing to obtain a monthly orthostatic blood pressure. R29's care plan identified R29's cardiovascular diagnoses and conditions, including CHF and bilateral leg edema with medications that included Lasix (diuretic), but lacked direction for daily weights and notification of provider of increase of 3 pounds overnight or 5 pounds weekly. R29's care guide lacked direction to obtain daily weights and weight gain guidelines for notification of the physician. R29's Order Summary Report with Active Orders as of 11/19/19, included orders for: -check vital signs daily. Order 9/17/19. -daily weights every day shift, call Heart Center if weight gain of 3 pounds overnight or 5 pounds in one week. Call heart center of shortness of breath, orthopnea, edema or bloating. Order date 9/30/19. -Monthly orthostatic blood pressure (lying, sitting, and standing) the 24th of every month. Nursing order date 8/26/18. -Lasix (diuretic) 40 milligrams (mg) twice daily for CHF. Order start date 10/23/19. -Melatonin 3 mg at bedtime for difficulty sleeping manifestations. -Metoprolol succinate (for blood pressure) extended release 24 hour; 25 mg in the a.m. -Sertraline HCL (antidepressant) 50 mg at bedtime. Order start date 9/17/19. -Olanzapine (antipsychotic) 5 mg every evening for bipolar disorder. Order start dated 9/17/19.	2 830		

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2 830	Continued From page 11 R29's nurse practitioner (NP) visit note dated 9/27/19, indicated R29 had been hospitalized from 9/5/19, through 9/17/19, with CHF, potential intestinal bleed, encphalopathy (brain disease, damage, or malfunction). R29's NP visit note further indicated R29 was discharged from the hospital with orders for Lasix and daily weights, and referral to the heart clinic. R29's Treatment Administration Record (TAR) for September 2019, indicated R29 had daily weights completed only on 9/18/19, and 9/19/19, then weekly weights. R29's Physician Visit Record dated 9/30/19, included signed NP orders for daily weights, and to call the heart center if weight gain of 3 pounds overnight or 5 pounds in one week, and if symptoms of shortness of breath, orthopnea, edema or bloating. R29's NP visit notes dated 10/11/19, indicated R29 had been hospitalized 9/5/19 through 9/17/19, with a GI bleed, acute encephalopathy, and CHF. R29 was discharged with orders for daily weights, Lasix and a referral to the heart failure clinic. R29's TAR for 10/1/19, through 10/31/19, indicated R29's daily weight was to be obtained daily starting 10/1/19, and R29's daily weights were not obtained 10/1/19, 10/2/19, 10/10/19, 10/17/19, and 10/22/19. R29's TAR for October 2019 indicated R29's weight on 10/3/19, was 180 pounds. R29's TAR for September 2019, indicated R29's previous weight was 171.5 on 9/25/19. R29's TAR for 11/1/19, through 11/20/19, indicated R29's daily weight was not obtained on	2 830		

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2 830	Continued From page 12 11/3/19, or 11/14/19. R29's TAR indicated R29 had more than a 3 pound weight gain from 11/11/19, to 11/12/19, and it increased slightly again on 11/13/19. R29's progress notes dated 11/12/19, and 11/13/19, lacked documentation of notification of the physician regarding the weight increase of greater than 3 pounds, and lacked documentation of monitoring of symptoms of CHF, edema or respiratory status. R29's Weights and Vitals summary for 9/21/19, through 11/20/19, indicated R29 had missed daily weights from 10/1/19, through 10/3/19, 10/10/19, 10/17/19, 10/18/19, 10/22/19, 11/3/19, and 11/14/19. -R29's weight record indicated R29 had a weight gain of 8.5 pounds from 9/25,/19 to 10/3/19. No weights were recorded in R29's medical record between 9/25/19, and 10/3/19. R29's progress notes dated 10/4/19, indicated the weight gain was reported to the physician, though lacked evidence of monitoring for symptoms of CHF, increased edema and respiratory status. -R29's weight record indicated R29 had a weight gain of 4 pounds from 10/5/19, to 10/6/19. R29's Progress notes lacked documentation of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain. - R29's weight record indicated R29 had a weight gain of 4 pounds from 10/9/19, through 10/11/19, with no weight recorded on 10/10/19. Progress notes lacked documentation of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain. -R29's weight record indicated R29 had a weight gain of 3.7 pounds from 10/16/19, to 10/19/19, but had not obtained a weight on 10/17/19, or 10/18/19. Progress notes lacked documentation	2 830		

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2 830	Continued From page 13	2 830		

of notification of physician, monitoring for signs and symptoms of CHF, respiratory status, or increased edema, related to R29's weight gain. R29's progress notes dated 10/23/19, indicated NP increased R29's Lasix for 3 days, following a visit.
-R29's weight record indicated R29 had a weight gain of 12.9 pounds from 10/29/19, to 10/30/19. R29's medical record indicated R29 went to the CHF clinic that day and daily weights were ordered. R29's medical record lacked documentation of monitoring for symptoms of CHF, increased edema and respiratory status.
-R29's weight record indicated R29 had a weight gain of 3.2 pounds from 11/11/19, to 11/12/19. R29's medical record lacked evidence of notification of the physician or heart clinic of weight gain and lacked documentation of monitoring for symptoms of CHF, increased edema and respiratory status.
-R29's weight record indicated R29 had a weight gain of 7.5 pounds from 11/17/19, to 11/18/19, though had a weight loss of 6.5 pounds the previous day.

R29's nurse practitioner (NP) visit notes dated 10/30/19, indicated R29's Lasix had been increased a week prior, and R29's weight was down 5 pounds, along with decreased edema, though the NP visit was prior to R29's weight that same day.

On 11/18/19, at 9:47 a.m. R29's resident representative (RR)-F expressed concern that R29's weight is not checked daily.

On 11/20/19, at 4:28 p.m. director of nursing (DON) verified missing weights and lack of notification to the physician. DON stated nursing should monitor for symptoms of CHF with

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2 830	Continued From page 14 increased weight. DON verified nursing should have notified the heart center and monitored R29 with the increased weight. DON also verified orthostatic BP's should be obtained for monitoring of psychotropic medications and should be documented. The facility policy Heart Failure-Clinical Protocol revised 11/18, lacked direction for monitoring for symptoms of CHF, following physician orders for monitoring and management of CHF, and notification of physician of symptoms. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current policies and procedures for monitoring medical conditions as ordered and monitoring of symptoms to ensure appropriate treatment. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced	2 850		1/3/20

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2 850	Continued From page 15 by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 4 dependent residents (R41) reviewed for activities of daily living (ADLs). Findings include: R41's Face Sheet printed 11/20/19, indicated R41's diagnoses included Parkinson's disease, anxiety, schizoaffective disorder, and bipolar. R41's annual Minimum Data Set (MDS) dated 10/14/19, indicated R41 was cognitively intact, and required extensive assistance for ADLs, which included grooming. R41's Care Area Assessment (CAA) Summary dated 10/15/19, indicated R41 required extensive assistance with grooming. R41's nursing assistant care guide dated 11/17/19, indicated R41 required assistance with grooming, and preferred to have facial hair shaved. On 11/17/19, at 2:06 p.m. R41 was observed lying in her bed in a hospital gown. R41 had dark stubble of facial hair on her upper lip and chin. On 11/18/19, at 9:25 a.m. R41 was observed and the facial hair remained on her upper lip and chin. R41 stated she was supposed to have a shower twice a week, which did not always occur. R41 stated she was unable to remove the facial hair herself, and depended on staff to assist with shaving. R41 further stated having facial hair bothered her, and she preferred to have her facial hair removed.	2 850	Corrected	

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2 850	Continued From page 16 On 11/19/19, at 1:10 p.m. R41's facial hair remained. R41 stated staff did not offer to assistance with shaving during morning cares. On 11/19/19, at 1:26 p.m. nursing assistant (NA)-A stated R41 was dependent on staff for all ADLs including shaving. NA-A stated grooming assistance was provided for R41 during morning cares, but did not offer to assist R41 with shaving. NA-A further stated facial hair was noted that morning, and it appeared R41 facial hair had been present for several days. NA-A verified R41's nursing care guide indicated R41 was dependent on staff for grooming, and preferred to have facial hair removed. On 11/20/19, at 4:39 p.m. the director of nursing (DON) stated she would expect a resident that required assistance with shaving to be shaved if that was the resident's desire. DON stated if a resident's plan of care included a resident preferred to have facial hair removed, she would expect staff to follow the resident preferences. The DON futher stated the lack of grooming for a resident that preferred to have facial hair removed was a dignity issue. The facility policy Shaving the Resident dated 2/18, indicated the purpose was to promote cleanliness and to provide skin cares to the resident. The policy directed staff to review the residents' care plan to assess for any special needs of the resident, and to notify the supervisor if the resident refuses the procedure. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure all residents that were dependent on staff	2 850		

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2 850	Continued From page 17 received assistance with personal hygiene. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to track compliance and report results to the Quality Assurance and Performance Improvement (QAPI) committee. QAPI could conduct audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
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 ensure consistent wound assessment to prevent worsening of pressure ulcers and evaluate the effectiveness of	2 900	Corrected	1/3/20

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2 900	Continued From page 18 treatment for 2 of 4 residents (R5, R50) reviewed for pressure ulcers. Findings include: National Pressure Injury Advisory Panel staging definitions for pressure injuries (pressure ulcers) Pressure Injury: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep	2 900		

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2 900	Continued From page 19	2 900		

wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed

R5's Admission Record printed 11/20/19, indicated R20's diagnoses included diabetes with neuropathy, pressure ulcer of right heel, non-pressure related chronic ulcer of left foot, anemia, edema, and encephalopathy (brain damage, disorder, or disease).

R5's annual Minimum Data Set (MDS) dated 8/27/19, indicated R5 had a severe cognitive impairment, had no rejection of cares during the assessment period, required extensive assistance of two staff for bed mobility, total assistance of two staff for transfers, and was nonambulatory.
R5's MDS further indicated R5 was at risk for

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2 900	Continued From page 20	2 900		

pressure ulcers, and had an unstageable pressure ulcer with slough (dead yellow/creamy/greyish tissue in a wound bed) or eschar (dead thick, leathery, black tissue in a wound bed) present.

R5's Care Area Assessment for Pressure Ulcer/Injury dated 8/27/19, indicated weekly skin check would be completed by a licensed nurse as R5 allowed.

R5's physician appointment dated 9/4/19, indicated R5 had a large pressure ulcer at the base of the right heel with dark tissue overlying the wound, and tender to touch. Physician documentation indicated R5's pressure ulcer did not appear to be acutely infected at that time.

R5's care plan initiated 10/3/18, indicated R5 had a mobility impairment, and directed staff to reposition every 2 hours, and noted R5 frequently refused repositioning. R5's care plan further indicated R5 had a history of skin breakdown, including pressure ulcers to bilateral heels, and directed nursing to offer repositioning every 2 hours. Interventions dated 11/14/19, indicated R5 was followed by hospital wound care.

R5's Weekly Skin Inspections dated 9/10/19, indicated there were no new areas of concern, and R5 continued to have an unstageable pressure area to the right heel.

R5's Weekly Pressure Ulcer Wound Evaluation dated 9/11/19, indicated R5's left heel pressure ulcer measured 3.8 centimeters (cm) x 4.0 cm and was unstageable with 100% eschar. R5's pressure ulcer was documented as ongoing and unchanged.

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2 900	Continued From page 21 R5's Weekly Pressure Ulcer Wound Evaluation dated 9/17/19, indicated R5's left heel pressure ulcer measured 3.4 cm x 5.0 cm and was unstageable with 20% eschar, 70% slough and 10% granulation (new connective tissue) tissue, and moderate serosanguineous (clear liquid mixed with the blood) drainage with odor. R5's pressure ulcer was documented as ongoing and improved. R5's Weekly Skin Inspection dated 9/24/19, indicated there were no new areas of concern, and continued to have an unstageable pressure area to the right heel. R5 had not had a Weekly Skin inspection since 9/11/19. R5's Weekly Skin Inspection dated 10/1/19, indicated R5 had no new areas of concern, and continued unstageable pressure area to right heel. R5's Weekly Pressure Wound Evaluation dated 10/3/19, indicated R5's left heel pressure ulcer measured 3.2 cm x 4.5 cm, and was unstageable with 25% granulation, 75% slough, and moderate amount of serosanguineous drainage with an odor. R5's pressure area was documented as ongoing and declined. R5 had not had a registered nurse assess the wound between 9/17/19, and 10/3/19, and the wound had worsened during that time. R5's Weekly Pressure Wound Evaluation dated 10/8/19, indicated R5's right heel pressure ulcer measured 4.0 cm x 4.5 cm and was unstageable, was 10% granulation and 90% slough, with moderate brownish, green drainage and no odor. R5's pressure ulcer was documented as ongoing and improved, though measurements and slough had increased with decreased granulation tissue.	2 900		

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2 900	Continued From page 22 In addition, the right heel pressure ulcer had previously been documented on the Weekly Pressure Wound Evaluations as the left heel. R5's progress notes dated 10/14/19, indicated R5 went to wound clinic R5's Weekly Skin Inspection dated 10/15/19, indicated R5 continued to have an unstageable pressure area to the right heel, outer aspect of right great toe and top of right second toe. R5 had not had a weekly skin inspection since 10/1/19. R5's Weekly Pressure Wound Evaluation dated 10/17/19, indicated R5's right heel pressure ulcer measured 3.5 cm x 3.0 cm and was unstageable with 75% granulation, and 25% slough, and moderate serosanguineous drainage with no odor. R5's pressure ulcer was documented as improved. In addition, R5's wound evaluation indicted R5 had a stage one pressure area on his left toe that had healed. R5's progress notes dated 10/22/19, indicated a physician called with orders for an antibiotic, a wound culture, and follow up appointment for a worsening heel ulcer with possible infection. R5's progress notes dated 10/23/19, indicated an antibiotic was ordered for a wound infection. R5's progress notes indicated R5 had a wound culture result with a moderate amount of pseudomonas aurginosa (bacteria organism). R5's progress notes dated 10/26/19, indicated R5 had a new order for a change in antibiotic to treat a wound infection with pseudomonas until 11/1/19. R5's progress notes, the same day	2 900		

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2 900	Continued From page 23	2 900		

indicated R5 had gone to wound dare and treatment orders had changed to right heel and left medial fifth toe, including cleansing with soap and water and a vinegar solution.

R5's Weekly Skin Inspection dated 10/29/19, indicated R5 continued to have unstageable pressure ulcer to the right heel, outer aspect of right great toe, and top of right second toe, along with a superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/15/19.

R5's Braden Scale Assessment (a tool to assist in determining risk for skin breakdown), dated 11/7/19, indicated R5 was at risk for skin breakdown.

R5's progress notes dated 11/8/19, indicated R5 refused to go to wound care appointment and appointment was rescheduled for 11/22/19.

R5's Weekly Skin Inspection dated 11/12/19, indicated R5 continued to have a right heel pressure ulcer, along with the outer aspect of the right great toe and tope of right second toe, and superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/29/19.

R5's Weekly Pressure Wound Evaluation dated 11/14/19, indicated R5's right heel pressure ulcer measured 3.3 cm x 5.2 cm and was unstageable with 25% granulation and 75% slough with a moderate amount of serosanguineous drainage with no odor. R5's pressure ulcer was documented as improved, though measurements had increased, the granulation tissue had decreased and slough had increased. R5 had not had an RN assessment of the pressure ulcer

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2 900	Continued From page 24 at the facility since 10/17/19, though R5 had been treated for a worsening pressure ulcer with infection. R5's Weekly Skin Inspection dated 11/19/19, was not completed. R5's progress notes dated 11/20/19, indicated R5's right heel ulcer measured 5 cm x 3.5 cm x 0.3 cm with a minimal amount of tan drainage. On 11/19/19, at 10:58 a.m. the assistant director of nursing (ADON) stated R5 had an unstageable pressure ulcer on the right heel. ADON stated R5 goes to wound care, but R5 was non-compliant. ADON stated R5's pressure ulcer was improving and they have a good treatment for it. On 11/20/19, at 8:44 a.m. licensed practical nurse (LPN)-A looked at R5's right heel wound after he had showered. R5's right heel ulcer had regular edges, light slough, and was unstageable. On 11/20/19, at 9:45 a.m. LPN-A stated R5's wound looked better, with some slough and some drainage. LPN-A stated R5 had previously had an infection in the right heel ulcer. On 11/20/19, at 1:51 p.m. LPN-A with registered nurse (RN)-F, soaked right heel and left 5th toe pressure ulcers in vinegar solution as ordered. LPN-A sanitized hands, gloved, and measured the right heel pressure ulcer at 5 cm x 3.5 cm x 0.3 cm. LPN-A used a cotton tip swab to attempt to remove some slough. LPN-A removed gloves, sanitized hands, gloved, and completed treatment as ordered. LPN-A stated R5's wound base had 50% slough. LPN-A stated it had been debrided and was cleaner since starting the vinegar solution.	2 900		

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2 900	Continued From page 25 On 11/20/19, at 4:04 p.m. director of nursing (DON) verified wound assessments were not done weekly, R5 had a wound infection, and weekly wound assessments would be done weekly. The facility policy for Skin Assessment and Wound Management dated 12/18, directed a weekly skin inspection would be completed by licensed staff, document skin condition weekly on the Pressure Wound Evaluation, and review skin conditions with interdisciplinary team at least monthly. R50's Admission Record printed 11/20/19, indicated diagnoses that included chronic non-pressure right heel and mid foot ulcer, type 2 diabetes, anemia, and chronic kidney disease. R50's quarterly MDS dated 10/28/19, indicated R50 had a severe cognitive impairment, required extensive assistance with bed mobility, transfers, toileting, and was total dependent on person hygiene. MDS further indicated R50 had an unstageable pressure ulcer. R50's physician orders directed to wash left heel ulcer with soap and water, dry, smear a small amount of Iososorb on Xeroform (yellow gauze), wrap with kerlix and place surgilast, and change every 2 days. Wear heel boot while in bed, post-op boot while in chair. R50's care plan updated 3/29/19, indicated R50 had a wound to right heel and interventions included to offload heels by floatation off pillow when R50 was in bed, and treatment per physician orders. R50's medical record lacked Weekly Pressure	2 900		

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2 900	Continued From page 26 Wound Evaluations from 5/23/19-6/12/19, 6/27/19-9/6/19, and 10/22/19-11/19/19. On 11/20/19, at 2:10 p.m. the ADON stated R50's left heel pressure ulcer was identified on 3/29/19. The ADON verified she did not complete weekly wound assessments for R50 from 10/22/19, to 11/19/19. The ADON stated at that time, R50's dressing was changed every three days, and she did not coordinate with the nurses when the dressing was changed to complete the weekly wound evaluation. The ADON stated it was important to complete weekly wound assessments to monitor the progress of the wound. On 11/20/19, at 4:39 p.m. the DON, stated she would expect wound assessments to be completed weekly. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents that have pressure ulcers are assessed weekly for monitoring progress and to prevent worsening of pressure ulcers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		1/3/20

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2 910	Continued From page 27 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 ensure timely toileting to prevent incontinence for 1 of 2 residents (R29) reviewed for incontinence. In addition, the facility failed to assess and develop a toileting program to maintain continence of bowel and bladder for 1 of 2 residents (R53) reviewed for incontinence. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure, and anxiety disorder. R29's annual Minimum Data Set (MDS) dated 10/2/19, indicated R29 was cognitively intact with	2 910	Corrected	

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2 910	Continued From page 28	2 910		

no resistive behaviors, delirium, psychosis or mood symptoms during the assessment period. R29's MDS further indicated R29 was frequently incontinent of bowel and bladder, required extensive assistance of two staff for toileting cares, and received a diuretic on a regular basis.

R29's undated Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, completed for annual MDS with the reference date of 9/23/19, indicated R29 required assistance with toileting cares, was frequently incontinent of bladder, and had recently been hospitalized with a urinary tract infection (UTI). R29's CAA indicated R29 was offered toileting every 2 hours and as needed, and was transferred using a stand-aide assist lift. R29 did not always alert staff to the need to use the toilet. R29 received Lasix, which could increase the risk for urgency and frequency. R29's CAA further indicated R29 was able to communicate needs.

R29's care plan revised 10/2/19, indicated R29 was able to communicate needs, was understood by others, and could usually understand simple conversation. R29's care plan indicated R29 was frequently incontinent of bowel and bladder, and directed staff to toilet every 2 hours and as necessary.

R29's care guide/pocket care plan dated 11/17/19, indicated R29 was incontinent, and directed staff to provide hourly toileting while awake.

R29's Order Summary Report for Active Orders as of 11/19/19, included orders for Lasix (diuretic medication) 40 milligrams (mg) twice daily.

R29's progress notes dated 10/21/19, through

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2 910	Continued From page 29 11/19/19, indicated R29 had not had incidents of refusing toileting cares. On 11/18/19, at 9:47 a.m. resident representative (RR)-F was interviewed and expressed concern that R29 did not get toileted frequently enough. On 11/19/19, during observations from 7:25 a.m. through 8:58 a.m., R29 was in her room watching television, received her hearing aide, visited with RR-F, and ate breakfast. Staff had not entered her room since RR-F arrived at 8:05 a.m., and R29 was not offered toilet use since 7:25 a.m. -At 8:51 a.m. RR-F talked to R29 about going to exercise group, turned on the call light, and told R29 she would be back 10 minutes prior to her appointment, later that morning. Before RR-F left the room, staff entered R29's room and RR-F informed staff R29 would like to go to exercise group and then she would come back before the appointment, and stated R29 would need to be toileted prior to the appointment. Staff did not offer toilet use prior to exercise group. -At 8:58 a.m. RR-F took R29 downstairs to exercise group. -At 9:46 a.m. R29 returned from exercise group and the nurse change R29's oxygen. -At 9:48 a.m. staff brought R29 down to her room. On 11/19/19, at 9:51 a.m. R29 stated she had not been to the bathroom yet, and had just put on her call light to ask to go. Staff entered the room and R29 told them she had to go to the bathroom. On 11/19/19, at 9: 55 a.m. nursing assistant (NA)-F entered R29's room with the stand-assist lift and transferred her to the commode. R29 voided in the commode. NA-F verified R29's incontinent brief was a little damp. NA-F stated R29 was to be toileted at least every 2 hours, but	2 910		

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2 910	Continued From page 30 usually was toileted per her request. On 11/19/19, at 10:26 a.m. NA-G stated R29 would usually call and tell them when she had to go to the bathroom, and they would answer promptly. At that time, NA-H verified the care guide directed toilet use every hour for R29. NA-H stated she would check on her and R29 would ask, but verified staff should offer. On 11/19/19, at 11:04 a.m. the assistant director of nursing (ADON) stated nursing assistants should provide care according to the care guide sheets. ADON stated R29's family had wanted her toileted every hour for awhile when R29 was incontinent more frequently, and stated the care plan directed every 2 hours and as needed. ADON verified the care guide sheets were not changed when the care plan was changed. The facility policy for ADL (activities of daily living) Assistance per Care Plan revised 5/20/19, directed to provide ADL assistance to all residents based on the assessment and care plan. Incontinent residents were to be checked and toileted according to the care plan. R53's Admission Record printed 11/20/19, indicated R53's diagnoses included Parkinson's disease, morbid obesity, and a gastrostomy tube (a tube inserted through the belly that brings nutrition directly to the stomach). R53's quarterly MDS dated 11/5/19, indicated R53 was cognitively intact, and required extensive assistance with toileting, and was not on a toileting program. R53's CAA dated 8/19/19, indicated R53 was	2 910		

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2 910	Continued From page 31	2 910		

frequently incontinent of urine. The CAA indicated toileting needs would be care planned for R53 to continue to offer toileting, check, and change every two hours, and overall goal was to improve urinary incontinence.

R53's care plan dated 8/26/19, indicated R53 had alteration in elimination related to a history or urinary tract infections (UTI), urinary retention, impaired mobility, and was incontinent of bowel and bladder. R53's goal was to remain clean, dry, odor free, and to be free from signs and symptoms of UTI. R53 interventions included assistance of two and a Hoyer (mechanical lift) with toileting needs including peri care, pad, and clothing adjustments.

R53's Bladder Evaluation dated 9/20/19, indicated R53 was incontinent of bowel and bladder, did not inform staff of need to void, and occasionally would ask staff for a urinal but R53 had already voided and did not void in a urinal. R53 required two assists with toileting including a Hoyer for transfers, clothing and pad management, and peri care. Staff was to offer toileting, check, and change every two hours. R53 was able to make needs known and understand others.

R53's nursing assistant care guide sheet dated 11/17/19, indicated R53 was incontinent and required two assist and a Hoyer with toileting.

On 11/17/19, at 1:16 p.m. R53 stated he urinated in his pants because he was unable to use the bathroom, and would be unable to use the urinal on his own.

During observation on 11/19/19, at 10:07 a.m. R53 had verbalized he had to "pee" during

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2 910	Continued From page 32	2 910		

morning cares. NA-A instructed R53 just to "pee" in his pants because he was wearing an incontinent brief. NA-B asked NA-A if R53 had a urinal. NA-A stated R53 did not have urinal, and told R53 that NA-A would change and get him cleaned up when he was done.

On 11/19/19, 11:24 a.m. licensed practical nurse (LPN)-B confirmed R53 was incontinent of bowel and bladder, and stated R53 was getting stronger and maybe would be able to use a urinal with assistance. LPN-B stated R53 should be assessed for a toileting program, and should be offered to use the urinal or to be toileted.

On 11/19/19, at 12:50 p.m. R53 stated he would prefer to use the bathroom and not "pee" in his pants. R53 stated staff did not offer to take him to the bathroom or offer a urinal. R53 stated when staff would come into his room, R53 would say he had to "pee" and the staff was used to him going in his pants.

On 11/20/19, at 2:10 p.m. the ADON stated bowel and bladder assessments were completed upon admission, annually, and with any resident changes. The ADON stated if a resident showed signs that he/she may be able to be continent of bowel or bladder, the resident would be started on a toileting program.

On 11/20/19, at 4:39 p.m. the DON stated if a resident was able to verbalize they had to urinate, the resident should be on a bowel and bladder program. A toileting log would be initiated to assess the resident's urinary patterns to promote highest bladder functioning.

The facility policy Behavioral Programs and Toileting Plans for Urinary Incontinence dated

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2 910	Continued From page 33 10/10, directed a review of the residents care plan to assess for any special needs of the resident. Conduct a thorough assessment of the resident and his or her environment to determine factors that may have contributed to any recent decline in urinary incontinence. Monitor, record, and evaluate information about the resident's bladder habits, and continence or incontinence. Assess the resident for appropriateness of behavioral programs which promote urinary incontinence. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are assisted with toileting as determined necessary by their individualized assessment. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 910		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms.	21025		1/3/20

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21025	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at the appropriate temperature to ensure food safety and prevent food borne illness. This had a potential to affect 63 of 65 residents who ate food prepared in the facility kitchen. Findings include: On 11/17/19, at 5:34 p.m. review of the facility food temperature log for November 2019, revealed temperatures were not taken for the following meals: Breakfast food temperatures for 11/4, 11/5, 11/8, 11/9, 11/13, and 11/14. Lunch food temperatures for 11/4, 11/5, 11/8, 11/9, 11/13, and 11/14. Supper food temperatures for 11/2, 11/3, 11/9, and 11/15. On 11/19/19, at 12:57 p.m. dietary manager (DM)-A was interviewed, and stated she had not reviewed November food temperature logs. DM-A stated this was the responsibility of the assistant dietary manager. DM-A stated she soul have been notified if food temperatures were not being taken so retraining of staff could have occurred. DM-A stated food safety and temperature of food was important to ensure bacterial growth does not occur which could lead to food borne illness for the residents. On 11/20/19, at 3:00 p.m. the director of nursing (DON) stated taking food temperature before serving food was important not only for food	21025	Corrected	

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21025	Continued From page 35 safety and preventing food borne illness, but also palpability of food. The facility policy Culinary Department dated 12/16, directed cooking foods at proper temperatures and maintaining proper temperatures are necessary to prevent pathogens (disease producing bacteria). The facility policy Food Re-Heating and Handling undated, directed staff that all potentially hazardous food must be reheated to 165 degrees Fahrenheit or above for 15 seconds within two hours, and held above 150 degrees Fahrenheit until served to prevent bacteria from growth. The facility training material Food Preparation undated, directed kitchen staff to check and record food temperatures prior to service. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could review and/or revise the current food temperature policies and procedures to ensure food is cooked and held to appropriate temperatures to prevent food-borne illnesses. The dietary manager or designee could educate the appropriate staff on the policies/procedures. The dietary manager or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the	21385		1/3/20

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21385	Continued From page 36 infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use during personal cares and toileting cares to prevent cross contamination for 1 of 3 residents (R29) reviewed for bowel and bladder. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure, and anxiety disorder. R29's annual Minimum Data Set (MDS) completed 10/2/19, indicated R29 was cognitively intact with no resistive behaviors, delirium, psychosis or mood symptoms during the assessment period. R29's MDS further indicated R29 was frequently incontinent of bowel and bladder, required extensive assistance of two staff for toileting cares, and received a diuretic on a regular basis. R29's undated Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, completed for annual MDS with the reference date of 9/23/19, indicated R29 required assistance with toileting cares, was frequently incontinent of bladder, and had recently been	21385	Corrected	

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hospitalized with a urinary tract infection (UTI). R29's CAA indicated R29 was offered toileting every 2 hours and as needed, and was transferred using a stand-aide assist lift. R29 did not always alert staff to the need to use the toilet. R29 received Lasix (diuretic), which could increase the risk for urinary urgency and frequency. R29's CAA further indicated R29 was able to communicate needs.

R29's care plan revised 10/2/19, indicated R29 was able to communicate needs, was understood by others, and could usually understand simple conversation. R29's care plan indicated R29 was frequently incontinent of bowel and bladder, and directed staff to toilet every 2 hours and as necessary.

R29's care guide/pocket care plan dated 11/17/19, indicated R29 was incontinent, and directed staff to provide hourly toileting while awake.

On 11/19/19, at 9: 55 a.m. nursing assistant (NA)-F entered R29's room with the stand-assist lift to assist R29 with toileting cares. NA-F washed her hands, donned gloves, closed the curtain and shades, and positioned the stand-assist lift up to R29. NA-F hooked up the canvas and calf straps, and removed her soiled gloves, sanitized her hands and without performing hand hygiene donned clean gloves, and removed R29's oxygen canula. NA-F raised R29 to a standing position in the stand-assist lift, lowered R29's incontinent brief, and lowered R29 to the commode. NA-F stated R29's brief was a little damp with urine. NA-F removed her soiled gloves and sanitized her hands, as R29 voided a moderate amount of yellow urine in the commode. Without performing hand hygiene,

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NA-F donned clean gloves, raised R29 in the stand-assist lift, wiped R29's peri area with a personal cleansing wipe. NA-F did not remove her soiled gloves and perform hand hygiene, and put on clean gloves. NA-F put a clean incontinent brief on R29, moved the commode out of the way, put the wheelchair in place, lowered R29 into the wheelchair, unbuckled the canvas, pushed the wheelchair back, and then removed her soiled gloves. NA-F sanitized her hands and donned clean gloves. NA-F placed R29's oxygen canula on R19's face. NA-F moved the stand-assist lift out of R29's room and brought it into the tub room. NA-F stated she thought she had changed gloves and sanitized following peri care, and said she should have.

On 11/19/19, at 11:04 a.m. the assistant director of nursing (ADON) stated staff should remove soiled gloves, sanitize or wash hands, and put clean gloves on going from dirty to clean areas and tasks.

The facility Handwashing policy dated 1/08, directed handwashing should be completed when hands are visibly soiled, and when hands are not visibly soiled, to use an alcohol based hand rub. The policy further directed hand hygiene should be performed before and after contact with residents, before doing an invasive procedure, after contact with bodily fluids, before moving from contaminated body site to a clean body site during resident cares, after contact with mechanical equipment, after removing gloves.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and/or revise the current hand hygiene and cleaning of medical equipment policies and

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21385	Continued From page 39 procedures to ensure prevention of cross-contamination. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	Corrected	1/3/20

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21426	Continued From page 40	21426		

facility failed to ensure resident's second step Tuberculin skin test (TST, a skin test used to check for tuberculosis infection) was completed for 1 of 5 residents (R2) reviewed for TST.

Findings include:

R2's Face Sheet printed 11/20/19, indicated R2's diagnoses included asthma.

R2's Baseline Tuberculin (TB) Screening form indicated R2 received his first step TST on 5/24/19, but lacked information indicating the date, time, and interpretation of the TST. R2's TB screening form had provided space to record a second TST however, it was left blank. R2's medical record lacked documentation R2 received a second step TST.

On 11/20/19, at 2:34 p.m. the assistant director of nursing (ADON) verified R2's TB Screening form did not indicate results from the first step TST, and also lacked evidence that R2 received the required second step TST. The ADON stated documentation of the TST results should include a positive or negative reading, along with the millimeters (mm) of induration, date, and time the TST was read.

On 11/21/19, at 4:37 p.m. the director of nursing (DON) verified R2 did not receive the required second TST, and would expect the second step TST to be completed. The DON further stated if the second step TST was not administered, she would expect the TST to be repeated.

The facility policy Resident Baseline Tuberculosis Screening of Resident dated 11/10, directed qualified nurses interpret the TST 48 to 72 hours after administration of the TST. All test results

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21426	Continued From page 41 must be read in millimeter. Document the time of interpretation. Time of interpretation must not be greater than 72 hours after time of administration. The policy further indicated residents whose first step TST is negative will receive a second step TST one to three weeks after the initial TST was administered. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the facility's process to ensure TB testing for resident is completed and documented as required. The DON or designee could re-educate nursing staff on the process and TB policy. The DON or designee could review current monitoring or audit system to ensure compliance of TB screening and documentation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending	21540		1/3/20

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21540	Continued From page 42 physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure orthostatic blood pressures for monitoring of potential side effects related psychotropic medications were completed for 3 of 6 residents (R29, R39, R3) reviewed for unnecessary medications. In addition, the facility failed to ensure appropriate diagnoses for use of medications for 1 of 6 residents (R39) reviewed for unnecessary medications. In addition, the facility failed to ensure monitoring of weights as ordered by a physician regarding a medical condition for 1 of 6 residents (R29) reviewed for unnecessary medications. Findings include: R29's Admission Record printed 11/19/19, indicated R29's diagnoses included pulmonary embolism (blood clot in one of the pulmonary arteries in the lungs), acute and chronic respiratory failure, vascular dementia, congestive heart failure (CHF), edema, bipolar disorder, and anxiety disorder. R29's care plan initiated 8/24/18, indicated R29 was at risk for falls related to medical conditions, including CHF, edema, bipolar disorder, and vascular dementia. R29's care plan indicated	21540	Corrected	

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21540	Continued From page 43 R29 was taking psychotropic medications (mood and behavior altering medications), and directed nursing to obtain a monthly orthostatic blood pressure. R29's Order Summary Report with Active Orders as of 11/19/19, included orders for: -check vital signs daily. Order 9/17/19. -Monthly psychotropic side effect monitoring, if side effects, update physician. Every day shift on the 24th, monthly. -Sertraline HCL (antidepressant) 50 mg at bedtime. Order start date 9/17/19. -Olanzapine (antipsychotic) 5 mg every evening for bipolar disorder. Order start dated 9/17/19. R29's progress notes dated 9/24/19, indicated R29 refused an orthostatic blood pressure. R29's progress notes lacked documentation of any attempts to re-approach R29 for an orthostatic blood pressure. R29's Treatment Administration Record (TAR) indicated R29's orthostatic blood pressure was not completed. R29's Weights and Vitals Summary for 9/24/19, lacked documentation of an orthostatic blood pressure. R29's TAR for October 2019, indicated R29's orthostatic blood pressures for monitoring of psychotropic medications were obtained on 10/24/19, but lacked documentation of orthostatic blood pressure results. R29's progress notes dated 10/24/19, lacked documentation of R29's orthostatic blood pressure results.	21540		

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21540	Continued From page 44 R29's Weights and Vitals Summary for 10/24/19, lacked documentation of an orthostatic blood pressure. R29's TAR for November 2019, indicated R29's orthostatic blood pressure had not yet been taken, and was scheduled for 11/24/19. R29's TAR indicated R29 was to be monitored monthly for psychotropic side effect monitoring monthly on the 24th. R29's Weights and Vitals Summary dated 10/3/19, through 11/20/19, indicated no orthostatic blood pressures were obtained or recorded for R29. On 11/20/19, at 4:28 p.m. director of nursing (DON) verified orthostatic BP's should be obtained for monitoring of psychotropic medications. R39's Admission Record printed 11/20/19, indicated R39's diagnoses included CHF, mild cognitive impairment, encephalopathy (brain damage, disease, or malfunction), major depressive disorder, and insomnia. R39's Order Summary Report for active orders as of 11/20/19, included orders for: -quetiapine (antipsychotic medication) 50 milligrams (mg) at bedtime for primary insomnia, order dated 10/29/19. -Sertraline (antidepressant medication) 100 mg tablet; take 2 tabs daily for depression, order dated 10/29/19 In addition, R39's orders included the following medications without diagnoses for use of the medications: -Pregabalin Capsule (nerve pain medication)	21540		

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21540	Continued From page 45 -Slow Mag tablet DR (magnesium supplement) -Metoprolol Tartrate (for chest pain or high blood pressure) -Melatonin (hormone used for sleep) -Lisinopril (for high blood pressure and heart failure) -Furosemide (diuretic) -Atorvastatin Calcium (for high cholesterol) -Diltiazem CD ER 24 hour (high blood pressure and heart failure) -cholestyramine light packet (for high cholesterol) -cholecalciferol (vitamin D supplement) -Budesonide capsule DR (anti-inflammatory for Crohn's or ulcerative colitis) - Aspirin R39's order summary lacked direction for monitoring of psychotropic medication side effects, and orthostatic blood pressures for monitoring of psychotropic medications. R39's care plan initiated 8/29/19, indicated R39 received psychotropic medications and was at risk for adverse side effects. R29's care plan directed nursing to monitor for adverse drug reactions and obtain monthly orthostatic blood pressures. R39's Consultant Pharmacist's Medication Review dated 7/19/19, recommendations included monitoring of antipsychotics including orthostatic blood pressures, side effects, and target behaviors. Nursing signed recommendation as completed on 8/12/19. R39's Medication Administration Record (MAR) for September 2019, indicated R39 received quetiapine fumarate for insomnia on 9/10/19 through 9/12/19, melatonin daily for insomnia, and sertraline for depression daily. R39's MAR	21540		

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21540	Continued From page 46 included directives for antipsychotic side effect monitoring monthly and was documented as completed on 9/6/19. R39's Treatment Administration Record (TAR) for September 2019, directed nursing to obtain a lying and sitting (orthostatic) blood pressure due to antipsychotic medication monthly. R39's orthostatic blood pressure was documented as done, but without results. R39's progress notes dated 9/619, lacked documentation of orthostatic blood pressure results or attempts to reapproach for the orthostatic blood pressure. R39's Weights and Vitals Summary report for 9/6/29, lacked documentation of an orthostatic blood pressure. R39's MAR for October 2019, indicated R39 received quetiapine fumarate for insomnia and depression, and sertraline for depression, and melatonin for insomnia. R39's MAR included directives for antipsychotic side effect monitoring monthly and was documented as completed on 10/6/19. R39's TAR for October 2019, directed nursing to obtain an orthostatic blood pressure monthly due to antipsychotic medication. R39's TAR indicated an orthostatic blood pressure was obtained on 10/6/19, but lacked documentation of results. R39's Weights and Vitals Summary for 10/6/19, indicated R39's orthostatic blood pressure was completed, and indicated no orthostatic hypotension (drop in blood pressure) with change in position from lying to sitting.	21540		

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21540	Continued From page 47 R39's MAR for November 2019, indicated R39 received melatonin, quetiapine fumarate for insomnia, and sertraline for depression. R39's MAR lacked direction to monitor for antipsychotic medication side effects. R39's TAR for November 2019, lacked direction to obtain orthostatic blood pressures monthly due to psychotropic medications. R39's Weights and vitals Summary since readmission on 10/29/19, indicated no orthostatic blood pressures had been obtained. R39's progress notes since readmission on 10/29/19, lacked documentation of orthostatic blood pressures, or clarification of diagnosis for use of quetiapine or other medications. R39's Psychotropic Medication review dated 10/10/19, was not completed and signed. R39's Target Behavior Form was not completed 11/14/19. R39's NP visit note dated 9/4/19, indicated R39 had received quetiapine every night for agitation, nursing reported no agitation since admission, and R39 was unable to indicate when and why quetiapine was prescribed. NP discontinued quetiapine and started melatonin every evening. R39's progress notes dated 9/8/19, indicated R39 had not been sleeping well and was concerned the physician had discontinued the quetiapine that had helped her sleep good previously. R39's progress notes dated 9/9/19, indicated R39's primary care physician sated insomnia had recurred since quetiapine was discontinued, so	21540		

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21540	Continued From page 48 reordered quetiapine at bedtime. R39's progress notes dated 9/12/19, indicated insomnia was not an approved diagnosis for quetiapine. R39's Consultant Pharmacist's Medication Review dated 9/12/19, identified an irregularity regarding quetiapine. The pharmacist indicated sleep was not an approved indication for quetiapine and recommended a review and assessment of the current use of quetiapine for R39, and if the diagnosis is sleep, to discontinue use of quetiapine. R39's physician responded by changing R39's diagnosis for use of quetiapine to depression. R39's physician visit notes dated 9/13/19, indicated R39 had seen her primary care physician on 9/9/19, and the physician felt she should restart quetiapine for insomnia, so it had been restarted. R39's progress notes dated 9/13/19, indicated R39's diagnosis for quetiapine was changed to depression. R39's Consultant Pharmacist Medication Review dated 9/18/19, identified an irregularity regarding use of quetiapine. The pharmacist indicated on 8/30/19, R39 was not showing signs of agitation and quetiapine was discontinued. Resident then complained of not being able to sleep and quetiapine was started with a diagnosis of sleep and then changed to a diagnosis of depression. The consultant pharmacist recommended tapering R39 off the quetiapine and starting a medication that would target sleep, such as trazodone or mirtazapine that would also help with depression. R39's physician addressed the pharmacist's recommendation by ordering	21540		

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21540	Continued From page 49 trazodone in place of quetiapine. R39's physician notes dated 11/4/19, indicated R39 had been readmitted from a hospital stay during 10/24/19 to 10/29/19, for heart failure exacerbation. R39's physician visit notes indicated medications were reviewed, but diagnoses were not provided for use of medications, and lacked diagnoses for psychosis or psychotic behaviors. R39's physician visit notes further indicated R39 had not significant behavioral changes. R39's NP visit notes dated 11/11/19, lacked diagnoses for medications received by R39 per orders. R39's NP visit notes indicated R39's mood was good, and had no significant behavioral changes. R39's NP visit notes further indicated R39 received quetiapine for chronic insomnia, and the plan was to continue the medication as ordered. R39's nurse practitioner (NP) visit notes dated 11/20/19, indicated orthostatic blood pressures had not been checked between 11/19/19 and 11/21/19, and lacked diagnoses for medications received by R39 per orders. On 11/19/19, at 1:22 p.m. R39 stated she felt her medications were helpful and she had not experienced any side effects. On 11/20/19, at 4:19 p.m. director of nursing (DON) stated she would expect orthostatic blood pressures to be done when a resident is receiving any psychotropic medication. DON verified quetiapine is not an appropriate medication for sleep and verified R39's orthostatic blood pressures were not completed and antipsychotic side effect monitoring was not on the TAR	21540		

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21540	Continued From page 50	21540		

following R39's hospital return and should have been done. DON verified the NP and physician had seen R39 since her return from the hospital and nursing should have put in a request for diagnoses of medications at that time. DON verified R39's Psychotropic Medication review had not been completed as dated for 10/10/19, and Target Behavior Form was not completed for 11/14/19.

The facility policy Antipsychotic Medication Use revised 12/16, directed residents would "only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective." The facility policy and procedure further directed the physician to identify, evaluate and document symptoms that may warrant the use of antipsychotic medications, and the diagnosis of a specific condition for which the antipsychotic medications are necessary to treat would be based on a comprehensive assessment. Antipsychotic mediations would not be used if the only symptoms were one or more of symptoms including restlessness, insomnia, nervousness, or mild anxiety.

R3's Admission Record dated 11/20/19, indicated R3's diagnoses included major depressive disorder and anxiety disorder.

R3's quarterly MDS dated 8/21/19, identified R3 had moderately impaired cognition. R3's MDS also identified she was administered antidepressant medication for seven days, during the seven day lookback period, and had two or more falls without injury.

R3's Order Summary Report dated 11/20/19, indicated R3 was ordered orthostatic blood

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21540	Continued From page 51	21540		

pressures monitoring due to psychotropic medication usage on the 10th day of every month. Further, R3 was ordered fluoxetine (antidepressant) 20 mg daily for depression on 8/30/19.

R3's care plan dated 3/14/19, indicated R3 had potential for psychotropic adverse drug reactions related to fluoxetine medication usage. Interventions included monitoring for adverse drug reactions.

R3's November 2019 TAR lacked indication orthostatic blood pressures were taken.

Review of R3's weights and vitals summary dated 12/2/19, lacked indication orthostatic blood pressures were recorded from 8/1/19, to 11/21/19.

On 11/20/19, at 10:34 a.m. an interview was conducted with registered nurse (RN)-E. RN-E confirmed she was unable to locate orthostatic blood pressures in R3's medical record. RN-E stated staff were expected to follow the order and a process for leaving a progress notes with results was being put into place.

On 11/20/19, at 3:37 p.m. an interview was conducted with the DON. The DON stated she expected staff were to complete full sets of orthostatic blood pressures as indicated, and there should had been a note.

The facility policy Antipsychotic Medication Use revised 12/16, directed nursing staff to observe, document, and report adverse consequences to the attending physician such as "orthostatic hypotension."

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21540	Continued From page 52 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current monitoring of psychotropic medication policies and procedures to ensure potential side effects are identified and managed. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single	21545		1/3/20

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21545	Continued From page 53 medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a correct dosage of a narcotic pain medication was administered to 1 of 8 residents (R52) reviewed for medication administration. Findings include: R52's Admission Record dated 11/19/19, indicated R52's diagnoses included humerus fracture (fracture of upper arm) and mild cognitive impairment. R52's admission Minimum Data Set (MDS) dated 10/28/19, identified R52 had intact cognition.	21545	Corrected	

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21545	Continued From page 54 R52's MDS further identified he received as needed pain medication, had occasional pain, and received opioid pain medication for seven days. R52's Order Summary Report dated 11/19/19, indicated R52 was prescribed Norco (a narcotic pain medication) 10-325 milligrams (mg) every six hours as needed for pain rated six or greater on the numeric pain scale. The order was placed on 11/18/19. R52's care plan dated 11/1/19, indicated R58 did not wish to self-administer medications, and had a mild cognitive impairment. The care plan further indicated R58 would be administered medications per physician orders and by a licensed nurse. R52's November 2018 Medication Administration Record (MAR) printed 11/19/19, indicated R58 was prescribed hydrocodone-acetaminophen (Norco) 5-325 mg. R58 was to take one tablet every four hours as needed for pain rated 4-7, or two tablets as needed for pain rated 8-10 on the numeric pain scale. The MAR further identified R58 was administered Norco 11/12/19, at 4:39 p.m. and 11/14/19, at 1:06 a.m. The order was started on 11/6/19, and discontinued on 11/15/19. R52's November 2018 MAR printed 11/19/19, indicated R58 was prescribed Norco 5-325 mg. R58 was to take one tablet every six hours, as needed, for pain rated 4-7 or two tablets, as needed, for pain rated 8-10 on the numeric pain scale. The MAR further identified R58 was administered Norco on 11/16/19, at 6:31 a.m., and 11/17/19, at 8:46 a.m. The order was started on 11/15/19, and discontinued on 11/18/19.	21545		

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21545	Continued From page 55 On 11/17/19, at 7:17 p.m., licensed practical nurse (LPN)-C and LPN-E were observed administering medications. R58 approached LPN-C and LPN-E and stated he needed pain medication. LPN-C removed a medication card labeled Norco 10-325 mg, belonging to R58, from a locked compartment within the medication cart. LPN-C compared the medication card label to the electronic medication administration record (eMAR) and verbalized the dosage on medication card label did not match the physicians order. LPN-C did not administer the Norco and requested LPN-E to check the physicians order located in R58's paper medical record. LPN-C verified six doses of Norco 10-325 mg had been dispensed from the medication card. Registered nurse (RN)-E walked to the medication cart and informed LPN-C the physician order indicated the correct dosage was Norco 5-325, and stated she would start a medication error form. On 11/17/19, at 7:27 p.m., an interview was conducted with RN-E. RN-E audited R58's medical record, and stated R58's Norco order was updated in the eMAR on 11/15/19. RN-E verbalized the Norco frequency was changed from every four hours to every six hours however, the dosage of 5-325 mg remained the same. RN-E stated the order transcription was accurate, according to the written physician order, and the error occurred as staff had failed to verify the medication label against the medication order to ensure accuracy. The medication card was again observed, and RN-E confirmed six doses were incorrectly administered. The medication card was documented as filled on 11/12/19. A Medication Error Reconciliation Form dated 11/17/19, indicated, "Dose sent from pharmacy 10-325 administered total of 6 times. Escript sent	21545		

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21545	Continued From page 56	21545		

to pharmacy but not facility for updated dose on 11/12/19." The Medication Error Reconciliation Form further indicated the wrong drug/dosage was administered and "an error occurred that reached the patient but did not cause patient harm."

On 11/20/19, at 3:36 p.m. an interview was conducted with the director of nursing (DON). The DON stated the nurses were to check medication labels against the medication orders prior to administration. The DON further stated adverse consequences of receiving double doses of opioid pain medication could include confusion and constipation.

The facility policy Administering Medications revised 4/19, directed, "The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and/or revise the current medication administration and medication error policies and procedures to prevent significant medication errors.
The DON or designee could educate the appropriate staff on the policies/procedures.
The DON or designee could develop a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21880	Continued From page 57	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		1/3/20

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21880	Continued From page 58 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written response to a grievance for 1 of 1 residents (R12) reviewed for grievances. Findings include: R12's Admission Record printed 11/20/19, indicated R12's diagnoses included unspecified intellectual disabilities, and unspecified convulsions (seizures). R12's quarterly Minimum Data Set (MDS) dated 9/10/19, indicated R12 had a moderate cognitive deficit, was able to speak clearly, was understood, and understood others. R12's MDS indicated R12 displayed no behaviors, no signs or symptoms of delirium or psychosis, and had no mood symptoms. R12's care plan initiated 4/20/17, indicated R12 was cognitively intact, was able to understand others, was able to be understood by others, and was able to communicate needs effectively. R12's progress notes dated 10/23/19 through 11/19/19, lacked documentation regarding missing clothing. On 11/17/19, at 2:17 p.m. R12 was interviewed and stated she had three to four pairs of missing	21880	Corrected	

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purple shorts. R12 stated the facility looked for the shorts, and she was told after she asked, the facility was unable to find them. R12 stated she had reported it to the lady who did the laundry. R12 denied getting a written response in regards to the missing clothing.

On 11/19/19, at 7:40 a.m. laundry aide (LA)-A stated R12 had been missing two purple shorts for 3 to 4 months. LA-A stated she has looked through everything and was unable to find them. LA-A stated R12's family knew about it.

On 11/20/19, at 2:40 p.m. social services director (SS)-A stated she had not heard about R12's missing clothing. SS-A stated the resident or family gets updated with the results of the grievance investigation, but they do not provide a written response.

On 11/20/19, at 2:43 p.m. social services regional director (SS)-B stated R12's missing shorts occurred some time ago. SS-B stated the administrator was supposed to purchase new shorts, but the re was a problem finding the appropriate size. SS-B confirmed the facility did not provide a written response to R12 or the resident representative. SS-B stated they would keep the grievance form on file.

R12's grievance form was requested and not provided.

The facility policy Complaints and Grievance Procedure dated 9/01, directed a grievance form to be completed, and turned into the administrator as soon as reasonable possible when the verbal complaint had been voiced. The administrator would provide a verbal summary, unless a written summary was required, to the complainant no

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21880	Continued From page 60 later than 5 business days after the receipt of the grievance. If the grievance was not resolved, the grievance form was to be sent to the corporate Grievance Office, and within 7 days, the grievance officer would attempt to resolve the grievance and notify the complainant in writing of the proposed action. If the grievance was not resolved, it would be submitted to the Board of Directors and the Board would issue a written summary to the complainant of proposed action no later than 30 days after receipt of the grievance. All completed grievance forms would be kept on record at the facility for no less than 3 years. SUGGESTED METHOD OF CORRECTION: The administrator, social services director or designee could review and/or revise the current grievances policies and procedures to ensure a written response/resolution to a grievance is provided. The administrator, social services director, or designee could educate the appropriate staff on the policies/procedures. The administrator, social services director, or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its	21925		1/3/20

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21925	Continued From page 61 justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notification of reason for transfer to a hospital was provided for 2 of 5 residents (R19, R50) reviewed for transfer/discharge. Findings include: R19's Admission Record printed 11/20/19, indicated R19's diagnoses included anemia, chronic kidney disease, and congestive heart failure. R19's hospital discharge paperwork dated 9/25/19, indicated R19 was admitted to the hospital on 9/23/19, for evaluation after a fall.	21925	Corrected	

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R19's medical record lacked evidence a written notice for transfer was obtained and provided in writing to R19 and/or R19's representative.

R19's progress note dated 10/20/19, indicated R19 had a fall and was sent to the emergency room for evaluation and returned back to the facility on 10/20/19. R19's medical record lacked evidence a written notice for transfer was provided in writing to R19 and/or R19's representative.

R50's Admission Record printed 11/20/19, indicated R50's diagnoses included chronic kidney disease, diabetes type 2, and had a mild cognitive impairment.

R50's progress note dated 5/1/19, at 2:31 p.m. indicated R50 was admitted to the hospital on 5/1/19, for Influenza. R50's medical record lacked evidence a written notice of transfer was provided in writing to R50 and/or R50's representative.

R50's Interagency Referral Form dated 8/16/19, indicated R50 was hospitalized 8/12/16, for swollen leg, fatigue and poor appetite. R50's medical record lacked evidence a written notice for transfer was provided in writing to R50 and/or R50's representative.

On 11/20/19, at 1:38 p.m. director of social services stated when a resident goes into the hospital from the facility, the nurses will obtain a signed bed hold and a written notification of transfer from the resident to sign if the resident is able to sign for themselves, and if not will obtain a verbal from the residents representative. A written Bed-Hold Notice for Hospital Transfer and Therapeutic Leave form given to the resident or

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21925	Continued From page 63 representative, and best practice would be to document in the resident's medical record that a written was provided to the resident and/or resident representative. On 11/20/19, at 2:00 p.m. licensed practical nurse (LPN)-A stated if a resident goes into the hospital from the facility, the resident would sign a bed hold form including reason for transfer, and if the resident was unable to sign, a verbal consent would be obtained from the resident's representative over the phone and documented in the resident's medical record. LPN-A stated the completed form was put into the resident's chart, and the director of nursing (DON) was notified in person or by email of the hospitalization. On 11/20/19, at 4:39 p.m. the DON verified the facility was not providing a written notice of transfer to residents and/or resident representatives only upon request. The facility was unable to provide a policy on written notice of transfer. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures on discharges and/or transfers to ensure a written notification of reason for transfer is provided. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.	21925		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults	21995		1/3/20

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21995	Continued From page 64 Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report bruises of unknown origin to the State Agency within 2 hours for 1 of 3 residents (R21) reviewed for abuse. Findings include: R21's Admission Record printed 11/20/19, indicated R21's diagnoses included vascular dementia with behavioral disturbance, and cerebral infarction (stroke). R21's quarterly Minimum Data Set (MDS) dated 9/19/19, indicated R21 had a severe cognitive impairment, displayed no symptoms of delirium or psychosis, no behaviors during the assessment period, and required extensive assistance with all activities of daily living (ADLs). R21's care plan initiated 4/24/17, indicated R21 was unable to remove self from harmful situations due to physical and cognitive deficits, and directed staff to observe for and report any changes in vulnerability. R21's care plan directed staff to provide physical assistance with all ADLs and mobility, indicated R21 could be resistive to	21995	Corrected	

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21995	Continued From page 65	21995		

assistance with cares, and directed staff to re-approach as R21 allowed. R21's care plan further indicated R21 was forgetful and confused, had a modified independence with decision making and required some assistance in new situations, and had an impaired short term memory and moderately impaired long term memory.

R21's nursing assistant care guide sheet directed staff to give space, and re-approach when demonstrating agitated behaviors, and Tubigrips (stockinette) from knuckles to elbows as she allows.

R21's Order Summary Report with active orders as of 11/20/19, included a chewable 81 milligram (mg) aspirin daily. R21's orders did not include any orders for anticoagulant or steroid medications.

R21's progress notes dated 10/31/19, at 12:19 a.m. indicated staff had reported bruises to both of R21's hands at the base of the thumbs, with the right thumb bruise measuring 2.0 centimeters (cm) by 1.0 cm, and the left thumb measuring 3.8 cm x 4.0 cm. The bruises were documented as being black and blue. R21 did not respond to questions of how she got the bruises, or if she were being hurt. The oncoming licensed nurse was updated on the bruises.

R21's progress notes dated 11/1/19, at 9:55 a.m. indicated the interdisciplinary team (IDT) met on 10/31/19, to review R21's bruises noted on 10/30/19. The IDT noted R21 would frequently grab at staff and strike out with her hands, and refuse medications and treatments. IDT decided to place Tubigrips to both arms from knuckles to elbows for protection as R21 allowed.

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21995	Continued From page 66	21995		

R21's progress notes lacked indication of a specific event that led to R21's bruises, and lacked indication that R21's bruises were reported to the State Agency.

R21's physician visit note dated 11/4/19, indicated R21 resisted examination, and was seen for increased behaviors and refusal behaviors the previous month. R21's physician note lacked notation of bruises on bilateral thumbs.

On 11/20/19, at 4:12 p.m. the director of nursing (DON) stated staff should have been asked at the time of the incident for possible causes of bruising, and if no one knew how it could have happened, it should have been reported to the state agency within 2 hours, as a potential abuse.

The facility policy for Abuse Prevention/Vulnerable Adult Plan dated 12/18, directed staff to immediately notify the unit nurse, who was then to attempt to determine the cause of the injury of unknown origin, immediately notify the administrator of an injury of unknown origin, and suspected abuse would be reported to the state agency no later than 2 hours after forming the suspicion.

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON), social services director, or designee could review and/or revise the current vulnerable adult and abuse policies and procedures to ensure timely reporting of potential abuse allegations.
The administrator, director of nursing (DON), social services director or designee could educate the appropriate staff on the policies/procedures.
The administrator, director of nursing (DON),

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21995	Continued From page 67 social services director or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		