Protecting, Maintaining and Improving the Health of Minnesotans

Independent Informal Dispute Requested

This facility has requested an Independent Informal Dispute on the tag(s) identified below.

Facility (City) HFID#	Exit Date Being Disputed	Tag# - Scope/Severity Disputed
Haven Homes Of Maple Plain – Maple Plain, MN 00950	**09/12/2014**	**F314 revised to a D** **~~F278 was removed~~** **F282 was upheld to a D**

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

February 6, 2015

Rebecca K. Coffin
Voigt, Rode, and Boxeth LLC
2550 University Avenue West
Suite 190 South
St. Paul, MN 55114

sent via fax: February 6, 2015
(651) 209-6160

RE: OAH Docket 66-0900-31984

Dear Ms. Coffin:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by Haven Homes, Maple Plain, regarding two deficiencies issued as a result of a standard licensing and recertification survey, exit date, September 12, 2014. Haven Homes requested a review of Tags F278, F282, F314 and F353. Based on information provided to the Minnesota Department of Health (MDH) prior to the IIDR, the MDH rescinded Tag F278. Prior to the IIDR Haven Homes withdrew its dispute of Tag F353. The IIDR was held before Administrative Law Judge Thomas Wexler. The Department received Judge Wexlers's recommended decision on January, 6, 2015.

Decision

After careful review of Judge Wexler's recommendation and the material submitted to the Judge in support of each party's position, I do not concur with Judge Wexler's recommendation on Tag F314 that the tag be rescinded. The finding that Resident #56 was not repositioned every two hours as assessed by the facility to be required, is a deficient practice. This deficient practice created the potential for harm, and F314 is valid at a scope and severity of Level D. I also disagree with the recommendation that Tag F282 be rescinded for Resident #56. The care plan for Resident #56 directed staff to reposition the resident every two hours, and the resident was not. The tag is valid as written a scope and severity of Level E.

Rationale

Tag F314 requires that, based on the comprehensive assessment of a resident, a nursing facility must ensure that (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. F314 further defines avoidable pressure ulcers to be those in which the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

Resident #56 had no cognitive impairment, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for developing pressure ulcers, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed.

Resident #56 was on a turning and repositioning program and per physician order was to be repositioned at no greater than two hour intervals. The resident's Skin Observation Reports dated 1/2/14 through 6/5/14 indicated the resident's skin was intact and had no pressure ulcers. A 6/17/14 Skin Injury/Wound Report indicated Resident #56 developed a pressure ulcer in the right gluteal fold. This pressure ulcer had worsened by 9/10/14. A second pressure ulcer was identified on a Skin Injury/Wound Report dated 7/27/14, also located on the right buttock.

Current physician orders dated 9/5/14 instructed staff to reposition every two hours instead of every three hours. Nursing notes dated 6/2/14 indicated that Resident #56 was being seen at a wound clinic for two stage 4 pressure ulcers on the right and left heel. There was no evidence the wound clinic assessed or treated any of the pressure areas on Resident #56's buttocks/sacral area.

During survey on 9/10/14 it was observed from 7:18 a.m. to 9:46 a.m. that Resident #56 was sitting in a wheelchair, on a cushion, unable to shift his weight independently, and was not approached by staff to reposition after a two hour interval had passed. During interviews on 9/10/14 and 9/11/14 staff was not aware of Resident #56's worsening pressure ulcers. An interview with Resident #56 at 7:20 a.m. on 9/10/14 noted the resident stated he had pain in his buttocks. At that time Resident #56 clarified he had been in the wheelchair since 6:00 a.m.

On 6/17/14 Resident #56's primary physician was notified of the new pressure ulcer and sent an order for skin care. On 6/19/14 facility nursing staff requested a change from the physician to use an alternative dressing with a border, the physician approved. Resident #56's physician was notified the same day as a second pressure ulcer was noted. On 7/27/14 a new pressure ulcer was identified on Resident #56's right buttocks. Treatment was prescribed and followed. Facility progress notes reflect continuing attention to the cares of the buttock area ulcers. The facility performed numerous tissue tolerance evaluations, predisposing disease risk evaluations, and Braden scale assessments. There were at least 55 days recorded in the nurses' notes where there was at least one communication with a doctor and many of those communications related to the ulcers on the buttocks, requesting advice and change orders in the cares.

There is undisputed evidence that the facility did not reposition Resident #56 for more than two hours on September 10, 2014. This is a lapse in following the care plan, however, it is the only lapse observed. During interview with NA-A, she stated the facility was short staffed and they were not always able to complete resident cares as scheduled. Simultaneous review of F353 supports the nursing assistant's interview that staffing was an issue contributing to consistently completing resident cares according to the plan of care. Further, although there was discussion of refusals of care during the IIDR meeting, the concern was never identified or reported by facility staff during the survey. Careful review of facility documentation identified behavioral assessments cited no behaviors further documenting no refusal of cares. The facility pressure ulcer assessment failed to identify any behavioral issue related to non-compliance with interventions. Review of the care plan provided by the facility as the current care plan, identified no concern with behaviors and therefore no interventions were in place to address the refusal of cares. In addition, although the wound clinic regularly reviewed the heel pressure ulcers, there was no evidence in the record of the wound clinic addressing any other pressure ulcers. If the wound clinic had

provided services for any other areas, there would have been documentation of the service(s) provided in the consultation documentation.

Without consistently providing the services required to minimize the risk for pressure ulcers, the facility is unable to demonstrate the pressure ulcers on the buttocks/sacral area were unavoidable. This lapse creates a potential for harm, however, given other interventions and cares were provided to Resident #56, it cannot be determined that it caused actual harm. The deficiency remains; however, it is reduced in severity from a Level G to a Level D.

Tag F282 requires that the services provided by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Resident #56's plan of care clearly directed staff to reposition him no greater than every two hours. This direction was supported by a physician order.

There is undisputed evidence that the facility did not reposition Resident #56 for more than two hours on September 10, 2014. This is a lapse in following the care plan, however, it is the only lapse observed. During interview with NA-A, she stated the facility was short staffed and they were not always able to complete resident cares as scheduled. Simultaneous review of F353 supports the nursing assistant's interview that staffing was an issue in consistently completing resident cares according to the plan of care.

This lapse creates a potential for harm. This is a valid deficiency. This deficiency is appropriately cited at the scope and severity Level E.

This concludes the IIDR process. As noted in the Department of Health's Information Bulletin 04-07, the final decision of the Department is not binding on the Centers for Medicare and Medicaid Services.

Sincerely,

Edward P. Ehlinger, M.D., MSPH
Commissioner
P.O. Box 64975
Saint Paul, Minnesota 55164-0975

cc: Judge Thomas Wexler
Jan M. Suzuki, CMS Region V
Deb Holtz
Darcy Miner
Christine Campbell
Monica Larson

Olson, Cynthia (MDH)

From: rcoffin@vrb-law.com
Sent: Friday, October 10, 2014 1:52 PM
To: *MDH_FPC-IDR
Subject: IDR Form

PROVIDER - 00950, HAVEN HOMES OF MAPLE PLAIN

IDR Type - IIDR

Tags: FF278, F282, F310, F314, F317, F318, F353
Survey Date(Exit Date): September 12, 2014

Review will be conducted - In person

Dates when facility cannot participate: To be determined

Will attorney for facility be attending: Yes

No of persons attending: 6-7
Submitter Name: Rebecca Coffin
Email:rcoffin@vrb-law.com

OAH 66-0900-31984

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Haven Homes (IIDR) **RECOMMENDED DECISION**

This matter came before Administrative Law Judge Thomas W. Wexler for an informal dispute resolution meeting on December 22, 2014. The meeting concluded on that date.

Christine Campbell appeared on behalf of the Minnesota Department of Health (MDH). Mary Cahill also attended on behalf of MDH. Holly Kranz, the compliance survey team leader, testified on behalf of MDH.

Rebecca Coffin, Voight, Rode & Boxeth LLC, appeared on behalf of Haven Homes (Facility or Home). Jessica Sellner, Sue Boyd, Diane Lynch and Renee Anderson also attended on behalf of the Facility. Angie Tormanen, the Nursing Supervisor, and Brenda Anderson, an LPN at the Home, testified on behalf of the Facility.

Based upon the testimony and exhibits submitted at the resolution meeting, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. The Commissioner of Health (Commissioner) should further recommend that tag F282 be set aside as the evidence does not establish a deficient practice.

2. The Commissioner should further recommend that tag F314 be set aside because the evidence does not establish a deficient practice and the outcome was unavoidable.

Dated: January 6, 2014

s/Thomas W. Wexler

THOMAS W. WEXLER
Administrative law Judge

Reported: Digital Recording; no transcript prepared

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) (2014), this recommended decision is not binding upon the Commissioner of Health. Pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge, within ten (10) calendar days of receipt of this recommended decision.

MEMORANDUM

General Statutory and Regulatory Background

This matter arises out of a state compliance survey conducted at the Facility between September 8 and 12, 2014.[1]

Participation requirements for skilled nursing and long-term care facilities in the Medicare program are set forth in 42 C.F.R. pt. 483, subp. B (2014). Provisions governing the surveying of such entities and compliance enforcement are set forth in 42 C.F.R., pt. 488, especially subp. E, F (2014).

Compliance with participation requirements is monitored by periodic surveys by state agencies such as the MDH. The state agency reports any deficiencies on a form called a "Statement of Deficiencies and Plan of Correction" (form CMS 2567).[2]

A "deficiency" is a failure to meet a participation requirement in 42 C.F.R. 483, subp. B.[3] Deficiencies are designated by alpha-numeric "tags" corresponding to a regulatory requirement in Part 483 (2014).

The survey findings also include a determination as to the severity of each deficiency.[4] The seriousness of a deficiency depends on both its "scope" and its "severity."[5]

When citing deficiencies, the state surveyors use the CMS Guidance on Deficiency Categorization. There are four levels of severity and three columns of scope. The range of deficiencies is set out on a grid. Each square on the grid has a letter designation. "A" is the least serious and "L" is the most serious.[6] On the bottom row of the grid are the least serious deficiencies and the top row are most serious in terms of harm or threatened harm to the resident.

If a facility is not in substantial compliance, CMS may either terminate the facility's provider agreement or allow the facility the opportunity to correct the deficiency

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[1] MDH Ex.J.
[2] Centers for Medicare and Medicaid Services (CMS).
[3] *See* 42 C.F.R. § 488.301 (2014)
[4] *See* 42 C.F.R. § 488.404.
[5] *See* 42 C.F.R. § 488.404(b).
[6] MDH Ex. D.

pursuant to a plan of correction.[7] Depending upon the severity of the deficiency, CMS may also impose intermediate remedies, such as monetary penalties, for each day the facility was not in substantial compliance with the participation agreement.[8]

A facility may request an informal opportunity to dispute condition-level survey findings.[9]

On October 10, 2014, MDH issued a statement of deficiencies (form CMS 2567) following survey of the Facility.[10] The statement designated certain "F-Tags." Only two of those F-Tags were in dispute at this resolution meeting. Both of the disputed F-Tags relate to the care of resident number 56 (R56). The disputed F-Tags are F282 and F314.

F282 relates to failure to ensure the care plan for repositioning of resident R56. This tag was issued at a severity level E,[11] which means a pattern deficiency that results in no immediate jeopardy and no actual harm, but has potential for more than minimal physical, mental and/or psychological discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.[12]

F314 relates to failure to ensure interventions as assessed and to re-evaluate to prevent new pressure ulcers from developing. This tag was issued at a severity level G,[13] which means an isolated deficiency that results in actual harm that has compromised the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.[14]

MDH had also cited tag F278, failure to ensure accuracy of the Minimum Data Set, resident status assessment, for R56, but MDH has agreed that citation is to be withdrawn.

As to F282, the Facility contends that it had qualified staff who knew of the policy to provide repositioning of R56 every two hours and that was routinely done, although it was exceeded on the day of observation, September 10, 2014. The Facility also alleges that R56 often resisted repositioning when offered. The Facility requests that references to R56 be removed from F282 because it was in substantial compliance with the regulations.

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[7] *See* 42 C.F.R. §§ 488.400, subp. F *et seq.*
[8] *Id.*
[9] *See* 42 C.F.R. § 488.745; Minn. Stat. § 144A.10, subd. 16 (2014).
[10] MDH Ex. J.
[11] *Id.* at J-13.
[12] Facility Exs. C, D, G-J.
[13] *Id.* at J-25.
[14] Facility Exs. C, D, G-J.

As to F314, the Facility contends that the pressure ulcers that R56 developed were "unavoidable" and that it was in substantial compliance with the regulations in assessing, monitoring, and providing appropriate interventions to address R56's pressure ulcers. The Facility requests that this F314 be rescinded.

"Substantial compliance" is a term of art. 42 C.F.R. § 488.301 defines substantial compliance as follows:

> Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

"Minimal harm" is not specifically defined. However, 42 C.F.R. § 488.404(b) establishes guidelines to determine the seriousness of a deficiency, as follows:

> (b) *Determining seriousness of deficiencies.* To determine the seriousness of the deficiency, CMS considers and the state must consider at least the following factors:
>
> (1) Whether a facility's deficiencies constitute-
>
> (i) No actual harm with a potential for minimal harm;
>
> (ii) No actual harm with a potential for more than minimal harm, but not immediate jeopardy;
>
> (iii) Actual harm that is not immediate jeopardy; or
>
> (iv) Immediate jeopardy to resident health or safety.
>
> (2) Whether the deficiencies-
>
> (i) Are isolated;
>
> (ii) Constitute a pattern; or
>
> (iii) Are widespread.

Seriousness of a deficiency thus involves two components: level of harm to the resident and scope of the conduct in the facility.

There are voluminous studies and writings addressing pressure sores (commonly referred to as pressure ulcers). The writings address evaluation of susceptibility to ulcers, care practices to avoid ulcers (especially frequency of repositioning), periodic re-evaluations as may be required to modify care practices for a particular resident, bed and chair devices, off-loading practice, and wound cares. Pressure ulcers are one of the principal concerns of hospital and nursing facility care, and thus, are specifically

addressed in the C.F.R. and extensively addressed in the survey regulations. 42 C.F.R. § 483.25(c) provides as follows:

> (c) *Pressure sores.* Based on the comprehensive assessment of a resident, the facility must ensure that—
>
> (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
>
> (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
>
> (emphasis added)

What is "avoidable" and "unavoidable" is defined as follows:

> "Avoidable" means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.
>
> "Unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.[15]

Nursing facilities and skilled nursing facilities are not unconditional guarantors of favorable outcomes, but the regulations on quality of care impose a duty to provide services designed to achieve those outcomes to the highest degree practicable.[16]

The surveying agency has the burden of setting forth the factual basis for its determination that the facility was not in substantial compliance. It must also produce evidence related to any disputed statement of fact.[17] MDH has met that minimal burden. This does not appear to be a burden of proof, but rather a burden of production. When that showing is made, then the burden shifts to the facility to show that the alleged

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[15] State Operations Manual (SOM), MDH Exhibit G-2. The SOM is actually a federal document that includes regulations for facilities enrolled in the Medicare/Medicaid program.
[16] *Florence Park Care Center v. CMS,* HHS departmental Appeals Board, Appellate Division, July 13, 2004 (MDH Exhibit E, at E-9).
[17] *Id.* at p. E-12.

deficiencies were isolated and did not increase the risk for the affected resident to potentially cause more than minimal harm.[18]

Course of Treatment for Resident Number 56

Resident 56 (R56) is a male born January 21, 1923. He was admitted to the Facility on December 10, 2013. He was then 90 years of age, was 5' 9" tall and weighed 133.2 pounds. He had multiple diagnoses upon admission including the following:

A. Benign prostatic hyperplasia/bladder outlet obstruction.

B. Hypertension.

C. Diabetes mellitus type II.

D. Foot drop.

E. Hyperglycemia

F. Mild leukocytosis.

G. Weakness.

H. Bilateral pressure ulcers on his heels.

I. A pressure ulcer on his coccyx.

J. He was alert and oriented.

K. His speech was clear.[19]

A comprehensive care plan was developed upon admission.[20]

The tags in this case relate primarily to the alleged failure of the Facility to properly address the requirements directed to avoidance of pressure ulcers. Thus the findings and discussion here will focus on those allegations.

The coccyx ulcer, that was present on admission was 1.3 x 0.3 cm, was an open ulcer within a larger red rash area. The ulcer resolved by January 2, 2014, and the Facility continued to monitor the area thereafter.[21]

The bilateral heel ulcers never resolved.[22] There is no contention that the Facility did not adequately monitor and care for the heel ulcers. It appears that they were well cared for and that these vulnerable ulcers never became infected. The care and

[18] *Id.*at p. E-13 and 42 C.F.R. § 488.301.
[19] Facility Exs. 1, 34 (p. 1).
[20] Facility Ex. 34.
[21] Facility Ex. 2.
[22] Facility Ex. 3.

treatment of the heel condition is relevant here. It shows the regularity of doctor visits, the doctors' primary concerns for patient welfare, and that it likely required bed positioning with feet elevated, a regimen that heightened stress to the buttock area.[23] The Facility records reflect regular attention to and treatment of the heel ulcers. R56 was seen on approximately a monthly basis by Dr. Jennifer Rysso at Ridgeview Medical Center for treatment of his heel ulcers.[24] Dr. Rysso was R56's primary care doctor.

R56 was seen on or about March 14, 2014 by Dr. Dawn Stapleton at the Lakeview Clinic, who performed a wound debridement on the heel ulcers.[25]

R56 was also being seen for the heel ulcers by a Wound, Ostomy and Continence Nurse (WOC or WOCN). On May 13, 2014, the WOC felt that she did not have anything further to offer R56 with respect to his heel ulcers and recommended referral to a formal wound clinic.[26]

R56 was also seen by Dr. Matthew Melin, a vascular surgeon, on June 2 and again on June 25, 2014. Dr. Melin diagnosed probable peripheral arterial disease, he viewed the heel ulcers, did not recommend revascularization, but did discuss the option of hospice care. He specified cares for the foot ulcers.[27]

Dr. Rysso's exam records reflect approximate monthly visits from March 2014 through June 2014, after which R56 was seen more frequently. He was seen three times in July and again on August 1, 2014.[28] None of these progress notes mention pressure sores on his gluteal area, sacrum or coccyx, although Dr. Rysso was notified of these developments by the Facility as they appeared and as hereafter noted.

On June 17, 2014, the Facility first noted two areas of skin breakdown on R56's gluteal folds. There was a red raised area on his left gluteal fold[29] and an open area on his right gluteal fold.[30] The left gluteal fold condition resolved by July 9, 2014. The right gluteal fold condition was consistently monitored, but did not heal. Dr. Rysso was promptly informed on June 17 of the of the gluteal fold issues and she sent an order for that skin care.[31]

On June 19 nursing requested a change from the doctor for treatment of the right gluteal fold to use an alternative dressing with border.[32]

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[23] Facility Exs. 4-10, 18, 46.
[24] Facility Exs. 11-17, nursing visit summaries.
[25] Facility Ex. 31.
[26] Facility Ex. 17.
[27] Facility Exs. 29, 30.
[28] Facility Exs. 20 to 28.
[29] Facility Ex. 41.
[30] Facility Ex. 42.
[31] Facility Ex. 43, nurses note on June 17, 2014.
[32] Facility Ex. 43, p. 8.

The progress notes reflect continuing attention to the cares of the gluteal fold and other buttock area ulcers.[33]

On June 21, 2014, R56 complained about his Stimulite chair cushion because it felt like he was sitting in a hole.[34] The nurse consulted with physical therapy and it was decided to provide a vector pressure redistribution cushion.[35] The nursing staff then did a sitting tissue tolerance assessment on 6/23/2014 and a new Braden scale evaluation on that same day.[36]

Dr. Rysso's report of July 18, 2014 opines that R56 has experienced significant gradual decline in overall medical status and suggested that the code status be changed to comfort care status.[37]

On July 27, the Facility noted a new open wound on R56's right buttocks.[38] The doctor was notified, prescribed treatment and the Facility implemented the treatment.[39] The new open area was not likely due to repositioning issues. It was likely the result of trauma from the adhesive edge of the right gluteal fold dressing.[40] The Facility then requested permission from the doctor to change the wound dressing to prevent further fragile skin trauma.[41]

On August 24, 2014 nursing noted a new reddened area on R56's sacrum/coccyx region, requested a treatment order, and on August 25, 2014, Dr. Rysso was notified of the reddened area.[42] Dr. Rysso observed the reddened area on September 5.[43] The Facility again notified the doctor, received and carried out care instructions, and completed a new tissue tolerance assessment which concluded that the same repositioning schedule was appropriate.[44]

R56 was vulnerable to skin issues. In addition to his foot, sacrum and buttock skin issues, he had skin issues with his scrotum, elbows, finger, left bunion, bottom side of penis, both hands, and right lateral foot.[45] Some of these issues resolved with Facility

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[33] Facility Ex. 43 on dates of June 19, 20, 21, 22; July 9, 12, 14, 16, 18, 27, 28, 31; August 1, 12, 24, 25; and September 1, 3, 5, 6.
[34] Facility Ex. 43, nurse's note 6/21/2014.
[35] Facility Ex. 43, note 6/21/2014, Exs. 7-10; Testimony of Brenda Anderson.
[36] Facility Exs. 35; 38.
[37] Facility Ex. 22.
[38] Facility Ex. 43.
[39] Facility Exs. 8-10.
[40] Facility Ex. 43, nurse's note 7/31/2014.
[41] *Id.*
[42] Facility Ex. 32; Ex. 43, 8/25/14.
[43] Facility Ex. 43, 9/5/14.
[44] Facility Exs. 9, 10, 35, 43.
[45] Facility Ex. 43, skin injury notes of: Buttocks 8/28/14, 9/5/14; Scrotum 5/12/14, 5/27/14, 6/21/14, 8/1/14 (resolved); Right hand 5/18/14, 5/19/14, 6/23/14 (resolved); General 5/28/14; Elbows 6/8/14 (resolved), 6/20/14 (new elbow injury), 6/23/14, 7/20/14 (resolved); Clipped finger 6/24/14, 6/25/14, 7/3/14 (resolved); Bunion 6/29 - 7/1/14, 7/21/14, 7/23/14; Right lateral foot 7/7/14 (resolved); Penis 7/14/14, 7/16/14, 7/18/14; Back of left hand 8/28/14.

care as noted in the footnote below. A few of the skin issues resulted from what appear to be mild traumas.

R56 was not always cooperative with attempts to reposition him.[46] On at least two occasions, June 21, 2014 and July 12, 2014, he was counselled about the importance of repositioning.[47] As part of his repositioning regimen, R56 was scheduled for bedrest in the A.M. and the P.M.[48] R56's wife, who also resides in the Facility and was regularly attendant with R56, agrees that R56 did not always want to be repositioned.[49] On other occasions, when R56 was resistant to repositioning, Facility staff would off-load him.[50]

The Facility regularly followed physician orders, WOC recommendations, and their own assessments. [51]

The Facility performed tissue tolerance evaluations, predisposing disease risk evaluations, and Braden scale assessments of R56.[52] There were seven tissue tolerance evaluations between January 10, 2014 and August 25, 2014.[53] There were three Braden evaluations—in March, May and June 2014—which indicated mild risk for ulcers, but the Facility treated him as "high risk" notwithstanding the lower Braden score.[54]

The facility was implementing a variety of cares to address R56's multiple needs, including turning and repositioning, elbow protectors, elevating his legs, creams, sheep skin on wheelchair arms, changing ulcer dressings and applying medications, pressure guard air mattress, cushion for the wheel chair or room chair, and diabetic diet with protein supplement to assist with wound healing.[55]

Dr. Rysso was concerned about R56's diet. Based upon Dr. Rysso's order, the facility performed a dietary assessment. The assessment recommended that they continue with the current diet which included nightly snacks and protein supplements. R56's weight had remained stable.[56]

R56 has recently been moved to hospice care.[57]

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[46] Facility Exs. 51, 52; Test. of B. Anderson.
[47] *Id.*
[48] Facility Exs. 5-10.
[49] Facility Ex. 50.
[50] Test. of B. Anderson.
[51] Facility Exs. 4-10.
[52] Facility Exs. 35-40.
[53] Facility Ex. 35. The CMS 2567 notes some apparent inconsistencies in the evaluations with respect to ability to reposition independently in the lying position. However, the care plan did not change and continued to require repositioning intervals not to exceed two hours.
[54] Facility Ex. 36; Test. of B. Anderson.
[55] Facility Exs. 4-10, 34 (care plan and p. 10).
[56] Facility Exs. 21, 43 (note of 8/12/2014).
[57] Advice at the meeting.

It is undisputed that on one survey day, September 10, 2014, R56 was not repositioned or off-loaded within two hours. However, that appears to be an exception to the common practice at the Facility and there is no evidence that one occasion caused R56 any harm.

Analysis

None of the literature that has been presented or researched by the undersigned states that frequent repositioning of a resident assures that pressure ulcers will not occur. It appears that a pressure ulcer can begin within two to six hours.[58] Typically the ulcer commences below the epidermis, in the dermis, and progresses outward due to bony pressure on the skin. The appearance of the ulcer may not become apparent for days after it begins. An ulcer can also be precipitated by shear and friction forces, which can occur when a resident is moved on bed sheets.[59] A white paper publication of the National Pressure Ulcer Advisory Panel (NPUAP) states that pressure ulcers occurring at the end of life are often not preventable, because of the frail condition and co-morbidities.[60]

The determination that an ulcer is a pressure ulcer cannot be made based merely on its location over a pressure point. It could also be precipitated by a shear event.[61]

Of course, the resident's failing condition would not justify failure to implement appropriate cares to minimize pressure ulcer risk. However, the preponderance of the evidence in this case is that the Facility regularly repositioned R56 to minimize the risk of pressure ulcers. That conclusion is supported by the following:

1. That the sacrum ulcer present upon admission resolved.

2. There were no new pressure ulcers for six months after admission.

3. The left side gluteal fold ulcer, that appeared on June 17, 2014, resolved by July 9, 2014.

4. The Facility was devoting regular attention to skin issues by performing tissue tolerance tests and Braden Scale assessments and considered R56's status to be high risk in spite of the Braden scale score.

5. R56 was frequently resisting repositioning, staff had to counsel R56 about the importance of repositioning.

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[58] MDH Ex. G-6.
[59] MDH Ex. G-2.
[60] *"Pressure Ulcers in Individuals Receiving Palliative Care: A National Pressure Ulcer Advisory Panel White Paper,"* Advances in Skin and Wound Care, February 2010. CMS acknowledges NPUAP as an authoritative agency, MDH Exhibit M-32.
[61] MDH Ex. M-32.

6. Doctors were promptly notified of the presence of new ulcers and orders obtained and implemented.

7. The treatment of ulcers was effective to prevent infection.

8. R56 was provided with a special air mattress for his bed.

9. R56 was provided with a therapeutic chair cushion and months later, when R56 reported it to be uncomfortable, the Facility provided him with a new therapeutic cushion which R56 found to be comfortable. MDH argues that there was no appropriate evaluation of the new chair cushion by Occupational Therapy, but R56 found it comfortable and Physical Therapy recommended it.

10. The medication administration records reflect consistent attention to all of the cares prescribed in those records, some of which were prescribed to prevent skin breakdown and to assist with healing.

11. The primary healing concern from admission onwards was always the open heel wounds, and they were well cared for. Though they never healed, they did not become infected. No one contends that there was any deficiency in the Facility care of the heel pressure ulcers.

12. The records reflect that there were many doctors visits and constant communication to and from the doctors relating to many aspects of R56's care. There were at least 55 days recorded in the nurses' notes where there was at least one communication with a doctor and there was more than one such communication on many of those days. Many of those communications related to the ulcers on the sacrum and gluteal fold, requesting advice and change orders in the cares.

13. The Facility had a repositioning policy and a wound care policy. Each of those policies assigned qualified staff to those responsibilities.[62]

All of these facts support the conclusion that the Facility paid careful attention to the risk of pressure ulcers, and to the cares required to prevent pressure ulcers.

There is admitted evidence that the Facility did not reposition R56 for more than two hours on September 10, 2014, perhaps for much more than two hours on that day. No actual harm is shown to be related to that incident. The best evidence is that the September 10 incident was an isolated occurrence, and MDH has classified it as an isolated occurrence.

[62] Facility Exs. 48, 49.

R56 was not always in the care of the Facility at times possibly relevant to the development of the gluteal fold pressure ulcers on June 17, 2014. On June 2, 2014, R56 was taken by transport to the Methodist Hospital Wound Clinic. He left the Facility at 9:15 A.M. and returned at 12:30 P.M.[63] It is foreseeable that the beginning of pressure ulcers could happen during that time.

R56 was also transported to the hospital on May 6, 2014, during which time he was gone from 10:45 A.M. to 4:00 P.M.[64]

Another ulcer appeared on July 27, 2014, but this appears to be related to trauma caused by removal of a bandage/dressing from one of the gluteal ulcers. The Facility promptly contacted the doctor to request approval for use of a different dressing and that request was approved. This was not a pressure ulcer.

One other pressure ulcer appeared on the sacrum on August 25, 2014.

The requirement that the heels had to be elevated in bed likely made repositioning more complicated to avoid backside pressure. Without minimizing the need to relieve backside pressure, it is undeniably true that the heel ulcers were always the primary concern, and that the potential of serious infection and leg amputation was avoided by the attentive care provided.

R56's wife also resided in the Facility[65] and was regularly involved with R56 and with his care. She signed a statement that should be fairly interpreted to mean that repositioning was commonly provided at appropriate intervals, and that R56 sometimes declined repositioning when offered. She also acknowledges that the Facility advised of the risk of not repositioning every two hours.

A CNA was interviewed by the survey team and was understood to say that sometimes they could not get to R56 for repositioning every two hours. That CNA provided a statement, however, that when she was on duty she always repositioned R56 every two hours. However, the CNA also appears to state that R56 sometimes refused to be repositioned.

There are very few, if any, chart reports of pain complaints by R56 associated with the gluteal fold and sacrum pressure ulcers. It appears the Facility was appropriately managing the comfort level of R56 related to the pressure ulcers. On September 10, 2014, R56 did tell the survey interviewer that he had pain in the buttocks at that time.

The Facility contends that R56's co-morbidities, especially his diabetes, impaired circulation and low prealbumin levels,[66] made the pressure ulcers on his sacrum and buttocks unavoidable. All of these conditions are well known to impair skin health. The

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[63] Facility Ex. 43.
[64] *Id.*
[65] Facility Ex. 34, p. 6 of 16.
[66] Facility Ex. 25.

prealbumin levels were in the range of 8 to 9, which indicates malnutrition and in turn relates to the ability of skin cells to regenerate. The doctors were informed of the lab results and ordered diet supplements which were provided by the Facility. R56's weight was stable.

Fecal incontinence is known to exacerbate vulnerability to skin ulcers.[67] R56 suffered from such incontinence.

R56 received necessary treatment and services to promote healing. Individualized procedures were observed in the care and treatment of R56 and of his susceptibility to pressure ulcers. R56's ulcers were treated appropriately and consistent with doctor recommendations. Doctors were kept informed. R56 did not experience significant discomfort associated with the pressure ulcers and was generally comfortable.

The evidence and exhibits reflect that R56's condition and multiple comorbidities were well-evaluated upon admission, and that his pressure ulcer risk factors were noted and an appropriate care plan developed and implemented consistent with R56's needs. He was evaluated as at high risk for pressure ulcers and placed on two hour repositioning from the inception of his residence.[68] The preponderance of the evidence is that the care plan was appropriate and consistent with the standards of practice.

Conclusion

The Administrative Law Judge recommends that the Commissioner further recommend that the "G" level deficiency issued under F314, and the "E" level deficiency issued under tag F282 be set aside.

T. W. W.

[67] MDH Ex. G-8.
[68] Facility Ex. 4 at entry of 1/9/14.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CERTIFIED MAIL # 7003 2260 0000 9987 7248
March 25, 2015

Ms. Diane Lynch, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue
Maple Plain, Minnesota 55359

Re: Haven Homes Of Maple Plain Independent Informal Dispute Resolution
Provider # 245497
Project # S5497023

Dear Ms. Lynch:

In a request dated October 10, 2014, Haven Homes Of Maple Plain requested removal of deficiencies cited at F282 and F314 as a result of a survey completed on September 12, 2014 by the Licensing and Certification program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated February 6, 2015. The revised CMS 2567 is enclosed.

Also, corresponding State licensing orders cited at MN Rule 4658.0525 Subp. 3 has been reviewed and revised. The revised Minnesota Department of Health order form is enclosed.

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

Sincerely,

Christine Campbell

Christine Campbell

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

Haven Homes IIDR

MDH L&C 3201

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ms. Diane Lynch, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue
Maple Plain, MN 55359

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Linda Strieve ☐ Agent ☐ Addressee

B. Received by (Printed Name) Linda Strieve

C. Date of Delivery 3-27-15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

PLEASE DATE

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

7003 2260 0000 9987 7248 IIDR

ML/Please return within 5 days

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On September 8, 9, 10, 11 and 12th, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	F 000	REVISED	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to	F 156		10/22/14

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

10/10/2014

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

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F 156	Continued From page 1 the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance	F 156		

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F 156	Continued From page 2 directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents (R11, R57) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, informing them of their right to an appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services. Findings include: R11 was admitted to the facility with skilled medicare coverage on 2/13/14. On 4/22/14, the facility determined R11 no longer met medicare coverage criteria and issued a notice of medicare non-coverage on continued stay, with the first non-covered day listed as 4/25/14. The facility did not have record R11 received the CMS 10123, informing her of her rights for an expedited appeal.	F 156		

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F 156	Continued From page 3 R57 was admitted to the facility with skilled medicare coverage on 1/17/14. R57's denial letters contained only the CMS 10123, indicating R57's last covered day was 3/19/14. R57 records did not contain the required notice of medicare coverage on continued stay. R57 remained in the facility after her medicare coverage was discontinued. During interview on 9/11/14, at approximately 10:00 a.m. director of nursing (DON) stated the facility did not have a policy specific to how to issue medicare denials, and verified there were no other denial letters on file for R11 or R57. DON provided copies of a Haven Homes Medicare Assessment Tool and a blank notice of medicare coverage on continued stay, however, these did not address the facility process on how to inform residents of medicare appeal rights or for required denial letters the residents must receive.	F 156		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents observed during dining who required staff assistance, (R12, R52, R66 and R7), were provided assistance in a dignified manner.	F 241		10/22/14

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F 241	Continued From page 4 R12's quarterly minimum data set (MDS) dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and required extensive staff assistance with dining. R66's quarterly MDS dated 8/6/14, identified R66 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/27/14, identified R7 had severe cognitive impairment and required extensive staff assistance with dining. During dining observation on 9/8/14, at approximately 5:40 p.m. nursing assistant (NA)-P was observed sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident giving them a bite of food, and then rolling on the stool using her feet, to the next resident. NA-P would give a resident a bite of food, set the fork or spoon down, and immediately roll over to the next resident, and continued rolling around the table on the stool the entire meal. During interview on 9/8/14, at 6:01 p.m. NA-P stated she was required to feed multiple residents at a time, and needed to use the rolling stool so she was able to go from resident to resident to ensure they all received their meal. NA-P stated there was not enough staff to ensure all the residents were being fed timely, so the NA's do	F 241		

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F 241	Continued From page 5 what they have to so the residents receive their meals. A policy on feeding residents was requested but not provided.	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 48 residents (R46) bathrooms had bathroom equipment in good repair. In addition, the facility failed to ensure 2 of 48 residents (R46, R24) were provided adequate water pressure to their bathroom sink. Findings include: R46's annual minimum data set (MDS) dated 8/6/14, identified the resident had no cognitive impairment. During interview on 9/8/14, at 4:30 p.m. R46 stated her bathroom sink was cracked and she had very little water pressure in her bathroom sink. She stated she had talked to several of the staff about both issues with her bathroom sink, and no one did anything about it. R46 stated the low water pressure and cracked sink had been like this since her admission to the facility which was over a year ago.	F 253		10/22/14

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F 253	Continued From page 6 During a tour of the facility on 9/12/14, at 1:00 p.m. maintenance supervisor (MS)-F verified R46's sink had two large cracks, one extending from the faucet knob down the entire sink almost to the drain, and a second crack on the left edge of the sink. MS-F also verified the water pressure in R46's bathroom sink was very low and the water trickled out of the faucet. MS-F stated he had not been informed of the cracked sink, which he stated had the potential to, "Scratch" the resident, and he was not aware of the low water pressure in R46's room. MS-F stated he did daily rounds of the facility looking for damaged equipment, however, he did not go into any of the resident rooms or bathrooms during the inspection. He stated it was the expectation nursing staff inform him of broken items so maintence could repair them. R24's quarterly MDS dated 6/24/14, identified the resident had severe cognitive impairment and required extensive assistance of two staff for personal cares. During observations on 9/8/14, at 7:14 p.m. and 9/11/14, at 11:00 a.m. R24's water flowed out of the bathroom sink faucet slowly and took a long time for the temperature of the water to heat up to get warm. During the tour of the facility on 9/12/14, at 1:00 p.m. MS-F verified R24's bathroom sink water pressure was very low. MS-F stated he was not aware of the R24's low water pressure until now, and it was an easy fix if he had been informed of the problem for his department to address the issue. MS-F stated nursing staff are to notify him	F 253		

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F 253	Continued From page 7 of any maintenance problems. A facility maintence policy was requested but not provided.	F 253		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was implemented for repositioning for 1 of 2 residents (R56), reviewed for pressure ulcers, for 1 of 1 residents bathing needs (R11), reviewed who required assistance with bathing, and for or 2 of 5 residents ROM programs (R31, R11) reviewed for range of motion services. Findings include: R56's quarterly Minimum data set dated 6/11/14, identified R56 had no cognitive impairments, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for pressure ulcer development, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's care plan dated 8/16/14, identified R56 had a unstageable pressure ulcer measuring 1.3 x 0.3 the coccyx. The care plan instructed R56 to be	F 282		10/22/14

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F 282	Continued From page 8 repositioned at no greater than 2 hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m. the resident was not repositioned and was unable to shift his weight independently in the wheelchair. During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up in his chair since approximately 6:00 a.m. that morning. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned at least every two hours, and should lie down after breakfast. LPN-B requested assistance to lay R56 down in bed. NA-B and LPN-B transfered R56 to his bed to lay down on 9/10/14, at 10:05 a.m. Although R56's care plan instructed staff to reposition R56 every two hours, the resident had been in his chair for a total of 2 hours and 47 minutes without being repositioned. R31's quarterly MDS dated 6/11/14, indicated R31 had no current functional losses of range of motion (contractures) in the upper or lower extremities. R31s care plan dated 8/20/14, identified R31 was to receive passive range of motion daily to hips, knees, and ankles, 10-15 repetitions, as well as to bilateral shoulders, elbows, wrists and digits daily. Review of R31s ROM documentation indicated the resident recieved range of motion services 12 days in the last month (8/12/14 through 9/14/14).	F 282		

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F 282	Continued From page 9 R31's restorative documentation for 7/2014, was not documented as being completed for 28 out of 31 days. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive any range of motion services other than routine dressing activities. During interview on 9/11/14, at 3:18 p.m. R31 stated he had a stroke a while back and did not walk anymore, but would like to use his legs and complete leg exercises. R11 quarterly MDS dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene and was able to provide partial physical help with bathing. The care plan dated 9/4/14, identified R11 needed the assist of one staff for bathing and preferred to have a bath versus a shower. Staff was directed to to honor resident's preferences and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated recently she had gone for a couple of weeks without a bath because the facility didn't have any bath aids. R11's point of care bathing record indicated R11 received a tub bath on 7/31/14, and the next entry was a partial bath on 8/28/14, which was 28 days later. During interview on 9/12/14, at 9:34 a.m. NA-B stated it was possible R11 went for weeks without a bath because there is not enough staff to assist residents with bathing.	F 282		

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HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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F 282	Continued From page 10 R1's quarterly MDS dated 6/25/14, indicated R1 had functional limitation in range of motion (ROM) to one side of the upper and lower extremities. R1 care plan dated 7/2/14, identified R1 was to receive passive range of motion (PROM) daily, 10-15 reps to bilateral shoulders, elbows, wrists, and digits. R1's PROM restorative nursing sheets were reviewed from April 2014 - September 2014. There was no documentation to determine if R1 was recieving PROM as directed by the care plan. During interview on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility no longer had a restorative aid, and the NAs are not able to complete R1's PROM as directed by the care plan. During interview on 9/11/14, at 9:25 a.m. R1 non-verbally indicated by motioning in a back and forth motion with her hand to indicate 'so-so,' when asked if staff were assisting her with PROM on a daily basis. When asked for a frequency of the PROM being done, R1 spelled out, "monthly," on her communication board.	F 282		
F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability	F 310		10/22/14

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F 310	Continued From page 11 to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Findings include: R47's quarterly Minimum Data Set (MDS) dated 7/2/14, indicated R47 had no cognitive impairment, needed extensive assistance of one staff for transfers and ambulation, and used a wheelchair or a walker to aid her ambulation. R47's balance was not steady during transfers and walking and she had no loss of upper and lower function range of motion (contractures). R47's Care Area Assessments (CAA) dated 10/9/13, identified R47 was alert and oriented, had clear speech, and she was understood and able to understand others. R47 had an unsteady gait, was able to bear weight, and required a wheelchair behind her when she was involved in the restorative walking program. During interview on 9/8/14, at 7:11 p.m. R47 stated she was concerned she was going to lose her ability to walk because staff had not been assisting her to ambulate. She stated she was	F 310		

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supposed to be walked twice a day but there was not enough staff to do this. She indicated she was, "Very rarely being walked."

Another interview was completed on 9/11/14, at 11:00 a.m. R47 stated she was, "upset, " about not being walked twice a day due to staff shortage. She stated, "They just don't have time to walk me." R47 stated she had been involved in therapy and the therapist recommended she be walked. Because staff had not been assisting her to walk, R47 stated her joints are getting stiff and was not able to move as easily as she had in the recent past. She stated the last time she could remember she was walked was about 7-10 days ago.

R47's care plan dated 7/9/14, indicated R47 was to be ambulated per the "Restorative program." The restorative program was not specified in the plan of care.

R47's nursing assistant care sheet, dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet, twice per day with assistance of one staff, a transfer belt, rolling walker, and wheelchair behind.

R47's physical therapy note dated 8/7/14, indicated the resident was able to ambulate up to 80 feet with a rolling walker and contact guard assistance.

R47 was seen in the occupational therapy (OT) department from 7/14/14 to 8/14/14. R47 was considered to be alert and able to follow directions. R47's discharge from OT on 8/14/14, indicated she transferred with contact guard assistance (CGA- the therapist would hold a

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transfer belt for stabilization), tolerated standing for greater than three minutes while she maintained a safe balance while using a 4 wheeled walker, had an increase in her endurance while performing her activities of daily living, and reported no increase in fatigue while performing her exercises.

R47's physician orders dated 9/5/14, directed staff to ambulate the resident 57-115 feet twice daily with a wheelchair behind, using a rolling walker and transfer belt.

R47's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, were reviewed from April 2014, to September 11, 2014 identified the following:

-April 1 to June 30, 2014, R47 was ambulating twice a day, walking 57 to 115 feet consistently.
-July, 2014, R47 was walked 15 times on the day shift, and twice on the evening shift. The last documentation of R47 being ambulated was 7/23/14, when she walked 115 feet.
-August 2014, to September 11 2014, there was no documentation regarding R47 ambulating.

During interview on 9/11/14, at 9:44 a.m. nursing assistant (NA)-J stated he was aware R47 was to be ambulated twice a day, however, he had never assisted R47 to ambulate. NA-J stated staff does not have time to complete R47 ambulation program because of short staff.

During interview on 9/11/14, at 11:15 a.m. licensed practical nurse (LPN)-C stated R47 was to be ambulated twice a day, however, she stated

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F 310	Continued From page 14 there was no way to determine if R47 was being ambulated because there was no documentation. During interview on 9/11/14, at 2:39 p.m. physical therapy assistant (PTA)-E stated she had worked with R47 from 7/14/14, until her discharge from physical therapy on 8/12/14. PTA-E had recommended R47 be ambulated twice a day, 57-111 feet. PTA-E stated R47, "loved to be walked," and was able to consistently walk 80 feet when discharged from PT on 8/12/14. During interview on 9/11/14, at 3:24 p.m. registered nurse (RN)-A (who was identified as the person in charge of Rehab/Restorative Services), stated there was no record of staff efforts to walk R47. RN-A stated staff was to ambulate R47 twice a day, however, she was not sure if this was being done, and was unsure if R47 had declined in her ability to ambulate. RN-A stated there was no formal nursing assessment completed of R47's ambulation program to ensure it was appropriate and being implemented as ordered. RN-A stated NA's had complained to her that they were unable to assist residents with ambulation related to being short staffed, however, NA-A verified the ambulation programs were not reassessed and no changes had been made with the program to ensure it was being completed. During observation on 9/11/14, at 3:55 p.m. PTA-E assisted R47 to ambulate. R47 was able to walk 45-60 feet before becoming short of breath and needed to sit down. PTA-E stated R47's current ambulation ability was a decline from when the resident was discharged from physical therapy on 8/12/14.	F 310		

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F 310	Continued From page 15 Although the facility was aware R47 was not being ambulated as assessed by PT, the facility did not reassess and put interventions into place to ensure the resident did not decline in the ability to ambulate. R47's decline in ambulation ability related to the lack of the facility completing the ambulation program as assessed resulted in actual harm for R47. R7's annual MDS dated 8/27/14, identified R7 had severe cognitive impairment, had impairment (contracture) to one side of the upper extremity, required extensive two person assistance with transfers and walking in the corridor, was only able to stabilize when standing with staff assistance, and walking in the resident room, unit, and off the unit had not occurred during the 7 day prior look back period of the MDS completion date of 8/27/14. R7's CAAs dated 8/27/14, did not address R7's walking, transfer ability, or current contractures. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and both knees were bent and raised off the bed. R7's Physical Therapist Progress & Discharge Summary dated 3/4/14, indicated R7 was to ambulate 20-30 feet, using a four wheeled walker with assist of two staff, two times a day. R7 was able to hang onto the walker without hand support and did not need the platform walker on even services. PT also indicated R7's knee range of motion (ROM) was 26 degrees of left knee extension, and 22 degree of right knee extension. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57	F 310		

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F 310	Continued From page 16 feet with assistance of two staff, two times daily using a walker. R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, from April 2014 - September 2014, instructed two staff to walk the resident 29-57 feet, two times daily. There was no documentation identifying if staff was ambulating R7 from 4/2014- 9/2014. R7's care plan dated 9/3/14, indicated staff pushed R7 to all destinations in the wheelchair and transferred with assist of two with a transfer belt and walker. R7's care plan did not address if the resident was able to ambulate, nor did it instruct staff on R7's assessed ambulation program. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative/ ambulating program was in shambles right now, and she was trying to revamp the program to ensure residents were receiving their programs as assessed. RN-A was not aware R7 had not been ambulating or had a decline in transfer ability or ambulation, however, RN-A stated NA's had complained to her they were not able to complete residents ambulation programs becasue of short staffing. During interview on 9/11/14, at 1:42 p.m. NA-F stated R7 had a decline in ambulating as well as transfers, and staff was supposed to be walking her, however, R7 no longer walks, and staff did not have time to spend to try to assist her in walking prior. NA-F stated recently she had to order foot pedals for R7 because she could no	F 310		

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F 310	Continued From page 17 longer raise her feet up when in the wheelchair when staff were pushing her to destinations. During interview on 9/11/14, at 1:57 p.m. RN-D stated she had observed R7 ambulating and transferring a few months ago, and R7, "got to the point," of being unable to bear weight on the walker, so staff was transferring the resident using a hand in hand method. RN-D stated she had done no formal assessment of R7's ambulation program when it was noted R7's ambulation program was not being implemented as assessed and R7 was noted to be declining in her ability to transfer and ambulate. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, and stated R7 was resistive and had some contractures in her left hand and bilateral knees. PTA-E and COTA-D transferred R7 from the wheelchair to her bed. During the transfer, R7 did not take any steps, bear any weight on her feet, and was lifted into bed with heavy assist. During the evaluation, R7 stated, "ouch," on multiple occasions and grimaced when staff was attempting to straighten the resident's knees. PTA-E and COTA-D both verified R7 would benefit from therapy and should have been referred back to therapy when staff noted the resident was declining in transfers and no longer ambulating. COTA-D stated residents have expressed concerns with not being ambulated. Although the facility was aware R7's ambulation program was not being completed as assessed, and the resident was no longer ambulating and had a decline in transfers, the facility failed to reassess and refer the resident back to therapy. This resulted in actual harm for R7.	F 310		

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F 312	Continued From page 18	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to provide bathing assistance for 1 of 3 residents (R11) reviewed who was dependent on staff for bathing. Findings include: R11 quarterly Minimum data set (MDS) dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene, and was able to provide partial physical help for bathing. R11 care plan dated 9/4/14, indicated R11 needed assist of one staff for bathing and preferred to have a bath versus a shower, and the goal was to respect the resident's wishes and maintain autonomy, and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated she had recently gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. R11's Point of Care Bathing Record (where the nursing assistants (NA) document when a resident received a bath/shower), identified R11	F 312		10/22/14

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F 312	Continued From page 19 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath completed on 8/28/14, 28 days later. During interview on 9/11/14, at 10:13 a.m. NA-H stated there were not enough staff to assist residents with baths and they were not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist with bathing. During interview on 9/12/14, at 9:34 a.m., NA-B stated the facility used to have a bath aid to provide resident baths, however, a few months ago the bath aid left the facility, so resident baths were not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, RN-A stated the facility was still working on a staffing pattern to ensure resident cares are being completed. A policy on resident bathing was requested but not provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		10/22/14

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F 314	Continued From page 20 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R56) who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing. Findings include: R56's quarterly Minimum Data Set (MDS) dated 6/11/14, identified R56 had no cognitive impairment, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for developing pressure ulcers, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's most recent Care Area Assessment (CAA) dated 6/23/14, revealed R56 was at risk for pressure ulcer development, was on a turning and repositioning program, receiving pressure ulcer care with dressing application, and had a pressure reducing device for the chair and bed. R56 was identified as being admitted with pressure ulcers both heels. R56's care plan dated 8/16/14, identified R56 had a 1.3 x 0.3 unstageable pressure ulcer on the coccyx, should be repositioned at no greater than	F 314		

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F 314	Continued From page 21 2 hour intervals, had a pressure redistribution mattress on the bed, and a pressure redistribution wheelchair cushion. R56's Skin Observation Reports dated 1/2/14, through 6/5/14, indicated the resident's skin was intact and had no pressure ulcers. R56's Braden Scale (a tool used to assess pressure ulcer risk) dated 6/8/14, indicated the resident had a mild risk of developing pressure ulcers. The Braden scale assessment indicated R56 had recently gotten a new wheelchair cushion related to the risk of developing pressure ulcers. R56's Tissue Tolerance Evaluation (assessment to determine skins ability to withstand pressure) dated 6/17/14, identified non-blanchable redness at the three hour mark in the lying position, and was unable to change position independently. The evaluation indicated R56 had no redness at the one, two or three hour mark in the sitting position and was unable to change position independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 6/23/14, identified no redness at the one or two hour mark in the lying position, and able to reposition independently. The evaluation indicated there was blanchable redness at the two hour mark while sitting and that R56 could reposition independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 8/25/14, identified blanchable redness at the two hour mark in the wheelchair and the resident was unable to reposition independently. There was no	F 314		

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F 314	Continued From page 22 further assessment of the tissue tolerance evaluation. R56's Skin Injury/Wound Report(s) dated 6/17/14, indicated R56 developed a pressure ulcer in the right gluteal fold measuring 0.5 centimeter (cm) x 0.8 cm with a pink wound bed, and was a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough). The area was cleansed and a protective cream applied, and the physician was faxed for further orders. Measurements of the pressure ulcer were documented weekly on the Skin Injury/ Wound Report. Review of the weekly monitoring from 6/17/14, through 9/10/14, indicated the pressure ulcer had worsened increasing in size and developing into an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough, yellow, tan, gray, green or brown, and/or eschar, tan, brown or black tissue, in the wound bed). On 9/10/14, the pressure ulcer was 1.5 cm x 2 cm, with a 70% slough yellow wound base and was unstageable. Another pressure ulcer was identified on a Skin Injury/Wound Report(s) dated 7/27/14, on the right buttock measuring 0.5 cm x 0.4 cm was identified by staff as, "trauma from the adhesive dressing being used on the gluteal fold." However, the area was identified as a "pressure ulcer," on the Skin Injury/Wound Report because it was located on a pressure area. On 8/29/14, the facility identified the pressure ulcer was a stage 2. The documentation of the pressure ulcer on 9/10/14, identified the pressure ulcer had worsened to an unstageable pressure ulcer, and increased in size with a description of the pressure ulcer as 2.5 cm x 2 cm, with 50% white/	F 314		

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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 314	Continued From page 23 yellow slough wound bed, and was currently unstageable. R56's current physician orders dated 9/5/14, instructed staff to apply Tegaderm with foam dressing to reddened area on the sacrum, check every shift, and change every three days and as needed (PRN). Tegaderm with a foam dressing was to be applied to the right buttock, sacrum, and gluteal fold every 3 days and as needed (PRN). The physician orders also instructed staff that R56 was not appropriate to have three hour intervals ordered for repositioning programs due to skin issues, therefore, needed to be repositioned at no greater than every two hours. R56's Nurses notes dated 6/2/14. indicated the resident was admitted with two, stage 4 pressure ulcers on the right and left heel. R56 was being seen at the wound clinic for these wounds, and they had been debrided by the surgeon in the past. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair on a cushion, and was unable to shift his weight independently. Throughout the 2 hour and 28 minute observation, R56 was not approached by staff to reposition as assessed. During interview on 9/10/14, at 7:20 a.m., R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NAs did their best to assist residents to reposition as assessed. NA-A stated she was	F 314		

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F 314	Continued From page 24 aware of R56's pressure ulcers on his buttocks and, "They were pretty open," right now. NA-A verified R56 was to be repositioned every 2 hours. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned after 2 hours and should lie down after breakfast. LPN-B requested assistance from staff to lay R56 down. During observation on 9/10/14, at 10:05 a.m. NA-B entered R56's room to reposition him, which was 2 hours and 47 minutes after the initial constant observation began, and 4 hours and 5 minutes since R56 stated he had been up in his chair. NA-B lifted R56 out of his chair using a standing lift and removed his brief. R56's buttocks were dark red in color and had a foam dressing on the right buttock. During interview on 9/10/14, at 11:23 a.m. registered nurse (RN)-A stated LPN-B had been the wound nurse, however, there was a recent re-assignment of wound duties and she was delegating them out to the staff. RN-A was unsure of the current condition of R56's ulcers. During interview on 9/10/14, at 11:35 a.m. LPN-B stated R56 had gotten a new wheelchair cushion when the buttock pressure ulcers developed around 6/21/14, and she though the resident currently had three pressure ulcers, however, LPN-B was not clear on the current condition of the pressure ulcers. LPN-B stated nursing decided to get R56 a new wheelchair cushion because the resident had complained he felt like he was sitting in a hole. LPN-B stated OT did not evaluate the resident to ensure the wheelchair	F 314		

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F 314	Continued From page 25 cushion was appropriate. During observation of R56's current pressure ulcers on 9/10/14, at 1:58 p.m. the director of nursing (DON) and LPN-B verified R56 had two open areas on his buttocks, one on the upper gluteal cleft which was whitish at the wound base and was an unstageable pressure ulcer with 90% slough wound bed which currently measured 1.5 cm x 2 cm. The second pressure ulcer was on the right buttock and had 60-70% slough that was whitish in color at the wound base and measured 2.5 cm x 2 cm, and was also unstageable. LPN-B stated both pressure ulcers had increased in size and stage since the last time she had seen them, however, LPN-B was unable to verify the last time she had observed R56 pressure ulcers. During interview on 9/10/14, at 2:17 p.m. certified occupational therapy assistant (COTA)-D stated she had not been involved in assessing R56 for adequate wheelchair positioning or the wheelchair cushion. During interview on 9/11/14, at 1:07 p.m. director of nursing (DON) stated she was not aware of R56's worsening pressure ulcers. DON stated R56 repositioning schedule of every two hours should have been re-evaluated after the pressure ulcers developed and worsened to ensure the schedule was individualized and adequate to promote healing of the pressure ulcers. During interview on 9/11/14, at 1:10 p.m. RN-B stated she was not aware of R56's worsening pressure ulcers so she had not discussed interventions with OT, nor had she reassessed the current interventions in place to ensure they were being implemented and were adequate to	F 314		

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F 314	Continued From page 26 prevent further pressure ulcers. On 9/11/14, at 1:39 p.m., a call was placed to R56's medical doctor (MD)-C who was unable to be reached to discuss R56's pressure ulcers. The facility policy, titled Repositioning, undated, indicated it was the policy of the facility to have in place a system to identify repositioning programs for each resident and repositioning every two hours or more frequently depending upon the resident's condition and tolerance of the tissue load may be implemented, and more frequent repositioning (i.e. off loading hourly) may be warranted for individuals at high risk for pressure ulcer development. The policy indicated the therapy department assessed postural alignment, weight distribution, sitting balance, stability, and pressure redistribution along with cushion/mattress recommendations in coordination with the nursing department. The facility policy titled Wound/Skin Care Policy, last revised 12/01/97, indicated an at-risk resident who sits too long on a static surface may be more prone to get ischial ulcerations.	F 314		
F 317 SS=G	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.	F 317		10/22/14

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F 317	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, range of motion (ROM) services were not provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Findings include: R55's quarterly Minimum Data Set (MDS) dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM (contractures), and was totally dependent on staff for transferring, toileting, dressing, and all activities of daily living. During interview on 9/8/14, at 5:55 p.m. registered nurse (RN)-A stated R55 had contractures (fixed high resistance to passive stretch of a muscle) in both knees only, did not utilize any splint devices, and was not receiving any formal ROM program. R55's care plan, last updated 6/9/14, did not identify the presence of any contractures nor did it instruct staff on the type of ROM exercises to be completed by staff. R55's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, was located in the restorative nursing book dated 1/1/14, through 6/30/14, and instructed staff R55 was to receive daily restorative nursing treatments which included the following: -Shoulder passive range of motion (PROM) 10-15 REPS-bilateral flexion/extension -Wrist PROM 10-15 reps bilateral	F 317		

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F 317	Continued From page 28 flexion/extension -Ankle PROM 10-15 reps bilateral dorsiflexion/flexion -Digits PROM 10-15 reps bilateral flexion/extension -Elbow PROM 10-15 reps bilateral flexion/extension -Knee PROM 10-15 reps bilateral flexion/extension The 7/2014 restorative nursing sheet identified 3 restorative treatments were provided out of the 31 opportunities. The facility was unable to provide any restorative nursing sheets for R55 for the months of 8/2014, or 9/2014. The facility had no documentation any ROM was done for R55 for 2 months. The facility was unable to verify when R55's ROM program was started, and if it had been reassessed at any time to determine if it was appropriate for R55. Review of R55's Electronic Point Of Care Record from 7/1/14, to 9/12/14, did not identify R55 received any ROM services, nor was there any assessment to ensure the ROM program was appropriate for R55. During observation on 9/10/14, at 7:18 a.m. R55 was observed being assisted with dressing. R55's legs would not fully extend and rest on the bed, and the residents knees stayed bent. Nursing assistant (NA)-B was unable to raise R55's arms above her head to put on her shirt, and instead needed to slide the shirt up R55's arms and then stretch it over her head. R55 was not able to lift up her arms or straighten her arms from the elbow. NA-B verified R55 was becoming more stiff.	F 317		

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F 317	Continued From page 29 During interview on 9/10/14, at 11:50 a.m. NA-B stated R55's ROM exercises were not being completed because they didn't have enough staff to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises which the resident had been assessed as needing. During interview on 9/10/14, at 12:45 p.m., RN-C stated when restorative services or ROM was provided to the residents, the NAs should document in Point of Care when it was completed. RN-C was unable to provide any further documentation that R55 was receiving any ROM services, and verified there was no documentation in Point of Care R55 was receiving any ROM services. During interview on 9/11/14, at 9:38 a.m. licensed practical nurse (LPN)-B stated the NAs were responsible for completing the ROM treatments for the residents as well as charting when it was completed in the residents electronic point of care record. LPN-B was not aware R55's ROM was not being completed. R55's Physical Therapy Discharge Summary dated 9/6/11, indicated R55 demonstrated passive stretching of the right knee to 22 degrees and 25 degrees of the left knee. R55 was noted to be pain free and would be discharged to continue bilateral lower extremity ROM program with staff. R55's Occupational Therapy Discharge Summary dated 7/17/12, indicated R55 exhibited proper hip/knee/ankle alignment while in the wheelchair. The summary did not note the presence of any	F 317		

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F 317	Continued From page 30 upper extremity contractures. During interview on 9/10/14, at 2:03 p.m. certified occupational therapy assistant (COTA)-D examined R55's upper extremities and indicated R55 was somewhat resistant when attempting to evaluate total ROM, so she was unable to completely assess the degree of the shoulder, wrist, and finger contractures. However, COTA-D indicated R55 appeared to have bilateral upper extremity contractures, which she was not aware of prior. COTA-D stated R55 would definitely benefit from a splint device for the right thumb which was identified to be the most contracted joint during the exam. Physical therapy assistant (PTA)-E was also interviewed at this time and completed an exam of R55's lower extremities. PTA-E stated when compared to the most recent physical therapy discharge summary dated 9/6/11, R55's knee contractures had worsened. PTA-E stated the right knee contractures had worsened to 55 degrees compared to 22 degrees before, and the left knee was now at 35 degrees compared to 25 degrees prior. COTA-D and PTA-E both verified R55 should be receiving ROM as had been assessed, and should have been referred back to OT/PT when staff noted R55's knees were becoming more contracted, and noted a decline in the resident's ability to move the upper extremities when being assisted with dressing. During interview on 9/11/14, at 9:09 a.m. family (FM)-A stated recently staff had asked him to purchase larger pants and different types of shirts so it would be easier to dress R55. FM-A stated R55 was becoming so stiff she was not able to lift her arms and straighten her knees so it was a struggle to get her dressed every day. FM-A	F 317		

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F 317	Continued From page 31 stated staff asked for shirts that opened in the back, as well as larger pants, to make it slide on better. During interview on 9/11/14, at 10:13 a.m. NA-H stated range of motion services were not being completed and R55 was becoming stiff as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult, so staff asked the resident's family member to bring in different clothing. During another interview on 9/11/14, at 11:10 a.m. RN-A confirmed there was no formal ROM assessment in place for R55 to ensure the current restorative program was being implemented as assessed, nor to ensure the program is adequate to prevent further decrease in ROM. RN-A stated the NA's had brought up concerns about not having enough staff to complete resident ROM programs, however, she stated the facility had not reviewed the current resorative nursing programs to ensure they could be completed. The facility failed to ensure R55's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R55 was having further difficulty with dressing related to decrease in ROM, the facility failed to provide further interventions and reassessment which resulted in actual harm to R55. R7's annual MDS dated 8/27/14, indicated R7 had severe cognitive impairment and had ROM impairment (contracture) to one side of the upper	F 317		

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F 317	Continued From page 32 extremity. R7's clinic note dated 3/21/14, indicated the resident had a chronic right hand contracture which was released with surgery, had no pain, and was regaining muscular function back in the right hand. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and her left hand was in a fist. During observation on 9/10/14, at 6:53 a.m. R7 was sitting in her wheelchair in the activities room and her left hand was closed in a fist. During observation on 9/11/14, at 9:40 a.m. R7 was sitting in the activity room with her left hand closed in a fist. During observation on 9/12/14, at 8:40 a.m. R7 was sitting in the dining room with her left hand up to her face with her fingers bent inward. During observation of R7 from 9/9/14- 9/12/14, R7 was not observed to release the fist of her left hand, nor did she attempt to use her left hand. R7's PT Progress and Discharge Summary dated 3/4/14, indicated the resident was able to hang onto the walker without hand support, and was to receive ROM. R7's current Physician Orders sheets for September 2014, instructed staff the resident was to receive the following restorative nursing program: · Ankle PROM 0-15 reps bilateral	F 317		

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F 317	Continued From page 33 dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 · Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, indicated the resident had a right hand contracture. The restorative nursing sheets reviewed from April 2014, - September 2014, noted the following program to be completed for R7 on the day shift: · Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral	F 317		

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F 317	Continued From page 34 flexion/extension 1x · Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 · Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets for April 2014 - September 2014, noted the restorative nursing program to be completed for R7 on the day shift, however, there was no documentation R7 was receiving any ROM. R7's care plan dated 6/11/14, identified R7 had a right hand contracture. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, who both verified R7 was resistive and had some contracture(s) in her left hand and bilateral knees. During the evaluation R7 grimaced and stated, "Ouch" on multiple occasions when PTA-E and COTA-D were attempting ROM. COTA-D and PTA-E both stated R7 would benefit from therapy and possibly a splint or cone for the new contracture in her left hand. During interview on 9/9/14, at 9:46 a.m. RN-A stated R7 had a contracture to her right hand and had surgery to release part of the contracture. RN-A stated the restorative program was not being completed for residents as assessed, and she was trying to revamp the program. RN-A stated R7 should be receiving the ROM services as had been assessed by PT. RN-A was not aware of R7's left hand or bilateral knee contractures. An interview on 9/10/14, at 1:00 p.m. was	F 317		

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F 317	Continued From page 35 completed with NA-A who stated staff was not able to complete ROM for residents and stated, "I feel sorry for the residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. During interview on 9/11/14, at 1:57 p.m. RN-D stated R7 had a contracture to the right hand, which was repaired via surgery, and was the contracture identified on the resident's MDS. RN-D stated several months ago R7 got to the point of being unable to hang onto the walker with her hands, so staff was ambulating the resident hand in hand. RN-D stated R7 was noted at that time to have a decline in ROM in her left hand related to being unable to hang onto the walker, however, R7's restorative program was not reassessed, and the resident was not referred back to PT to prevent further decline in ROM ability. The facility failed to ensure R7's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R7 was no longer able to hang onto the walker to ambulate, the facility failed to provide further interventions and reassessment which resulted in actual harm to R7. The facility policy titled Restorative Nursing, undated, identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical and psychosocial level. Restorative nursing is a	F 317		

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F 317	Continued From page 36 planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy further identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned. The summary of the policy documented the following, "Restorative nursing was mandated by OBRA [Omnibus Budget Reconciliation Act] in 1987, as a means to keep residents at their highest possible practicable physical, mental and psychosocial level. Maintaining function enhances dignity and self-esteem. It is the primary reason for implementing effective restorative nursing programs. A comprehensive organized program guides staff to accurately identify restorative needs, implement restorative programs that assure residents receive the restorative services as planned and document to maintain a permanent record of the entire	F 317		

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F 317	Continued From page 37 process. It does not feel good to lose function. Loss of function decreases a person's self-worth and one's ability to experience and enjoy quality of life. An organized restorative program that delivers systematic care based on the resident's individual needs increases self-esteem and worth and enhances well being."	F 317		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure range of motion and/ or ambulation services were provided to maintain current level of functioning for 3 of 5 residents (R31, R64, and R1) reviewed for range of motion and/ or ambulation services. Findings include: R31's quarterly Minimum data set (MDS) dated 6/11/14, indicated R31 had no current functional losses of range of motion in the upper or lower extremities. R31's care plan dated 8/20/14, indicated R31 was to receive 10-15 repetitions daily, passive range of motion (PROM) to hips, knees, bilateral	F 318		10/22/14

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F 318	Continued From page 38 shoulders, elbows, writs, fingers, and ankles. R31's restorative nursing PROM documentation from 7/2014, to 9/14/14, indicated R31 received range of motion services 3 out of 31 days for the month of 7/2014, and 12 days in the last month (8/12/14, through 9/14/14). During observation on 9/10/14, at 9:39 a.m. R31 was sitting in his wheelchair. R31 was not observed on 9/10/14, 9/11/14, and 9/12/14, receiving any ROM services. During interview on 9/10/14, at 2:00 p.m. physical therapy assistant (PTA)-E stated R31 had no current functional loss of range of motion in his lower extremities, however, would be at high risk for development of contractures if he continued to not receive the assessed range of motion services. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not receive any range of motion services other than routine dressing activities for the last several months related to lack of staffing. During interview on 9/11/14, at 3:18 p.m., R31 stated he had a stroke a while back and did not walk anymore, but would like to use his legs if he was given the chance. R31 stated he would be agreeable to completing leg exercises, however, he had not been completing them at the facility in the last few months. R64's quarterly MDS dated 8/13/14, indicated R64 had severe cognitive impairment, required extensive assistance for all ADL's including bed mobility, transferring, and walking. R64 was not	F 318		

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F 318	Continued From page 39 steady, and was only able to stabilize with staff assistance. R64 had no impairment to his upper or lower extremity range of motion. R64's Physical therapy discharge summary dated 5/16/14, indicated R64 had significant improvement in bed mobility and pivot transfers, could ambulate up to 230 feet, and was discharged on a restorative nursing ambulation program. R64's occupational therapy discharge summary dated 5/16/14, instructed the resident was to continue on the restorative nursing ambulation program. During a review of R64's care plan dated 8/15/14, R64 was to have cervical (neck) active (subject moves their own joint) range of motion per physical therapy (PT) and occupational therapy (OT) recommendations. The care plan also directed staff R64 was to ambulate with restorative nursing. A Nursing Assistant Care Sheet (which staff used to know a residents individual care needs) dated 9/12/14, directed staff to ambulate R64, 115-230 feet twice a day on the day shift, with assist of 1 staff using a transfer belt and a walker. R64's nursing rehab time log in the electronic medical record, (which identified if the resident received any PROM or ambulation), lacked evidence any nursing rehab (ambulation or PROM) was completed for the months of 7/14, 8/14, or 9/14. During interview on 9/10/14, at 1:00 p.m. nursing assistant (NA)-A stated staff did not have time to	F 318		

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F 318	Continued From page 40 ambulate or do resident ROM program for R64 because they are short staffed. During interview on 9/11/14, at 10:45 a.m. physical therapy assistant (PTA)-E stated R64 had contractures of his knees and needed to be walked and receive the PROM to ensure the contractures don't get worse. During observation on 9/11/14, at 1:50 p.m. R64 was assisted by PTA-E and COTA-D to ambulate in the hallway. R64 needed encouragement and time to get up from his recliner, but did ambulate with his walker to the nurse's station. PTA-E and COTA-D stated R64's ability to ambulate was, "About the same," as when he was discharged from services on 5/16/14, and there was no decline in ROM or ambulation. During an interview on 9/12/14, at 11:00 a.m. registered nurse (RN)-C stated the nursing assistants should be documenting the completion of passive range of motion and ambulation in the residents electronic medical record program. RN-C verified R64's nursing rehab time log was blank for 7/14, 8/14, and 9/14, therefore, there was no way for the facility to identify if R64 was receiving PROM or being ambulated. RN-C stated there currently was not a nurse who was responsible for assessing residents restorative nursing program to ensure it was being completed or was appropriate for the residents. R1 Quarterly MDS dated 6/25/14, indicated R1 had functional limitation in range of motion (ROM) to one side of the upper and lower extremities. R1's care plan dated 7/2/14, indicated R1 was to	F 318		

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F 318	Continued From page 41 receive daily passive range of motion (PROM) 10-15 reps, to bilateral shoulders, elbows, wrists, and fingers. R1's restorative nursing program identified the resident was to receive the following daily: · Ankle PROM 10-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 0-15 reps bilateral flexion/extension abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Wrist PROM 10-15 reps bilateral flexion/extension 1x Review of R1's documentation of the restorative nursing program from April 2014, through September 2014, were all blank, indicating the ROM program had not been completed for 5 months. When interviewed on 9/10/14, at 7:10 a.m. licensed practical nurse (LPN)-A stated there was no longer a restorative NA employed by the facility, so the NA's staffed on the floor are supposed to be providing the ROM and ambulation for the residents, however, they don't have enough staff to ensure this is being completed. LPN-A stated residents have complained of not walking or receiving their ROM and feel they have lost strength.	F 318		

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F 318	Continued From page 42 When interviewed on 9/10/14, at 9:18 a.m. NA-E stated ROM and ambulation of residents was not being done due to being short staffed, and verified R1's restorative nursing was not being completed. During interview on 9/11/14, at 9:25 a.m. R1 non-verbally responded by motioning in a back and forth motion with her hand to indicate, "so-so," when asked if staff was assisting her with ROM and ambulation on a daily basis. When R1 was asked how often staff was assisting, R1 spelled out, "monthly" on her communication board. When interviewed on 9/12/14, at 9:49 a.m. COTA-D stated R1 would be at risk for increased contractures if PROM and ambulation was not being done, however, COTA-D was not aware of R1 having any declines in ROM or ambulation. The facility undated policy titled Restorative Nursing identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical, and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement	F 318		

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F 318	Continued From page 43 in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident falls were thoroughly assessed to ensure appropriate/pertinent interventions could be implemented or revised, for 2 of 2 residents (R64, R3), with multiple falls. Findings include: R64 admission face sheet, dated 2/24/12, indicated the resident had diagnoses including	F 323		10/22/14

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F 323	Continued From page 44	F 323		

weakness, dementia, and incontinence. R64's quarterly Minimum Data Set (MDS) dated 8/13/14, indicated R64 had severe cognitive impairment, required extensive assistance for all activities of daily living (ADL), including bed mobility, transfer, walking, and toilet use. R64 was not steady, and only able to stabilize with staff assistance.

R64's care plan dated 8/19/14, indicated R64 was at high risk for falls and had falls prior to and after admission to the the facility. Staff were directed to anticipate R64's toileting needs, place the floor mat on the floor when in bed, have the call light safety alarm system on while in bed, wear gripper socks while in bed, ensure safety alarm was on R64's wheelchair/chair, and ensure an anti-rollback device was on the residents wheelchair.

R64's Fall Risk/Restraint Evaluation Review dated 5/20/14, indicated, "Resident remains high falls risk; [six] 6 falls in [three] 3 months. Resident attempts self transfers frequently. Confused and delusional reverting to his days of being a pastor... Gripper socks when in bed; W/C [wheelchair] alarm; motion sensor; Bed alarm system remain appropriate. Floor mat added."

R64's progress notes indicated the resident had a fall on 7/27/14. According to the progress notes, R64's alarm sounded, and the resident was observed sitting on the floor at his bedside and had no injuries. R64 was alert, and reported he wanted to go to school and rolled out of bed. R64 told staff he needed to go to the bathroom and staff assisted the resident to the bathroom and he urinated. Staff was unable to provide any further assessment or investigation of the fall to

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F 323	Continued From page 45 determine if current interventions were appropriate, new interventions were needed, and if R64's toileting plan was being implemented and was appropriate to prevent further falls. R64's progress notes indicated the resident had another fall on 8/24/14. According to the progress notes, R64's alarm sounded, and he was observed on the floor on his buttocks. No injuries were noted. R64 indicated he needed to clip his nails. Staff was unable to provide any further assessment or investigation of the fall to determine if current interventions were appropriate, if there were any trends with the residents falls, or if new interventions were needed to prevent further falls. During interview on 9/12/14, at 10:00 a.m., registered nurse (RN)-B stated she was in charge of conducting post fall investigations. RN-B stated there was no further information available regarding these falls, and post fall assessments were not completed to determine what may have caused the fall, if there were any trends noted, if the current interventions were appropriate, or if the interventions needed to be modified. RN-B stated, "We are working on that...I didn't even know he [R64] had a fall last week." Although R64's fall assessment dated 5/20/14, indicated the resident had fallen six times in the prior three months while a resident in the facility , the facility was unable to provide progress notes, incident reports, or any documentation regarding the falls they had identified in the fall assessment. R3's diagnoses listed on the undated facesheet included visual loss, spasm of muscle, abnormal	F 323		

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F 323	Continued From page 46 involuntary movements, lack of coordination, dementia, and frequency of urination. R3's quarterly MDS dated 7/2/14, indicated R3 was severely cognitively impaired, required extensive assistance with all ADL's, and was not steady when standing or transferring. During an interview on 9/8/14, at 4:20 p.m., RN-A stated R3 had three recent falls, on 8/20/14, 8/22/14, and 9/4/14. RN-A stated R3 was impulsive and leaned forward in her chair and often rolled out of her chair. RN-A stated R3 was not injured during these falls. During multiple observations on 9/10/14, R3 was seated in her wheelchair, in the area in front of the nurses station. R3 had a alarm clipped to the back of her blouse, and had a Safe-T-Mate anti-rollback device on her wheelchair. R3 attempted to stand many times and multiple staff members attempted to redirect R3 and assisted her to sit down. R3 was able to self propel her wheelchair and would often lean forward in her wheelchair which would sound the alarm which was attached to her. On one occasion, a staff member offered R3 a magazine, which R3 sat and read calmly in her wheelchair for several minutes paging through the magazine and talking about each picture. R3's care plan dated 7/8/14, indicated R3 was at risk for additional falls due to a history of frequent falls. Staff were directed to observe for unsafe practices and to anticipate R3's needs, especially toileting needs. The care plan also directed staff to offer activities to keep her busy, to offer towels for folding, cloths to wipe surfaces she could reach, and dolls to dress and undress.	F 323		

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F 323	Continued From page 47 R3's progress notes related to her recent falls, included the following: On 8/20/14, R3 stood up from her wheelchair outside of her room and fell to her knees. There were no injuries noted. R3 indicated she was going to get to her appointment. Staff noted increased confusion after lunchtime and R3 was toileted and laid down for nap. Staff was unable to provide any further assessment of the fall to determine the cause of the fall, if current interventions were appropriate, or if new interventions were needed. On 08/22/2014, R3's alarm sounded and she was observed slowly falling to the floor in the activity room. No injuries were noted. R3 stated she was attempting to get up and walk out of the activity room when she fell. R3 was assisted back into her wheelchair and promptly assisted to the restroom to be toileted. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. On 9/5/14, R3's alarm sounded and staff witnessed her standing and then falling by the desk in the main parlor. R3 stated she was standing to reach for the watermelon that was in front of her at the desk. R3 was assisted back into her wheelchair and the food was placed closer to her. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. During an interview on 9/12/14, at 10:00 a.m., registered nurse (RN)-B indicated she was in charge of conducting post fall investigations. RN-B stated there was no further information available regarding R3's falls. Post fall	F 323		

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F 323	Continued From page 48 assessments were not completed to determine what may have caused R3's falls, if there were any trends noted, if the current interventions were appropriate, or if the plan of care was being followed. The facility undated policy titled Fall Prevention and Risk/Restraint Evaluation included, "The Post Fall Evaluation will be completed by the DON [director of nursing] or her/his designee within 72 hours after a resident fall."	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 353		10/22/14

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F 353	Continued From page 49 by: Based on observation, interview, and document review, the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility. R7 was not being walked according to the assessed restorative nursing orders. During interview on 9/11/14, at 1:42 p.m. NA-F stated the facility did not have enough staff to walk R7, and as a result, she felt R7 had a decline in ambulation and possibly range of motion. NA-F reported R7 had difficulty with transferring now, and was unable to raise her feet up while in the wheelchair. R7's annual Minimum Data Set (MDS) dated 8/27/14, identified she had severe cognitive impairment, impairment (contractures) to one side of the upper extremity, and required extensive two person assistance with transfers/walking. Her balance was impaired and she could only stand with staff assistance. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57 feet with assistance of two staff, twice daily using a walker. R7's restorative nursing documentation from April 2014 - September 2014, lacked documentation that R7 had been walked/ambulated by staff from 4/2014 to 9/2014.	F 353		

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F 353	Continued From page 50 When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative program was in shambles right now, and she was trying to revamp the program. She verified there was no evidence that R7 was being walked. An interview on 9/10/14, at 1:00 p.m. was completed with NA-A who stated staff tries to ambulate residents, but it does not always happen because of the lack of staffing. NA-A stated staff was not able to complete ROM for residents either, and stated, "I feel sorry for the residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. R47 stated during interview on 9/8/14, at 3:57 p.m., there was not sufficient staff at the present time. She stated she waited for over 20 minutes and all the way up to an hour for staff to respond to her call light and did not feel that was acceptable. She also reported that due to staffing shortage, she had to wait a long time to be served her food and by the time she gets her food it is cold. During a second interview on 9/8/14, at 7:02 p.m. R47 stated she would transfer herself to the bathroom as staff does not respond to her call light. She stated she, "Refuses," to be incontinent of urine or stool because of having to wait for staff, and as a result will transfer herself. She stated she was aware she was not supposed to transfer herself to the bathroom because of previous falls, however, she can not wait for staff over 20 minutes for assistance. She reported the nursing assistants are aware she does this due to staff shortage. R47 stated she is	F 353		

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F 353	Continued From page 51 supposed to be assisted with walking twice a day, however, staff is not able to do this as they just don't have time, and she didn't think she had been walked for about 10 days. A family member (FM)-B of R47 was interviewed on 9/10/14, at 1:15 p.m. and stated he had talked to staff a "couple of times" that R47 was not being walked and he was concerned she would lose strength. FM-B stated R47 was to be walked twice each day, but it seldom happened. FM-B stated R47 had fallen a couple of times as she was not willing to be incontinent while waiting for assistance from staff when her call light was not answered for long periods of time. FM-B also stated there were times when he visited and the call light was on for over 15 minutes and he would have to go out to the hall and try to find staff to assist her. R47's quarterly MDS dated 7/2/14, indicated R47 was cognitively intact with no signs or symptoms of delirium. She needed extensive assistance of two staff with bed mobility, extensive assistance of one staff for transfers, dressing, toilet use and personal hygiene. R47 needed extensive assistance of one staff with ambulation. R47's nursing assistant care sheet dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet twice per day with assistance of one staff, a transfer belt, rolling walker and wheelchair behind. Physician orders, signed 9/5/14, directed staff to complete passive range of motion to wrists, ankles, digits, knees, elbows, shoulder and hips daily. In addition, the physician ordered that R47 be walked 57-115 feet twice a daily with a	F 353		

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F 353	Continued From page 52 wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets for August, 2014 to September, 2014 were reviewed and there was no documentation that R47 received any passive range of motion to extremities or ambulation. An interview with licensed practical nurse (LPN)-C was completed on 9/11/14, at 11:15 a.m. and she stated she was aware R47 was to be walked twice a day with staff assistance. LPN-C stated there was no documentation on the restorative nursing sheets to identify if R47 had been assisted with ambulation or any PROM in the prior months. R1 reported on 9/9/14, at 1:10 p.m. she did not feel there were sufficient staff and she has been incontinent because the call light was not being answered fast enough. R1 also was concerned she had not been receiving ROM, and when asked how often she had been receiving ROM services, she spelt out, "monthly," using her communication board. R1's quarterly MDS completed 6/25/14, indicated R1 had moderate cognitive ability, had no signs or symptoms of delirium/ psychosis, had no behavioral issues, and had limitations to one side of her upper and lower extremity (contractures). R1's care plan dated 7/2/14, and restorative nursing sheets from 4/2014- 9/2014, directed staff to provide passive range of motion daily to both shoulders, elbows, wrists, and fingers. R1's restorative nursing sheets for April 2014, to September 12, 2014 lacked any documentation	F 353		

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F 353	Continued From page 53 that passive range of motion was being done for R1. During an interview on 9/10/14, at 7:10 a.m. licensed practical nurse (LPN)-A stated NAs did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14, at 1:25 p.m. NA-B stated the restorative aide position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to residents. When interviewed on 9/11/14 at 10:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated NA's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to help him. R31's quarterly MDS dated 6/11/14, indicated R31 was cognitively impaired, totally dependent on two staff for all transfers, and needed extensive assistance of one staff for all locomotion.	F 353		

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F 353	Continued From page 54 R31's care plan dated 8/20/14, indicated R31 was to receive PROM motion to hips, knees, and ankles 10-15 repetitions daily as well as to bilateral shoulders, elbows, wrists and fingers. A review of R31's restorative nursing sheets from 8/12/14, through 9/14/14, indicated R31 received PROM only 12 times. RN-A stated the facility did not currently offer formalized restorative programs at the present time due to lack of staffing. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive any range of motion services. R55 was not receiving range of motion due to staff shortage. R55's quarterly MDS dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM, and was totally dependent on staff for transferring, toileting, dressing and all activities of daily living. R55 sheets from the restorative nursing book dated 1/1/14-6/30/14, instructed staff to ensure R55 received daily restorative treatments which included the following passive range of motion to shoulder, wrist, ankle, finger, elbows and knees. The 7/2014 MAR identified 3 restorative services were provided out of the 31 opportunities. The facility was unable to provide evidence that R55 had received passive range of motion from 8/14, to 9/11/14. During interview on 9/10/14, at 11:50 a.m., NA-B	F 353		

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F 353	Continued From page 55 stated R55's ROM exercises were often not done because they didn't have enough staff to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises which the resident had been assessed as needing. During interview on 9/11/14, at 10:13 a.m., NA-H stated range of motion services were not being completed and R55 was becoming stiffer as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult so facility staff asked the residents family member to bring in different clothing. R56 stated on 9/8/14, at 3:50 p.m. he did not feel the facility had enough staff. He reported having to wait a long time to have his call light answered. During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. The quarterly MDS dated 6/11/14, identified R56 was cognitively intact and he required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, and was at risk for developing pressure ulcers. He currently had one stage IV (Unstageable) pressure ulcer, that was present on admission over a year ago, and was unhealed. R56's admission care area assessment (CAA) dated 12/17/13, identified R56 was to be repositioned at no greater than two hour intervals. During continuous observation of R56 on 9/10/14,	F 353		

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F 353	Continued From page 56 from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair and was unable to shift his weight independently, and was not approached by staff to assist the resident to reposition as assessed. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NA's did their best to assist residents to reposition as assessed but at times were unable to do so. NA-A verified R56 had not been repositioned every two hours as assessed because of the facility not having sufficient staffing to provide resident cares. R11 stated during an interview on 9/8/14, at 4:23 p.m. she had gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. In addition, R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. She stated this happened a lot, and a few nights ago she had her call light on for over 40 minutes to go to the bathroom, no staff came to help her to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for toileting. R11's Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later.	F 353		

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F 353	Continued From page 57 During interview on 9/9/14, at 3:03 p.m. NA-K stated there are not enough staff to provide residents a bath. NA-K stated she often is not able to complete all the resident cares because of the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to being short staffed. During interview on 9/10/14, at 2:23 p.m., NA-F stated it was possible that some residents had gone for weeks without getting a bath because the facility does not have enough staff to complete all the resident cares. NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected. During interview on 9/11/14, at 10:13 a.m., NA-H stated there was not enough staff to accommodate baths for the residents, and resident baths are not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist residents. During interview on 9/12/14, at 9:34 a.m., NA-B stated resident baths are not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, the	F 353		

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F 353	Continued From page 58 facility is still working on the staffing concerns. During dining observation on 9/8/14, at approximately 5:40 p.m. NA-P was observed sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident giving them a bite of food, and then rolling on the stool using her feet to the next resident. NA-P would give a resident a bite of food, set the fork or spoon down, and immediately roll over to the next resident, and continued rolling around the table on the stool the entire meal. R12's quarterly MDS dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and required extensive staff assistance with dining. R66's quarterly MDS dated 8/6/14, identified R66 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/27/14, identified R7 had severe cognitive impairment and required extensive staff assistance with dining. During interview on 9/8/14, at 6:01 p.m. NA-P stated she was required to feed multiple residents at a time, and needed to use the rolling stool so she was able to go from resident to resident to ensure they all received their meal. NA-P stated there was not enough staff to ensure all the residents were being fed timely, so the NA's do	F 353		

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F 353	Continued From page 59 what they have to so the residents receive their meals. When interviewed on 9/10/14, at 7:10 a.m. LPN-A stated sometimes the residents needed to wait for help because the facility is short staffed. LPN-A stated the managers are not typically assisting residents with dining, however, the week during the survey, they have been helping out. LPN-A stated residents have voiced concerns of the call lights not being answered and not having cares provided. LPN-A stated restorative nursing/ ambulation for the residents is not being completed, and residents have complained of not walking and feel they are losing strength. LPN-A stated on the weekends, the staff brings residents with behavioral issues to the lobby and this falls on the nurse to provide additional supervision,which makes it difficult to complete all the resident cares which need to be completed. When interviewed on 9/10/14, at 6:50 a.m. NA-L stated there were not enough staff on the night shift and staff was struggling to provide the necessary care for over 2 months. NA-L stated residents have been complaining of waiting 45 - 60 minutes for help. NA-L stated when there is a sick call, the staff is not replaced and they work short, and there have been nights the facility had only one nurse working to take care of all the residents in the facility. When interviewed on 9/10/14, at 6:57 a.m. NA-M stated residents have voiced concerns about not having enough staff to complete the cares and she had reported this to the charge nurse on duty multiple times. NA-M stated nothing had changed with staffing, even after reporting residents are not receiving the cares they require.	F 353		

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F 353	Continued From page 60 When interviewed on 9/10/14, at 7:01 a.m. NA-N stated the night shift, sick calls are not replaced, and they often work short staffed. When interviewed on 9/10/14 at 7:46 a.m. NA-H stated residents are not getting the quality care they need and deserve, and there had been no restorative services for 3 months. The restorative aid and bath aid positions were eliminated several months ago, and staff had quit due to short staffing. She stated residents not being helped in the dining room to eat, and during survey management had been helping in the dining room, which never happens on a regular week. NA-H stated residents have voiced concerns they are not receiving their baths because staff does not have time to do this extra task. NA-H also stated some residents are only assisted twice per shift to use the bathroom due to staffing, and residents are not getting walked so they get restless and then try to walk alone. When interviewed on 9/10/14, at 9:18 a.m. NA-E stated she did not feel there were enough staff and nursing assistants were not able to provide all cares, including baths, shaving, ROM, and ambulation. NA-E stated residents have complained of the call lights not being answered, and R11 complained of having less strength due to ROM not being done. During an interview on 9/10/14, at 1:15 p.m., NA-F stated the NA's constantly feel rushed. She stated the NA's are supposed to do ROM, ambulation, and baths for residents, and the NA's are not able to complete this because of short staffing.	F 353		

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F 353	Continued From page 61 When interviewed on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility did not have sufficient staff to complete resident cares. NA-B had tears in her eyes as she stated they are unable to complete resident cares, especially bathing, ROM, dining, and ambulation. When interviewed on 9/10/14, at 2:07 p.m. NA-O stated it is difficult to provide resident cares due to being short staffed. On 9/11/14, at 9:08 a.m. a print out of the call light times was requested from the DON, who stated they did not have the capability of printing out the report. She did not identify the process the facility was using to monitor call light response times. When interviewed on 9/11/14 at 10:30 a.m. RN-A verified there is no formal restorative program at this time. RN-A confirmed there have been complaints from NA's about not having enough staff to complete resident cares or ROM and ambulation. RN-A stated the NA's were asked to do ROM on residents while assisting to dress them, and verified this was not a formal program and did not meet the intention of a restorative nursing program. During interview on 9/11/14, at 10:13 a.m., NA-H stated the facility was short staffed and the resident cares were not being completed. NA-H stated ROM was not being completed for residents, specifically R55 who was becoming stiffer as a result. NA-H stated there were not enough staff to accommodate baths for the residents and they were often skipped. NA-H stated the NA's had complained to the administration staff at the nurse meetings about	F 353		

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F 353	Continued From page 62 short staffing, however, nothing had been done to correct the staffing issue. When interviewed on 9/12/14, at 10:34 a.m., the staffing coordinator (MR)-J stated when there was a sick call, replacement depended on the number of staff scheduled. She reported if a sick call resulted in staff working a shift with less than established minimums, she would consult with the director of nursing (DON). She indicated there is no policy on staffing. When interviewed on 9/12/14, at 11:04 a.m. the DON and administrator stated staffing was based on census, not necessarily on resident care levels. The goal was to have six nursing assistants on both the day and evening shift, and three nursing assistants on the night shift. If there is a call in, they have not been replacing the staff if it would require overtime. They stated they had not reduced the hours of staff, and there had not been layoffs, however, they would not replace staff if someone left or retired, until they met the right staff . They stated they felt the facility was significantly overstaffed, and did not believe their was an issue with lack of staffing. They stated they had been trying to educate staff on being more efficient in providing residents cares. They NA's should have been able to complete all of the duties necessary with less staff and they felt the NA's were making a choice to not complete things such as baths or restorative nursing services. DON stated they used to have nine NA's working at a time and now they have six, because having nine, "Just didn't make good business sense."	F 353		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		10/22/14

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F 431	Continued From page 63 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to establish a system to	F 431		

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F 431	Continued From page 64 ensure expired medications were removed from medication storage in 2 of 2 medication carts and in the storage area in the east hallway. In addition, the facility failed to date an open, multi-dose vial in 1 of 1 medication refrigerators in the medication storage room. This had the potential to affect all 48 residents currently residing in the facility, as well as any newly admitted residents. Findings include: During observation of the medication storage room on 9/12/14, at 8:40 a.m., with director of nursing (DON)-A and licensed practical nurse (LPN)-A, the refrigerator contained an opened, undated, vial of Tuberculin protein (used for testing for tuberculosis). DON-A and LPN-A verified the vial was not labeled with the date it was opened, and were unable to determine how long the vial had been opened in the refrigerator. DON-A stated on the facility's, "Recommended Minimum Medication Storage Parameters," from Omnicare, Inc. dated 2013, tuberculin protein should have, "Date when opened; discard unused portion after 30 days." DON-A and LPN-A stated the tuberculin protein was used for newly admitted residents and new employees and was in the refrigerator, available for use. In addition, the refrigerator in the medication storage room also contained a bottle of liquid Lorazepam (medication used for seizures) 2mg/ml (milligram/milliliter) for R2. The bottle was labeled with an opened date of 3/13/14, with a pharmacy sticker that directed staff to discard after 90 days. LPN-A stated R2 had a current PRN (as needed) order for the medication and that was the only bottle available for use if R2 required a dose of the medication. DON-A and LPN-A indicated it	F 431		

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F 431	Continued From page 65 was expected that all staff giving medications were responsible for going through medication storage areas to check for expired medications and proper labeling of medications. During observation on 9/12/14, at 8:50 a.m. with LPN-A, the locked medication storage cabinet at the end of the East hallway, contained four unopened stock bottles of Geri Care Enteric Coated Aspirin 325 mg, with an expiration date of 8/14. LPN-A stated the bottles of Aspirin were available for use but were expired and should have been removed. During an observation on 9/12/14, at 8:55 a.m. with LPN-A, the North/ East medication cart contained Aspir-low 81 mg tablets for R38, with an expiration date of 9/13. LPN-A stated R38 had been using chewable aspirin since 2/14/14, but stated the Aspir-low tablets were expired a year ago, and should have been removed from the cart. During observation on 9/12/14, at 9:20 a.m. with LPN-B, the South medication cart contained a stock bottle of Geri Care Enteric Coated Aspirin 325 mg, with an expiration date of 8/14. LPN-B stated the Aspirin were available for resident use and were expired and should have been removed from the medication cart. The medication cart also contained Actavis Nystatin Cream, 100,000 units per gram, for R55, which had expired on 8/14. R55's physician orders, dated 9/14, included a current order for Nystatin cream to be used PRN. Another tube of Actavis Nystatin Cream 100,000 units per gram, for R17 was in the medication cart and expired 8/14. R17's current physician orders, dated 9/14, included a current order for Nystatin cream to be used PRN.	F 431		

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F 431	Continued From page 66 In addition, Hydrocortisone Butyrate 0.1% cream for R40 had an expiration date on the tube of 5/14, however, the pharmacy sticker indicated the prescription was filled on 5/31/13, and was to be disposed of 14 days after being filled. A review of R40's current physician orders, dated 9/14, lacked evidence of an order for this medication. LPN-B verified these medications were expired but remained available for use. LPN-B reported all staff giving medications were responsible to check expiration dates, however, the facility lacked a system to assure this was being completed. Review of the facility's Storage and Expiration of Medications, Biologicals, Syringes and Needles policy, dated 12/1/07, included, "Facility should ensure that medications and biologicals: Have an Expiration Date on the label; Have not been retained longer than recommended by manufacturer or supplier guidelines...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened... Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals...Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		10/22/14

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F 441	Continued From page 67 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff	F 441		

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F 441	Continued From page 68 performed hand hygiene following providing personal cares for 1 of 3 residents (R55) observed during personal cares. Findings include: R55's quarterly Minimum Data Set (MDS) dated 6/4/14, identified R55 had severe cognitive impairment and was totally dependent on staff for all activities of daily living, bed mobility, and personal hygiene. During observation on 9/10/14, at 7:18 a.m. nursing assistant (NA)-B was observed providing incontinence care to R55 while still in bed. R55's brief was wet and had a small amount of stool in it. NA-B removed the soiled pad and wiped R55 with multiple disposable wipes. Without changing gloves, NA-B placed a clean pad under R55, and started to pull up R55's pants. NA-B used the same gloved hands as she used to wipe R55's stool. NA-B then removed the gloves, finished pulling up R55's pants and proceeded to assist R55 out of bed and into the wheelchair. Once R55 was in the wheelchair, NA-B went into the bathroom and washed her hands. An interview was conducted with NA-B at the completion of R55's cares and NA-B stated the gloves should have been removed and hand washing completed immediately after wiping up R55's incontinent stool, however, she had not done that. During interview on 9/12/14, at 10:12 a.m. director of nursing (DON) stated the staff should wash their hands after removing gloves contaminated with stool.	F 441		

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F 441	Continued From page 69 The facility policy titled Hand Hygiene, undated, identified according to the Centers for Disease Control, hand hygiene is the most effective, single procedure for preventing infections. The policy directed staff to complete hand hygiene before and after gloving, and also before and after providing resident cares.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		10/22/14

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F 520	Continued From page 70 Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required. In addition, the facility failed to develop and implement appropriate action plans for identified areas of concern related to resident care concerns in the facility. This had the potential to affect all 48 residents who currently resided in the facility. Findings include: Refer to F278 as the facility failed to ensure accuracy of the minimum data set (MDS) assessment for 1 of 2 residents (R56) reviewed for pressure ulcers who had multiple unhealed pressure sores, failed to ensure transfer and mobility status was accurately coded for 2 of 2 residents (R20, R59) reviewed for rehabilitation services and failed to accurately code contractures for 2 of 5 residents (R7, R55) reviewed for range of motion. Refer to F310 as the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Refer to F312 as the facility failed to provide appropriate bathing and grooming assistance for 1 of 3 residents (R11) reviewed, who were dependent on staff for activities of daily living (ADL's). Refer to F314 as the facility failed to ensure 1 of 1 resident (R56), who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure	F 520		

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F 520	Continued From page 71 ulcers from developing, which resulted in actual harm for R56 related to the development of multiple pressure ulcers after admission to the facility. Refer to F317 as the facility failed to ensure range of motion (ROM) services were provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Refer to F318 as the facility failed to ensure range of motion and/ or ambulation services were provided to maintain current level of functioning for 3 of 5 residents (R31, R64, and R1) reviewed for range of motion and/ or ambulation services. Refer to F353 as the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility. On 9/12/14, at 11:31 a.m., the administrator and registered nurse (RN)-B who had recently served as the interim director of nursing, were interviewed. The administrator stated she had been brought in as the new administrator in 1/14, and had conducted her first QAA committee meeting on 6/6/14. When asked to provide the dates of all of the QAA meetings for the last year, the administrator was only able to find one other documented meeting on 5/10/13. The administrator acknowledged that the facility hadn't been holding the required quarterly meetings. RN-B stated they were aware of the concerns	F 520		

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F 520	Continued From page 72 with staffing, however, staffing was based on resident census. RN-B stated the staffing concerns had not been discussed at the QA meeting because the facility management felt there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility's QAA committee, whether the committee was currently working on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee or what the purpose/role of the committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident cares. RN-A was unaware of any current quality improvement projects/action plans put into place by the QAA committee, and	F 520		

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F 520	Continued From page 73 stated she was not aware what was discussed at the facility QA meetings. The facility's policy Quality Assessment and Assurance Committee dated 5/14, indicated the facility was to have an ongoing QAA committee that would meet at least quarterly, or more often as the facility deemed necessary, to fulfill committee functions and operate effectively. Further, the policy identified that the facility would implement action plans to address quality deficiencies which would include processes to revise plans that were not achieving or sustaining desired outcomes.	F 520		

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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: The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site	2 000	REVISED	

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2 000	Continued From page 1 revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required. In addition, the facility failed to develop and implement appropriate action plans for identified areas of concern related to resident care concerns in the facility. This had the potential to affect all 48 residents who currently resided in the facility. Findings include: Refer to F278 as the facility failed to ensure	2 255		10/22/14

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2 255	Continued From page 2 accuracy of the minimum data set (MDS) assessment for 1 of 2 residents (R56) reviewed for pressure ulcers who had multiple unhealed pressure sores, failed to ensure transfer and mobility status was accurately coded for 2 of 2 residents (R20, R59) reviewed for rehabilitation services and failed to accurately code contractures for 2 of 5 residents (R7, R55) reviewed for range of motion. Refer to F310 as the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Refer to F312 as the facility failed to provide appropriate bathing and grooming assistance for 1 of 3 residents (R11) reviewed, who were dependent on staff for activities of daily living (ADL's). Refer to F314 as the facility failed to ensure 1 of 1 resident (R56), who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing, which resulted in actual harm for R56 related to the development of multiple pressure ulcers after admission to the facility. Refer to F317 as the facility failed to ensure range of motion (ROM) services were provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Refer to F318 as the facility failed to ensure range of motion and/ or ambulation services were provided to maintain current level of functioning for 3 of 5 residents (R31, R64, and R1) reviewed	2 255		

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2 255	Continued From page 3 for range of motion and/ or ambulation services. Refer to F353 as the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility. On 9/12/14, at 11:31 a.m., the administrator and registered nurse (RN)-B who had recently served as the interim director of nursing, were interviewed. The administrator stated she had been brought in as the new administrator in 1/14, and had conducted her first QAA committee meeting on 6/6/14. When asked to provide the dates of all of the QAA meetings for the last year, the administrator was only able to find one other documented meeting on 5/10/13. The administrator acknowledged that the facility hadn't been holding the required quarterly meetings. RN-B stated they were aware of the concerns with staffing, however, staffing was based on resident census. RN-B stated the staffing concerns had not been discussed at the QA meeting because the facility management felt there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the	2 255		

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2 255	Continued From page 4 discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility's QAA committee, whether the committee was currently working on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee or what the purpose/role of the committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident cares. RN-A was unaware of any current quality improvement projects/action plans put into place by the QAA committee, and stated she was not aware what was discussed at the facility QA meetings. The facility's policy Quality Assessment and Assurance Committee dated 5/14, indicated the facility was to have an ongoing QAA committee that would meet at least quarterly, or more often as the facility deemed necessary, to fulfill committee functions and operate effectively. Further, the policy identified that the facility would implement action plans to address quality deficiencies which would include processes to revise plans that were not achieving or sustaining desired outcomes.	2 255		

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2 255	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The administrator could work with the DON or designee, medical director, and governing body to update polices and procedures, identify issues, develop improvement plans, and ensure the committee meets quarterly. The administrator and DON could audit cares to ensure resident needs are met, audit charts for completion of restorative and range of motion programs, and report results to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was implemented for repositioning for 1 of 2 residents (R56), reviewed for pressure ulcers, for 1 of 1 residents bathing needs (R11), reviewed who required assistance with bathing, and for or 2 of 5 residents ROM programs (R31, R11) reviewed for range of motion services. Findings include: R56's quarterly Minimum data set dated 6/11/14, identified R56 had no cognitive impairments,	2 565		10/22/14

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2 565	Continued From page 6 required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for pressure ulcer development, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's care plan dated 8/16/14, identified R56 had a unstageable pressure ulcer measuring 1.3 x 0.3 the coccyx. The care plan instructed R56 to be repositioned at no greater than 2 hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m. the resident was not repositioned and was unable to shift his weight independently in the wheelchair. During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up in his chair since approximately 6:00 a.m. that morning. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned at least every two hours, and should lie down after breakfast. LPN-B requested assistance to lay R56 down in bed. NA-B and LPN-B transfered R56 to his bed to lay down on 9/10/14, at 10:05 a.m. Although R56's care plan instructed staff to reposition R56 every two hours, the resident had been in his chair for a total of 2 hours and 47 minutes without being repositioned. R31's quarterly MDS dated 6/11/14, indicated R31 had no current functional losses of range of motion (contractures) in the upper or lower extremities.	2 565		

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2 565	Continued From page 7 R31s care plan dated 8/20/14, identified R31 was to receive passive range of motion daily to hips, knees, and ankles, 10-15 repetitions, as well as to bilateral shoulders, elbows, wrists and digits daily. Review of R31s ROM documentation indicated the resident recieved range of motion services 12 days in the last month (8/12/14 through 9/14/14). R31's restorative documentation for 7/2014, was not documented as being completed for 28 out of 31 days. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive any range of motion services other than routine dressing activities. During interview on 9/11/14, at 3:18 p.m. R31 stated he had a stroke a while back and did not walk anymore, but would like to use his legs and complete leg exercises. R11 quarterly MDS dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene and was able to provide partial physical help with bathing. The care plan dated 9/4/14, identified R11 needed the assist of one staff for bathing and preferred to have a bath versus a shower. Staff was directed to to honor resident's preferences and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated recently she had gone for a couple of weeks without a bath because the facility didn't have any bath aids. R11's point of care bathing record indicated R11	2 565		

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2 565	Continued From page 8 received a tub bath on 7/31/14, and the next entry was a partial bath on 8/28/14, which was 28 days later. During interview on 9/12/14, at 9:34 a.m. NA-B stated it was possible R11 went for weeks without a bath because there is not enough staff to assist residents with bathing. R1's quarterly MDS dated 6/25/14, indicated R1 had functional limitation in range of motion (ROM) to one side of the upper and lower extremities. R1 care plan dated 7/2/14, identified R1 was to receive passive range of motion (PROM) daily, 10-15 reps to bilateral shoulders, elbows, wrists, and digits. R1's PROM restorative nursing sheets were reviewed from April 2014 - September 2014. There was no documentation to determine if R1 was recieving PROM as directed by the care plan. During interview on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility no longer had a restorative aid, and the NAs are not able to complete R1's PROM as directed by the care plan. During interview on 9/11/14, at 9:25 a.m. R1 non-verbally indicated by motioning in a back and forth motion with her hand to indicate 'so-so,' when asked if staff were assisting her with PROM on a daily basis. When asked for a frequency of the PROM being done, R1 spelled out, "monthly," on her communication board. SUGGESTED METHOD OF CORRECTION:	2 565		

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2 565	Continued From page 9 The facility could develop a system which ensures that resident care plans are current and that all staff are delivering care according to the care plan and educate all care givers and nurse managers. The facility could monitor resident care for accurate delivery of care plan interventions and develop and auditing system to track ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility.	2 800		10/22/14

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2 800	Continued From page 10 R7 was not being walked according to the assessed restorative nursing orders. During interview on 9/11/14, at 1:42 p.m. NA-F stated the facility did not have enough staff to walk R7, and as a result, she felt R7 had a decline in ambulation and possibly range of motion. NA-F reported R7 had difficulty with transferring now, and was unable to raise her feet up while in the wheelchair. R7's Annual minimum data set (MDS) dated 8/27/14, identified she had severe cognitive impairment, impairment (contractures) to one side of the upper extremity, and required extensive two person assistance with transfers/walking. Her balance was impaired and she could only stand with staff assistance. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57 feet with assistance of two staff, twice daily using a walker. R7's restorative nursing documentation from April 2014 - September 2014, lacked documentation that R7 had been walked/ambulated by staff from 4/2014 to 9/2014. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative program was in shambles right now, and she is trying to revamp the program. She verified there was no evidence that R7 was being walked. An interview on 9/10/14 at 1:00 p.m. was completed with NA-A who stated staff tries to ambulate residents, but it does not always happen because of the lack of staffing. NA-A stated staff is not able to complete ROM for resident either, and stated, "I feel sorry for the	2 800		

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2 800	Continued From page 11 residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. R47 stated during interview on 9/8/14, at 3:57 p.m., there was not sufficient staff at the present time. She stated she waited for over 20 minutes and all the way up to an hour for staff to respond to her call light and did not feel that was acceptable. She also reported that due to staffing shortage, she had to wait a long time to be served her food and by the time she gets her food it is cold. During a second interview on 9/8/14, at 7:02 p.m. R47 stated would transfer herself to the bathroom as staff does not respond to her call light. She stated she, "Refuses," to be incontinent of urine or stool because of having to wait for staff, and as a result will transfer herself. She stated she is aware she is not supposed to transfer herself to the bathroom because of previous falls, however, she can not wait for staff over 20 minutes for assistance. She reported the nursing assistants are aware she does this due to staff shortage. R47 stated she is supposed to be assisted with walking twice a day, however, staff is not able to do this as they just don't have time, and she didn't think she had been walked for about 10 days. A family member (FM)-B of R47 was interviewed on 9/10/14, at 1:15 p.m. and stated he had talked to staff a, "couple of time" that R47 was not being walked and he was concerned she would lose strength. FM-B stated R47 was to be walked twice each day, but it seldom happened. FM-B stated R47 had fallen a couple of times as she was not willing to be incontinent while waiting for assistance from staff when her call light is not answered for long periods of time. FM-B also	2 800		

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2 800	Continued From page 12 stated there were times when he visited and the call light was on for over 15 minutes and he would have to go out to the hall and try to find staff to assist her. R47's quarterly MDS dated 7/2/14, indicated R47 was cognitively intact with no signs or symptoms of delirium. She needed extensive assistance of two staff with bed mobility, extensive assistance of one staff for transfers, dressing, toilet use and personal hygiene. R47 needed extensive assistance of one staff with ambulation. R47's nursing assistant care sheet dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet twice per day with assistance of one staff, a transfer belt, rolling walker and wheelchair behind. Physician orders, signed 9/5/14, directed staff to complete passive range of motion to wrists, ankles, digits, knees, elbows, shoulder and hips daily. In addition, the physician ordered that R47 be walked 57-115 feet twice a daily with a wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets for August, 2014 to September, 2014 were reviewed and there was no documentation that R47 received any passive range of motion to extremities or ambulation. An interview with licensed practical nurse (LPN)-C was completed on 9/11/14 at 11:15 a.m. and she stated she was aware R47 was to be walked twice a day with staff assistance. LPN-C stated there was no documentation on the restorative nursing sheets to identify if R47 had been assisted with ambulation or any PROM in the prior months.	2 800		

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2 800	Continued From page 13 R1 reported on 9/9/14 at 1:10 p.m., she did not feel there were sufficient staff and she has been incontinent because the call light was not being answered fast enough. R1 also was concerned she had not been receiving ROM, and when asked how often she had been receiving ROM services, she spelt out,"monthly," using her communication board. R1's quarterly MDS, completed 6/25/14, indicated R1 had moderate cognitive ability, had no signs or symptoms of delirium/ psychosis, had no behavioral issues, and had limitations to one side of her upper and lower extremity (contractures). R1's care plan dated 7/2/14, and restorative nursing sheets from 4/2014- 9/2014, directed staff to provide passive range of motion daily to both shoulders, elbows, wrists, and fingers. R1's restorative nursing sheets for April, 2014 to September 12, 2014 lacked any documentation that passive range of motion was being done for R1. During an interview on 9/10/14, at 7:10 a.m. licensed practical nurse (LPN)-A stated a NA's did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14, at 1:25 p.m. NA-B stated the restorative aid position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to	2 800		

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2 800	Continued From page 14 residents. When interviewed on 9/11/14 at 10:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated NA's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to help him. R31's quarterly MDS dated 6/11/14, indicated R31 was cognitively impaired, totally dependent on two staff for all transfers, and needed extensive assistance of one staff for all locomotion. R31's care plan dated 8/20/14, indicated R31 was to receive PROM motion to hips, knees, and ankles 10-15 repetitions daily as well as to bilateral shoulders, elbows, wrists and fingers. A review of R31's restorative nursing sheets from 8/12/14, through 9/14/14, indicated R31 received PROM only 12 times. RN-A stated the facility did not currently offer formalized restorative programs at the present time due to lack of staffing. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive any range of motion services.	2 800		

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2 800	Continued From page 15 R55 was not receiving range of motion due to staff shortage. R55's quarterly MDS dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM, and was totally dependent on staff for transferring, toileting, dressing and all activities of daily living. R55 sheets from the restorative nursing book dated 1/1/14-6/30/14, instructed staff to ensure R55 received daily restorative treatments which included the following passive range of motion to shoulder, wrist, ankle, finger, elbows and knees. The 7/2014 MAR identified 3 restorative services were provided out of the 31 opportunities. The facility was unable to provide evidence that R55 had received passive range of motion from 8/14, to 9/11/14. During interview on 9/10/14, at 11:50 a.m., NA-B stated R55's ROM exercises were often not done because they didn't have enough staff to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises which the resident had been assessed as needing. During interview on 9/11/14, at 10:13 a.m., NA-H stated range of motion services were not being completed and R55 was becoming stiffer as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult so facility staff asked the residents family member to bring in different clothing. R56 stated on 9/8/14, at 3:50 p.m. he did not feel the facility had enough staff. He reported having to wait a long time to have his call light answered.	2 800		

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2 800	Continued From page 16 During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. The quarterly MDS dated 6/11/14, identified R56 was cognitively intact and he required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, and was at risk for developing pressure ulcers. He currently had one stage IV (Unstageable) pressure ulcer, that was present on admission over a year ago, and was unhealed. R56's admission care area assessment (CAA) dated 12/17/13, identified R56 was to be repositioned at no greater than two hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair and was unable to shift his weight independently, and was not approached by staff to assist the resident to reposition as assessed. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NA's did their best to assist residents to reposition as assessed but at times were unable to do so. NA-A verified R56 had not been repositioned every two hours as assessed because of the facility not having sufficient staffing to provide resident cares. R11 stated during an interview on 9/8/14, at 4:23 p.m. she had gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. In addition,	2 800		

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2 800	Continued From page 17 R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. She stated this happened a lot, and a few nights ago she had her call light on for over 40 minutes to go to the bathroom, no staff came to help her to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for toileting. R11's Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later. During interview on 9/9/14, at 3:03 p.m. NA-K stated there are not enough staff to provide residents a bath. NA-K stated she often is not able to complete all the resident cares because of the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to being short staffed. During interview on 9/10/14, at 2:23 p.m., NA-F stated it was possible that some residents had gone for weeks without getting a bath because the facility does not have enough staff to complete all the resident cares. NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected.	2 800		

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2 800	Continued From page 18 During interview on 9/11/14, at 10:13 a.m., NA-H stated there was not enough staff to accommodate baths for the residents, and resident baths are not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist residents. During interview on 9/12/14, at 9:34 a.m., NA-B stated resident baths are not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, the facility is still working on the staffing concerns. During dining observation on 9/8/14, at approximately 5:40 p.m. NA-P was observed sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident giving them a bite of food, and then rolling on the stool using her feet to the next resident. NA-P would give a resident a bite of food, set the fork or spoon down, and immediately roll over to the next resident, and continued rolling around the table on the stool the entire meal. R12's quarterly MDS dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and	2 800		

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2 800	Continued From page 19 required extensive staff assistance with dining. R66's quarterly MDS dated 8/6/14, identified R66 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/27/14, identified R7 had severe cognitive impairment and required extensive staff assistance with dining. During interview on 9/8/14, at 6:01 p.m. NA-P stated she was required to feed multiple residents at a time, and needed to use the rolling stool so she was able to go from resident to resident to ensure they all received their meal. NA-P stated there was not enough staff to ensure all the residents were being fed timely, so the NA's do what they have to so the residents receive their meals. When interviewed on 9/10/14, at 7:10 a.m. LPN-A stated sometimes the residents needed to wait for help because the facility is short staffed. LPN-A stated the managers are not typically assisting residents with dining, however, the week during the survey, they have been helping out. LPN-A stated residents have voiced concerns of the call lights not being answered and not having cares provided. LPN-A stated restorative nursing/ ambulation for the residents is not being completed, and residents have complained of not walking and feel they are losing strength. LPN-A stated on the weekends, the staff brings residents with behavioral issues to the lobby and this falls on the nurse to provide additional supervision,which makes it difficult to complete all the resident cares which need to be completed. When interviewed on 9/10/14, at 6:50 a.m. NA-L stated there were not enough staff on the night	2 800		

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2 800	Continued From page 20 shift and staff was struggling to provide the necessary care for over 2 months. NA-L stated residents have been complaining of waiting 45 - 60 minutes for help. NA-L stated when there is a sick call, the staff is not replaced and they work short, and there have been nights the facility had only one nurse working to take care of all the residents in the facility. When interviewed on 9/10/14, at 6:57 a.m. NA-M stated residents have voiced concerns about not having enough staff to complete the cares and she had reported this to the charge nurse on duty multiple times. NA-M stated nothing had changed with staffing, even after reporting residents are not receiving the cares they require. When interviewed on 9/10/14, at 7:01 a.m. NA-N stated the night shift, sick calls are not replaced, and they often work short staffed. When interviewed on 9/10/14 at 7:46 a.m. NA-H stated residents are not getting the quality care they need and deserve, and there had been no restorative services for 3 months. The restorative aid and bath aid positions were eliminated several months ago, and staff had quit due to short staffing. She stated residents not being helped in the dining room to eat, and during survey management had been helping in the dining room, which never happens on a regular week. NA-H stated residents have voiced concerns they are not receiving their baths because staff does not have time to do this extra task. NA-H also stated some residents are only assisted twice per shift to use the bathroom due to staffing, and residents are not getting walked so they get restless and then try to walk alone. When interviewed on 9/10/14, at 9:18 a.m. NA-E	2 800		

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2 800	Continued From page 21 stated she did not feel there were enough staff and nursing assistants were not able to provide all cares, including baths, shaving, ROM, and ambulation. NA-E stated residents have complained of the call lights not being answered, and R11 complained of having less strength due to ROM not being done. During an interview on 9/10/14, at 1:15 p.m., NA-F stated the NA's constantly feel rushed. She stated the NA's are supposed to do ROM, ambulation, and baths for residents, and the NA's are not able to complete this because of short staffing. When interviewed on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility did not have sufficient staff to complete resident cares. NA-B had tears in her eyes as she stated they are unable to complete resident cares, especially bathing, ROM, dining, and ambulation. When interviewed on 9/10/14, at 2:07 p.m. NA-O stated it is difficult to provide resident cares due to being short staffed. On 9/11/14, at 9:08 a.m. a print out of the call light times was requested from the DON, who stated they did not have the capability of printing out the report. She did not identify the process the facility was using to monitor call light response times. When interviewed on 9/11/14 at 10:30 a.m. RN-A verified there is no formal restorative program at this time. RN-A confirmed there have been complaints from NA's about not having enough staff to complete resident cares or ROM and ambulation. RN-A stated the NA's were asked to do ROM on residents while assisting to dress	2 800		

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2 800	Continued From page 22 them, and verified this was not a formal program and did not meet the intention of a restorative nursing program. During interview on 9/11/14, at 10:13 a.m., NA-H stated the facility was short staffed and the resident cares were not being completed. NA-H stated ROM was not being completed for residents, specifically R55 who was becoming stiffer as a result. NA-H stated there were not enough staff to accommodate baths for the residents and they were often skipped. NA-H stated the NA's had complained to the administration staff at the nurse meetings about short staffing, however, nothing had been done to correct the staffing issue. When interviewed on 9/12/14, at 10:34 a.m., the staffing coordinator (MR)-J stated when there was a sick call, replacement depended on the number of staff scheduled. She reported if a sick call resulted in staff working a shift with less than established minimums, she would consult with the director of nursing (DON). She indicated there is no policy on staffing. When interviewed on 9/12/14, at 11:04 a.m. the DON and administrator stated staffing was based on census, not necessarily on resident care levels. The goal was to have six nursing assistants on both the day and evening shift, and three nursing assistants on the night shift. If there is a call in, they have not been replacing the staff if it would require overtime. They stated they had not reduced the hours of staff, and there had not been layoffs, however, they would not replace staff if someone left or retired, until they met the right staff . They stated they felt the facility was significantly overstaffed, and did not believe their was an issue with lack of staffing.	2 800		

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2 800	Continued From page 23 They stated they had been trying to educate staff on being more efficient in providing residents cares. They NA's should have been able to complete all of the duties necessary with less staff and they felt the NA's were making a choice to not complete things such as baths or restorative nursing services. DON stated they used to have nine NA's working at a time and now they have six, because having nine, "Just didn't make good business sense." SUGGESTED METHOD OF CORRECTION: The facility could work with the Administrator to develop a system to ensure staffing levels are adequate to meet resident care needs. The facility could develop auditing tools to ensure the required resident care is being provided and report results to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		10/22/14

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2 830	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident falls were thoroughly assessed to ensure appropriate/pertinent interventions could be implemented or revised, for 2 of 2 residents (R64, R3), with multiple falls. Findings include: R64 admission face sheet, dated 2/24/12, indicated the resident had diagnoses including weakness, dementia, and incontinence. R64's quarterly Minimum Data Set (MDS) dated 8/13/14, indicated R64 had severe cognitive impairment, required extensive assistance for all activities of daily living (ADL), including bed mobility, transfer, walking, and toilet use. R64 was not steady, and only able to stabilize with staff assistance. R64's care plan dated 8/19/14, indicated R64 was at high risk for falls and had falls prior to and after admission to the the facility. Staff were directed to anticipate R64's toileting needs, place the floor mat on the floor when in bed, have the call light safety alarm system on while in bed, wear gripper socks while in bed, ensure safety alarm was on R64's wheelchair/chair, and ensure an anti-rollback device was on the residents wheelchair. R64's Fall Risk/Restraint Evaluation Review dated 5/20/14, indicated, "Resident remains high falls risk; [six] 6 falls in [three] 3 months. Resident attempts self transfers frequently. Confused and delusional reverting to his days of being a pastor... Gripper socks when in bed; W/C	2 830		

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2 830	Continued From page 25 [wheelchair] alarm; motion sensor; Bed alarm system remain appropriate. Floor mat added." R64's progress notes indicated the resident had a fall on 7/27/14. According to the progress notes, R64's alarm sounded, and the resident was observed sitting on the floor at his bedside and had no injuries. R64 was alert, and reported he wanted to go to school and rolled out of bed. R64 told staff he needed to go to the bathroom and staff assisted the resident to the bathroom and he urinated. Staff was unable to provide any further assessment or investigation of the fall to determine if current interventions were appropriate, new interventions were needed, and if R64's toileting plan was being implemented and was appropriate to prevent further falls. R64's progress notes indicated the resident had another fall on 8/24/14. According to the progress notes, R64's alarm sounded, and he was observed on the floor on his buttocks. No injuries were noted. R64 indicated he needed to clip his nails. Staff was unable to provide any further assessment or investigation of the fall to determine if current interventions were appropriate, if there were any trends with the residents falls, or if new interventions were needed to prevent further falls. During interview on 9/12/14, at 10:00 a.m., registered nurse (RN)-B stated she was in charge of conducting post fall investigations. RN-B stated there was no further information available regarding these falls, and post fall assessments were not completed to determine what may have caused the fall, if there were any trends noted, if the current interventions were appropriate, or if the interventions needed to be modified. RN-B stated, "We are working on that...I didn't even	2 830		

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2 830	Continued From page 26 know he [R64] had a fall last week." Although R64's fall assessment dated 5/20/14, indicated the resident had fallen six times in the prior three months while a resident in the facility , the facility was unable to provide progress notes, incident reports, or any documentation regarding the falls they had identified in the fall assessment. R3's diagnoses listed on the undated facesheet included visual loss, spasm of muscle, abnormal involuntary movements, lack of coordination, dementia, and frequency of urination. R3's quarterly MDS dated 7/2/14, indicated R3 was severely cognitively impaired, required extensive assistance with all ADL's, and was not steady when standing or transferring. During an interview on 9/8/14, at 4:20 p.m., RN-A stated R3 had three recent falls, on 8/20/14, 8/22/14, and 9/4/14. RN-A stated R3 was impulsive and leaned forward in her chair and often rolled out of her chair. RN-A stated R3 was not injured during these falls. During multiple observations on 9/10/14, R3 was seated in her wheelchair, in the area in front of the nurses station. R3 had a alarm clipped to the back of her blouse, and had a Safe-T-Mate anti-rollback device on her wheelchair. R3 attempted to stand many times and multiple staff members attempted to redirect R3 and assisted her to sit down. R3 was able to self propel her wheelchair and would often lean forward in her wheelchair which would sound the alarm which was attached to her. On one occasion, a staff member offered R3 a magazine, which R3 sat and read calmly in her wheelchair for several	2 830		

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2 830	Continued From page 27 minutes paging through the magazine and talking about each picture. R3's care plan dated 7/8/14, indicated R3 was at risk for additional falls due to a history of frequent falls. Staff were directed to observe for unsafe practices and to anticipate R3's needs, especially toileting needs. The care plan also directed staff to offer activities to keep her busy, to offer towels for folding, cloths to wipe surfaces she could reach, and dolls to dress and undress. R3's progress notes related to her recent falls, included the following: On 8/20/14, R3 stood up from her wheelchair outside of her room and fell to her knees. There were no injuries noted. R3 indicated she was going to get to her appointment. Staff noted increased confusion after lunchtime and R3 was toileted and laid down for nap. Staff was unable to provide any further assessment of the fall to determine the cause of the fall, if current interventions were appropriate, or if new interventions were needed. On 08/22/2014, R3's alarm sounded and she was observed slowly falling to the floor in the activity room. No injuries were noted. R3 stated she was attempting to get up and walk out of the activity room when she fell. R3 was assisted back into her wheelchair and promptly assisted to the restroom to be toileted. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. On 9/5/14, R3's alarm sounded and staff witnessed her standing and then falling by the desk in the main parlor. R3 stated she was standing to reach for the watermelon that was in front of her at the desk. R3 was assisted back into her wheelchair and the food was placed	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 28 closer to her. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. During an interview on 9/12/14, at 10:00 a.m., registered nurse (RN)-B indicated she was in charge of conducting post fall investigations. RN-B stated there was no further information available regarding R3's falls. Post fall assessments were not completed to determine what may have caused R3's falls, if there were any trends noted, if the current interventions were appropriate, or if the plan of care was being followed. The facility undated policy titled Fall Prevention and Risk/Restraint Evaluation included, "The Post Fall Evaluation will be completed by the DON [director of nursing] or her/his designee within 72 hours after a resident fall." SUGGESTED METHOD OF CORRECTION: The DON or desigee could work with the QA Committee to update policies and procedures for assessing causative factors for falls. The facility could also perform audits of post-fall documentation to ensure interventions were put into place and potential contributing factors were reviewed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program	2 890		10/22/14

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2 890	Continued From page 29 that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Findings include: R47's quarterly Minimum Data Set (MDS) dated 7/2/14, indicated R47 had no cognitive impairment, needed extensive assistance of one staff for transfers and ambulation, and used a wheelchair or a walker to aid her ambulation. R47's balance was not steady during transfers and walking and she had no loss of upper and lower function range of motion (contractures). R47's Care Area Assessments (CAA) dated 10/9/13, identified R47 was alert and oriented,	2 890		

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2 890	Continued From page 30 had clear speech, and she was understood and able to understand others. R47 had an unsteady gait, was able to bear weight, and required a wheelchair behind her when she was involved in the restorative walking program. During interview on 9/8/14, at 7:11 p.m. R47 stated she was concerned she was going to lose her ability to walk because staff had not been assisting her to ambulate. She stated she was supposed to be walked twice a day but there was not enough staff to do this. She indicated she was, "Very rarely being walked." Another interview was completed on 9/11/14, at 11:00 a.m. R47 stated she was, "upset, " about not being walked twice a day due to staff shortage. She stated, "They just don't have time to walk me." R47 stated she had been involved in therapy and the therapist recommended she be walked. Because staff had not been assisting her to walk, R47 stated her joints are getting stiff and was not able to move as easily as she had in the recent past. She stated the last time she could remember she was walked was about 7-10 days ago. R47's care plan dated 7/9/14, indicated R47 was to be ambulated per the "Restorative program." The restorative program was not specified in the plan of care. R47's nursing assistant care sheet, dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet, twice per day with assistance of one staff, a transfer belt, rolling walker, and wheelchair behind. R47's physical therapy note dated 8/7/14, indicated the resident was able to ambulate up to	2 890		

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2 890	Continued From page 31 80 feet with a rolling walker and contact guard assistance. R47 was seen in the occupational therapy (OT) department from 7/14/14 to 8/14/14. R47 was considered to be alert and able to follow directions. R47's discharge from OT on 8/14/14, indicated she transferred with contact guard assistance (CGA- the therapist would hold a transfer belt for stabilization), tolerated standing for greater than three minutes while she maintained a safe balance while using a 4 wheeled walker, had an increase in her endurance while performing her activities of daily living, and reported no increase in fatigue while performing her exercises. R47's physician orders dated 9/5/14, directed staff to ambulate the resident 57-115 feet twice daily with a wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, were reviewed from April 2014, to September 11, 2014 identified the following: -April 1 to June 30, 2014, R47 was ambulating twice a day, walking 57 to 115 feet consistently. -July, 2014, R47 was walked 15 times on the day shift, and twice on the evening shift. The last documentation of R47 being ambulated was 7/23/14, when she walked 115 feet. -August 2014, to September 11 2014, there was no documentation regarding R47 ambulating. During interview on 9/11/14, at 9:44 a.m. nursing assistant (NA)-J stated he was aware R47 was to	2 890		

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2 890	Continued From page 32 be ambulated twice a day, however, he had never assisted R47 to ambulate. NA-J stated staff does not have time to complete R47 ambulation program because of short staff. During interview on 9/11/14, at 11:15 a.m. licensed practical nurse (LPN)-C stated R47 was to be ambulated twice a day, however, she stated there was no way to determine if R47 was being ambulated because there was no documentation. During interview on 9/11/14, at 2:39 p.m. physical therapy assistant (PTA)-E stated she had worked with R47 from 7/14/14, until her discharge from physical therapy on 8/12/14. PTA-E had recommended R47 be ambulated twice a day, 57-111 feet. PTA-E stated R47, "loved to be walked," and was able to consistently walk 80 feet when discharged from PT on 8/12/14. During interview on 9/11/14, at 3:24 p.m. registered nurse (RN)-A (who was identified as the person in charge of Rehab/Restorative Services), stated there was no record of staff efforts to walk R47. RN-A stated staff was to ambulate R47 twice a day, however, she was not sure if this was being done, and was unsure if R47 had declined in her ability to ambulate. RN-A stated there was no formal nursing assessment completed of R47's ambulation program to ensure it was appropriate and being implemented as ordered. During observation on 9/11/14, at 3:55 p.m. PTA-E assisted R47 to ambulate. R47 was able to walk 45-60 feet before becoming short of breath and needed to sit down. PTA-E stated R47's current ambulation ability was a decline from when the resident was discharged from physical therapy on 8/12/14.	2 890		

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2 890	Continued From page 33 Although the facility was aware R47 was not being ambulated as assessed by PT, the facility did not reassess and put interventions into place to ensure the resident did not decline in the ability to ambulate. R47's decline in ambulation ability related to the lack of the facility completing the ambulation program as assessed resulted in actual harm for R47. R7's annual MDS dated 8/27/14, identified R7 had severe cognitive impairment, had impairment (contracture) to one side of the upper extremity, required extensive two person assistance with transfers and walking in the corridor, was only able to stabilize when standing with staff assistance, and walking in the resident room, unit, and off the unit had not occurred during the 7 day prior look back period of the MDS completion date of 8/27/14. R7's CAAs dated 8/27/14, did not address R7's walking, transfer ability, or current contractures. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and both knees were bent and raised off the bed. R7's Physical Therapist Progress & Discharge Summary dated 3/4/14, indicated R7 was to ambulate 20-30 feet, using a four wheeled walker with assist of two staff, two times a day. R7 was able to hang onto the walker without hand support and did not need the platform walker on even services. PT also indicated R7's knee range of motion (ROM) was 26 degrees of left knee extension, and 22 degree of right knee extension. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57	2 890		

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2 890	Continued From page 34 feet with assistance of two staff, two times daily using a walker. R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, from April 2014 - September 2014, instructed two staff to walk the resident 29-57 feet, two times daily. There was no documentation identifying if staff was ambulating R7 from 4/2014- 9/2014. R7's care plan dated 9/3/14, indicated staff pushed R7 to all destinations in the wheelchair and transferred with assist of two with a transfer belt and walker. R7's care plan did not address if the resident was able to ambulate, nor did it instruct staff on R7's assessed ambulation program. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative/ ambulating program was in shambles right now, and she was trying to revamp the program to ensure residents were receiving their programs as assessed. RN-A was not aware R7 had not been ambulating or had a decline in transfer ability or ambulation. During interview on 9/11/14, at 1:42 p.m. NA-F stated R7 had a decline in ambulating as well as transfers, and staff was supposed to be walking her, however, R7 no longer walks, and staff did not have time to spend to try to assist her in walking prior. NA-F stated recently she had to order foot pedals for R7 because she could no longer raise her feet up when in the wheelchair when staff were pushing her to destinations. During interview on 9/11/14, at 1:57 p.m. RN-D	2 890		

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2 890	Continued From page 35 stated she had observed R7 ambulating and transferring a few months ago, and R7, "got to the point," of being unable to bear weight on the walker, so staff was transferring the resident using a hand in hand method. RN-D stated she had done no formal assessment of R7's ambulation program when it was noted R7's ambulation program was not being implemented as assessed and R7 was noted to be declining in her ability to transfer and ambulate. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, and stated R7 was resistive and had some contractures in her left hand and bilateral knees. PTA-E and COTA-D transferred R7 from the wheelchair to her bed. During the transfer, R7 did not take any steps, bear any weight on her feet, and was lifted into bed with heavy assist. During the evaluation, R7 stated, "ouch," on multiple occasions and grimaced when staff was attempting to straighten the resident's knees. PTA-E and COTA-D both verified R7 would benefit from therapy and should have been referred back to therapy when staff noted the resident was declining in transfers and no longer ambulating. COTA-D stated residents have expressed concerns with not being ambulated. Although the facility was aware R7's ambulation program was not being completed as assessed, and the resident was no longer ambulating and had a decline in transfers, the facility failed to reassess and refer the resident back to therapy. This resulted in actual harm for R7. SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of	2 890		

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2 890	Continued From page 36 motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, range of motion (ROM) services were not provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Findings include: R55's quarterly Minimum Data Set (MDS) dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM (contractures), and was totally dependent on staff for transferring,	2 895		10/22/14

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2 895	Continued From page 37 toileting, dressing, and all activities of daily living. During interview on 9/8/14, at 5:55 p.m. registered nurse (RN)-A stated R55 had contractures (fixed high resistance to passive stretch of a muscle) in both knees only, did not utilize any splint devices, and was not receiving any formal ROM program. R55's care plan, last updated 6/9/14, did not identify the presence of any contractures nor did it instruct staff on the type of ROM exercises to be completed by staff. R55's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, was located in the restorative nursing book dated 1/1/14, through 6/30/14, and instructed staff R55 was to receive daily restorative nursing treatments which included the following: -Shoulder passive range of motion (PROM) 10-15 REPS-bilateral flexion/extension -Wrist PROM 10-15 reps bilateral flexion/extension -Ankle PROM 10-15 reps bilateral dorsiflexion/flexion -Digits PROM 10-15 reps bilateral flexion/extension -Elbow PROM 10-15 reps bilateral flexion/extension -Knee PROM 10-15 reps bilateral flexion/extension The 7/2014 restorative nursing sheet identified 3 restorative treatments were provided out of the 31 opportunities.	2 895		

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2 895	Continued From page 38 The facility was unable to provide any restorative nursing sheets for R55 for the months of 8/2014, or 9/2014. The facility had no documentation any ROM was done for R55 for 2 months. The facility was unable to verify when R55's ROM program was started, and if it had been reassessed at any time to determine if it was appropriate for R55. Review of R55's Electronic Point Of Care Record from 7/1/14, to 9/12/14, did not identify R55 received any ROM services, nor was there any assessment to ensure the ROM program was appropriate for R55. During observation on 9/10/14, at 7:18 a.m. R55 was observed being assisted with dressing. R55's legs would not fully extend and rest on the bed, and the residents knees stayed bent. Nursing assistant (NA)-B was unable to raise R55's arms above her head to put on her shirt, and instead needed to slide the shirt up R55's arms and then stretch it over her head. R55 was not able to lift up her arms or straighten her arms from the elbow. NA-B verified R55 was becoming more stiff. During interview on 9/10/14, at 11:50 a.m. NA-B stated R55's ROM exercises were not being completed because they didn't have enough staff to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises which the resident had been assessed as needing. During interview on 9/10/14, at 12:45 p.m., RN-C stated when restorative services or ROM was provided to the residents, the NAs should document in Point of Care when it was completed. RN-C was unable to provide any further documentation that R55 was receiving any	2 895		

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2 895	Continued From page 39 ROM services, and verified there was no documentation in Point of Care R55 was receiving any ROM services. During interview on 9/11/14, at 9:38 a.m. licensed practical nurse (LPN)-B stated the NAs were responsible for completing the ROM treatments for the residents as well as charting when it was completed in the residents electronic point of care record. LPN-B was not aware R55's ROM was not being completed. R55's Physical Therapy Discharge Summary dated 9/6/11, indicated R55 demonstrated passive stretching of the right knee to 22 degrees and 25 degrees of the left knee. R55 was noted to be pain free and would be discharged to continue bilateral lower extremity ROM program with staff. R55's Occupational Therapy Discharge Summary dated 7/17/12, indicated R55 exhibited proper hip/knee/ankle alignment while in the wheelchair. The summary did not note the presence of any upper extremity contractures. During interview on 9/10/14, at 2:03 p.m. certified occupational therapy assistant (COTA)-D examined R55's upper extremities and indicated R55 was somewhat resistant when attempting to evaluate total ROM, so she was unable to completely assess the degree of the shoulder, wrist, and finger contractures. However, COTA-D indicated R55 appeared to have bilateral upper extremity contractures, which she was not aware of prior. COTA-D stated R55 would definitely benefit from a splint device for the right thumb which was identified to be the most contracted joint during the exam. Physical therapy assistant (PTA)-E was also interviewed at this time and	2 895		

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2 895	Continued From page 40 completed an exam of R55's lower extremities. PTA-E stated when compared to the most recent physical therapy discharge summary dated 9/6/11, R55's knee contractures had worsened. PTA-E stated the right knee contractures had worsened to 55 degrees compared to 22 degrees before, and the left knee was now at 35 degrees compared to 25 degrees prior. COTA-D and PTA-E both verified R55 should be receiving ROM as had been assessed, and should have been referred back to OT/PT when staff noted R55's knees were becoming more contracted, and noted a decline in the resident's ability to move the upper extremities when being assisted with dressing. During interview on 9/11/14, at 9:09 a.m. family (FM)-A stated recently staff had asked him to purchase larger pants and different types of shirts so it would be easier to dress R55. FM-A stated R55 was becoming so stiff she was not able to lift her arms and straighten her knees so it was a struggle to get her dressed every day. FM-A stated staff asked for shirts that opened in the back, as well as larger pants, to make it slide on better. During interview on 9/11/14, at 10:13 a.m. NA-H stated range of motion services were not being completed and R55 was becoming stiff as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult, so staff asked the resident's family member to bring in different clothing. During interview on 9/11/14, at 11:10 a.m. RN-A confirmed there was no formal ROM assessment in place for R55 to ensure the current restorative program was being implemented as assessed,	2 895		

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2 895	Continued From page 41 nor to ensure the program is adequate to prevent further decrease in ROM. The facility failed to ensure R55's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R55 was having further difficulty with dressing related to decrease in ROM, the facility failed to provide further interventions and reassessment which resulted in actual harm to R55. R7's annual MDS dated 8/27/14, indicated R7 had severe cognitive impairment and had ROM impairment (contracture) to one side of the upper extremity. R7's clinic note dated 3/21/14, indicated the resident had a chronic right hand contracture which was released with surgery, had no pain, and was regaining muscular function back in the right hand. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and her left hand was in a fist. During observation on 9/10/14, at 6:53 a.m. R7 was sitting in her wheelchair in the activities room and her left hand was closed in a fist. During observation on 9/11/14, at 9:40 a.m. R7 was sitting in the activity room with her left hand closed in a fist. During observation on 9/12/14, at 8:40 a.m. R7 was sitting in the dining room with her left hand up to her face with her fingers bent inward.	2 895		

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2 895	Continued From page 42 During observation of R7 from 9/9/14- 9/12/14, R7 was not observed to release the fist of her left hand, nor did she attempt to use her left hand. R7's PT Progress and Discharge Summary dated 3/4/14, indicated the resident was able to hang onto the walker without hand support, and was to receive ROM. R7's current Physician Orders sheets for September 2014, instructed staff the resident was to receive the following restorative nursing program: · Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 · Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, indicated the resident had a right hand contracture. The restorative nursing sheets reviewed from April 2014, - September 2014,	2 895		

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2 895	Continued From page 43 noted the following program to be completed for R7 on the day shift: · Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 · Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets for April 2014 - September 2014, noted the restorative nursing program to be completed for R7 on the day shift, however, there was no documentation R7 was receiving any ROM. R7's care plan dated 6/11/14, identified R7 had a right hand contracture. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, who both verified R7 was resistive and had some contracture(s) in her left hand and bilateral knees. During the evaluation R7 grimaced and stated, "Ouch" on multiple occasions when PTA-E and COTA-D were attempting ROM. COTA-D and PTA-E both stated R7 would benefit from therapy and possibly a splint or cone for the new contracture in her left hand.	2 895		

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2 895	Continued From page 44 During interview on 9/9/14, at 9:46 a.m. RN-A stated R7 had a contracture to her right hand and had surgery to release part of the contracture. RN-A stated the restorative program was not being completed for residents as assessed, and she was trying to revamp the program. RN-A stated R7 should be receiving the ROM services as had been assessed by PT. RN-A was not aware of R7's left hand or bilateral knee contractures. An interview on 9/10/14, at 1:00 p.m. was completed with NA-A who stated staff was not able to complete ROM for residents and stated, "I feel sorry for the residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. During interview on 9/11/14, at 1:57 p.m. RN-D stated R7 had a contracture to the right hand, which was repaired via surgery, and was the contracture identified on the resident's MDS. RN-D stated several months ago R7 got to the point of being unable to hang onto the walker with her hands, so staff was ambulating the resident hand in hand. RN-D stated R7 was noted at that time to have a decline in ROM in her left hand related to being unable to hang onto the walker, however, R7's restorative program was not reassessed, and the resident was not referred back to PT to prevent further decline in ROM ability. The facility failed to ensure R7's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R7 was no longer	2 895		

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2 895	Continued From page 45 able to hang onto the walker to ambulate, the facility failed to provide further interventions and reassessment which resulted in actual harm to R7. The facility policy titled Restorative Nursing, undated, identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy further identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned. The summary of the policy documented the following, "Restorative nursing was mandated by OBRA [Omnibus Budget Reconciliation Act] in	2 895		

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2 895	Continued From page 46 1987, as a means to keep residents at their highest possible practicable physical, mental and psychosocial level. Maintaining function enhances dignity and self-esteem. It is the primary reason for implementing effective restorative nursing programs. A comprehensive organized program guides staff to accurately identify restorative needs, implement restorative programs that assure residents receive the restorative services as planned and document to maintain a permanent record of the entire process. It does not feel good to lose function. Loss of function decreases a person's self-worth and one's ability to experience and enjoy quality of life. An organized restorative program that delivers systematic care based on the resident's individual needs increases self-esteem and worth and enhances well being." SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
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:	2 900		10/22/14

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2 900	Continued From page 47 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 1 of 1 resident (R56) who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing. Findings include: R56's quarterly Minimum Data Set (MDS) dated 6/11/14, identified R56 had no cognitive impairment, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for developing pressure ulcers, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's most recent Care Area Assessment (CAA) dated 6/23/14, revealed R56 was at risk for pressure ulcer development, was on a turning and repositioning program, receiving pressure ulcer care with dressing application, and had a pressure reducing device for the chair and bed. R56 was identified as being admitted with	2 900		

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2 900	Continued From page 48 pressure ulcers both heels. R56's care plan dated 8/16/14, identified R56 had a 1.3 x 0.3 unstageable pressure ulcer on the coccyx, should be repositioned at no greater than 2 hour intervals, had a pressure redistribution mattress on the bed, and a pressure redistribution wheelchair cushion. R56's Skin Observation Reports dated 1/2/14, through 6/5/14, indicated the resident's skin was intact and had no pressure ulcers. R56's Braden Scale (a tool used to assess pressure ulcer risk) dated 6/8/14, indicated the resident had a mild risk of developing pressure ulcers. The Braden scale assessment indicated R56 had recently gotten a new wheelchair cushion related to the risk of developing pressure ulcers. R56's Tissue Tolerance Evaluation (assessment to determine skins ability to withstand pressure) dated 6/17/14, identified non-blanchable redness at the three hour mark in the lying position, and was unable to change position independently. The evaluation indicated R56 had no redness at the one, two or three hour mark in the sitting position and was unable to change position independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 6/23/14, identified no redness at the one or two hour mark in the lying position, and able to reposition independently. The evaluation indicated there was blanchable redness at the two hour mark while sitting and that R56 could reposition independently. There was no further assessment.	2 900		

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2 900	Continued From page 49 R56's Tissue Tolerance Evaluation dated 8/25/14, identified blanchable redness at the two hour mark in the wheelchair and the resident was unable to reposition independently. There was no further assessment of the tissue tolerance evaluation. R56's Skin Injury/Wound Report(s) dated 6/17/14, indicated R56 developed a pressure ulcer in the right gluteal fold measuring 0.5 centimeter (cm) x 0.8 cm with a pink wound bed, and was a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough). The area was cleansed and a protective cream applied, and the physician was faxed for further orders. Measurements of the pressure ulcer were documented weekly on the Skin Injury/ Wound Report. Review of the weekly monitoring from 6/17/14, through 9/10/14, indicated the pressure ulcer had worsened increasing in size and developing into an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough, yellow, tan, gray, green or brown, and/or eschar, tan, brown or black tissue, in the wound bed). On 9/10/14, the pressure ulcer was 1.5 cm x 2 cm, with a 70% slough yellow wound base and was unstageable. Another pressure ulcer was identified on a Skin Injury/Wound Report(s) dated 7/27/14, on the right buttock measuring 0.5 cm x 0.4 cm was identified by staff as, "trauma from the adhesive dressing being used on the gluteal fold." However, the area was identified as a "pressure ulcer," on the Skin Injury/Wound Report because it was located on a pressure area. On 8/29/14, the facility identified the pressure ulcer was a stage 2. The documentation of the pressure ulcer on 9/10/14, identified the pressure ulcer had	2 900		

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2 900	Continued From page 50 worsened to an unstageable pressure ulcer, and increased in size with a description of the pressure ulcer as 2.5 cm x 2 cm, with 50% white/ yellow slough wound bed, and was currently unstageable. R56's current physician orders dated 9/5/14, instructed staff to apply Tegaderm with foam dressing to reddened area on the sacrum, check every shift, and change every three days and as needed (PRN). Tegaderm with a foam dressing was to be applied to the right buttock, sacrum, and gluteal fold every 3 days and as needed (PRN). The physician orders also instructed staff that R56 was not appropriate to have three hour intervals ordered for repositioning programs due to skin issues, therefore, needed to be repositioned at no greater than every two hours. R56's Nurses notes dated 6/2/14. indicated the resident was admitted with two, stage 4 pressure ulcers on the right and left heel. R56 was being seen at the wound clinic for these wounds, and they had been debrided by the surgeon in the past. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair on a cushion, and was unable to shift his weight independently. Throughout the 2 hour and 28 minute observation, R56 was not approached by staff to reposition as assessed. During interview on 9/10/14, at 7:20 a.m., R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short	2 900		

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2 900	Continued From page 51 staffed and NAs did their best to assist residents to reposition as assessed. NA-A stated she was aware of R56's pressure ulcers on his buttocks and, "They were pretty open," right now. NA-A verified R56 was to be repositioned every 2 hours. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned after 2 hours and should lie down after breakfast. LPN-B requested assistance from staff to lay R56 down. During observation on 9/10/14, at 10:05 a.m. NA-B entered R56's room to reposition him, which was 2 hours and 47 minutes after the initial constant observation began, and 4 hours and 5 minutes since R56 stated he had been up in his chair. NA-B lifted R56 out of his chair using a standing lift and removed his brief. R56's buttocks were dark red in color and had a foam dressing on the right buttock. During interview on 9/10/14, at 11:23 a.m. registered nurse (RN)-A stated LPN-B had been the wound nurse, however, there was a recent re-assignment of wound duties and she was delegating them out to the staff. RN-A was unsure of the current condition of R56's ulcers. During interview on 9/10/14, at 11:35 a.m. LPN-B stated R56 had gotten a new wheelchair cushion when the buttock pressure ulcers developed around 6/21/14, and she though the resident currently had three pressure ulcers, however, LPN-B was not clear on the current condition of the pressure ulcers. LPN-B stated nursing decided to get R56 a new wheelchair cushion because the resident had complained he felt like he was sitting in a hole. LPN-B stated OT did not	2 900		

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2 900	Continued From page 52 evaluate the resident to ensure the wheelchair cushion was appropriate. During observation of R56's current pressure ulcers on 9/10/14, at 1:58 p.m. the director of nursing (DON) and LPN-B verified R56 had two open areas on his buttocks, one on the upper gluteal cleft which was whitish at the wound base and was an unstageable pressure ulcer with 90% slough wound bed which currently measured 1.5 cm x 2 cm. The second pressure ulcer was on the right buttock and had 60-70% slough that was whitish in color at the wound base and measured 2.5 cm x 2 cm, and was also unstageable. LPN-B stated both pressure ulcers had increased in size and stage since the last time she had seen them, however, LPN-B was unable to verify the last time she had observed R56 pressure ulcers. During interview on 9/10/14, at 2:17 p.m. certified occupational therapy assistant (COTA)-D stated she had not been involved in assessing R56 for adequate wheelchair positioning or the wheelchair cushion. During interview on 9/11/14, at 1:07 p.m. director of nursing (DON) stated she was not aware of R56's worsening pressure ulcers. DON stated R56 repositioning schedule of every two hours should have been re-evaluated after the pressure ulcers developed and worsened to ensure the schedule was individualized and adequate to promote healing of the pressure ulcers. During interview on 9/11/14, at 1:10 p.m. RN-B stated she was not aware of R56's worsening pressure ulcers so she had not discussed interventions with OT, nor had she reassessed the current interventions in place to ensure they were being implemented and were adequate to	2 900		

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2 900	Continued From page 53 prevent further pressure ulcers. On 9/11/14, at 1:39 p.m., a call was placed to R56's medical doctor (MD)-C who was unable to be reached to discuss R56's pressure ulcers. The facility policy, titled Repositioning, undated, indicated it was the policy of the facility to have in place a system to identify repositioning programs for each resident and repositioning every two hours or more frequently depending upon the resident's condition and tolerance of the tissue load may be implemented, and more frequent repositioning (i.e. off loading hourly) may be warranted for individuals at high risk for pressure ulcer development. The policy indicated the therapy department assessed postural alignment, weight distribution, sitting balance, stability, and pressure redistribution along with cushion/mattress recommendations in coordination with the nursing department. The facility policy titled Wound/Skin Care Policy, last revised 12/01/97, indicated an at-risk resident who sits too long on a static surface may be more prone to get ischial ulcerations. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could assign the interdisciplinary team to review all residents with pressure sores to assure they are receiving the necessary treatment/services to prevent pressure sores from developing and to promote healing. The Director of Nursing could assign the Quality Assurance Committee to provide on-going monitoring of the delivery of care to residents to ensure that pressure sores do not develop unless the resident's clinical condition demonstrates that they were unavoidable.	2 900		

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2 900	Continued From page 54 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on interview and documentation review, the facility failed to provide bathing assistance for 1 of 3 residents (R11) reviewed who was dependent on staff for bathing. Findings include: R11 quarterly Minimum data set (MDS) dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene, and was able to provide partial physical help for bathing. R11 care plan dated 9/4/14, indicated R11 needed assist of one staff for bathing and preferred to have a bath versus a shower, and the goal was to respect the resident's wishes and maintain autonomy, and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated she had recently gone for a couple of weeks without a bath because the facility didn't	2 920		10/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(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
2 920	Continued From page 55 have any bath aids to provide bathing assistance. R11's Point of Care Bathing Record (where the nursing assistants (NA) document when a resident received a bath/shower), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath completed on 8/28/14, 28 days later. During interview on 9/11/14, at 10:13 a.m. NA-H stated there were not enough staff to assist residents with baths and they were not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist with bathing. During interview on 9/12/14, at 9:34 a.m., NA-B stated the facility used to have a bath aid to provide resident baths, however, a few months ago the bath aid left the facility, so resident baths were not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, RN-A stated the facility was still working on a staffing pattern to ensure resident cares are being completed. A policy on resident bathing was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could provide education	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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2 920	Continued From page 56 on the performance of providing activities of daily living and follow up with audits/observation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
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 facility failed to ensure 1 of 5 residents (R37), who was reviewed for tuberculosis screening, received a two-step mantoux or a baseline	21426		10/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21426	Continued From page 57 tuberculosis symptom screen. Findings include: R37 was admitted to the facility on 5/22/14. R37's medical record lacked any documentation of a tuberculosis symptom screen or baseline mantoux testing. Copies of any further information were requested from the DON on 9/12/14, at 10:12 a.m., none were provided. DON verified there was no record of R37 receiving a tuberculosis symtpom screen or baseline mantoux testing. A facility policy on resident tuberculosis testing was requested but not provided. SUGGESTED METHOD OF CORRECTION: The facility could develop an auditing system to ensure all residents receive a baseline tuberculosis symptom screen and appropriate testing. The facility could report findings to the QA Committee to develop a system for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		10/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21695	Continued From page 58 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 48 residents (R46) bathrooms had bathroom equipment in good repair. In addition, the facility failed to ensure 2 of 48 residents (R46, R24) were provided adequate water pressure to their bathroom sink. Findings include: R46's annual minimum data set (MDS) dated 8/6/14, identified the resident had no cognitive impairment. During interview on 9/8/14, at 4:30 p.m. R46 stated her bathroom sink was cracked and she had very little water pressure in her bathroom sink. She stated she had talked to several of the staff about both issues with her bathroom sink, and no one did anything about it. R46 stated the low water pressure and cracked sink had been like this since her admission to the facility which was over a year ago. During a tour of the facility on 9/12/14, at 1:00 p.m. maintenance supervisor (MS)-F verified R46's sink had two large cracks, one extending from the faucet knob down the entire sink almost to the drain, and a second crack on the left edge of the sink. MS-F also verified the water pressure in R46's bathroom sink was very low and the water trickled out of the faucet. MS-F stated he had not been informed of the cracked sink, which he stated had the potential to, "Scratch" the resident, and he was not aware of the low water pressure in R46's room. MS-F stated he did daily rounds of the facility looking for damaged	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21695	Continued From page 59 equipment, however, he did not go into any of the resident rooms or bathrooms during the inspection. He stated it was the expectation nursing staff inform him of broken items so maintence could repair them. R24's quarterly MDS dated 6/24/14, identified the resident had severe cognitive impairment and required extensive assistance of two staff for personal cares. During observations on 9/8/14, at 7:14 p.m. and 9/11/14, at 11:00 a.m. R24's water flowed out of the bathroom sink faucet slowly and took a long time for the temperature of the water to heat up to get warm. During the tour of the facility on 9/12/14, at 1:00 p.m. MS-F verified R24's bathroom sink water pressure was very low. MS-F stated he was not aware of the R24's low water pressure until now, and it was an easy fix if he had been informed of the problem for his department to address the issue. MS-F stated nursing staff are to notify him of any maintenance problems. A facility maintence policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rooms and bathrooms are in functional working order. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21695	Continued From page 60 (21) days.	21695		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by:	21800		10/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21800	Continued From page 61 Based on interview and document review, the facility failed to ensure 2 of 3 residents (R11, R57) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, informing them of their right to an appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services. Findings include: R11 was admitted to the facility with skilled medicare coverage on 2/13/14. On 4/22/14, the facility determined R11 no longer met medicare coverage criteria and issued a notice of medicare non-coverage on continued stay, with the first non-covered day listed as 4/25/14. The facility did not have record R11 received the CMS 10123, informing her of her rights for an expedited appeal. R57 was admitted to the facility with skilled medicare coverage on 1/17/14. R57's denial letters contained only the CMS 10123, indicating R57's last covered day was 3/19/14. R57 records did not contain the required notice of medicare coverage on continued stay. R57 remained in the facility after her medicare coverage was discontinued. During interview on 9/11/14, at approximately 10:00 a.m. director of nursing (DON) stated the facility did not have a policy specific to how to issue medicare denials, and verified there were no other denial letters on file for R11 or R57. DON provided copies of a Haven Homes Medicare Assessment Tool and a blank notice of medicare coverage on continued stay, however, these did not address the facility process on how	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21800	Continued From page 62 to inform residents of medicare appeal rights or for required denial letters the residents must receive. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents receive proper documentation regarding liability and demand bill notices in a timely manner. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JMZ1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00950

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245497**

2.STATE VENDOR OR MEDICAID NO.
(L2) **064742000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVEN HOMES OF MAPLE PLAIN**
(L4) **1520 WYMAN AVENUE**
(L5) **MAPLE PLAIN, MN** (L6) **55359**

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) **10/01/2004**

6. DATE OF SURVEY **12/08/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Marilyn Kaelke, HFE NE II — 12/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 1/9/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(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.
03001
(L31)

30. REMARKS
Posted 01/23/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/13/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5497
Continuation of Item #16
Page #2

On 11/14/2014, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on 09/12/2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey completed on 09/12/2014.

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

- State Monitoring effective November 29, 2014. (42 CFR 488.422)

In addition, this department is recommending the follow action related to the remedy imposed in their letter of November 19, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2014, remain in effect. (42 CFR 488.417 (b))

On 12/8/2014, this department completed a PCR. Findings demonstrate compliance with federal certification deficiencies issued pursuant to the standard survey completed on 09/12/2014. State monitoring is rescinded as of 12/4/2014, previous to DPNA effective date of 12/12/2014. Therefore, this department recommended and CMS concurred with rescinding:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2014,

Refer to the CMS 2567B for health.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245497
January 9, 2015

Ms. Diane Lynch, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue
Maple Plain, Minnesota 55359

Dear Ms. Lynch:

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

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

Effective December 4, 2014 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 24, 2014

Ms. Diane Lynch, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue, P.O. Box 369
Maple Plain, Minnesota 55359

Re: Enclosed Reinspection Results - Project Number S5497024

Dear Ms. Lynch:

On December 8, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 12, 2014, with orders received by you on October 4, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245497	A. Building B. Wing	12/8/2014

Name of Facility	Street Address, City, State, Zip Code
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **12/04/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **12/04/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/04/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/04/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	12/24/2014	27059	12/08/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/12/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00950	A. Building B. Wing	12/8/2014

Name of Facility	Street Address, City, State, Zip Code
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp. 2.B** LSC	Correction Completed **12/08/2014**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **12/08/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 4** LSC	Correction Completed **12/08/2014**
ID Prefix **21800** Reg. # **MN St. Statute144.651 Subd. 4** LSC	Correction Completed **12/08/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	12/24/2014	27059	12/08/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/12/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JMZ1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00950

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245497**

2.STATE VENDOR OR MEDICAID NO.
(L2) **064742000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVEN HOMES OF MAPLE PLAIN**
(L4) **1520 WYMAN AVENUE, PO BOX 369**
(L5) **MAPLE PLAIN, MN** (L6) **55359**

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) **10/01/2004**

6. DATE OF SURVEY **11/05/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date : 11/07/2014
Holly Kranz, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL — Date: 01/02/2015
Kate JohnsTon, Enforcement Specialist (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
10/01/1987
(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.
03001
(L31)

30. REMARKS
Posted 01/23/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/13/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5497
Continuation of Item #16 Page #2

CCN: 24-5497
Continuation of Item #16
Page #2

On 11/14/2014, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard, completed on 09/12/2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on 09/12/2014.

The deficiency(ies) not corrected is/are as follows:

F0156 -- S/S: D -- 483.10(b)(5) - (10), 483.10(b)(1) -- Notice Of Rights, Rules, Services, Charges
F0278 -- S/S: D -- 483.20(g) - (j) -- Assessment Accuracy/coordination/certified
F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion

In addition, at the time of this revisit, we identified the following deficiency(ies):

F0311 -- S/S: E -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls

The most serious deficiencies in your facility pursuant to the standard survey were found to isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

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

- State Monitoring effective November 29, 2014. (42 CFR 488.422)

In addition, this department is recommending the follow action related to the remedy imposed in their letter of November 19, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2014, remain in effect. (42 CFR 488.417 (b))

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0877

November 24, 2014

Ms. Diane Lynch, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue, P.O. Box 369
Maple Plain, Minnesota 55359

RE: Project Number S5497024

Dear Ms. Lynch:

On October 1, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an standard survey, completed on September 12, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 14, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 12, 2014. Due to health survey compliance not being verified as of our document dated November 19, 2014, we recommended that CMS impose Mandatory Denial of Payment, effective December 12, 2014.

On November 5, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on September 12, 2014. The deficiency(ies) not corrected is/are as follows:

F0156 -- S/S: D -- 483.10(b)(5) - (10), 483.10(b)(1) -- Notice Of Rights, Rules, Services, Charges
F0278 -- S/S: D -- 483.20(g) - (j) -- Assessment Accuracy/coordination/certified
F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion

In addition, at the time of this revisit, we identified the following deficiency(ies):

F0311 -- S/S: E -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as

evidenced by the attached CMS-2567, whereby corrections are required.

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

- State Monitoring effective November 29, 2014. (42 CFR 488.422)

However, as we notified you in our letter of October 1, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 12, 2014.

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7365

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	R 11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 11/3/14, 11/4/14, and 11/5/14, to determine compliance with federal deficiencies issued during a recertification survey exited on 9/12/14. The following deficiencies were found not corrected.	{F 000}	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that the statement of a deficiency was correctly cited or factually based and it's also not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.	
{F 156} SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or	{F 156}	1. R11 and her financial Power of Attorney were contacted on 10/20/14 and provided an explanation regarding the facility's failure to provide notice of Medicare's denial of coverage with the Notice of Medicare Non-Coverage (NOMNC), at least 48 hours prior to the end of services, per CMS regulations. It was also explained at that time that notice was provided 24 hours in advance, but still failed to meet the 48 hour regulation. She was also provided reassurance that, in the future, the facility would be sure to supply them with required notices in a timelier manner.	

Kelly accepted 12/5/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Lyren — TITLE: Administrator — (X6) DATE: 12/3/2014

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	R 11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

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{F 156}	Continued From page 1 at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the	{F 156}	R17 and her financial Power of Attorney were contacted on 12/1/14 and were provided an explanation regarding the facility's failure to provide notice of Medicare's denial of coverage with the Notice of Medicare Non-Coverage (NOMNC), at least 48 hours prior to the end of services, per CMS regulations. It was also explained at that time that notice was provided 24 hours in advance, but still failed to meet the 48 hour regulation. They were provided reassurance that, in the future, the facility would be sure to supply them with required notices in a timelier manner. R90 was contacted on 11/18/14 and provided an explanation regarding the facility's failure to provide notice of Medicare's denial of coverage with the Notice of Medicare Non-Coverage (NOMNC), at least 48 hours prior to the end of services, per CMS regulations. It was also explained at that time that notice was provided 24 hours in advance, but still failed to meet the 48 hour regulation. They were provided reassurance that, in the future, the facility would be sure to supply them with required notices in a timelier manner.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	R 11/05/2014

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{F 156}	Continued From page 2 physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 6 residents (R11, R17, and R90) reviewed for liability notices received the Notice of Medicare Non-Coverage (CMS form 10123) within the required timeframe of 48 hours prior to skilled services ending. Findings include: R11's 5-day Medicare Minimum Data Set (MDS) assessment dated 9/30/14, indicated R11 was admitted to the facility with skilled coverage beginning 9/23/14. R11's Medicare denial notice indicated R11's Medicare coverage would be ending on 10/3/14, however, the facility did not notify R11 of the non-coverage until 10/2/14, 24 hours prior to the end of skilled coverage. R17's 14-day Medicare MDS dated 9/30/14, indicated R17 was admitted to the facility with skilled coverage beginning 9/17/14. Review of R17's Medicare denial notices indicated the facility reviewed R17's Medicare coverage and determined her last covered day was 10/3/14. R17 was issued the Notice of Medicare	{F 156}	2. The facility has determined that all residents being discharge from therapy, or otherwise ending coverage for skilled services are at risk of being affected. Residents with the potential to be discontinued off of Medicare A will be discussed at Medicare Meetings to ensure at least 48 hour notification is given to resident or representative per CMS guidelines. 3. Responsibility for issuance of Notice of Medicare Non-Coverage and corresponding documents has been reassigned to the Business Office Manager on 11/6/14 due to an audit of a denial given on 11/5/14 that was not given timely. Back-up responsibilities for issuance of Notice of Medicare Non-Coverage and corresponding documents are assigned to DON. Education was provided to the Business Office Manager on 12/1/14. Both the DON and the Administrator are monitoring this process at this time. The facility has restructured the overall process of the Medicare meetings, including whose is in attendance, process, documentation and communication.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	R 11/05/2014

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{F 156}	Continued From page 3 Non-Coverage on 10/2/14, 24 hours prior to the end of skilled services. R90's 14-day Medicare MDS dated 9/18/14, indicated R90 was admitted to the facility with skilled coverage beginning 9/5/14. Review of R90's Medicare denial notices indicated R90 was issued the Notice of Medicare Non-Coverage on 10/2/14, 24 hours prior to the end of skilled services. During interview on 11/04/2014, at 1:12 p.m. the assistant director of nursing (ADON) stated she was aware Medicare coverage was ending for R11, R17 and R90, however she did not issue the notices in a timely manner. The ADON stated a Medicare meeting had not been held that week and it was better for the notices to be issued, "One day than no days," ahead of time. ADON was aware the Medicare denial notices were not issued within the 48 hour timeframe. During interview on 11/05/2014, at 2:36 p.m. the director of nursing (DON) stated she was aware the facility had some concerns with issuing Medicare Denial Letters. The facility social worker was on leave and the ADON was one of the backups for issuing the Medicare denial notices until she returned.	{F 156}	R93 and her financial Power of Attorney were also contacted on 12/1/14, in response to the late notice given on 11/5/14, and they were provided an explanation regarding the facility's failure to provide notice of Medicare's denial of coverage with the Notice of Medicare Non-Coverage (NOMNC), at least 48 hours prior to the end of services, per CMS regulations. It was also explained at that time that notice was provided 24 hours in advance, but still failed to meet the 48 hour regulation. They were provided reassurance that, in the future, the facility would be sure to supply them with required notices in a timelier manner. 4. The DON/Designee will conduct audits on residents receiving Medicare A denials weekly x 4 weeks, and then 3 per month x 4 months. Results will be brought to the QA Committee for further review and/or recommendation.	
{F 278} SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	{F 278}	5. 12/4/14	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	R 11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

(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 278}	Continued From page 4 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure accuracy of the Minimum Data Set (MDS) assessment for 2 of 4 residents (R25 and R31) reviewed for range of motion (ROM) and contractures which were not accurately coded on the MDS. Findings include: R25's annual MDS dated 8/27/14, identified R25 had no functional limitations in ROM (contractures). A physical therapy discharge note dated	{F 278}	1. R31 has been re-assessed for functional limitations in range of motion following the exact steps listed in section G0400: Functional Limitation in Range of Motion in the CMS Long-Term Care Resident Assessment Instrument. Assessment findings were then used as a reference for the modifications of the MDS Assessments (ARD of 9/10/14) that were coded inaccurately. These assessment modifications were re-submitted on 11/17/14. R25 has been re-assessed for functional limitations in range of motion following the exact steps listed in section G0400: Functional Limitation in Range of Motion in the CMS Long-Term Care Resident Assessment Instrument. Assessment findings were then used as a reference for the modifications of the MDS Assessments (ARD of 8/27/14) that were coded inaccurately. These assessment modifications were re-submitted on 11/18/14. 2. Resident's with contractures have a potential to be affected for miscoding on MDS. Residents will be reviewed using the Query tool to determine if they were correctly coded on the MDS for contractures on most recent MDS assessment to verify MDS accuracy.	

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{F 278}	Continued From page 5 10/17/14, identified R25 would continue on a nursing rehab ROM program, and listed the ROM extension of the left knee to be -13 degrees, and the right knee at -19 degrees, indicating R25 had contractures in both knees. R31's quarterly MDS dated 9/10/14, identified R31 had no functional limitations in ROM. A physical therapy discharge note dated 10/29/14, identified R31 had ROM extension of the left knee at -25 degrees and the right knee was -22 degrees, indicating R31 had contractures in both knees. During interview on 11/5/14, at 9:06 a.m. registered nurse (RN)-A stated some resident MDS's had recently been reviewed for accuracy, but neither she nor the other MDS nurse had reviewed every single residents' MDS. RN-A stated the facility corporate nurses had reviewed all resident MDS's in the facility for accuracy, but was unsure why R25 and R31's MDS had not been corrected to reflect their contractures. During interview on 11/5/14, at 10:06 a.m. the director of nursing (DON) reviewed the electronic charts of R25 and R31, and verified the residents both had identified knee contractures, however, neither R25 or R31's MDS's were coded correctly to identify the bilateral lower contractures.	{F 278}	3. MDS nurses will receive education on the accurate method of identifying limitation of functional ROM limitations per the RAI manual on 12/1/14. Understanding of process will be confirmed through supervised return demonstration for 5 MDSs by DON. Residents will be reviewed using the Query tool to determine if they were correctly coded on the MDS for contractures on most recent MDS assessment to verify MDS accuracy. If inaccurate, modifications of MDS will be completed and resubmitted. 4. The DON/Designee will run Query Tool every month to audit residents limited ROM scores on previous MDS to determine MDS accuracy. Results will be brought to the QA Committee for further review and/or recommendation. 5. 12/4/14	
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		

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F 311	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with ambulation services for 4 of 4 residents (R94, R89, R93 and R69) who required assistance from staff with ambulation. Findings include: R94's Admission Minimum Data Set (MDS) dated 10/8/14, identified R94 had moderately impaired cognition and required physical assistance of one person with ambulation. R94's Interdepartmental Communication form provided to nursing and signed by physical therapy (PT) on 10/16/14, indicated.R94 was to ambulate daily 50-100 feet with a rolling walker and assist of one staff member. The Nursing Assistant Care sheet dated 11/3/14, identified R94 was to be walked 50-100 feet with a rolling walker, transfer belt and assist of one staff. Review of the electronic point of care restorative nursing section, which was identified by the facility as the documentation of when and how far a resident ambulates, indicated R94 had walked only four of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14. R94 was observed lying in bed on 11/5/14, at 2:49 p.m. and was interviewed. R94 stated he needed assistance to walk in the hallway and was not offered the opportunity to walk by staff.	F 311	1. R94 is offered assistance with walking daily. Resident frequently refuses to ambulate with care staff, but an ambulation program is still offered routinely. At times, upon being reminded of risks and benefits, resident is more willing to participate. The updated program and interventions for refusals have been communicated to the care staff to carry out according to the resident care plan. R89 was admitted to Hospice on 11/17/14. Ambulation program was discontinued per family request, and ROM has been offered daily since to avoid risk of increased pain at end of life related to contracture development.. R93 was discharged 11/6/14. R69 was referred back to therapy due to refusals to work with staff, and remains in therapy at this time. Resident is still ambulated daily by nursing staff with minimal refusals, in conjunction with therapy.	

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F 311	Continued From page 7 R89's Admission MDS dated 10/6/14, identified R89 had moderate cognitive impairment, and required physical assistance of one staff with ambulation. R89's Interdepartmental Communication form provided to nursing and signed by PT on 10/16/14, indicated R89 was to ambulate daily 25-50 feet with a rolling walker and assist of one staff member. R89's Nursing Assistant Care sheet dated 11/3/14, identified R89 was to walk daily 25-50 feet with a transfer belt, rolling walker, and assist of one staff member. R89's electronic point of care restorative nursing section indicated the resident had walked nine of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14. R89 was observed seated in the wheelchair near the bird aviary on 11/5/14, at 3:03 p.m. and was interviewed. R89 stated he required assistance from the staff to walk and staff had offered to assist the resident with walking, however, he stated staff did not offer to assist him with walking everyday. R93's Admission MDS dated 10/10/14, identified R93 had severe cognitive impairment and required physical assistance of one person with ambulation in the corridor. R93's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R93 was to ambulate twice a day 100-200 feet feet with a rolling walker and assist of one staff member.	F 311	2. All residents being discharged from therapy with FMP (Functional Maintenance Program) or ambulation programs have potential to be affected. 3. An in-service was provided to Nurses on 11/19/14 and CNAs on 11/21/14 regarding the multitude of risks and comorbidities associated with contractures and immobility, and how that affects the overall health, level of functional mobility, mood and quality of life in the elderly population. Education included how the old culture of nursing homes (alarms, psychotropic, etc.) contributes to these risks, as well as relating the effect immobility can have on falls, and how the importance of completing ROM/AMB/FMP Programs for all residents who have them.	

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F 311	Continued From page 8 R93's Nursing Assistant Care sheet dated 11/3/14, identified R93 was to walk 100-200 feet with a rolling walker, transfer belt, and assist of one staff member. R93's electronic point of care restorative nursing section indicated R93 had walked 9 of the 38 opportunities from the starting date of 10/16/14, until the review date of 11/4/14. R93 was observed on 11/5/14, at 2:42 p.m. sitting in a wheelchair near the nurses station. R93 was not observed ambulating. R69's quarterly MDS dated 10/14/14, identified R69 had severe cognitive impairment and required physical assistance of one person with ambulation. R69's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R69 was to ambulate twice a day 75-100 feet with a rolling walker and a transfer belt, with assistance of one staff member. R69's Nursing Assistant Care sheet dated 11/3/14, identified R69 was to walk 75-100 feet with a transfer belt, rolling walker, and assist of one staff member. R69's electronic point of care restorative nursing section indicated R69 had walked 3 of the 28 opportunities, from 10/22/14, through the review date of 11/4/14. During interview on 11/5/14, at 1:46 p.m. director of nursing (DON) and corporate registered nurse	F 311	A Restorative committee meeting was held 11/25/14. The DON, 5 restorative aides, and the Restorative RN were in attendance. Residents with an FMP and/or AMB program was reviewed by committee for overall effectiveness of the program, resident's compliance with exercises, and possible interventions that might assist with the overall success of the maintenance program for each resident. Any declines in functional ability and/or consistent refusals were referred back to therapy and/or discontinued after educating about risks associated with regarding refusals to participate in the program. 4. DON/Designee will continue to perform weekly audits of documentation summaries for all residents to ensure documentation compliance of FMP/AMB program weekly x 6 weeks with results brought to the QA committee for further review. 5. 12/4/14	

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F 311	Continued From page 9 (CRN)-A stated R69 was receiving PT and OT services from 10/9/14, and was discharged from therapy on 10/31/14. DON and CRN-A were not aware why therapy had assessed R69 to be walked twice a day by staff when she was receiving therapy. However, they had not spoken to therapy about the ambulation assessment therapy had completed on 10/17/14, for R69 to be ambulated twice a day. During interview on 11/05/2014, at 2:23 p.m. physical therapy assistant (PTA)-A and occupational therapy assistant (OTA)-A stated R69 was receiving therapy services with PT and OT from 10/9/14, through 10/31/14, once a day, Monday through Friday. PTA-A and OTA-A stated R69 was referred to nursing on 10/17/14, to be ambulated twice a day by staff, so nursing staff would assist R69 with ambulating in the evenings and on weekends. PTA-A stated R69 had been independent with ambulating in the past, and the goal was to possibly get the resident back to being independent with ambulation. During an observation on 11/5/14, at 2:43 p.m. R69 was lying in her bed. R69 stated she could transfer from the wheelchair to the toilet with no problems, but could not recall the last time she walked in the hallway by staff. R69 stated, "But I love to walk." During interview on 11/4/14, at 10:47 a.m. physical therapist (PT)-A stated they had recently assessed the ambulation and/or range of motion therapy needs of all the residents in the facility. PT-A stated the Interdepartmental Communication forms were completed and sent to nursing to implement. PT-A stated if any resident was assessed to be on an ambulation	F 311		

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F 311	Continued From page 10 program, it was expected they be walked at least daily, and for some residents twice a day to maintain their ambulation ability.	F 311		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure range of motion services (ROM) were provided to maintain and/or improve current level of functioning for 2 of 8 residents (R6 and R55) reviewed for range of motion services. Findings include: R6's significant change Minimum Data Set (MDS) dated 9/29/14, indicated R6 had severe cognitive impairment and had functional limitations of ROM to both upper extremities. R6's Interdepartmental Communication form provided to nursing, and signed by physical therapy (PT) and occupational therapy (OT) on 10/23/14, indicated R6 was to receive 10 repetitions twice a week of active assisted range of motion (AAROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, and fingers.	{F 318}	1. R6 is receiving AAROM at least 2x/week and appropriate documentation tools were put into place on 11/25/14. R55 is receiving PROM at least 2x/week and appropriate documentation tools were put into place on 11/25/14. 2. All residents being discharged from therapy with FMP (Functional Maintenance Program) or ambulation programs have potential to be affected. 3. The Director of Nursing and the Physical Therapy Assistant met on 11/26/14 and 12/3/14 to set up a process to ensure that the Interdepartmental Communication Forms from therapy are given to the Director of Nursing to be implemented by the nursing department in a timelier, more proactive manner so all residents discharging from PT/OT/ST services may have a seamless transition into his/her maintenance plan.	

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{F 318}	Continued From page 11 The Functional Maintenance and Restorative Program documentation book, which was identified as the documentation of completion of resident ROM programs, which included treatment sheets for 10/14, and 11/14, lacked any documentation that R6's AAROM plan had been implemented or provided to R6 since being assessed on 10/23/14. During observations on 11/4/14, at 8:29 a.m., and 11/5/14, at 8:30 a.m., and again at 10:44 a.m. on 11/5/14, R6 was sitting in her wheelchair. R6 was not observed on to receive any ROM services. R55's modified MDS dated 10/27/14, identified R55 had severe cognitive impairment and had functional limitations of ROM to both upper and lower extremities. R55's Interdepartmental Communication form provided to nursing and signed by PT and OT on 10/23/14, indicated R55 was to receive 10 repetitions twice a week, of passive range of motion (PROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, fingers, and 10 repetitions of cervical neck ROM with a gentle stretch. The Functional Maintenance and Restorative Program documentation book which included treatment sheets for 10/14, and 11/14, lacked any documentation that R55's PROM plan had been implemented or provided to R55 since being assessed on 10/23/14. During observation on 11/3/14, at 1:19 p.m. R55 was sleeping in her wheelchair in her room. R55 was not observed on 11/3/14, to receive any	{F 318}	While the Restorative Nursing policy remains unchanged, the Functional Maintenance Program policy was developed. This policy was created to help distinguish the differences between restorative and functional maintenance programs in the context of preventing decline of physical functioning and/or preventing further limitations in functional range of motion for residents. An in-service was provided to Nurses on 11/19/14 and CNAs on 11/21/14 regarding the multitude of risks and comorbidities associated with contractures and immobility, and how that affects the overall health, level of functional mobility, mood and quality of life in the elderly population. Education included how the old culture of nursing homes (alarms, psychotropic, etc.) contributes to these risks, as well as relating the effect immobility can have on falls, and how the importance of completing ROM/AMB/FMP Programs for all residents who have them.	

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{F 318}	Continued From page 12 ROM services. During interview on 11/3/14, at 2:01 p.m. director of nursing (DON) stated residents who were on a range of motion program would have paper sheets in the Functional Maintenance and Restorative Program documentation book which the staff were to document on when ROM was completed. During interview on 11/4/14, at 8:40 a.m. physical therapy assistant (PTA)-A stated therapies had worked with R6 and R55 until they were discharged from therapy services on 10/23/14. PTA-A stated at that time the interdepartmental Communication forms were filled out and provided to the nursing staff so they could implement the ongoing functional ROM program for the residents. During interview on 11/4/14, at 8:56 a.m. physical therapist (PT)-A stated he had reassessed R55 the prior evening (11/3/14), because nursing staff had confusion about starting R55's ROM program which was to start on 10/23/14. PT-A stated they wanted to be sure R55 had no decrease in ROM since 10/23/14, when she was discharged from therapy and was to begin ROM with nursing. PT-A stated there was no change or decline. During interview on 11/4/14, at 2:10 p.m. nursing assistant (NA)-D, stated she carried the Functional Maintenance Book when working as the restorative which was used to identify residents who were on an ROM program. NA-D was not able to identify why the resident ROM programs were not being completed. The facility undated policy titled Restorative Nursing identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have	{F 318}	A Restorative committee meeting was held 11/25/14. The DON, 5 restorative aides, and the Restorative RN were in attendance. Residents with an FMP and/or AMB program was reviewed by committee for overall effectiveness of the program, resident's compliance with exercises, and possible interventions that might assist with the overall success of the maintenance program for each resident. Any declines in functional ability and/or consistent refusals were referred back to therapy and/or discontinued after educating about risks associated with regarding refusals to participate in the program. 4. DON/Designee will continue to perform weekly audits of all ROM/AMB/FMP documentation for all residents to ensure compliance of FMP/AMB programs weekly x 6 weeks with results brought to the QA committee for further review. 5. 12/4/14	

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{F 318}	Continued From page 13 the services available to him/her to reach their highest possible, practicable physical, and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned.	{F 318}		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245497	A. Building / B. Wing: 01 - MAIN BUILDING 01	11/14/2014

Name of Facility	Street Address, City, State, Zip Code
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix: Reg. # NFPA 101 LSC K0029	10/20/2014	ID Prefix: Reg. # NFPA 101 LSC K0130	10/10/2014	ID Prefix: Reg. # LSC	
ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC	
ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC	
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ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	11/19/2014	19251	11/14/2014
CMS RO				

Followup to Survey Completed on: 9/15/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	R 11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 11/3/14, 11/4/14, and 11/5/14, to determine compliance with federal deficiencies issued during a recertification survey exited on 9/12/14. The following deficiencies were found not corrected.	{F 000}		
{F 156} SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or	{F 156}		

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

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

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{F 156}	Continued From page 1 at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the	{F 156}		

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{F 156}	Continued From page 2 physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 6 residents (R11, R17, and R90) reviewed for liability notices received the Notice of Medicare Non-Coverage (CMS form 10123) within the required timeframe of 48 hours prior to skilled services ending. Findings include: R11's 5-day Medicare Minimum Data Set (MDS) assessment dated 9/30/14, indicated R11 was admitted to the facility with skilled coverage beginning 9/23/14. R11's Medicare denial notice indicated R11's Medicare coverage would be ending on 10/3/14, however, the facility did not notify R11 of the non-coverage until 10/2/14, 24 hours prior to the end of skilled coverage. R17's 14-day Medicare MDS dated 9/30/14, indicated R17 was admitted to the facility with skilled coverage beginning 9/17/14. Review of R17's Medicare denial notices indicated the facility reviewed R17's Medicare coverage and determined her last covered day was 10/3/14. R17 was issued the Notice of Medicare	{F 156}		

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{F 156}	Continued From page 3 Non-Coverage on 10/2/14, 24 hours prior to the end of skilled services. R90's 14-day Medicare MDS dated 9/18/14, indicated R90 was admitted to the facility with skilled coverage beginning 9/5/14. Review of R90's Medicare denial notices indicated R90 was issued the Notice of Medicare Non-Coverage on 10/2/14, 24 hours prior to the end of skilled services. During interview on 11/04/2014, at 1:12 p.m. the assistant director of nursing (ADON) stated she was aware Medicare coverage was ending for R11, R17 and R90, however she did not issue the notices in a timely manner. The ADON stated a Medicare meeting had not been held that week and it was better for the notices to be issued, "One day than no days," ahead of time. ADON was aware the Medicare denial notices were not issued within the 48 hour timeframe. During interview on 11/05/2014, at 2:36 p.m. the director of nursing (DON) stated she was aware the facility had some concerns with issuing Medicare Denial Letters. The facility social worker was on leave and the ADON was one of the backups for issuing the Medicare denial notices until she returned.	{F 156}		
{F 278} SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	{F 278}		

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{F 278}	Continued From page 4 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure accuracy of the Minimum Data Set (MDS) assessment for 2 of 4 residents (R25 and R31) reviewed for range of motion (ROM) and contractures which were not accurately coded on the MDS. Findings include: R25's annual MDS dated 8/27/14, identified R25 had no functional limitations in ROM (contractures). A physical therapy discharge note dated	{F 278}		

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{F 278}	Continued From page 5 10/17/14, identified R25 would continue on a nursing rehab ROM program, and listed the ROM extension of the left knee to be -13 degrees, and the right knee at -19 degrees, indicating R25 had contractures in both knees. R31's quarterly MDS dated 9/10/14, identified R31 had no functional limitations in ROM. A physical therapy discharge note dated 10/29/14, identified R31 had ROM extension of the left knee at -25 degrees and the right knee was -22 degrees, indicating R31 had contractures in both knees. During interview on 11/5/14, at 9:06 a.m. registered nurse (RN)-A stated some resident MDS's had recently been reviewed for accuracy, but neither she nor the other MDS nurse had reviewed every single residents' MDS. RN-A stated the facility corporate nurses had reviewed all resident MDS's in the facility for accuracy, but was unsure why R25 and R31's MDS had not been corrected to reflect their contractures. During interview on 11/5/14, at 10:06 a.m. the director of nursing (DON) reviewed the electronic charts of R25 and R31, and verified the residents both had identified knee contractures, however, neither R25 or R31's MDS's were coded correctly to identify the bilateral lower contractures.	{F 278}		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		

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F 311	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with ambulation services for 4 of 4 residents (R94, R89, R93 and R69) who required assistance from staff with ambulation. Findings include: R94's Admission Minimum Data Set (MDS) dated 10/8/14, identified R94 had moderately impaired cognition and required physical assistance of one person with ambulation. R94's Interdepartmental Communication form provided to nursing and signed by physical therapy (PT) on 10/16/14, indicated R94 was to ambulate daily 50-100 feet with a rolling walker and assist of one staff member. The Nursing Assistant Care sheet dated 11/3/14, identified R94 was to be walked 50-100 feet with a rolling walker, transfer belt and assist of one staff. Review of the electronic point of care restorative nursing section, which was identified by the facility as the documentation of when and how far a resident ambulates, indicated R94 had walked only four of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14. R94 was observed lying in bed on 11/5/14, at 2:49 p.m. and was interviewed. R94 stated he needed assistance to walk in the hallway and was not offered the opportunity to walk by staff.	F 311		

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F 311	Continued From page 7	F 311		

R89's Admission MDS dated 10/6/14, identified R89 had moderate cognitive impairment, and required physical assistance of one staff with ambulation.

R89's Interdepartmental Communication form provided to nursing and signed by PT on 10/16/14, indicated R89 was to ambulate daily 25-50 feet with a rolling walker and assist of one staff member.

R89's Nursing Assistant Care sheet dated 11/3/14, identified R89 was to walk daily 25-50 feet with a transfer belt, rolling walker, and assist of one staff member.

R89's electronic point of care restorative nursing section indicated the resident had walked nine of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14.

R89 was observed seated in the wheelchair near the bird aviary on 11/5/14, at 3:03 p.m. and was interviewed. R89 stated he required assistance from the staff to walk and staff had offered to assist the resident with walking, however, he stated staff did not offer to assist him with walking everyday.

R93's Admission MDS dated 10/10/14, identified R93 had severe cognitive impairment and required physical assistance of one person with ambulation in the corridor.

R93's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R93 was to ambulate twice a day 100-200 feet feet with a rolling walker and assist of one staff member.

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F 311	Continued From page 8 R93's Nursing Assistant Care sheet dated 11/3/14, identified R93 was to walk 100-200 feet with a rolling walker, transfer belt, and assist of one staff member. R93's electronic point of care restorative nursing section indicated R93 had walked 9 of the 38 opportunities from the starting date of 10/16/14, until the review date of 11/4/14. R93 was observed on 11/5/14, at 2:42 p.m. sitting in a wheelchair near the nurses station. R93 was not observed ambulating. R69's quarterly MDS dated 10/14/14, identified R69 had severe cognitive impairment and required physical assistance of one person with ambulation. R69's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R69 was to ambulate twice a day 75-100 feet with a rolling walker and a transfer belt, with assistance of one staff member. R69's Nursing Assistant Care sheet dated 11/3/14, identified R69 was to walk 75-100 feet with a transfer belt, rolling walker, and assist of one staff member. R69's electronic point of care restorative nursing section indicated R69 had walked 3 of the 28 opportunities, from 10/22/14, through the review date of 11/4/14. During interview on 11/5/14, at 1:46 p.m. director of nursing (DON) and corporate registered nurse	F 311		

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F 311	Continued From page 9	F 311		

(CRN)-A stated R69 was receiving PT and OT services from 10/9/14, and was discharged from therapy on 10/31/14. DON and CRN-A were not aware why therapy had assessed R69 to be walked twice a day by staff when she was receiving therapy. However, they had not spoken to therapy about the ambulation assessment therapy had completed on 10/17/14, for R69 to be ambulated twice a day.

During interview on 11/05/2014, at 2:23 p.m. physical therapy assistant (PTA)-A and occupational therapy assistant (OTA)-A stated R69 was receiving therapy services with PT and OT from 10/9/14, through 10/31/14, once a day, Monday through Friday. PTA-A and OTA-A stated R69 was referred to nursing on 10/17/14, to be ambulated twice a day by staff, so nursing staff would assist R69 with ambulating in the evenings and on weekends. PTA-A stated R69 had been independent with ambulating in the past, and the goal was to possibly get the resident back to being independent with ambulation.

During an observation on 11/5/14, at 2:43 p.m. R69 was lying in her bed. R69 stated she could transfer from the wheelchair to the toilet with no problems, but could not recall the last time she walked in the hallway by staff. R69 stated, "But I love to walk."

During interview on 11/4/14, at 10:47 a.m. physical therapist (PT)-A stated they had recently assessed the ambulation and/or range of motion therapy needs of all the residents in the facility. PT-A stated the Interdepartmental Communication forms were completed and sent to nursing to implement. PT-A stated if any resident was assessed to be on an ambulation

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F 311	Continued From page 10 program, it was expected they be walked at least daily, and for some residents twice a day to maintain their ambulation ability.	F 311		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure range of motion services (ROM) were provided to maintain and/or improve current level of functioning for 2 of 8 residents (R6 and R55) reviewed for range of motion services. Findings include: R6's significant change Minimum Data Set (MDS) dated 9/29/14, indicated R6 had severe cognitive impairment and had functional limitations of ROM to both upper extremities. R6's Interdepartmental Communication form provided to nursing, and signed by physical therapy (PT) and occupational therapy (OT) on 10/23/14, indicated R6 was to receive 10 repetitions twice a week of active assisted range of motion (AAROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, and fingers.	{F 318}		

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{F 318}	Continued From page 11 The Functional Maintenance and Restorative Program documentation book, which was identified as the documentation of completion of resident ROM programs, which included treatment sheets for 10/14, and 11/14, lacked any documentation that R6's AAROM plan had been implemented or provided to R6 since being assessed on 10/23/14. During observations on 11/4/14, at 8:29 a.m., and 11/5/14, at 8:30 a.m., and again at 10:44 a.m. on 11/5/14, R6 was sitting in her wheelchair. R6 was not observed on to receive any ROM services. R55's modified MDS dated 10/27/14, identified R55 had severe cognitive impairment and had functional limitations of ROM to both upper and lower extremities. R55's Interdepartmental Communication form provided to nursing and signed by PT and OT on 10/23/14, indicated R55 was to receive 10 repetitions twice a week, of passive range of motion (PROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, fingers, and 10 repetitions of cervical neck ROM with a gentle stretch. The Functional Maintenance and Restorative Program documentation book which included treatment sheets for 10/14, and 11/14, lacked any documentation that R55's PROM plan had been implemented or provided to R55 since being assessed on 10/23/14. During observation on 11/3/14, at 1:19 p.m. R55 was sleeping in her wheelchair in her room. R55 was not observed on 11/3/14, to receive any	{F 318}		

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{F 318}	Continued From page 12	{F 318}		

ROM services.

During interview on 11/3/14, at 2:01 p.m. director of nursing (DON) stated residents who were on a range of motion program would have paper sheets in the Functional Maintenance and Restorative Program documentation book which the staff were to document on when ROM was completed.
During interview on 11/4/14, at 8:40 a.m. physical therapy assistant (PTA)-A stated therapies had worked with R6 and R55 until they were discharged from therapy services on 10/23/14. PTA-A stated at that time the Interdepartmental Communication forms were filled out and provided to the nursing staff so they could implement the ongoing functional ROM program for the residents.
During interview on 11/4/14, at 8:56 a.m. physical therapist (PT)-A stated he had reassessed R55 the prior evening (11/3/14), because nursing staff had confusion about starting R55's ROM program which was to start on 10/23/14. PT-A stated they wanted to be sure R55 had no decrease in ROM since 10/23/14, when she was discharged from therapy and was to begin ROM with nursing. PT-A stated there was no change or decline.
During interview on 11/4/14, at 2:10 p.m. nursing assistant (NA)-D, stated she carried the Functional Maintenance Book when working as the restorative which was used to identify residents who were on an ROM program. NA-D was not able to identify why the resident ROM programs were not being completed.

The facility undated policy titled Restorative Nursing identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 318}	Continued From page 13 the services available to him/her to reach their highest possible, practicable physical, and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned.	{F 318}		

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	00950	A. BUILDING: _____ B. WING _____	R 11/05/2014

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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: An onsite follow-up visit was completed on 11/3/14, 11/4/14, and 11/5/14. During this visit it was determined that the following correction orders were not corrected. This uncorrected orders will remain in effect and will be reviewed at the next site visit. To be reviewed for possible penalty assessments.	{2 000}		

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{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: *Uncorrected based on the following findings. The original licensing order issued on 9/12/14, will remain in effect. Penalty assessment issued. Based on observation, interview, and document review, the facility failed to ensure range of motion services (ROM) were provided to maintain and/or improve current level of functioning for 2 of 8 residents (R6 and R55) reviewed for range of motion services. Findings include: R6's significant change Minimum Data Set (MDS) dated 9/29/14, indicated R6 had severe cognitive impairment and had functional limitations of ROM to both upper extremities. R6's Interdepartmental Communication form provided to nursing, and signed by physical therapy (PT) and occupational therapy (OT) on	{2 895}		

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{2 895}	Continued From page 2 10/23/14, indicated R6 was to receive 10 repetitions twice a week of active assisted range of motion (AAROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, and fingers. The Functional Maintenance and Restorative Program documentation book, which was identified as the documentation of completion of resident ROM programs, which included treatment sheets for 10/14, and 11/14, lacked any documentation that R6's AAROM plan had been implemented or provided to R6 since being assessed on 10/23/14. During observations on 11/4/14, at 8:29 a.m., and 11/5/14, at 8:30 a.m., and again at 10:44 a.m. on 11/5/14, R6 was sitting in her wheelchair. R6 was not observed to receive any ROM services. R55's modified MDS dated 10/27/14, identified R55 had severe cognitive impairment and had functional limitations of ROM to both upper and lower extremities. R55's Interdepartmental Communication form provided to nursing and signed by PT and OT on 10/23/14, indicated R55 was to receive 10 repetitions twice a week, of passive range of motion (PROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, fingers, and 10 repetitions of cervical neck ROM with a gentle stretch. The Functional Maintenance and Restorative Program documentation book which included treatment sheets for 10/14, and 11/14, lacked any documentation that R55's PROM plan had been implemented or provided to R55 since being assessed on 10/23/14.	{2 895}		

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{2 895}	Continued From page 3 During observation on 11/3/14, at 1:19 p.m. R55 was sleeping in her wheelchair in her room. R55 was not observed on 11/3/14, to receive any ROM services. During interview on 11/3/14, at 2:01 p.m. director of nursing (DON) stated residents who were on a range of motion program would have paper sheets in the Functional Maintenance and Restorative Program documentation book which the staff were to document on when ROM was completed. During interview on 11/4/14, at 8:40 a.m. physical therapy assistant (PTA)-A stated therapies had worked with R6 and R55 until they were discharged from therapy services on 10/23/14. PTA-A stated at that time the Interdepartmental Communication forms were filled out and provided to the nursing staff so they could implement the ongoing functional ROM program for the residents. During interview on 11/4/14, at 8:56 a.m. physical therapist (PT)-A stated he had reassessed R55 the prior evening (11/3/14), because nursing staff had confusion about starting R55's ROM program which was assessed to have started on 10/23/14. PT-A stated they wanted to be sure R55 had no decrease in ROM since 10/23/14, when she was discharged from therapy and was to begin ROM with nursing. The facility undated policy titled Restorative Nursing identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical, and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following	{2 895}		

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{2 895}	Continued From page 4 criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned.	{2 895}		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other	2 915		

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2 915	Continued From page 5 functional communication systems; and This MN Requirement is not met as evidenced by: *Uncorrected based on the following findings. The original licensing order issued on 11/5/14, will remain in effect. Penalty assessment issued. Based on observation, interview, and document review the facility failed to provide assistance with ambulation services as assessed for 4 of 4 residents (R94, R89, R93 and R69) who required assistance from staff with ambulation. Findings include: R94's Admission Minimum Data Set (MDS) dated 10/8/14, identified R94 had moderately impaired cognition and required physical assistance of one person with ambulation. R94's Interdepartmental Communication form provided to nursing and signed by physical therapy (PT) on 10/16/14, indicated R94 was to ambulate daily 50-100 feet with a rolling walker and assist of one staff member. The Nursing Assistant Care sheet dated 11/3/14, identified R94 was to be walked 50-100 feet with a rolling walker, transfer belt and assist of one staff. Review of the electronic point of care restorative nursing section, which was identified by the facility as the documentation of when and how far a resident ambulates, indicated R94 had walked	2 915		

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2 915	Continued From page 6	2 915		

only four of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14.

R94 was observed lying in bed on 11/5/14, at 2:49 p.m. and was interviewed. R94 stated he needed assistance to walk in the hallway and was not offered the opportunity to walk by staff.

R89's Admission MDS dated 10/6/14, identified R89 had moderate cognitive impairment, and required physical assistance of one staff with ambulation.

R89's Interdepartmental Communication form provided to nursing and signed by PT on 10/16/14, indicated R89 was to ambulate daily 25-50 feet with a rolling walker and assist of one staff member.

R89's Nursing Assistant Care sheet dated 11/3/14, identified R89 was to walk daily 25-50 feet with a transfer belt, rolling walker, and assist of one staff member.

R89's electronic point of care restorative nursing section indicated the resident had walked nine of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14.

R89 was observed seated in the wheelchair near the bird aviary on 11/5/14, at 3:03 p.m. and was interviewed. R89 stated he required assistance from the staff to walk and staff had offered to assist the resident with walking, however, he stated staff did not offer to assist him with walking everyday.

R93's Admission MDS dated 10/10/14, identified R93 had severe cognitive impairment and required physical assistance of one person with

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2 915	Continued From page 7 ambulation in the corridor. R93's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R93 was to ambulate twice a day 100-200 feet feet with a rolling walker and assist of one staff member. R93's Nursing Assistant Care sheet dated 11/3/14, identified R93 was to walk 100-200 feet with a rolling walker, transfer belt, and assist of one staff member. R93's electronic point of care restorative nursing section indicated R93 had walked 9 of the 38 opportunities from the starting date of 10/16/14, until the review date of 11/4/14. R93 was observed on 11/5/14, at 2:42 p.m. sitting in a wheelchair near the nurses station. R93 was not observed ambulating. R69's quarterly MDS dated 10/14/14, identified R69 had severe cognitive impairment and required physical assistance of one person with ambulation. R69's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R69 was to ambulate twice a day 75-100 feet with a rolling walker and a transfer belt, with assistance of one staff member. R69's Nursing Assistant Care sheet dated 11/3/14, identified R69 was to walk 75-100 feet with a transfer belt, rolling walker, and assist of one staff member.	2 915		

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2 915	Continued From page 8 R69's electronic point of care restorative nursing section indicated R69 had walked 3 of the 28 opportunities, from 10/22/14, through the review date of 11/4/14. During interview on 11/5/14, at 1:46 p.m. director of nursing (DON) and corporate registered nurse (CRN)-A stated R69 was receiving PT and OT services from 10/9/14, and was discharged from therapy on 10/31/14. DON and CRN-A were not aware why therapy had assessed R69 to be walked twice a day by staff when she was receiving therapy. However, they had not spoken to therapy about the ambulation assessment therapy had completed on 10/17/14, for R69 to be ambulated twice a day. During interview on 11/05/2014, at 2:23 p.m. physical therapy assistant (PTA)-A and occupational therapy assistant (OTA)-A stated R69 was receiving therapy services with PT and OT from 10/9/14, through 10/31/14, once a day, Monday through Friday. PTA-A and OTA-A stated R69 was referred to nursing on 10/17/14, to be ambulated twice a day by staff, so nursing staff would assist R69 with ambulating in the evenings and on weekends. PTA-A stated R69 had been independent with ambulating in the past, and the goal was to possibly get the resident back to being independent with ambulation. During an observation on 11/5/14, at 2:43 p.m. R69 was lying in her bed. R69 stated she could transfer from the wheelchair to the toilet with no problems, but could not recall the last time she walked in the hallway by staff. R69 stated, "But I love to walk." During interview on 11/4/14, at 10:47 a.m. physical therapist (PT)-A stated they had recently	2 915		

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2 915	Continued From page 9 assessed the ambulation and/or range of motion therapy needs of all the residents in the facility. PT-A stated the Interdepartmental Communication forms were completed and sent to nursing to implement. PT-A stated if any resident was assessed to be on an ambulation program, it was expected they be walked at least daily, and for some residents twice a day to maintain their ambulation ability.	2 915		
{21426}	MN St. Statute 144A.04 Subd. 4 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: Uncorrected based on the following findings. The original licensing order issued on 9/12/14, will	{21426}		

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{21426}	Continued From page 10 remain in effect. Penalty assessment issued. Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed within 72 hours of admission for 2 of 7 residents (R96 and R98), reviewed for TB screening. In addition, the facility failed to assess the results of tuberculin skin test (TST), within 48-72 hours of being administered, for 1 of 7 residents (R97) reviewed for TB screening. Findings include: The Minnesota Department of Health (MDH) Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, directed all residents must receive a baseline TB screening within 72 hours of admission or within 3 months prior to admission. R96 was admitted to the facility on 10/19/14, according to the Admit/Discharge report provided by the facility. R96 received the Tuberculin Skin Test (TST)-1st Step on 10/23/14, four days after admission to the facility. R98 was admitted to the facility on 10/22/14, according to the Admit/Discharge report. R98 received the TST-1st Step on 11/3/14, 12 days after admission to the facility. The Minnesota Department of Health (MDH) Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, directed results of the TST be assessed within 48-72 hours of being administered. R97 was admitted to the facility on 10/20/14, according to the Admit/Discharge report. R97	{21426}		

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{21426}	Continued From page 11 received the TST-2nd Step on 10/31/14, but the results were not assessed until 11/3/14, four days after being administered. During interview on 11/05/2014, at 10:29 a.m. director of nursing (DON) stated she was aware of the requirements for resident TB screening. The facility policy titled Administering and Reading the Tuberculin Skin Test (TST), undated, indicated the facility would have a procedure in place for administering and reading the TST for residents and staff. The policy directed staff to "Read for a reaction in 48-72 hours." No further information was provided.	{21426}		
{21800}	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current	{21800}		

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{21800}	Continued From page 12 facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: *Uncorrected based on the following findings. The original licensing order issued on 9/12/14, will remain in effect. Penalty assessment issued. Based on interview and document review, the facility failed to ensure 3 of 6 residents (R11, R17, and R90) reviewed for liability notices received the Notice of Medicare Non-Coverage (CMS form 10123) within the required timeframe of 48 hours prior to skilled services ending. Findings include: R11's 5-day Medicare Minimum Data Set (MDS) assessment dated 9/30/14, indicated R11 was admitted to the facility with skilled coverage beginning 9/23/14. R11's Medicare denial notice indicated R11's Medicare coverage would be ending on 10/3/14, however, the facility did not notify R11 of the non-coverage until 10/2/14, 24 hours prior to the end of skilled coverage. R17's 14-day Medicare MDS dated 9/30/14, indicated R17 was admitted to the facility with skilled coverage beginning 9/17/14. Review of R17's Medicare denial notices indicated the	{21800}		

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{21800}	Continued From page 13 facility reviewed R17's Medicare coverage and determined her last covered day was 10/3/14. R17 was issued the Notice of Medicare Non-Coverage on 10/2/14, 24 hours prior to the end of skilled services. R90's 14-day Medicare MDS dated 9/18/14, indicated R90 was admitted to the facility with skilled coverage beginning 9/5/14. Review of R90's Medicare denial notices indicated R90 was issued the Notice of Medicare Non-Coverage on 10/2/14, 24 hours prior to the end of skilled services. During interview on 11/04/2014, at 1:12 p.m. the assistant director of nursing (ADON) stated she was aware Medicare coverage was ending for R11, R17 and R90, however, she did not issue the notices in a timely manner. The ADON stated a Medicare meeting had not been held that week and it was better for the notices to be issued, "One day than no days," ahead of time. ADON was aware the Medicare denial notices were not issued within the 48 hour timeframe. During interview on 11/05/2014, at 2:36 p.m. the director of nursing (DON) stated she was aware the facility had some concerns with issuing Medicare Denial Letters. The facility social worker was on leave and the ADON was one of the backups for issuing the Medicare denial notices until she returned.	{21800}		

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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: An onsite follow-up visit was completed on 11/3/14, 11/4/14, and 11/5/14. During this visit it was determined that the following correction orders were not corrected. This uncorrected orders will remain in effect and will be reviewed at the next site visit. To be reviewed for possible penalty assessments.	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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{2 000}	Continued From page 1	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	{2 895}		

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{2 895}	Continued From page 2 B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: *Uncorrected based on the following findings. The original licensing order issued on 9/12/14, will remain in effect. Penalty assessment issued. Based on observation, interview, and document review, the facility failed to ensure range of motion services (ROM) were provided to maintain and/or improve current level of functioning for 2 of 8 residents (R6 and R55) reviewed for range of motion services. Findings include: R6's significant change Minimum Data Set (MDS) dated 9/29/14, indicated R6 had severe cognitive impairment and had functional limitations of ROM to both upper extremities. R6's Interdepartmental Communication form provided to nursing, and signed by physical therapy (PT) and occupational therapy (OT) on 10/23/14, indicated R6 was to receive 10 repetitions twice a week of active assisted range of motion (AAROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, and fingers. The Functional Maintenance and Restorative Program documentation book, which was identified as the documentation of completion of resident ROM programs, which included treatment sheets for 10/14, and 11/14, lacked any documentation that R6's AAROM plan had been	{2 895}		

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{2 895}	Continued From page 3 implemented or provided to R6 since being assessed on 10/23/14. During observations on 11/4/14, at 8:29 a.m., and 11/5/14, at 8:30 a.m., and again at 10:44 a.m. on 11/5/14, R6 was sitting in her wheelchair. R6 was not observed to receive any ROM services. R55's modified MDS dated 10/27/14, identified R55 had severe cognitive impairment and had functional limitations of ROM to both upper and lower extremities. R55's Interdepartmental Communication form provided to nursing and signed by PT and OT on 10/23/14, indicated R55 was to receive 10 repetitions twice a week, of passive range of motion (PROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, fingers, and 10 repetitions of cervical neck ROM with a gentle stretch. The Functional Maintenance and Restorative Program documentation book which included treatment sheets for 10/14, and 11/14, lacked any documentation that R55's PROM plan had been implemented or provided to R55 since being assessed on 10/23/14. During observation on 11/3/14, at 1:19 p.m. R55 was sleeping in her wheelchair in her room. R55 was not observed on 11/3/14, to receive any ROM services. During interview on 11/3/14, at 2:01 p.m. director of nursing (DON) stated residents who were on a range of motion program would have paper sheets in the Functional Maintenance and Restorative Program documentation book which the staff were to document on when ROM was	{2 895}		

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{2 895}	Continued From page 4 completed. During interview on 11/4/14, at 8:40 a.m. physical therapy assistant (PTA)-A stated therapies had worked with R6 and R55 until they were discharged from therapy services on 10/23/14. PTA-A stated at that time the Interdepartmental Communication forms were filled out and provided to the nursing staff so they could implement the ongoing functional ROM program for the residents. During interview on 11/4/14, at 8:56 a.m. physical therapist (PT)-A stated he had reassessed R55 the prior evening (11/3/14), because nursing staff had confusion about starting R55's ROM program which was assessed to have started on 10/23/14. PT-A stated they wanted to be sure R55 had no decrease in ROM since 10/23/14, when she was discharged from therapy and was to begin ROM with nursing. The facility undated policy titled Restorative Nursing identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical, and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff	{2 895}		

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{2 895}	Continued From page 5 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned.	{2 895}		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: *Uncorrected based on the following findings. The original licensing order issued on 11/5/14, will remain in effect. Penalty assessment issued.	2 915		

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2 915	Continued From page 6 Based on observation, interview, and document review the facility failed to provide assistance with ambulation services as assessed for 4 of 4 residents (R94, R89, R93 and R69) who required assistance from staff with ambulation. Findings include: R94's Admission Minimum Data Set (MDS) dated 10/8/14, identified R94 had moderately impaired cognition and required physical assistance of one person with ambulation. R94's Interdepartmental Communication form provided to nursing and signed by physical therapy (PT) on 10/16/14, indicated R94 was to ambulate daily 50-100 feet with a rolling walker and assist of one staff member. The Nursing Assistant Care sheet dated 11/3/14, identified R94 was to be walked 50-100 feet with a rolling walker, transfer belt and assist of one staff. Review of the electronic point of care restorative nursing section, which was identified by the facility as the documentation of when and how far a resident ambulates, indicated R94 had walked only four of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14. R94 was observed lying in bed on 11/5/14, at 2:49 p.m. and was interviewed. R94 stated he needed assistance to walk in the hallway and was not offered the opportunity to walk by staff. R89's Admission MDS dated 10/6/14, identified R89 had moderate cognitive impairment, and required physical assistance of one staff with	2 915		

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2 915	Continued From page 7 ambulation. R89's Interdepartmental Communication form provided to nursing and signed by PT on 10/16/14, indicated R89 was to ambulate daily 25-50 feet with a rolling walker and assist of one staff member. R89's Nursing Assistant Care sheet dated 11/3/14, identified R89 was to walk daily 25-50 feet with a transfer belt, rolling walker, and assist of one staff member. R89's electronic point of care restorative nursing section indicated the resident had walked nine of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14. R89 was observed seated in the wheelchair near the bird aviary on 11/5/14, at 3:03 p.m. and was interviewed. R89 stated he required assistance from the staff to walk and staff had offered to assist the resident with walking, however, he stated staff did not offer to assist him with walking everyday. R93's Admission MDS dated 10/10/14, identified R93 had severe cognitive impairment and required physical assistance of one person with ambulation in the corridor. R93's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R93 was to ambulate twice a day 100-200 feet feet with a rolling walker and assist of one staff member. R93's Nursing Assistant Care sheet dated 11/3/14, identified R93 was to walk 100-200 feet with a rolling walker, transfer belt, and assist of	2 915		

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2 915	Continued From page 8 one staff member. R93's electronic point of care restorative nursing section indicated R93 had walked 9 of the 38 opportunities from the starting date of 10/16/14, until the review date of 11/4/14. R93 was observed on 11/5/14, at 2:42 p.m. sitting in a wheelchair near the nurses station. R93 was not observed ambulating. R69's quarterly MDS dated 10/14/14, identified R69 had severe cognitive impairment and required physical assistance of one person with ambulation. R69's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R69 was to ambulate twice a day 75-100 feet with a rolling walker and a transfer belt, with assistance of one staff member. R69's Nursing Assistant Care sheet dated 11/3/14, identified R69 was to walk 75-100 feet with a transfer belt, rolling walker, and assist of one staff member. R69's electronic point of care restorative nursing section indicated R69 had walked 3 of the 28 opportunities, from 10/22/14, through the review date of 11/4/14. During interview on 11/5/14, at 1:46 p.m. director of nursing (DON) and corporate registered nurse (CRN)-A stated R69 was receiving PT and OT services from 10/9/14, and was discharged from therapy on 10/31/14. DON and CRN-A were not aware why therapy had assessed R69 to be	2 915		

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2 915	Continued From page 9 walked twice a day by staff when she was receiving therapy. However, they had not spoken to therapy about the ambulation assessment therapy had completed on 10/17/14, for R69 to be ambulated twice a day. During interview on 11/05/2014, at 2:23 p.m. physical therapy assistant (PTA)-A and occupational therapy assistant (OTA)-A stated R69 was receiving therapy services with PT and OT from 10/9/14, through 10/31/14, once a day, Monday through Friday. PTA-A and OTA-A stated R69 was referred to nursing on 10/17/14, to be ambulated twice a day by staff, so nursing staff would assist R69 with ambulating in the evenings and on weekends. PTA-A stated R69 had been independent with ambulating in the past, and the goal was to possibly get the resident back to being independent with ambulation. During an observation on 11/5/14, at 2:43 p.m. R69 was lying in her bed. R69 stated she could transfer from the wheelchair to the toilet with no problems, but could not recall the last time she walked in the hallway by staff. R69 stated, "But I love to walk." During interview on 11/4/14, at 10:47 a.m. physical therapist (PT)-A stated they had recently assessed the ambulation and/or range of motion therapy needs of all the residents in the facility. PT-A stated the Interdepartmental Communication forms were completed and sent to nursing to implement. PT-A stated if any resident was assessed to be on an ambulation program, it was expected they be walked at least daily, and for some residents twice a day to maintain their ambulation ability.	2 915		

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{21426}	Continued From page 10	{21426}		
{21426}	MN St. Statute 144A.04 Subd. 4 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: Uncorrected based on the following findings. The original licensing order issued on 9/12/14, will remain in effect. Penalty assessment issued. Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed within 72 hours of admission for 2 of 7 residents (R96 and R98), reviewed for TB screening. In addition, the facility failed to assess the results of tuberculin skin test (TST), within 48-72 hours of being administered, for 1 of 7 residents (R97) reviewed for TB screening.	{21426}		

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{21426}	Continued From page 11 Findings include: The Minnesota Department of Health (MDH) Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, directed all residents must receive a baseline TB screening within 72 hours of admission or within 3 months prior to admission. R96 was admitted to the facility on 10/19/14, according to the Admit/Discharge report provided by the facility. R96 received the Tuberculin Skin Test (TST)-1st Step on 10/23/14, four days after admission to the facility. R98 was admitted to the facility on 10/22/14, according to the Admit/Discharge report. R98 received the TST-1st Step on 11/3/14, 12 days after admission to the facility. The Minnesota Department of Health (MDH) Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, directed results of the TST be assessed within 48-72 hours of being administered. R97 was admitted to the facility on 10/20/14, according to the Admit/Discharge report. R97 received the TST-2nd Step on 10/31/14, but the results were not assessed until 11/3/14, four days after being administered. During interview on 11/05/2014, at 10:29 a.m. director of nursing (DON) stated she was aware of the requirements for resident TB screening. The facility policy titled Administering and Reading the Tuberculin Skin Test (TST), undated, indicated the facility would have a procedure in	{21426}		

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HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

(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
{21426}	Continued From page 12 place for administering and reading the TST for residents and staff. The policy directed staff to "Read for a reaction in 48-72 hours." No further information was provided.	{21426}		
{21800}	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	{21800}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: _____ B. WING _____	R 11/05/2014

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{21800}	Continued From page 13 This MN Requirement is not met as evidenced by: *Uncorrected based on the following findings. The original licensing order issued on 9/12/14, will remain in effect. Penalty assessment issued. Based on interview and document review, the facility failed to ensure 3 of 6 residents (R11, R17, and R90) reviewed for liability notices received the Notice of Medicare Non-Coverage (CMS form 10123) within the required timeframe of 48 hours prior to skilled services ending. Findings include: R11's 5-day Medicare Minimum Data Set (MDS) assessment dated 9/30/14, indicated R11 was admitted to the facility with skilled coverage beginning 9/23/14. R11's Medicare denial notice indicated R11's Medicare coverage would be ending on 10/3/14, however, the facility did not notify R11 of the non-coverage until 10/2/14, 24 hours prior to the end of skilled coverage. R17's 14-day Medicare MDS dated 9/30/14, indicated R17 was admitted to the facility with skilled coverage beginning 9/17/14. Review of R17's Medicare denial notices indicated the facility reviewed R17's Medicare coverage and determined her last covered day was 10/3/14. R17 was issued the Notice of Medicare Non-Coverage on 10/2/14, 24 hours prior to the end of skilled services. R90's 14-day Medicare MDS dated 9/18/14, indicated R90 was admitted to the facility with skilled coverage beginning 9/5/14. Review of R90's Medicare denial notices indicated R90 was issued the Notice of Medicare Non-Coverage on	{21800}		

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{21800}	Continued From page 14 10/2/14, 24 hours prior to the end of skilled services. During interview on 11/04/2014, at 1:12 p.m. the assistant director of nursing (ADON) stated she was aware Medicare coverage was ending for R11, R17 and R90, however, she did not issue the notices in a timely manner. The ADON stated a Medicare meeting had not been held that week and it was better for the notices to be issued, "One day than no days," ahead of time. ADON was aware the Medicare denial notices were not issued within the 48 hour timeframe. During interview on 11/05/2014, at 2:36 p.m. the director of nursing (DON) stated she was aware the facility had some concerns with issuing Medicare Denial Letters. The facility social worker was on leave and the ADON was one of the backups for issuing the Medicare denial notices until she returned.	{21800}		

Minnesota Department of Health

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}	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: An onsite follow-up visit was completed on 11/3/14, 11/4/14, and 11/5/14. During this visit it was determined that the following correction orders were not corrected. This uncorrected orders will remain in effect and will be reviewed at the next site visit. To be reviewed for possible penalty assessments.	{2 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RN-BC, DON — 12/4/14

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JMZ1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00950

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245497**
2.STATE VENDOR OR MEDICAID NO.
(L2) **064742000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVEN HOMES OF MAPLE PLAIN**
(L4) **1520 WYMAN AVENUE, PO BOX 369**
(L5) **MAPLE PLAIN, MN** (L6) **55359**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2004**
6. DATE OF SURVEY **09/12/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **67** (L18)
13.Total Certified Beds **67** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(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 :
Holly Kranz, HFE NE II 11/7/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/13/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 5008

October 1, 2014

Ms. Diane Lynch, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue, P.O. Box 369
Maple Plain, Minnesota 55359

RE: Project Number S5497024

Dear Ms. Lynch:

On September 12, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 22, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 22, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If

the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 12, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING ______ B. WING ______	09/12/2014

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F 000	INITIAL COMMENTS On September 8, 9, 10, 11 and 12th, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	F 000	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of a deficiency was correctly cited or factually based and it's also not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.	5. October 22nd, 2014
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to	F 156	accepted 10-16-14 [signature] RN	

RECEIVED OCT 13 2014 MN Dept of Health St.Cloud

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 10/10/2014

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

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F 156	Continued From page 1 the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance	F 156	1. R11 and the resident's financial Power of Attorney were contacted on 10/8/14 and an explanation was given regarding the facility's inability to find documentation that would prove that they were provided notice of Medicare's denial of coverage with the CMS 10123, or Notice of Medicare Non-Coverage (NOMNC), on April 20th, 2014. A late notice was also provided at that time, along with the reassurance that, in the future, the facility would be sure to supply them with all the required notices in a timelier manner.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

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F 156	Continued From page 2 directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents (R11, R57) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, informing them of their right to an appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services. Findings include: R11 was admitted to the facility with skilled medicare coverage on 2/13/14. On 4/22/14, the facility determined R11 no longer met medicare coverage criteria and issued a notice of medicare non-coverage on continued stay, with the first non-covered day listed as 4/25/14. The facility did not have record R11 received the CMS 10123, informing her of her rights for an expedited appeal.	F 156	R57 & the resident's financial POA were also contacted on 10/8/14 and an explanation was given regarding the facility's inability to find documentation that would prove that they were provided Notification of the Exclusion of Medicare Benefits – Skilled Nursing Facility (NEMB-SNF), following the issuance of the Notice of Denial of Medicare Coverage on 3/19/14. A late notice was issued at that time, along with the reassurance that, in the future, the facility would be sure to supply them with all required notices in a timelier manner. 2. All residents that would have qualified to receive either one or both of the NOMNC and/or the NEMB-SNF within the last 14 months will be reviewed by 10/21/14 to ensure that all of the Medicare denials issued were in compliance according to CMS guidelines.	

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F 156	Continued From page 1 the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance	F 156	F 156 1. R11 and the resident's financial Power of Attorney were contacted on 10/8/14 and an explanation was given regarding the facility's inability to find documentation that would prove that they were provided notice of Medicare's denial of coverage with the CMS 10123, or Notice of Medicare Non-Coverage (NOMNC), on April 20th, 2014. A late notice was also provided at that time, along with the reassurance that, in the future, the facility would be sure to supply them with all the required notices in a timelier manner. R57 & the resident's financial POA were also contacted on 10/8/14 and an explanation was given regarding the facility's inability to find documentation that would prove that they were provided Notification of the Exclusion of Medicare Benefits – Skilled Nursing Facility (NEMB-SNF), following the issuance of the Notice of Denial of Medicare Coverage on 3/19/14. A late notice was issued at that time, along with the reassurance that, in the future, the facility would be sure to supply them with all required notices in a timelier manner. 2. All residents that would have qualified to receive either one or both of the NOMNC and/or the NEMB-SNF within the last 14 months will be reviewed by 10/21/14 to ensure that all of the Medicare denials issued were in compliance according to CMS guidelines.	5. October 22nd, 2014

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F 156	Continued From page 2 directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents (R11, R57) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, informing them of their right to an appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services. Findings include: R11 was admitted to the facility with skilled medicare coverage on 2/13/14. On 4/22/14, the facility determined R11 no longer met medicare coverage criteria and issued a notice of medicare non-coverage on continued stay, with the first non-covered day listed as 4/25/14. The facility did not have record R11 received the CMS 10123, informing her of her rights for an expedited appeal.	F 156	3. DON/Designee will conduct an in-service on 10/16/14 for employees who have been designated as the responsible parties for issuing the NOMNC and/or NEMB-SNF to the residents and/or their POAs, regarding the CMS forms that are required, as well as the proper way to issue these denials to the receiving party. The policy for issuing Medicare denials will also be reviewed at that time, and directions intended to guide	

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F 156	Continued From page 3 R57 was admitted to the facility with skilled medicare coverage on 1/17/14. R57's denial letters contained only the CMS 10123, indicating R57's last covered day was 3/19/14. R57 records did not contain the required notice of medicare coverage on continued stay. R57 remained in the facility after her medicare coverage was discontinued. During interview on 9/11/14, at approximately 10:00 a.m. director of nursing (DON) stated the facility did not have a policy specific to how to issue medicare denials, and verified there were no other denial letters on file for R11 or R57. DON provided copies of a Haven Homes Medicare Assessment Tool and a blank notice of medicare coverage on continued stay, however, these did not address the facility process on how to inform residents of medicare appeal rights or for required denial letters the residents must receive.	F 156		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents observed during dining who required staff assistance, (R12, R52, R66 and R7), were provided assistance in a dignified manner.	F 241	F-241 1. R12, R66 & R7 are currently provided assistance with dining in a more dignified manner. R52 expired on 9/23/14. NA-P was counseled on 10/8/14 regarding the proper procedures for maintaining resident dignity during mealtimes. 2. The facility has determined that all residents requiring feeding assistance for meals have the potential to be affected.	5. October 22nd, 2014

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F 241	Continued From page 4 R12's quarterly minimum data set (MDS) dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and required extensive staff assistance with dining. R66's quarterly MDS dated 8/6/14, identified R66 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/27/14, identified R7 had severe cognitive impairment and required extensive staff assistance with dining. During dining observation on 9/8/14, at approximately 5:40 p.m. nursing assistant (NA)-P was observed sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident giving them a bite of food, and then rolling on the stool using her feet, to the next resident. NA-P would give a resident a bite of food, set the fork or spoon down, and immediately roll over to the next resident, and continued rolling around the table on the stool the entire meal. During interview on 9/8/14, at 6:01 p.m. NA-P stated she was required to feed multiple residents at a time, and needed to use the rolling stool so she was able to go from resident to resident to ensure they all received their meal. NA-P stated there was not enough staff to ensure all the residents were being fed timely, so the NA's do	F 241	3. CNAs will be in-serviced on 10/9/14 or 10/10/14, regarding the proper procedures for assisting residents with meals to ensure resident dignity is maintained during mealtimes. A "Validation Checklist" was completed for each individual whose duties involve feeding assistance to determine if he/she was performing the procedure correctly. Findings were reviewed with each individual and additional counseling was provided as needed. 4. DON/Designee will conduct weekly random observation audits of staff during mealtimes over the next 2 months to ensure staff are promoting and maintaining resident dignity during meals in accordance with the facility's policy for resident dignity and resident rights. Observation reports and validation checklists will be reviewed in QA for further review and recommendation x2 months, or until consistent substantial compliance has been achieved, as determined by the QA Committee.	

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F 241	Continued From page 5 what they have to so the residents receive their meals. A policy on feeding residents was requested but not provided.	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 48 residents (R46) bathrooms had bathroom equipment in good repair. In addition, the facility failed to ensure 2 of 48 residents (R46, R24) were provided adequate water pressure to their bathroom sink. Findings include: R46's annual minimum data set (MDS) dated 8/6/14, identified the resident had no cognitive impairment. During interview on 9/8/14, at 4:30 p.m. R46 stated her bathroom sink was cracked and she had very little water pressure in her bathroom sink. She stated she had talked to several of the staff about both issues with her bathroom sink, and no one did anything about it. R46 stated the low water pressure and cracked sink had been like this since her admission to the facility which was over a year ago.	F 253	F 253 1. R46's bathroom sink was repaired on 10/1/14. The water pressure for her room was restored on 9/11/14 by Environmental Services Director. The water pressure in R24's room was also restored on the date listed above via the same method. 2. On 10/8/14, the water pressure and integrity of bathroom equipment was checked and deemed to be functioning and in good repair for all 19 resident bath rooms. 3. On 10/8/14, Housekeeping staff was re-educated regarding the following procedure for identifying and maintaining equipment repair: Housekeeping will be instructed to check sinks/toilets for damage/cracks/low water pressure/leaks each day while cleaning these areas. Any damage noticed or malfunction will be forwarded to the maintenance dept. via the work order system. Maintenance will investigate all requests and make the necessary repairs.	5. October 22nd, 2014

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F 253	Continued From page 6 During a tour of the facility on 9/12/14, at 1:00 p.m. maintenance supervisor (MS)-F verified R46's sink had two large cracks, one extending from the faucet knob down the entire sink almost to the drain, and a second crack on the left edge of the sink. MS-F also verified the water pressure in R46's bathroom sink was very low and the water trickled out of the faucet. MS-F stated he had not been informed of the cracked sink, which he stated had the potential to, "Scratch" the resident, and he was not aware of the low water pressure in R46's room. MS-F stated he did daily rounds of the facility looking for damaged equipment, however, he did not go into any of the resident rooms or bathrooms during the inspection. He stated it was the expectation nursing staff inform him of broken items so maintence could repair them. R24's quarterly MDS dated 6/24/14, identified the resident had severe cognitive impairment and required extensive assistance of two staff for personal cares. During observations on 9/8/14, at 7:14 p.m. and 9/11/14, at 11:00 a.m. R24's water flowed out of the bathroom sink faucet slowly and took a long time for the temperature of the water to heat up to get warm. During the tour of the facility on 9/12/14, at 1:00 p.m. MS-F verified R24's bathroom sink water pressure was very low. MS-F stated he was not aware of the R24's low water pressure until now, and it was an easy fix if he had been informed of the problem for his department to address the issue. MS-F stated nursing staff are to notify him	F 253	4. Environmental Services Director will conduct an audit regarding the integrity of the equipment in each resident bathroom monthly x3 months. He will also review all work orders received each week to ensure necessary maintenance/requests are fulfilled on a timely basis x6 weeks. Audit results will be brought to QA each month for further review and/or recommendation.	

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F 253	Continued From page 7 of any maintenance problems. A facility maintence policy was requested but not provided.	F 253		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	F-278 1. Corrections according to CMS guidelines have been made for the previously-inaccurate sections of the MDS assessments for R56, R20, R59, R7 and R55. These modified records will be submitted to CMS as "Modified Assessments" by 10/17/14. 2. MDS coordinators will re-review the most recent MDS assessment for all residents in the building for accuracy, with an emphasis on pressure ulcers, contractures, and/or significant changes in transfer status and/or declines in functional abilities, and submit modifications if data-entry errors are found. 3. On 10/16/14, DON provided re-education to both MDS Coordinators regarding all data sources to collect information for obtaining a comprehensive interdisciplinary review. MDS coordinators have completed (by 10/8/2014) a AANAC MDS 3.0 Knowledge Assessment in order to identify any knowledge areas of the MDS that require further development, and additional education has been provided based on those results.	5. October 22nd, 2014

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F 278	Continued From page 8 Based on interview and document review, the facility failed to ensure accuracy of the minimum data set (MDS) assessment for 1 of 2 residents (R56) reviewed for pressure ulcers who had multiple unhealed pressure sores, for 2 of 2 discharged residents (R20, R59) reviewed for rehabilitation services and transfer status which was not accurately coded, and for 2 of 5 residents (R7, R55) reviewed for range of motion and contractures which were not accurately coded. Findings include: R56's quarterly Minimum data set (MDS) dated 6/11/14, identified R56 was at risk for pressure ulcer development and currently had one stage IV (unstageable) pressure ulcer which had been present on admission and was unhealed. Review of R56's Skin Injury Report sheets with initial documentation dates of 5/22/14, and ending date of 6/20/14, identified R56 had two unstageable pressure ulcers, one on each heel. The forms indicated both pressure ulcers had been present since R56's admission on 12/10/13. During interview on 9/12/14, at 11:48 a.m. registered nurse (RN)-C stated she completed R56's MDS dated 6/11/14, and had only been aware of one of R56's unstageable pressure ulcers. RN-C verified according to facility documentation on R56's pressure ulcers, the MDS was not coded accurately to reflect R56's current pressure ulcers. R20's discharge MDS dated 8/20/14, indicated the resident required extensive assistance to transfer from surface to surface.	F 278	Nursing Assistants will also receive education on 10/9 & 10/10/14 related to the importance of consistent point-of-care documentation and accurate coding of ADLs, emphasizing the detrimental effect lack of coding and/or inaccurate coding can have on a Skilled Nursing Facility. 4. DON/Designee will conduct audits on CNA documentation for all ADLs, restorative and functional maintenance programs each week x6 weeks. Continued, random audits for a few months will be done which will be reported to Administration/QA team. DON/Designee will also randomly select 5 MDS assessments each month to conduct audits on section G, section M and Section O for accuracy. Audits will be conducted once a month x6 months. Results of all audits will be brought to QA Committee for review and further recommendation.	

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F 278	Continued From page 9 R20's physical therapy note dated 8/1/14, indicated she was weight bearing, was demonstrating slow progress, and required contact guard assistance to stand by assist only for pivot transfer and cues for proper techniques. R20 was discharged from occupational therapy on 8/21/14. R20 ambulated to all destinations with a 4 wheeled walker with stand by assistance only for safety and to ensure her balance and verbal cues were not needed. R20 was discharged from physical therapy on 8/21/14, and was able to independently do pivot transfers with verbal cues for proper techniques. During interview on 9/12/14, at 10:10 a.m., certified occupational therapy assistant (COTA)-D stated as of 8/7/14, R20 no longer needed extensive assistance with transfers and only required verbal cues and stand by assistance for safety. COTA-D stated R20 was discharged to an assisted living facility on 8/22/14, and was independent with all transfers. COTA-D stated the discharge MDS for R20 was incorrectly coded. During interview on 9/12/14, at 11:05 a.m. registered nurse (RN)-C stated she may have incorrectly coded R20's MDS. RN-C stated the facility does not have a good system to report changes in residents level of functioning and she is only able to obtain information from nursing assistant documentation in the computerized medical record on resident level of functioning, which is not always accurately documented. R59 discharge MDS dated 5/27/14, indicated the resident required limited assistance to transfer	F 278		

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F 278	Continued From page 10 from surface to surface. R59's nursing assistant flowsheet dated 5/23/14, instructed R20 required supervision only for transfers from surface to surface. R59's occupational therapy discharge note dated 5/23/14, indicated R59 was independent with all transfers. R59's last physical therapy note, dated 5/26/14 identified R59 was independent with all transfers. During interview on 9/12/14, at 10:10 a.m. COTA-D stated R59 was independent with all transfers at the time of her discharge to her own home and the residents discharge MDS was incorrectly coded related to R59's transfer ability. During interview on 9/12/14, at 10:07 a.m. RN-C stated R59's discharge MDS completed on 5/27/14, was not coded accurately related to the residents transfer ability. R7 annual MDS dated 8/27/14, identified R7 had impairment to one side of the upper extremity only, and had no impairment to the lower extremities. R7's Physical Therapist Progress & Discharge Summary dated 3/4/14, indicated R7 demonstrated 26 degrees of left knee extension and 22 degrees of right knee extension, indicating R7 had contractures of the lower extremities. During interview on 9/9/14, at 9:46 a.m. RN-A stated R7 had contractures to her right hand since admission, and had surgery to release part of the contractures.	F 278		

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F 278	Continued From page 11 On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D and both verified R7 had contractures in both knees. During interview on 9/11/14, at 1:57 p.m. registered nurse (RN)-D stated she was only aware of R7's right hand contractures, and was not aware of the bilateral knee contractures. RN-D verified R7's MDS was coded incorrectly as it did not accurately identify R7's lower extremity impairment. R55 quarterly MDS dated 9/3/14, identified R55 had no functional limitations in ROM (contracture's). During interview on 9/8/14, at 5:55 p.m. RN-A stated R55 had contractures (fixed high resistance to passive stretch of a muscle) in both knees. During interview on 9/10/14, at 2:05 p.m. physical therapy assistant (PTA)-E stated R55 had knee contractures present when she was last treated and discharged from PT on 9/6/11, about 2 years ago. During interview on 9/10/14, at 12:45 p.m. RN-C stated she was one of two nurses responsible for completing the MDS assessments. RN-C stated when completing an MDS, she gathered information from interviews with residents, families, staff, and the residents medical record to code the MDS's. RN-C was not aware R55 had any contractures and was unsure why the MDS was not coded to reflect the residents limitations.	F 278		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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	245497	A. BUILDING _____ B. WING _____	09/12/2014

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F 282 SS=E	Continued From page 12 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was implemented for repositioning for 1 of 2 residents (R56), reviewed for pressure ulcers, for 1 of 1 residents bathing needs (R11), reviewed who required assistance with bathing, and for or 2 of 5 residents ROM programs (R31, R11) reviewed for range of motion services. Findings include: R56's quarterly Minimum data set dated 6/11/14, identified R56 had no cognitive impairments, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for pressure ulcer development, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's care plan dated 8/16/14, identified R56 had a unstageable pressure ulcer measuring 1.3 x 0.3 the coccyx. The care plan instructed R56 to be repositioned at no greater than 2 hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m. the resident was not repositioned and was unable to shift his weight independently in the wheelchair.	F 282	F-282 1. R-56 was re-evaluated by nursing staff and is being turned and repositioned according to the care plan. R11 receives baths routinely according to the frequency specified in her plan of care, and occasionally in addition to this, per her request. R31 & R1 have all been evaluated by Physical and Occupational Therapies to establish a "baseline" of their current level of functional abilities, and a restorative OR functional maintenance program, that includes updated ambulation programs, has been set up in order to more effectively address any functional limitations the resident may have, as well as to prevent any further decline. These updated programs will be communicated to the CNAs and restorative nursing staff to be carried out consistently, and according to the resident care plan. 2. Care plans were reviewed for all of these residents who were previously set up with a restorative program and require assistance to complete ROM activities, currently have pressure ulcers, have a Braden score of 18 or less, and/or have co-morbidities that result in increased risk of pressure ulcer formation. Compliance with care plans was verified through the review of care plans and the review of daily documentation completed by registered nursing assistants every shift and via informal one on one staff interviews.	5. October 22nd, 2014

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F 282	Continued From page 13 During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up in his chair since approximately 6:00 a.m. that morning. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned at least every two hours, and should lie down after breakfast. LPN-B requested assistance to lay R56 down in bed. NA-B and LPN-B transfered R56 to his bed to lay down on 9/10/14, at 10:05 a.m. Although R56's care plan instructed staff to reposition R56 every two hours, the resident had been in his chair for a total of 2 hours and 47 minutes without being repositioned. R31's quarterly MDS dated 6/11/14, indicated R31 had no current functional losses of range of motion (contractures) in the upper or lower extremities. R31s care plan dated 8/20/14, identified R31 was to receive passive range of motion daily to hips, knees, and ankles, 10-15 repetitions, as well as to bilateral shoulders, elbows, wrists and digits daily. Review of R31s ROM documentation indicated the resident recieved range of motion services 12 days in the last month (8/12/14 through 9/14/14). R31's restorative documentation for 7/2014, was not documented as being completed for 28 out of 31 days. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive	F 282	3. On 10/9/14 or 10/10/14, all nursing staff were educated, verbally by the DON on the importance of remaining in compliance with the entire resident's care plan, including adhering to designated turning and repositioning schedules, restorative/functional maintenance programs, and/or honoring resident preferences. The facility has also added an additional intervention to the pressure ulcer prevention policy that states that all nursing assistants are required to carry resident assignment sheets with them when they are working. These resident assignment sheets will reflect resident-specific care plan interventions, including individual turning and repositioning schedules. A structured process has been created for monitoring CNAs to ensure bathing is being completed each day as it reflects in the resident care plan, and consistent assignment lists have been implemented to ensure accountability of staff. Education has been provided to ensure care delivery, in addition to very clear expectations for completion that all department staff will be held accountable for during each shift that they work. Further, education has been provided to train staff of the expected and appropriate actions(asking for assistance from peers, their nurse, the charge nurse or DON) to take if they feel they are unable to complete all of the assigned interventions as listed in the care plans, prior to falling behind or allowing resident care to be neglected.	

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F 282	Continued From page 14 any range of motion services other than routine dressing activities. During interview on 9/11/14, at 3:18 p.m. R31 stated he had a stroke a while back and did not walk anymore, but would like to use his legs and complete leg exercises. R11 quarterly MDS dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene and was able to provide partial physical help with bathing. The care plan dated 9/4/14, identified R11 needed the assist of one staff for bathing and preferred to have a bath versus a shower. Staff was directed to to honor resident's preferences and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated recently she had gone for a couple of weeks without a bath because the facility didn't have any bath aids. R11's point of care bathing record indicated R11 received a tub bath on 7/31/14, and the next entry was a partial bath on 8/28/14, which was 28 days later. During interview on 9/12/14, at 9:34 a.m. NA-B stated it was possible R11 went for weeks without a bath because there is not enough staff to assist residents with bathing. R1's quarterly MDS dated 6/25/14, indicated R1 had functional limitation in range of motion (ROM) to one side of the upper and lower extremities. R1 care plan dated 7/2/14, identified R1 was to	F 282	4. To ensure on-going compliance of care-plans, DON/Designee will ensure that turning and repositioning schedules are completed according to care plan by auditing compliance for 3 randomly-selected residents who currently have a pressure ulcer and/or are at risk of developing pressure ulcers weekly x6 weeks, then monthly x 4 months. To ensure that nursing assistants are carrying resident assignment sheets, Change Nurse will randomly select 2 nursing assistants each shift to verify that they have their resident assignment sheet with them. These audits will be completed for all 3 shifts daily x 7 days, then weekly thereafter on an ongoing basis. DON/Designee will audit compliance with bathing schedules and the associated documentation for every shift x3 days, then daily x7 days, then weekly x6 weeks. All audit results will be brought to QA each month for review and further recommendation until consistent substantial compliance is attained.	

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F 282	Continued From page 15 receive passive range of motion (PROM) daily, 10-15 reps to bilateral shoulders, elbows, wrists, and digits. R1's PROM restorative nursing sheets were reviewed from April 2014 - September 2014. There was no documentation to determine if R1 was recieving PROM as directed by the care plan. During interview on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility no longer had a restorative aid, and the NAs are not able to complete R1's PROM as directed by the care plan. During interview on 9/11/14, at 9:25 a.m. R1 non-verbally indicated by motioning in a back and forth motion with her hand to indicate 'so-so,' when asked if staff were assisting her with PROM on a daily basis. When asked for a frequency of the PROM being done, R1 spelled out, "monthly," on her communication board.	F 282		
F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced	F 310	F-310 1. R7 & R47 were both evaluated by Physical and Occupational Therapies to establish a "baseline" of their current level of functional abilities, and a restorative OR functional maintenance program, including updated ambulation programs has been set up in order to more effectively address any functional limitations the resident may have, as well as to prevent any further decline. These updated programs will be communicated to the CNAs and restorative nursing staff to carry out consistently and according to the resident care plan. R7's CAAs were reviewed and modified to address the resident's walking, transfer ability and current contractures. Resident care plans were updated.	5. October 22nd, 2014

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F 310	Continued From page 16 by: Based on observation, interview, and document review, the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Findings include: R47's quarterly Minimum Data Set (MDS) dated 7/2/14, indicated R47 had no cognitive impairment, needed extensive assistance of one staff for transfers and ambulation, and used a wheelchair or a walker to aid her ambulation. R47's balance was not steady during transfers and walking and she had no loss of upper and lower function range of motion (contractures). R47's Care Area Assessments (CAA) dated 10/9/13, identified R47 was alert and oriented, had clear speech, and she was understood and able to understand others. R47 had an unsteady gait, was able to bear weight, and required a wheelchair behind her when she was involved in the restorative walking program. During interview on 9/8/14, at 7:11 p.m. R47 stated she was concerned she was going to lose her ability to walk because staff had not been assisting her to ambulate. She stated she was supposed to be walked twice a day but there was not enough staff to do this. She indicated she was, "Very rarely being walked." Another interview was completed on 9/11/14, at 11:00 a.m. R47 stated she was, "upset, " about	F 310	2. All residents in the building will, have been and/or are currently in the process of being evaluated by physical and occupational therapies in order to establish a current "baseline" level of functioning as well as to determine the need for the appropriate restorative/functional maintenance/ambulation program. An effective restorative program is in the process of being established for all Residents who are assigned a restorative/functional maintenance/ambulation program. All newly-established restorative nursing programs will include measurable, attainable, individualized goals that will be reviewed on a monthly basis. 3. Both MDS Coordinators were sent to an in-service on Restorative Nursing Programs and ADL coding on 9/24/14. A designated Restorative RN and several restorative nursing assistants have been selected and are training for their roles in the newly-formulated Restorative Committee. They will soon play an active role in the development and effectiveness of the new restorative nursing programs. An educational in-service was held on 10/9/14 and 10/10/14 for all nursing department staff, regarding the importance of compliance with ambulation and other physical maintenance programs in order to promote resident dignity, independence and to maintain functional abilities, as well as	

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F 310	Continued From page 17 not being walked twice a day due to staff shortage. She stated, "They just don't have time to walk me." R47 stated she had been involved in therapy and the therapist recommended she be walked. Because staff had not been assisting her to walk, R47 stated her joints are getting stiff and was not able to move as easily as she had in the recent past. She stated the last time she could remember she was walked was about 7-10 days ago. R47's care plan dated 7/9/14, indicated R47 was to be ambulated per the "Restorative program." The restorative program was not specified in the plan of care. R47's nursing assistant care sheet, dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet, twice per day with assistance of one staff, a transfer belt, rolling walker, and wheelchair behind. R47's physical therapy note dated 8/7/14, indicated the resident was able to ambulate up to 80 feet with a rolling walker and contact guard assistance. R47 was seen in the occupational therapy (OT) department from 7/14/14 to 8/14/14. R47 was considered to be alert and able to follow directions. R47's discharge from OT on 8/14/14, indicated she transferred with contact guard assistance (CGA- the therapist would hold a transfer belt for stabilization), tolerated standing for greater than three minutes while she maintained a safe balance while using a 4 wheeled walker, had an increase in her endurance while performing her activities of daily living, and reported no increase in fatigue while	F 310	the equally important necessity of point-of-care documentation every time the programs are completed. Restorative Committee members will meet on a monthly basis and review the effectiveness and compliance of each resident's program, as well as to review the compliance associated with documentation of restorative program minutes. A structured process has been created for monitoring CNAs to ensure resident care is being completed each day as it reflects in the resident care plan, and consistent assignment lists have been implemented to ensure accountability of staff. Education has been provided to all nursing department staff about the new processes and assignments that have been put in place to help ensure care delivery, in addition to very clear expectations for completion that all department staff will be held accountable for during each shift that they work. Further, education has been provided to train staff of the expected and appropriate actions (asking for assistance from peers, their nurse, the Charge nurse or DON)to take if they feel they are unable to complete all of the assigned interventions as listed in the care plans, prior to falling behind or allowing resident care to be neglected. 4. DON will attend all monthly Restorative Meetings and DON/Designee will conduct random audits on residents with restorative and/or functional maintenance and/or ambulation programs for documentation compliance weekly x6 weeks, then monthly x3 months. In addition to the monthly restorative committee meeting minutes, results of all audits will be brought to QA for review and further recommendation.	

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F 310	Continued From page 18 performing her exercises. R47's physician orders dated 9/5/14, directed staff to ambulate the resident 57-115 feet twice daily with a wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, were reviewed from April 2014, to September 11, 2014 identified the following: -April 1 to June 30, 2014, R47 was ambulating twice a day, walking 57 to 115 feet consistently. -July, 2014, R47 was walked 15 times on the day shift, and twice on the evening shift. The last documentation of R47 being ambulated was 7/23/14, when she walked 115 feet. -August 2014, to September 11 2014, there was no documentation regarding R47 ambulating. During interview on 9/11/14, at 9:44 a.m. nursing assistant (NA)-J stated he was aware R47 was to be ambulated twice a day, however, he had never assisted R47 to ambulate. NA-J stated staff does not have time to complete R47 ambulation program because of short staff. During interview on 9/11/14, at 11:15 a.m. licensed practical nurse (LPN)-C stated R47 was to be ambulated twice a day, however, she stated there was no way to determine if R47 was being ambulated because there was no documentation. During interview on 9/11/14, at 2:39 p.m. physical therapy assistant (PTA)-E stated she had worked with R47 from 7/14/14, until her discharge from	F 310		

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F 310	Continued From page 19	F 310		

physical therapy on 8/12/14. PTA-E had recommended R47 be ambulated twice a day, 57-111 feet. PTA-E stated R47, "loved to be walked," and was able to consistently walk 80 feet when discharged from PT on 8/12/14.

During interview on 9/11/14, at 3:24 p.m. registered nurse (RN)-A (who was identified as the person in charge of Rehab/Restorative Services), stated there was no record of staff efforts to walk R47. RN-A stated staff was to ambulate R47 twice a day, however, she was not sure if this was being done, and was unsure if R47 had declined in her ability to ambulate. RN-A stated there was no formal nursing assessment completed of R47's ambulation program to ensure it was appropriate and being implemented as ordered. RN-A stated NA's had complained to her that they were unable to assist residents with ambulation related to being short staffed, however, NA-A verified the ambulation programs were not reassessed and no changes had been made with the program to ensure it was being completed.

During observation on 9/11/14, at 3:55 p.m. PTA-E assisted R47 to ambulate. R47 was able to walk 45-60 feet before becoming short of breath and needed to sit down. PTA-E stated R47's current ambulation ability was a decline from when the resident was discharged from physical therapy on 8/12/14.

Although the facility was aware R47 was not being ambulated as assessed by PT, the facility did not reassess and put interventions into place to ensure the resident did not decline in the ability to ambulate. R47's decline in ambulation ability related to the lack of the facility completing the

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F 310	Continued From page 20 ambulation program as assessed resulted in actual harm for R47. R7's annual MDS dated 8/27/14, identified R7 had severe cognitive impairment, had impairment (contracture) to one side of the upper extremity, required extensive two person assistance with transfers and walking in the corridor, was only able to stabilize when standing with staff assistance, and walking in the resident room, unit, and off the unit had not occurred during the 7 day prior look back period of the MDS completion date of 8/27/14. R7's CAAs dated 8/27/14, did not address R7's walking, transfer ability, or current contractures. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and both knees were bent and raised off the bed. R7's Physical Therapist Progress & Discharge Summary dated 3/4/14, indicated R7 was to ambulate 20-30 feet, using a four wheeled walker with assist of two staff, two times a day. R7 was able to hang onto the walker without hand support and did not need the platform walker on even services. PT also indicated R7's knee range of motion (ROM) was 26 degrees of left knee extension, and 22 degree of right knee extension. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57 feet with assistance of two staff, two times daily using a walker. R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine	F 310		

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F 310	Continued From page 21 Medications, located in the restorative nursing book, from April 2014 - September 2014, instructed two staff to walk the resident 29-57 feet, two times daily. There was no documentation identifying if staff was ambulating R7 from 4/2014- 9/2014. R7's care plan dated 9/3/14, indicated staff pushed R7 to all destinations in the wheelchair and transferred with assist of two with a transfer belt and walker. R7's care plan did not address if the resident was able to ambulate, nor did it instruct staff on R7's assessed ambulation program. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative/ ambulating program was in shambles right now, and she was trying to revamp the program to ensure residents were receiving their programs as assessed. RN-A was not aware R7 had not been ambulating or had a decline in transfer ability or ambulation, however, RN-A stated NA's had complained to her they were not able to complete residents ambulation programs becasue of short staffing. During interview on 9/11/14, at 1:42 p.m. NA-F stated R7 had a decline in ambulating as well as transfers, and staff was supposed to be walking her, however, R7 no longer walks, and staff did not have time to spend to try to assist her in walking prior. NA-F stated recently she had to order foot pedals for R7 because she could no longer raise her feet up when in the wheelchair when staff were pushing her to destinations. During interview on 9/11/14, at 1:57 p.m. RN-D stated she had observed R7 ambulating and transferring a few months ago, and R7, "got to	F 310		

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F 310	Continued From page 22 the point," of being unable to bear weight on the walker, so staff was transferring the resident using a hand in hand method. RN-D stated she had done no formal assessment of R7's ambulation program when it was noted R7's ambulation program was not being implemented as assessed and R7 was noted to be declining in her ability to transfer and ambulate. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, and stated R7 was resistive and had some contractures in her left hand and bilateral knees. PTA-E and COTA-D transferred R7 from the wheelchair to her bed. During the transfer, R7 did not take any steps, bear any weight on her feet, and was lifted into bed with heavy assist. During the evaluation, R7 stated, "ouch," on multiple occasions and grimaced when staff was attempting to straighten the resident's knees. PTA-E and COTA-D both verified R7 would benefit from therapy and should have been referred back to therapy when staff noted the resident was declining in transfers and no longer ambulating. COTA-D stated residents have expressed concerns with not being ambulated. Although the facility was aware R7's ambulation program was not being completed as assessed, and the resident was no longer ambulating and had a decline in transfers, the facility failed to reassess and refer the resident back to therapy. This resulted in actual harm for R7.	F 310		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 23 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to provide bathing assistance for 1 of 3 residents (R11) reviewed who was dependent on staff for bathing. Findings include: R11 quarterly Minimum data set (MDS) dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene, and was able to provide partial physical help for bathing. R11 care plan dated 9/4/14, indicated R11 needed assist of one staff for bathing and preferred to have a bath versus a shower, and the goal was to respect the resident's wishes and maintain autonomy, and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated she had recently gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. R11's Point of Care Bathing Record (where the nursing assistants (NA) document when a resident received a bath/shower), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath completed on 8/28/14, 28 days later. During interview on 9/11/14, at 10:13 a.m. NA-H	F 312	F-312 1. R11 receives baths routinely according to the frequency specified in her plan of care, and occasionally in addition to this, per her request. 2. Compliance with bathing schedules for all residents in the facility was reviewed and all residents are currently receiving their baths/showers at the frequency that is indicated in each individualized care plan. Further, the daily assignment schedules for resident bathing that the nursing assistants to follow each week was revised to be more evenly distributed across the span of the weekdays, and more evenly distributed amongst day and evening shifts, and thereby have become more manageable for the staff to complete each day. 3. A structured process has been created for monitoring CNAs to ensure bathing is being completed each day as it has been assigned, and consistent assignment lists have been implemented to ensure accountability of staff. Education has been provided to all nursing department staff about the new processes and assignments that have been put in place to help ensure care delivery, in addition to very clear expectations for completion that all department staff will be held accountable for during each shift that they work. Further, education has been	

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F 312	Continued From page 24 stated there were not enough staff to assist residents with baths and they were not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist with bathing. During interview on 9/12/14, at 9:34 a.m., NA-B stated the facility used to have a bath aid to provide resident baths, however, a few months ago the bath aid left the facility, so resident baths were not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, RN-A stated the facility was still working on a staffing pattern to ensure resident cares are being completed. A policy on resident bathing was requested but not provided.	F 312	provided to train staff of the expected and appropriate actions to take if they feel they are unable to complete the bath/showers that they are assigned each day, prior to ever falling behind and/or having a resident miss a bath/shower, in order to maintain the provision of quality resident care. 4. DON/Designee will audit compliance with bathing schedules and the associated documentation for every shift x7days, then weekly x6 weeks. Continued, random audits	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F-314 1. R-56 was re-evaluated by nursing staff and is now on a 1.5 hour turning and repositioning schedule, and being turned and repositioned according to the care plan. Nursing staff has been re-educated about the facilities pressure ulcer prevention policy, and the importance of compliance related to the turning and repositioning schedule in R[illegible]s care plan, as well as for all residents' care-planned turning and repositioning schedules. Due to resident's frequent refusals to be turned and repositioned, a low air loss alternating	5. Completion Date: October 22nd, 2014

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F 314	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R56) who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing. This resulted in actual harm for R56 related to the development of multiple pressure ulcers after admission to the facility. Findings include: R56's quarterly Minimum Data Set (MDS) dated 6/11/14, identified R56 had no cognitive impairment, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for developing pressure ulcers, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's most recent Care Area Assessment (CAA) dated 6/23/14, revealed R56 was at risk for pressure ulcer development, was on a turning and repositioning program, receiving pressure ulcer care with dressing application, and had a pressure reducing device for the chair and bed. R56 was identified as being admitted with pressure ulcers both heels. R56's care plan dated 8/16/14, identified R56 had a 1.3 x 0.3 unstageable pressure ulcer on the coccyx, should be repositioned at no greater than 2 hour intervals, had a pressure redistribution mattress on the bed, and a pressure redistribution wheelchair cushion.	F 314	pressure mattress has been implemented to help ensure turning and repositioning occurs as frequently as it is needed. Turning and repositioning schedules were reviewed for all residents who currently have pressure ulcers, and/or were identified to be at risk for pressure ulcers, to verify that all care plans reflect schedules that are effective in the pressure ulcer healing and/or prevention. NA-A has received counseling regarding the importance of following the care plan as well. 2. Other residents having the potential to be affected by the same deficient practice include residents who currently have pressure ulcers, have a Braden score of 18 or less, and/or have co-morbidities that result in increased risk of pressure ulcer formation. Care plans were reviewed for all of these residents and turning and repositioning compliance was verified through observation and the review of daily turning and repositioning documentation completed by registered nursing assistants every shift. 3. The following systemic changes have also been implemented to further assist the facility to prevent pressure ulcers: For all residents identified to be at risk of the formation of pressure ulcers, nursing assistants will complete daily skin checks every morning during routine cares and document their checks. In addition they	

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F 314	Continued From page 26 R56's Skin Observation Reports dated 1/2/14, through 6/5/14, indicated the resident's skin was intact and had no pressure ulcers. R56's Braden Scale (a tool used to assess pressure ulcer risk) dated 6/8/14, indicated the resident had a mild risk of developing pressure ulcers. The Braden scale assessment indicated R56 had recently gotten a new wheelchair cushion related to the risk of developing pressure ulcers. R56's Tissue Tolerance Evaluation (assessment to determine skins ability to withstand pressure) dated 6/17/14, identified non-blanchable redness at the three hour mark in the lying position, and was unable to change position independently. The evaluation indicated R56 had no redness at the one, two or three hour mark in the sitting position and was unable to change position independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 6/23/14, identified no redness at the one or two hour mark in the lying position, and able to reposition independently. The evaluation indicated there was blanchable redness at the two hour mark while sitting and that R56 could reposition independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 8/25/14, identified blanchable redness at the two hour mark in the wheelchair and the resident was unable to reposition independently. There was no further assessment of the tissue tolerance evaluation. R56's Skin Injury/Wound Report(s) dated 6/17/14,	F 314	must report any changes and/or unusual findings immediately to a licensed nurse for assessment and review. Additionally, licensed nurses will complete weekly skin assessments for these residents as well, and document assessment findings in resident progress notes. An in-service for all nursing staff was held on 10/9/14 & 10/10/14 to educate staff on the implementation of the new procedures regarding pressure ulcer prevention and monitoring. All nurses received education on the correct method for assessment/staging, intervention, evaluation & types of dressings according to the wound type on 10/15/14. 4. To ensure on-going compliance of care-planned turning and repositioning schedules, DON/Designee will ensure that turning and repositioning schedules are completed according to care plan by auditing compliance for 3 randomly-selected residents who currently have a pressure ulcer and/or are at risk of developing pressure ulcers weekly x6 weeks, then monthly x4 months. Audit results will be reported in monthly QA meetings x6 months for review and further recommendations. After 6 months, plans will be re-evaluated for continuation or satisfactory compliance	

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F 314	Continued From page 27 indicated R56 developed a pressure ulcer in the right gluteal fold measuring 0.5 centimeter (cm) x 0.8 cm with a pink wound bed, and was a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough). The area was cleansed and a protective cream applied, and the physician was faxed for further orders. Measurements of the pressure ulcer were documented weekly on the Skin Injury/ Wound Report. Review of the weekly monitoring from 6/17/14, through 9/10/14, indicated the pressure ulcer had worsened increasing in size and developing into an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough, yellow, tan, gray, green or brown, and/or eschar, tan, brown or black tissue, in the wound bed). On 9/10/14, the pressure ulcer was 1.5 cm x 2 cm, with a 70% slough yellow wound base and was unstageable. Another pressure ulcer was identified on a Skin Injury/Wound Report(s) dated 7/27/14, on the right buttock measuring 0.5 cm x 0.4 cm was identified by staff as, "trauma from the adhesive dressing being used on the gluteal fold." However, the area was identified as a "pressure ulcer," on the Skin Injury/Wound Report because it was located on a pressure area. On 8/29/14, the facility identified the pressure ulcer was a stage 2. The documentation of the pressure ulcer on 9/10/14, identified the pressure ulcer had worsened to an unstageable pressure ulcer, and increased in size with a description of the pressure ulcer as 2.5 cm x 2 cm, with 50% white/ yellow slough wound bed, and was currently unstageable. R56's current physician orders dated 9/5/14,	F 314		

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F 314	Continued From page 28 instructed staff to apply Tegaderm with foam dressing to reddened area on the sacrum, check every shift, and change every three days and as needed (PRN). Tegaderm with a foam dressing was to be applied to the right buttock, sacrum, and gluteal fold every 3 days and as needed (PRN). The physician orders also instructed staff that R56 was not appropriate to have three hour intervals ordered for repositioning programs due to skin issues, therefore, needed to be repositioned at no greater than every two hours. R56's Nurses notes dated 6/2/14. indicated the resident was admitted with two, stage 4 pressure ulcers on the right and left heel. R56 was being seen at the wound clinic for these wounds, and they had been debrided by the surgeon in the past. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair on a cushion, and was unable to shift his weight independently. Throughout the 2 hour and 28 minute observation, R56 was not approached by staff to reposition as assessed. During interview on 9/10/14, at 7:20 a.m., R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NAs did their best to assist residents to reposition as assessed. NA-A stated she was aware of R56's pressure ulcers on his buttocks and, "They were pretty open," right now. NA-A verified R56 was to be repositioned every 2 hours.	F 314		

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F 314	Continued From page 29 During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned after 2 hours and should lie down after breakfast. LPN-B requested assistance from staff to lay R56 down. During observation on 9/10/14, at 10:05 a.m. NA-B entered R56's room to reposition him, which was 2 hours and 47 minutes after the initial constant observation began, and 4 hours and 5 minutes since R56 stated he had been up in his chair. NA-B lifted R56 out of his chair using a standing lift and removed his brief. R56's buttocks were dark red in color and had a foam dressing on the right buttock. During interview on 9/10/14, at 11:23 a.m. registered nurse (RN)-A stated LPN-B had been the wound nurse, however, there was a recent re-assignment of wound duties and she was delegating them out to the staff. RN-A was unsure of the current condition of R56's ulcers. During interview on 9/10/14, at 11:35 a.m. LPN-B stated R56 had gotten a new wheelchair cushion when the buttock pressure ulcers developed around 6/21/14, and she though the resident currently had three pressure ulcers, however, LPN-B was not clear on the current condition of the pressure ulcers. LPN-B stated nursing decided to get R56 a new wheelchair cushion because the resident had complained he felt like he was sitting in a hole. LPN-B stated OT did not evaluate the resident to ensure the wheelchair cushion was appropriate. During observation of R56's current pressure ulcers on 9/10/14, at 1:58 p.m. the director of	F 314		

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F 314	Continued From page 30 nursing (DON) and LPN-B verified R56 had two open areas on his buttocks, one on the upper gluteal cleft which was whitish at the wound base and was an unstageable pressure ulcer with 90% slough wound bed which currently measured 1.5 cm x 2 cm. The second pressure ulcer was on the right buttock and had 60-70% slough that was whitish in color at the wound base and measured 2.5 cm x 2 cm, and was also unstageable. LPN-B stated both pressure ulcers had increased in size and stage since the last time she had seen them, however, LPN-B was unable to verify the last time she had observed R56 pressure ulcers. During interview on 9/10/14, at 2:17 p.m. certified occupational therapy assistant (COTA)-D stated she had not been involved in assessing R56 for adequate wheelchair positioning or the wheelchair cushion. During interview on 9/11/14, at 1:07 p.m. director of nursing (DON) stated she was not aware of R56's worsening pressure ulcers. DON stated R56 repositioning schedule of every two hours should have been re-evaluated after the pressure ulcers developed and worsened to ensure the schedule was individualized and adequate to promote healing of the pressure ulcers. During interview on 9/11/14, at 1:10 p.m. RN-B stated she was not aware of R56's worsening pressure ulcers so she had not discussed interventions with OT, nor had she reassessed the current interventions in place to ensure they were being implemented and were adequate to prevent further pressure ulcers. On 9/11/14, at 1:39 p.m., a call was placed to R56's medical doctor (MD)-C who was unable to	F 314		

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F 314	Continued From page 31 be reached to discuss R56's pressure ulcers. The facility policy, titled Repositioning, undated, indicated it was the policy of the facility to have in place a system to identify repositioning programs for each resident and repositioning every two hours or more frequently depending upon the resident's condition and tolerance of the tissue load may be implemented, and more frequent repositioning (i.e. off loading hourly) may be warranted for individuals at high risk for pressure ulcer development. The policy indicated the therapy department assessed postural alignment, weight distribution, sitting balance, stability, and pressure redistribution along with cushion/mattress recommendations in coordination with the nursing department. The facility policy titled Wound/Skin Care Policy, last revised 12/01/97, indicated an at-risk resident who sits too long on a static surface may be more prone to get ischial ulcerations.	F 314		
F 317 SS=G	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, range of motion (ROM) services were not	F 317	F-317 1. R7 & R55 were both evaluated by Physical and Occupational Therapies to establish a "baseline" of their current level of functional abilities, and a restorative OR functional maintenance program, including updated ambulation programs has been set up in order to more effectively address any functional limitations the resident may have, as well as to prevent any further decline. These updated programs will be communicated to the CNAs and restorative nursing staff to carry out consistently and according to the resident care plan. R7's CAAs were reviewed and modified to address the resident's walking, transfer ability and current contractures. All care plans were updated.	5. October 22nd, 2014

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F 317	Continued From page 32 provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Findings include: R55's quarterly Minimum Data Set (MDS) dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM (contractures), and was totally dependent on staff for transferring, toileting, dressing, and all activities of daily living. During interview on 9/8/14, at 5:55 p.m. registered nurse (RN)-A stated R55 had contractures (fixed high resistance to passive stretch of a muscle) in both knees only, did not utilize any splint devices, and was not receiving any formal ROM program. R55's care plan, last updated 6/9/14, did not identify the presence of any contractures nor did it instruct staff on the type of ROM exercises to be completed by staff. R55's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, was located in the restorative nursing book dated 1/1/14, through 6/30/14, and instructed staff R55 was to receive daily restorative nursing treatments which included the following: -Shoulder passive range of motion (PROM) 10-15 REPS-bilateral flexion/extension -Wrist PROM 10-15 reps bilateral flexion/extension -Ankle PROM 10-15 reps bilateral dorsiflexion/flexion -Digits PROM 10-15 reps bilateral	F 317	2. All residents in the building will, have been and/or are currently in the process of being evaluated by physical and occupational therapies in order to establish a current "baseline" level of functioning as well as to determine the need for the appropriate restorative/functional maintenance/ambulation program. An effective restorative program is in the process of being established for all Residents who are assigned a restorative/functional maintenance/ambulation program. All newly-established restorative nursing programs will include measurable, attainable, individualized goals that will be reviewed on a monthly basis. All recommended restorative programs will be part of the care plan and communicated to all nursing staff through both the care plan and the nursing communication book. 3. Both MDS Coordinators were sent to an in-service on Restorative Nursing Programs and ADL coding on 9/24/14. A designated Restorative RN and several restorative nursing assistants have been selected and are training for their roles in the newly-formulated Restorative Committee. They will soon play an active role in the development and effectiveness of the new restorative nursing programs. An educational in-service was held on 10/9/14 and 10/10/14 for all nursing department staff, regarding the importance of	

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F 317	Continued From page 33 flexion/extension -Elbow PROM 10-15 reps bilateral flexion/extension -Knee PROM 10-15 reps bilateral flexion/extension The 7/2014 restorative nursing sheet identified 3 restorative treatments were provided out of the 31 opportunities. The facility was unable to provide any restorative nursing sheets for R55 for the months of 8/2014, or 9/2014. The facility had no documentation any ROM was done for R55 for 2 months. The facility was unable to verify when R55's ROM program was started, and if it had been reassessed at any time to determine if it was appropriate for R55. Review of R55's Electronic Point Of Care Record from 7/1/14, to 9/12/14, did not identify R55 received any ROM services, nor was there any assessment to ensure the ROM program was appropriate for R55. During observation on 9/10/14, at 7:18 a.m. R55 was observed being assisted with dressing. R55's legs would not fully extend and rest on the bed, and the residents knees stayed bent. Nursing assistant (NA)-B was unable to raise R55's arms above her head to put on her shirt, and instead needed to slide the shirt up R55's arms and then stretch it over her head. R55 was not able to lift up her arms or straighten her arms from the elbow. NA-B verified R55 was becoming more stiff. During interview on 9/10/14, at 11:50 a.m. NA-B stated R55's ROM exercises were not being completed because they didn't have enough staff	F 317	compliance with ambulation and other physical maintenance programs in order to promote resident dignity, independence and to maintain functional abilities, as well as the equally important necessity of point-of-care documentation every time the programs are completed. Restorative Committee members will meet on a monthly basis and review the effectiveness and compliance of each resident's program, as well as to review the compliance associated with documentation of restorative program minutes. A structured process has been created for monitoring CNAs to ensure resident care is being completed each day as it reflects in the resident care plan, and consistent assignment lists have been implemented to ensure accountability of staff. Education has been provided to all nursing department staff about the new processes and assignments that have been put in place to help ensure care delivery, in addition to very clear expectations for completion that all department staff will be held accountable for during each shift that they work. Further, education has been provided to train staff of the expected and appropriate actions to take if they feel they are unable to complete all of the assigned interventions as listed in the care plans, prior to falling behind or allowing resident care to be neglected.	

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F 317	Continued From page 34 to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises which the resident had been assessed as needing. During interview on 9/10/14, at 12:45 p.m., RN-C stated when restorative services or ROM was provided to the residents, the NAs should document in Point of Care when it was completed. RN-C was unable to provide any further documentation that R55 was receiving any ROM services, and verified there was no documentation in Point of Care R55 was receiving any ROM services. During interview on 9/11/14, at 9:38 a.m. licensed practical nurse (LPN)-B stated the NAs were responsible for completing the ROM treatments for the residents as well as charting when it was completed in the residents electronic point of care record. LPN-B was not aware R55's ROM was not being completed. R55's Physical Therapy Discharge Summary dated 9/6/11, indicated R55 demonstrated passive stretching of the right knee to 22 degrees and 25 degrees of the left knee. R55 was noted to be pain free and would be discharged to continue bilateral lower extremity ROM program with staff. R55's Occupational Therapy Discharge Summary dated 7/17/12, indicated R55 exhibited proper hip/knee/ankle alignment while in the wheelchair. The summary did not note the presence of any upper extremity contractures. During interview on 9/10/14, at 2:03 p.m. certified occupational therapy assistant (COTA)-D	F 317	4. DON will attend all monthly Restorative Meetings and DON/Designee will conduct random audits on residents with restorative and/or functional maintenance and/or ambulation programs for documentation compliance weekly x6 weeks, then monthly x3 months. In addition to the monthly restorative committee meeting minutes, results of all audits will be brought to QA for review and further recommendation.	

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F 317	Continued From page 35 examined R55's upper extremities and indicated R55 was somewhat resistant when attempting to evaluate total ROM, so she was unable to completely assess the degree of the shoulder, wrist, and finger contractures. However, COTA-D indicated R55 appeared to have bilateral upper extremity contractures, which she was not aware of prior. COTA-D stated R55 would definitely benefit from a splint device for the right thumb which was identified to be the most contracted joint during the exam. Physical therapy assistant (PTA)-E was also interviewed at this time and completed an exam of R55's lower extremities. PTA-E stated when compared to the most recent physical therapy discharge summary dated 9/6/11, R55's knee contractures had worsened. PTA-E stated the right knee contractures had worsened to 55 degrees compared to 22 degrees before, and the left knee was now at 35 degrees compared to 25 degrees prior. COTA-D and PTA-E both verified R55 should be receiving ROM as had been assessed, and should have been referred back to OT/PT when staff noted R55's knees were becoming more contracted, and noted a decline in the resident's ability to move the upper extremities when being assisted with dressing. During interview on 9/11/14, at 9:09 a.m. family (FM)-A stated recently staff had asked him to purchase larger pants and different types of shirts so it would be easier to dress R55. FM-A stated R55 was becoming so stiff she was not able to lift her arms and straighten her knees so it was a struggle to get her dressed every day. FM-A stated staff asked for shirts that opened in the back, as well as larger pants, to make it slide on better.	F 317		

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F 317	Continued From page 36 During interview on 9/11/14, at 10:13 a.m. NA-H stated range of motion services were not being completed and R55 was becoming stiff as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult, so staff asked the resident's family member to bring in different clothing. During another interview on 9/11/14, at 11:10 a.m. RN-A confirmed there was no formal ROM assessment in place for R55 to ensure the current restorative program was being implemented as assessed, nor to ensure the program is adequate to prevent further decrease in ROM. RN-A stated the NA's had brought up concerns about not having enough staff to complete resident ROM programs, however, she stated the facility had not reviewed the current resorative nursing programs to ensure they could be completed. The facility failed to ensure R55's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R55 was having further difficulty with dressing related to decrease in ROM, the facility failed to provide further interventions and reassessment which resulted in actual harm to R55. R7's annual MDS dated 8/27/14, indicated R7 had severe cognitive impairment and had ROM impairment (contracture) to one side of the upper extremity. R7's clinic note dated 3/21/14, indicated the resident had a chronic right hand contracture	F 317		

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F 317	Continued From page 37 which was released with surgery, had no pain, and was regaining muscular function back in the right hand. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and her left hand was in a fist. During observation on 9/10/14, at 6:53 a.m. R7 was sitting in her wheelchair in the activities room and her left hand was closed in a fist. During observation on 9/11/14, at 9:40 a.m. R7 was sitting in the activity room with her left hand closed in a fist. During observation on 9/12/14, at 8:40 a.m. R7 was sitting in the dining room with her left hand up to her face with her fingers bent inward. During observation of R7 from 9/9/14- 9/12/14, R7 was not observed to release the fist of her left hand, nor did she attempt to use her left hand. R7's PT Progress and Discharge Summary dated 3/4/14, indicated the resident was able to hang onto the walker without hand support, and was to receive ROM. R7's current Physician Orders sheets for September 2014, instructed staff the resident was to receive the following restorative nursing program: · Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral	F 317		

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F 317	Continued From page 38 flexion/extension 1x · Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 · Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, indicated the resident had a right hand contracture. The restorative nursing sheets reviewed from April 2014, - September 2014, noted the following program to be completed for R7 on the day shift: · Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2	F 317		

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F 317	Continued From page 39 · Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets for April 2014 - September 2014, noted the restorative nursing program to be completed for R7 on the day shift, however, there was no documentation R7 was receiving any ROM. R7's care plan dated 6/11/14, identified R7 had a right hand contracture. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, who both verified R7 was resistive and had some contracture(s) in her left hand and bilateral knees. During the evaluation R7 grimaced and stated, "Ouch" on multiple occasions when PTA-E and COTA-D were attempting ROM. COTA-D and PTA-E both stated R7 would benefit from therapy and possibly a splint or cone for the new contracture in her left hand. During interview on 9/9/14, at 9:46 a.m. RN-A stated R7 had a contracture to her right hand and had surgery to release part of the contracture. RN-A stated the restorative program was not being completed for residents as assessed, and she was trying to revamp the program. RN-A stated R7 should be receiving the ROM services as had been assessed by PT. RN-A was not aware of R7's left hand or bilateral knee contractures. An interview on 9/10/14, at 1:00 p.m. was completed with NA-A who stated staff was not able to complete ROM for residents and stated, "I feel sorry for the residents because they need the range of motion." NA-A stated staff just does not	F 317		

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F 317	Continued From page 40 have any extra time to provide any ROM or ambulation. During interview on 9/11/14, at 1:57 p.m. RN-D stated R7 had a contracture to the right hand, which was repaired via surgery, and was the contracture identified on the resident's MDS. RN-D stated several months ago R7 got to the point of being unable to hang onto the walker with her hands, so staff was ambulating the resident hand in hand. RN-D stated R7 was noted at that time to have a decline in ROM in her left hand related to being unable to hang onto the walker, however, R7's restorative program was not reassessed, and the resident was not referred back to PT to prevent further decline in ROM ability. The facility failed to ensure R7's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R7 was no longer able to hang onto the walker to ambulate, the facility failed to provide further interventions and reassessment which resulted in actual harm to R7. The facility policy titled Restorative Nursing, undated, identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions	F 317		

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F 317	Continued From page 41 must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy further identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned. The summary of the policy documented the following, "Restorative nursing was mandated by OBRA [Omnibus Budget Reconciliation Act] in 1987, as a means to keep residents at their highest possible practicable physical, mental and psychosocial level. Maintaining function enhances dignity and self-esteem. It is the primary reason for implementing effective restorative nursing programs. A comprehensive organized program guides staff to accurately identify restorative needs, implement restorative programs that assure residents receive the restorative services as planned and document to maintain a permanent record of the entire process. It does not feel good to lose function. Loss of function decreases a person's self-worth and one's ability to experience and enjoy quality of life. An organized restorative program that	F 317		

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F 317	Continued From page 42 delivers systematic care based on the resident's individual needs increases self-esteem and worth and enhances well being."	F 317		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure range of motion and/ or ambulation services were provided to maintain current level of functioning for 3 of 5 residents (R31, R64, and R1) reviewed for range of motion and/ or ambulation services. Findings include: R31's quarterly Minimum data set (MDS) dated 6/11/14, indicated R31 had no current functional losses of range of motion in the upper or lower extremities. R31's care plan dated 8/20/14, indicated R31 was to receive 10-15 repetitions daily, passive range of motion (PROM) to hips, knees, bilateral shoulders, elbows, writs, fingers, and ankles. R31's restorative nursing PROM documentation from 7/2014, to 9/14/14, indicated R31 received	F 318	F-318 1. R31, R64 & R1 were all evaluated by Physical and Occupational Therapies to establish a "baseline" of their current level of functional abilities. A restorative OR functional maintenance program, including updated ambulation programs has been set up in order to more effectively address any functional limitations the resident may have, as well as to prevent any further decline. These updated programs will be communicated to the CNAs and restorative nursing staff to carry out consistently and according to the resident care plan. 2. All residents in the building will, have been and/or are currently in the process of being evaluated by physical and occupational therapies in order to establish a current "baseline" level of functioning as well as to determine the need for the appropriate restorative/functional maintenance/ambulation program. An effective restorative program is in the process of being established for all Residents who are assigned a restorative/functional maintenance/ambulation program. All newly-established restorative nursing programs will include measurable, attainable, individualized goals that will be reviewed on a monthly basis. . All recommended restorative programs will be part of the care plan and communicated to all nursing staff through both the care plan and the nursing communication book.	5. October 22nd, 2014

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F 318	Continued From page 43 range of motion services 3 out of 31 days for the month of 7/2014, and 12 days in the last month (8/12/14, through 9/14/14). During observation on 9/10/14, at 9:39 a.m. R31 was sitting in his wheelchair. R31 was not observed on 9/10/14, 9/11/14, and 9/12/14, receiving any ROM services. During interview on 9/10/14, at 2:00 p.m. physical therapy assistant (PTA)-E stated R31 had no current functional loss of range of motion in his lower extremities, however, would be at high risk for development of contractures if he continued to not receive the assessed range of motion services. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not receive any range of motion services other than routine dressing activities for the last several months related to lack of staffing. During interview on 9/11/14, at 3:18 p.m., R31 stated he had a stroke a while back and did not walk anymore, but would like to use his legs if he was given the chance. R31 stated he would be agreeable to completing leg exercises, however, he had not been completing them at the facility in the last few months. R64's quarterly MDS dated 8/13/14, indicated R64 had severe cognitive impairment, required extensive assistance for all ADL's including bed mobility, transferring, and walking. R64 was not steady, and was only able to stabilize with staff assistance. R64 had no impairment to his upper or lower extremity range of motion.	F 318	3. Both MDS Coordinators were sent to an in-service on Restorative Nursing Programs and ADL coding on 9/24/14. A designated Restorative RN and several restorative nursing assistants have been selected and are training for their roles in the newly-formulated Restorative Committee. They will soon play an active role in the development and effectiveness of the new restorative nursing programs. An educational in-service was held on 10/9/14 and 10/10/14 for all nursing department staff, regarding the importance of compliance with ambulation and other physical maintenance programs in order to promote resident dignity, independence and to maintain functional abilities, as well as the equally important necessity of point-of-care documentation every time the programs are completed. Restorative Committee members will meet on a monthly basis and review the effectiveness and compliance of each resident's program, as well as to review the compliance associated with documentation of restorative program minutes. A structured process has been created for monitoring CNAs to ensure resident care is being completed each day as it reflects in the resident care plan, and consistent assignment lists have been implemented to ensure accountability of staff. Education has been provided to all nursing department staff about the new processes and assignments that have been put in place to help ensure care delivery, in addition to very clear expectations for completion that all	

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F 318	Continued From page 44 R64's Physical therapy discharge summary dated 5/16/14, indicated R64 had significant improvement in bed mobility and pivot transfers, could ambulate up to 230 feet, and was discharged on a restorative nursing ambulation program. R64's occupational therapy discharge summary dated 5/16/14, instructed the resident was to continue on the restorative nursing ambulation program. During a review of R64's care plan dated 8/15/14, R64 was to have cervical (neck) active (subject moves their own joint) range of motion per physical therapy (PT) and occupational therapy (OT) recommendations. The care plan also directed staff R64 was to ambulate with restorative nursing. A Nursing Assistant Care Sheet (which staff used to know a residents individual care needs) dated 9/12/14, directed staff to ambulate R64, 115-230 feet twice a day on the day shift, with assist of 1 staff using a transfer belt and a walker. R64's nursing rehab time log in the electronic medical record, (which identified if the resident received any PROM or ambulation), lacked evidence any nursing rehab (ambulation or PROM) was completed for the months of 7/14, 8/14, or 9/14. During interview on 9/10/14, at 1:00 p.m. nursing assistant (NA)-A stated staff did not have time to ambulate or do resident ROM program for R64 because they are short staffed. During interview on 9/11/14, at 10:45 a.m.	F 318	department staff will be held accountable for during each shift that they work. Further, education has been provided to train staff of the expected and appropriate actions to take if they feel they are unable to complete all of the assigned interventions as listed in the care plans, prior to falling behind or allowing resident care to be neglected. 4. DON will attend all monthly Restorative Meetings and DON/Designee will conduct random audits on residents with restorative and/or functional maintenance and/or ambulation programs for documentation compliance weekly x6 weeks, then monthly x3 months. In addition to the monthly restorative committee meeting minutes, results of all audits will be brought to QA for review and further recommendation.	

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F 318	Continued From page 45 physical therapy assistant (PTA)-E stated R64 had contractures of his knees and needed to be walked and receive the PROM to ensure the contractures don't get worse. During observation on 9/11/14, at 1:50 p.m. R64 was assisted by PTA-E and COTA-D to ambulate in the hallway. R64 needed encouragement and time to get up from his recliner, but did ambulate with his walker to the nurse's station. PTA-E and COTA-D stated R64's ability to ambulate was, "About the same," as when he was discharged from services on 5/16/14, and there was no decline in ROM or ambulation. During an interview on 9/12/14, at 11:00 a.m. registered nurse (RN)-C stated the nursing assistants should be documenting the completion of passive range of motion and ambulation in the residents electronic medical record program. RN-C verified R64's nursing rehab time log was blank for 7/14, 8/14, and 9/14, therefore, there was no way for the facility to identify if R64 was receiving PROM or being ambulated. RN-C stated there currently was not a nurse who was responsible for assessing residents restorative nursing program to ensure it was being completed or was appropriate for the residents. R1 Quarterly MDS dated 6/25/14, indicated R1 had functional limitation in range of motion (ROM) to one side of the upper and lower extremities. R1's care plan dated 7/2/14, indicated R1 was to receive daily passive range of motion (PROM) 10-15 reps, to bilateral shoulders, elbows, wrists, and fingers.	F 318		

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F 318	Continued From page 46 R1's restorative nursing program identified the resident was to receive the following daily: · Ankle PROM 10-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 0-15 reps bilateral flexion/extension abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Wrist PROM 10-15 reps bilateral flexion/extension 1x Review of R1's documentation of the restorative nursing program from April 2014, through September 2014, were all blank, indicating the ROM program had not been completed for 5 months. When interviewed on 9/10/14, at 7:10 a.m. licensed practical nurse (LPN)-A stated there was no longer a restorative NA employed by the facility, so the NA's staffed on the floor are supposed to be providing the ROM and ambulation for the residents, however, they don't have enough staff to ensure this is being completed. LPN-A stated residents have complained of not walking or receiving their ROM and feel they have lost strength. When interviewed on 9/10/14, at 9:18 a.m. NA-E stated ROM and ambulation of residents was not being done due to being short staffed, and	F 318		

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F 318	Continued From page 47 verified R1's restorative nursing was not being completed. During interview on 9/11/14, at 9:25 a.m. R1 non-verbally responded by motioning in a back and forth motion with her hand to indicate, "so-so," when asked if staff was assisting her with ROM and ambulation on a daily basis. When R1 was asked how often staff was assisting, R1 spelled out, "monthly" on her communication board. When interviewed on 9/12/14, at 9:49 a.m. COTA-D stated R1 would be at risk for increased contractures if PROM and ambulation was not being done, however, COTA-D was not aware of R1 having any declines in ROM or ambulation. The facility undated policy titled Restorative Nursing identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical, and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided	F 318		

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F 318	Continued From page 48 a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident falls were thoroughly assessed to ensure appropriate/pertinent interventions could be implemented or revised, for 2 of 2 residents (R64, R3), with multiple falls. Findings include: R64 admission face sheet, dated 2/24/12, indicated the resident had diagnoses including weakness, dementia, and incontinence. R64's quarterly Minimum Data Set (MDS) dated 8/13/14, indicated R64 had severe cognitive impairment, required extensive assistance for all	F 323	1. The fall history over the past 14 months was reviewed for both R3 and R64. The review included a thorough investigation attempting to identify any patterns, trends contributing factors, and/or effectiveness of previous interventions. Full medication reviews were conducted as well. Based on these reviews, several new fall-prevention interventions were implemented and these new interventions will be evaluated for effectiveness on an as-needed basis.	

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F 156	Continued From page 3 R57 was admitted to the facility with skilled medicare coverage on 1/17/14. R57's denial letters contained only the CMS 10123, indicating R57's last covered day was 3/19/14. R57 records did not contain the required notice of medicare coverage on continued stay. R57 remained in the facility after her medicare coverage was discontinued. During interview on 9/11/14, at approximately 10:00 a.m. director of nursing (DON) stated the facility did not have a policy specific to how to issue medicare denials, and verified there were no other denial letters on file for R11 or R57. DON provided copies of a Haven Homes Medicare Assessment Tool and a blank notice of medicare coverage on continued stay, however, these did not address the facility process on how to inform residents of medicare appeal rights or for required denial letters the residents must receive.	F 156	3. DON/Designee will conduct an in-service on 10/16/14 for employees who have been designated as the responsible parties for issuing the NOMNC and/or NEMB-SNF to the residents and/or their POAs, regarding the CMS forms that are required, as well as the proper way to issue these denials to the receiving party. The policy for issuing Medicare denials will also be reviewed at that time, and directions intended to guide them with this process will be provided to the for them to use as a reference in the future.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents observed during dining who required staff assistance, (R12, R52, R66 and R7), were provided assistance in a dignified manner.	F 241	4. DON/Designee will conduct monthly audits of all Medicare Denials issued throughout each month for timeliness and use of the appropriate forms per CMS guidelines. This will be done each month x6 months. Results will be brought to the QA Committee for further review and/or recommendation. 5. October 22nd, 2014	

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F 323	Continued From page 49 activities of daily living (ADL), including bed mobility, transfer, walking, and toilet use. R64 was not steady, and only able to stabilize with staff assistance. R64's care plan dated 8/19/14, indicated R64 was at high risk for falls and had falls prior to and after admission to the the facility. Staff were directed to anticipate R64's toileting needs, place the floor mat on the floor when in bed, have the call light safety alarm system on while in bed, wear gripper socks while in bed, ensure safety alarm was on R64's wheelchair/chair, and ensure an anti-rollback device was on the residents wheelchair. R64's Fall Risk/Restraint Evaluation Review dated 5/20/14, indicated, "Resident remains high falls risk; [six] 6 falls in [three] 3 months. Resident attempts self transfers frequently. Confused and delusional reverting to his days of being a pastor... Gripper socks when in bed; W/C [wheelchair] alarm; motion sensor; Bed alarm system remain appropriate. Floor mat added." R64's progress notes indicated the resident had a fall on 7/27/14. According to the progress notes, R64's alarm sounded, and the resident was observed sitting on the floor at his bedside and had no injuries. R64 was alert, and reported he wanted to go to school and rolled out of bed. R64 told staff he needed to go to the bathroom and staff assisted the resident to the bathroom and he urinated. Staff was unable to provide any further assessment or investigation of the fall to determine if current interventions were appropriate, new interventions were needed, and if R64's toileting plan was being implemented and was appropriate to prevent further falls.	F 323	2. All residents with 3 or more falls in the past 2 months, OR one fall with major injury in the past 6 months, will be subject to the same review/investigation described in #1. Additional interventions were implemented for these residents as well. 3. On 10/9/14 or 10/10/14, DON held an in-service during which a thorough review of the Haven Homes Fall Prevention Policy was reviewed. During this time training was also provided for effective fall prevention techniques and interventions in the long term care environment, and what their role is in preventing resident falls. This policy operates under the notion that all nursing department employees are members of the Fall Reduction Committee, and all members are involved in the mandatory fall scene investigation report that is required to involve all staff on the floor at the time of the fall every time a fall occurs.	

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F 323	Continued From page 50 R64's progress notes indicated the resident had another fall on 8/24/14. According to the progress notes, R64's alarm sounded, and he was observed on the floor on his buttocks. No injuries were noted. R64 indicated he needed to clip his nails. Staff was unable to provide any further assessment or investigation of the fall to determine if current interventions were appropriate, if there were any trends with the residents falls, or if new interventions were needed to prevent further falls. During interview on 9/12/14, at 10:00 a.m., registered nurse (RN)-B stated she was in charge of conducting post fall investigations. RN-B stated there was no further information available regarding these falls, and post fall assessments were not completed to determine what may have caused the fall, if there were any trends noted, if the current interventions were appropriate, or if the interventions needed to be modified. RN-B stated, "We are working on that...I didn't even know he [R64] had a fall last week." Although R64's fall assessment dated 5/20/14, indicated the resident had fallen six times in the prior three months while a resident in the facility , the facility was unable to provide progress notes, incident reports, or any documentation regarding the falls they had identified in the fall assessment. R3's diagnoses listed on the undated facesheet included visual loss, spasm of muscle, abnormal involuntary movements, lack of coordination, dementia, and frequency of urination. R3's quarterly MDS dated 7/2/14, indicated R3	F 323	Staff are required to meet as soon as possible after the fall occurs to conduct an investigation to identify all contributing factors and conduct a root cause analysis for the ultimate cause of the fall. Finally, staff must come up with a new intervention related to the identified root cause, with the hopes of preventing additional falls of this type in the future. A educational in-service was provided on 10/9/14 or 10/10/14 for all members of the nursing team, where the fall prevention policy was reviewed and additional education regarding fall prevention interventions were reviewed.	

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F 323	Continued From page 51 was severely cognitively impaired, required extensive assistance with all ADL's, and was not steady when standing or transferring. During an interview on 9/8/14, at 4:20 p.m., RN-A stated R3 had three recent falls, on 8/20/14, 8/22/14, and 9/4/14. RN-A stated R3 was impulsive and leaned forward in her chair and often rolled out of her chair. RN-A stated R3 was not injured during these falls. During multiple observations on 9/10/14, R3 was seated in her wheelchair, in the area in front of the nurses station. R3 had a alarm clipped to the back of her blouse, and had a Safe-T-Mate anti-rollback device on her wheelchair. R3 attempted to stand many times and multiple staff members attempted to redirect R3 and assisted her to sit down. R3 was able to self propel her wheelchair and would often lean forward in her wheelchair which would sound the alarm which was attached to her. On one occasion, a staff member offered R3 a magazine, which R3 sat and read calmly in her wheelchair for several minutes paging through the magazine and talking about each picture. R3's care plan dated 7/8/14; indicated R3 was at risk for additional falls due to a history of frequent falls. Staff were directed to observe for unsafe practices and to anticipate R3's needs, especially toileting needs. The care plan also directed staff to offer activities to keep her busy, to offer towels for folding, cloths to wipe surfaces she could reach, and dolls to dress and undress. R3's progress notes related to her recent falls, included the following: On 8/20/14, R3 stood up from her wheelchair	F 323	4. DON/Designee will conduct post-fall reviews for the next 5 falls that occur in the building, in addition to random monthly audits of all falls that occurred in the facility throughout the previous month to ensure that policy is being followed. Monthly audits will continue x6 months with results to QA for review and further recommendation. 5. October 22nd, 2014	

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F 323	Continued From page 52 outside of her room and fell to her knees. There were no injuries noted. R3 indicated she was going to get to her appointment. Staff noted increased confusion after lunchtime and R3 was toileted and laid down for nap. Staff was unable to provide any further assessment of the fall to determine the cause of the fall, if current interventions were appropriate, or if new interventions were needed. On 08/22/2014, R3's alarm sounded and she was observed slowly falling to the floor in the activity room. No injuries were noted. R3 stated she was attempting to get up and walk out of the activity room when she fell. R3 was assisted back into her wheelchair and promptly assisted to the restroom to be toileted. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. On 9/5/14, R3's alarm sounded and staff witnessed her standing and then falling by the desk in the main parlor. R3 stated she was standing to reach for the watermelon that was in front of her at the desk. R3 was assisted back into her wheelchair and the food was placed closer to her. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. During an interview on 9/12/14, at 10:00 a.m., registered nurse (RN)-B indicated she was in charge of conducting post fall investigations. RN-B stated there was no further information available regarding R3's falls. Post fall assessments were not completed to determine what may have caused R3's falls, if there were any trends noted, if the current interventions were appropriate, or if the plan of care was being	F 323		

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F 323	Continued From page 53 followed. The facility undated policy titled Fall Prevention and Risk/Restraint Evaluation included, "The Post Fall Evaluation will be completed by the DON [director of nursing] or her/his designee within 72 hours after a resident fall."	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient nursing staff was available to provide services in	F 353	F 353 1. R11 receives baths routinely according to the frequency specified in her plan of care, and occasionally in addition to this, per her request. R1, R7, R47, R31 & R55 were all evaluated by Physical and Occupational Therapies to establish a "baseline" of their current level of functional abilities, and a restorative OR functional maintenance program, including updated ambulation programs has been set up in order to more effectively address any functional limitations the resident may have, as well as to prevent any further decline. These updated programs will be communicated to the CNAs and restorative nursing staff to carry out consistently and according to the resident care plan. R7's CAAs were reviewed and modified to address the resident's walking, transfer ability and current contractures. R 52 expired on 9/23/14. R-56 was re-evaluated by nursing staff and is now on a 1.5 hour turning and repositioning schedule, and being turned and repositioned according to the care plan. Nursing staff has been re-educated about the facilities pressure ulcer prevention policy, and the importance of compliance related to the	5. October 22nd 2014

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F 353	Continued From page 54 accordance with each resident's needs for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility. R7 was not being walked according to the assessed restorative nursing orders. During interview on 9/11/14, at 1:42 p.m. NA-F stated the facility did not have enough staff to walk R7, and as a result, she felt R7 had a decline in ambulation and possibly range of motion. NA-F reported R7 had difficulty with transferring now, and was unable to raise her feet up while in the wheelchair. R7's annual Minimum Data Set (MDS) dated 8/27/14, identified she had severe cognitive impairment, impairment (contractures) to one side of the upper extremity, and required extensive two person assistance with transfers/walking. Her balance was impaired and she could only stand with staff assistance. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57 feet with assistance of two staff, twice daily using a walker. R7's restorative nursing documentation from April 2014 - September 2014, lacked documentation that R7 had been walked/ambulated by staff from 4/2014 to 9/2014. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative program was in shambles right now, and she was trying to revamp the	F 353	turning and repositioning schedule in R-75's care plan, as well as for all residents' care-planned turning and repositioning schedules. R12, R66 & R7 are currently provided assistance with dining in a more dignified manner. DON contacted FM-B on 10/10/14 to inquire about the concerns brought forth on 9/10/14, as there was no previous record or formal complaint on file. FM-B was satisfied with explanation about cares and additional training . In the future DON will work with FM-B to resolve concerns according to the grievances policy. 2. The facility has determined that all other residents in the building are potentially at risk to be affected by this practice. 3. DON worked on the floor with the CNAs on several occasions & on all shifts in order to evaluate the workload and/or determine if there is enough staff present. DON and Administrator also investigated reasons and/or explanations for times when different employees successfully and timely completed all cares for all residents with, on one occasion, even 2 less CNAs as compared to what is normally staffed. CNA staffing hours have also been compared to high performing neighboring facilities with similar census and case mix, all of which show significantly less staff than Haven Homes. As a result, consistent assignments have been developed and will go into effect during the week of 10/13/14. Daily assignment	

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F 353	Continued From page 55 program. She verified there was no evidence that R7 was being walked. An interview on 9/10/14, at 1:00 p.m. was completed with NA-A who stated staff tries to ambulate residents, but it does not always happen because of the lack of staffing. NA-A stated staff was not able to complete ROM for residents either, and stated, "I feel sorry for the residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. R47 stated during interview on 9/8/14, at 3:57 p.m., there was not sufficient staff at the present time. She stated she waited for over 20 minutes and all the way up to an hour for staff to respond to her call light and did not feel that was acceptable. She also reported that due to staffing shortage, she had to wait a long time to be served her food and by the time she gets her food it is cold. During a second interview on 9/8/14, at 7:02 p.m. R47 stated she would transfer herself to the bathroom as staff does not respond to her call light. She stated she, "Refuses," to be incontinent of urine or stool because of having to wait for staff, and as a result will transfer herself. She stated she was aware she was not supposed to transfer herself to the bathroom because of previous falls, however, she can not wait for staff over 20 minutes for assistance. She reported the nursing assistants are aware she does this due to staff shortage. R47 stated she is supposed to be assisted with walking twice a day, however, staff is not able to do this as they just don't have time, and she didn't think she had been walked for about 10 days.	F 353	schedules for resident bathing that the nursing assistants to follow each week was revised to be more evenly distributed across the span of the weekdays, and more evenly distributed amongst day and evening shifts, and thereby have become more manageable for the staff to complete each day. No additional shfits were added. A structured process has been created for monitoring CNAs to ensure cares are being completed as it has been assigned, and consistent assignment lists have been implemented to ensure accountability of staff. Education has been provided to all nursing department staff on 10/9 & 10/10/14 about the new processes and assignments to help ensure care delivery, in addition to very clear expectations for completion that all department staff will be held accountable for during each shift that they work. Further, education has also been provided to train staff of the expected and appropriate actions to take if they feel they are unable to complete the bath/showers that they are assigned each day, prior to ever falling behind and/or having a resident miss a bath/shower, in order to maintain the provision of quality resident care. Additional training for Supervision for nurses in the building will be conducted on 10/13 to help the nurses be better able to hold CNAs accountable. DON will also provide some education on 10/9 or 10/10/14 regarding	

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F 353	Continued From page 56 A family member (FM)-B of R47 was interviewed on 9/10/14, at 1:15 p.m. and stated he had talked to staff a "couple of times" that R47 was not being walked and he was concerned she would lose strength. FM-B stated R47 was to be walked twice each day, but it seldom happened. FM-B stated R47 had fallen a couple of times as she was not willing to be incontinent while waiting for assistance from staff when her call light was not answered for long periods of time. FM-B also stated there were times when he visited and the call light was on for over 15 minutes and he would have to go out to the hall and try to find staff to assist her. R47's quarterly MDS dated 7/2/14, indicated R47 was cognitively intact with no signs or symptoms of delirium. She needed extensive assistance of two staff with bed mobility, extensive assistance of one staff for transfers, dressing, toilet use and personal hygiene. R47 needed extensive assistance of one staff with ambulation. R47's nursing assistant care sheet dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet twice per day with assistance of one staff, a transfer belt, rolling walker and wheelchair behind. Physician orders, signed 9/5/14, directed staff to complete passive range of motion to wrists, ankles, digits, knees, elbows, shoulder and hips daily. In addition, the physician ordered that R47 be walked 57-115 feet twice a daily with a wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets for August, 2014	F 353	the importance and necessity of point of care documentation and the indirect effect that it can have on staffing levels. 4. DON will ensure that staffing levels remain adequate and at a level where all residents receive the care they need via use of call light audits, documentation reviews of ambulation and/or restorative programs. Audits (completed by Charge Nurse) will be conducted daily x7 days, then weekly x6 weeks with results brought to QA for further review and recommendation.	

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F 353	Continued From page 57 to September, 2014 were reviewed and there was no documentation that R47 received any passive range of motion to extremities or ambulation. An interview with licensed practical nurse (LPN)-C was completed on 9/11/14, at 11:15 a.m. and she stated she was aware R47 was to be walked twice a day with staff assistance. LPN-C stated there was no documentation on the restorative nursing sheets to identify if R47 had been assisted with ambulation or any PROM in the prior months. R1 reported on 9/9/14, at 1:10 p.m. she did not feel there were sufficient staff and she has been incontinent because the call light was not being answered fast enough. R1 also was concerned she had not been receiving ROM, and when asked how often she had been receiving ROM services, she spelt out, "monthly," using her communication board. R1's quarterly MDS completed 6/25/14, indicated R1 had moderate cognitive ability, had no signs or symptoms of delirium/ psychosis, had no behavioral issues, and had limitations to one side of her upper and lower extremity (contractures). R1's care plan dated 7/2/14, and restorative nursing sheets from 4/2014- 9/2014, directed staff to provide passive range of motion daily to both shoulders, elbows, wrists, and fingers. R1's restorative nursing sheets for April 2014, to September 12, 2014 lacked any documentation that passive range of motion was being done for R1. During an interview on 9/10/14, at 7:10 a.m.	F 353		

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F 353	Continued From page 58 licensed practical nurse (LPN)-A stated NAs did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14, at 1:25 p.m. NA-B stated the restorative aide position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to residents. When interviewed on 9/11/14 at 10:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated NA's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to help him. R31's quarterly MDS dated 6/11/14, indicated R31 was cognitively impaired, totally dependent on two staff for all transfers, and needed extensive assistance of one staff for all locomotion. R31's care plan dated 8/20/14, indicated R31 was to receive PROM motion to hips, knees, and ankles 10-15 repetitions daily as well as to	F 353		

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F 353	Continued From page 59 bilateral shoulders, elbows, wrists and fingers. A review of R31's restorative nursing sheets from 8/12/14, through 9/14/14, indicated R31 received PROM only 12 times. RN-A stated the facility did not currently offer formalized restorative programs at the present time due to lack of staffing. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive any range of motion services. R55 was not receiving range of motion due to staff shortage. R55's quarterly MDS dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM, and was totally dependent on staff for transferring, toileting, dressing and all activities of daily living. R55 sheets from the restorative nursing book dated 1/1/14-6/30/14, instructed staff to ensure R55 received daily restorative treatments which included the following passive range of motion to shoulder, wrist, ankle, finger, elbows and knees. The 7/2014 MAR identified 3 restorative services were provided out of the 31 opportunities. The facility was unable to provide evidence that R55 had received passive range of motion from 8/14, to 9/11/14. During interview on 9/10/14, at 11:50 a.m., NA-B stated R55's ROM exercises were often not done because they didn't have enough staff to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises	F 353		

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F 353	Continued From page 60 which the resident had been assessed as needing. During interview on 9/11/14, at 10:13 a.m., NA-H stated range of motion services were not being completed and R55 was becoming stiffer as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult so facility staff asked the residents family member to bring in different clothing. R56 stated on 9/8/14, at 3:50 p.m. he did not feel the facility had enough staff. He reported having to wait a long time to have his call light answered. During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. The quarterly MDS dated 6/11/14, identified R56 was cognitively intact and he required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, and was at risk for developing pressure ulcers. He currently had one stage IV (Unstageable) pressure ulcer, that was present on admission over a year ago, and was unhealed. R56's admission care area assessment (CAA) dated 12/17/13, identified R56 was to be repositioned at no greater than two hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair and was unable to shift his weight independently, and was not approached by staff to assist the resident to reposition as	F 353		

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F 353	Continued From page 61 assessed. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NA's did their best to assist residents to reposition as assessed but at times were unable to do so. NA-A verified R56 had not been repositioned every two hours as assessed because of the facility not having sufficient staffing to provide resident cares. R11 stated during an interview on 9/8/14, at 4:23 p.m. she had gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. In addition, R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. She stated this happened a lot, and a few nights ago she had her call light on for over 40 minutes to go to the bathroom, no staff came to help her to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for toileting. R11's Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later. During interview on 9/9/14, at 3:03 p.m. NA-K stated there are not enough staff to provide residents a bath. NA-K stated she often is not able to complete all the resident cares because of	F 353		

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the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to being short staffed.

During interview on 9/10/14, at 2:23 p.m., NA-F stated it was possible that some residents had gone for weeks without getting a bath because the facility does not have enough staff to complete all the resident cares. NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected.

During interview on 9/11/14, at 10:13 a.m., NA-H stated there was not enough staff to accommodate baths for the residents, and resident baths are not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist residents.

During interview on 9/12/14, at 9:34 a.m., NA-B stated resident baths are not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing.

During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, the facility is still working on the staffing concerns.

During dining observation on 9/8/14, at approximately 5:40 p.m. NA-P was observed

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F 353	Continued From page 63 sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident giving them a bite of food, and then rolling on the stool using her feet to the next resident. NA-P would give a resident a bite of food, set the fork or spoon down, and immediately roll over to the next resident, and continued rolling around the table on the stool the entire meal. R12's quarterly MDS dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and required extensive staff assistance with dining. R66's quarterly MDS dated 8/6/14, identified R66 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/27/14, identified R7 had severe cognitive impairment and required extensive staff assistance with dining. During interview on 9/8/14, at 6:01 p.m. NA-P stated she was required to feed multiple residents at a time, and needed to use the rolling stool so she was able to go from resident to resident to ensure they all received their meal. NA-P stated there was not enough staff to ensure all the residents were being fed timely, so the NA's do what they have to so the residents receive their meals. When interviewed on 9/10/14, at 7:10 a.m.	F 353		

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F 353	Continued From page 64 LPN-A stated sometimes the residents needed to wait for help because the facility is short staffed. LPN-A stated the managers are not typically assisting residents with dining, however, the week during the survey, they have been helping out. LPN-A stated residents have voiced concerns of the call lights not being answered and not having cares provided. LPN-A stated restorative nursing/ ambulation for the residents is not being completed, and residents have complained of not walking and feel they are losing strength. LPN-A stated on the weekends, the staff brings residents with behavioral issues to the lobby and this falls on the nurse to provide additional supervision,which makes it difficult to complete all the resident cares which need to be completed. When interviewed on 9/10/14, at 6:50 a.m. NA-L stated there were not enough staff on the night shift and staff was struggling to provide the necessary care for over 2 months. NA-L stated residents have been complaining of waiting 45 - 60 minutes for help. NA-L stated when there is a sick call, the staff is not replaced and they work short, and there have been nights the facility had only one nurse working to take care of all the residents in the facility. When interviewed on 9/10/14, at 6:57 a.m. NA-M stated residents have voiced concerns about not having enough staff to complete the cares and she had reported this to the charge nurse on duty multiple times. NA-M stated nothing had changed with staffing, even after reporting residents are not receiving the cares they require. When interviewed on 9/10/14, at 7:01 a.m. NA-N stated the night shift, sick calls are not replaced, and they often work short staffed.	F 353		

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F 353	Continued From page 65 When interviewed on 9/10/14 at 7:46 a.m. NA-H stated residents are not getting the quality care they need and deserve, and there had been no restorative services for 3 months. The restorative aid and bath aid positions were eliminated several months ago, and staff had quit due to short staffing. She stated residents not being helped in the dining room to eat, and during survey management had been helping in the dining room, which never happens on a regular week. NA-H stated residents have voiced concerns they are not receiving their baths because staff does not have time to do this extra task. NA-H also stated some residents are only assisted twice per shift to use the bathroom due to staffing, and residents are not getting walked so they get restless and then try to walk alone. When interviewed on 9/10/14, at 9:18 a.m. NA-E stated she did not feel there were enough staff and nursing assistants were not able to provide all cares, including baths, shaving, ROM, and ambulation. NA-E stated residents have complained of the call lights not being answered, and R11 complained of having less strength due to ROM not being done. During an interview on 9/10/14, at 1:15 p.m., NA-F stated the NA's constantly feel rushed. She stated the NA's are supposed to do ROM, ambulation, and baths for residents, and the NA's are not able to complete this because of short staffing. When interviewed on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility did not have sufficient staff to complete resident cares. NA-B had tears in her eyes as she stated they are	F 353		

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F 353	Continued From page 66 unable to complete resident cares, especially bathing, ROM, dining, and ambulation. When interviewed on 9/10/14, at 2:07 p.m. NA-O stated it is difficult to provide resident cares due to being short staffed. On 9/11/14, at 9:08 a.m. a print out of the call light times was requested from the DON, who stated they did not have the capability of printing out the report. She did not identify the process the facility was using to monitor call light response times. When interviewed on 9/11/14 at 10:30 a.m. RN-A verified there is no formal restorative program at this time. RN-A confirmed there have been complaints from NA's about not having enough staff to complete resident cares or ROM and ambulation. RN-A stated the NA's were asked to do ROM on residents while assisting to dress them, and verified this was not a formal program and did not meet the intention of a restorative nursing program. During interview on 9/11/14, at 10:13 a.m., NA-H stated the facility was short staffed and the resident cares were not being completed. NA-H stated ROM was not being completed for residents, specifically R55 who was becoming stiffer as a result. NA-H stated there were not enough staff to accommodate baths for the residents and they were often skipped. NA-H stated the NA's had complained to the administration staff at the nurse meetings about short staffing, however, nothing had been done to correct the staffing issue. When interviewed on 9/12/14, at 10:34 a.m., the	F 353		

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F 353	Continued From page 67 staffing coordinator (MR)-J stated when there was a sick call, replacement depended on the number of staff scheduled. She reported if a sick call resulted in staff working a shift with less than established minimums, she would consult with the director of nursing (DON). She indicated there is no policy on staffing. When interviewed on 9/12/14, at 11:04 a.m. the DON and administrator stated staffing was based on census, not necessarily on resident care levels. The goal was to have six nursing assistants on both the day and evening shift, and three nursing assistants on the night shift. If there is a call in, they have not been replacing the staff if it would require overtime. They stated they had not reduced the hours of staff, and there had not been layoffs, however, they would not replace staff if someone left or retired, until they met the right staff . They stated they felt the facility was significantly overstaffed, and did not believe their was an issue with lack of staffing. They stated they had been trying to educate staff on being more efficient in providing residents cares. They NA's should have been able to complete all of the duties necessary with less staff and they felt the NA's were making a choice to not complete things such as baths or restorative nursing services. DON stated they used to have nine NA's working at a time and now they have six, because having nine, "Just didn't make good business sense."	F 353		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431	F-431 1. All expired medications have been removed from the medication carts and all undated multi-dose vials have been removed from the medication storage refrigerator. All newly-opened vials have been clearly marked with the date of opening.	5. October 22nd, 2014

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F 431	Continued From page 68 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to establish a system to ensure expired medications were removed from medication storage in 2 of 2 medication carts and in the storage area in the east hallway. In addition, the facility failed to date an open,	F 431	2. DON/Designee, partnering with our consultant pharmacist conducted a full review and inspection of all medications in all three medication to confirm that there were no more expired medications in any cart or medication storage area. 3. The facility's consultant pharmacist has agreed to conduct a more thorough review of the facility's medication carts each month, which includes the removal of all expired medications from the medication carts. In addition, all nurses and TMAs will be reminded during an educational in-service on 10/9/14 or 10/10/14 the importance of checking the expiration date for each medication prior to administration. 4. DON/Designee will conduct monthly audits of medication storage areas for expired medications monthly x6 months with results brought to QA meetings for review and further recommendations.	

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F 431	Continued From page 69 multi-dose vial in 1 of 1 medication refrigerators in the medication storage room. This had the potential to affect all 48 residents currently residing in the facility, as well as any newly admitted residents. Findings include: During observation of the medication storage room on 9/12/14, at 8:40 a.m., with director of nursing (DON)-A and licensed practical nurse (LPN)-A, the refrigerator contained an opened, undated, vial of Tuberculin protein (used for testing for tuberculosis). DON-A and LPN-A verified the vial was not labeled with the date it was opened, and were unable to determine how long the vial had been opened in the refrigerator. DON-A stated on the facility's, "Recommended Minimum Medication Storage Parameters," from Omnicare, Inc. dated 2013, tuberculin protein should have, "Date when opened; discard unused portion after 30 days." DON-A and LPN-A stated the tuberculin protein was used for newly admitted residents and new employees and was in the refrigerator, available for use. In addition, the refrigerator in the medication storage room also contained a bottle of liquid Lorazepam (medication used for seizures) 2mg/ml (milligram/milliliter) for R2. The bottle was labeled with an opened date of 3/13/14, with a pharmacy sticker that directed staff to discard after 90 days. LPN-A stated R2 had a current PRN (as needed) order for the medication and that was the only bottle available for use if R2 required a dose of the medication. DON-A and LPN-A indicated it was expected that all staff giving medications were responsible for going through medication storage areas to check for expired medications and proper labeling of medications.	F 431		

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F 431	Continued From page 70 During observation on 9/12/14, at 8:50 a.m. with LPN-A, the locked medication storage cabinet at the end of the East hallway, contained four unopened stock bottles of Geri Care Enteric Coated Aspirin 325 mg, with an expiration date of 8/14. LPN-A stated the bottles of Aspirin were available for use but were expired and should have been removed. During an observation on 9/12/14, at 8:55 a.m. with LPN-A, the North/ East medication cart contained Aspir-low 81 mg tablets for R38, with an expiration date of 9/13. LPN-A stated R38 had been using chewable aspirin since 2/14/14, but stated the Aspir-low tablets were expired a year ago, and should have been removed from the cart. During observation on 9/12/14, at 9:20 a.m. with LPN-B, the South medication cart contained a stock bottle of Geri Care Enteric Coated Aspirin 325 mg, with an expiration date of 8/14. LPN-B stated the Aspirin were available for resident use and were expired and should have been removed from the medication cart. The medication cart also contained Actavis Nystatin Cream, 100,000 units per gram, for R55, which had expired on 8/14. R55's physician orders, dated 9/14, included a current order for Nystatin cream to be used PRN. Another tube of Actavis Nystatin Cream 100,000 units per gram, for R17 was in the medication cart and expired 8/14. R17's current physician orders, dated 9/14, included a current order for Nystatin cream to be used PRN. In addition, Hydrocortisone Butyrate 0.1% cream for R40 had an expiration date on the tube of 5/14, however, the pharmacy sticker indicated the prescription was filled on 5/31/13, and was to be	F 431		

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F 431	Continued From page 71 disposed of 14 days after being filled. A review of R40's current physician orders, dated 9/14, lacked evidence of an order for this medication. LPN-B verified these medications were expired but remained available for use. LPN-B reported all staff giving medications were responsible to check expiration dates, however, the facility lacked a system to assure this was being completed. Review of the facility's Storage and Expiration of Medications, Biologicals, Syringes and Needles policy, dated 12/1/07, included, "Facility should ensure that medications and biologicals: Have an Expiration Date on the label; Have not been retained longer than recommended by manufacturer or supplier guidelines...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened... Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals...Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F-441 1. NA-B has been provided counseling and re-education related to the importance of hand washing on 10/8/14. Learning was verified via return demonstration and verbalization of the most important times/scenarios for washing hands.	

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F 441	Continued From page 72 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff performed hand hygiene following providing personal cares for 1 of 3 residents (R55) observed during personal cares.	F 441	2. DON/Designee will conduct random observation audits of staff at various times throughout the day to ensure that hand washing occurs at the appropriate times. 3. All staff has been provided re-education during an in-service held on 10/9/14 or 10/10/14 regarding the importance of hand washing in order to prevent the spread of infection, and the hand washing policy was reviewed at that time. 4. DON/Designee will conduct random audits with staff whenever situationally-appropriate, with results to QA for review and further recommendation.	5. October 22nd, 2014

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F 441	Continued From page 73 Findings include: R55's quarterly Minimum Data Set (MDS) dated 6/4/14, identified R55 had severe cognitive impairment and was totally dependent on staff for all activities of daily living, bed mobility, and personal hygiene. During observation on 9/10/14, at 7:18 a.m. nursing assistant (NA)-B was observed providing incontinence care to R55 while still in bed. R55's brief was wet and had a small amount of stool in it. NA-B removed the soiled pad and wiped R55 with multiple disposable wipes. Without changing gloves, NA-B placed a clean pad under R55, and started to pull up R55's pants. NA-B used the same gloved hands as she used to wipe R55's stool. NA-B then removed the gloves, finished pulling up R55's pants and proceeded to assist R55 out of bed and into the wheelchair. Once R55 was in the wheelchair, NA-B went into the bathroom and washed her hands. An interview was conducted with NA-B at the completion of R55's cares and NA-B stated the gloves should have been removed and hand washing completed immediately after wiping up R55's incontinent stool, however, she had not done that. During interview on 9/12/14, at 10:12 a.m. director of nursing (DON) stated the staff should wash their hands after removing gloves contaminated with stool. The facility policy titled Hand Hygiene, undated, identified according to the Centers for Disease Control, hand hygiene is the most effective, single procedure for preventing infections. The policy	F 441		

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F 441	Continued From page 74 directed staff to complete hand hygiene before and after gloving, and also before and after providing resident cares.	F 441	REVISION TO F-520: 1. This plan will be implemented to correct all deficient practices that affected all residents identified in the 2014 CMS-2567 for Haven Homes of Maple Plain.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required. In addition, the facility failed to develop	F 520	2. All residents in the facility have been identified as being affected by this deficiency. 3. The facility has created a Quality Assurance Committee (QAC) that is scheduled to meet monthly for the purposes of reviewing all deficiencies and to ensure corrections are maintained with ongoing compliance, as well as to address all other quality-related concerns that are brought forth throughout the previous month. The DON, Administrator, and department leaders will be required to attend this meeting on a regular basis. Frontline staff from all departments will be invited and encouraged to attend these meetings as well.	

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

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F 520	Continued From page 75 and implement appropriate action plans for identified areas of concern related to resident care concerns in the facility. This had the potential to affect all 48 residents who currently resided in the facility. Findings include: Refer to F278 as the facility failed to ensure accuracy of the minimum data set (MDS) assessment for 1 of 2 residents (R56) reviewed for pressure ulcers who had multiple unhealed pressure sores, failed to ensure transfer and mobility status was accurately coded for 2 of 2 residents (R20, R59) reviewed for rehabilitation services and failed to accurately code contractures for 2 of 5 residents (R7, R55) reviewed for range of motion. Refer to F310 as the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Refer to F312 as the facility failed to provide appropriate bathing and grooming assistance for 1 of 3 residents (R11) reviewed, who were dependent on staff for activities of daily living (ADL's). Refer to F314 as the facility failed to ensure 1 of 1 resident (R56), who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing, which resulted in actual harm for R56 related to the development of multiple pressure ulcers after admission to the facility.	F 520	A formal Quarterly QA & A (Quality Assessment & Assurance) meeting, consisting of the DON, Administrator, the consultant pharmacist, facility Medical Director, and all departmental team leaders will also be held routinely every 3 months. This meeting will be held in accordance with the Elim Care Quality Assessment and Assurance Policy. Facility Administrator will be responsible for ensuring that the Committee remains in compliance with the policy and for all quality concerns be presented and addressed at this meeting, and is ultimately responsible for the effectiveness and maintenance of this quarterly meeting.	

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F 520	Continued From page 76 Refer to F317 as the facility failed to ensure range of motion (ROM) services were provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Refer to F318 as the facility failed to ensure range of motion and/ or ambulation services were provided to maintain current level of functioning for 3 of 5 residents (R31, R64, and R1) reviewed for range of motion and/ or ambulation services. Refer to F353 as the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility. On 9/12/14, at 11:31 a.m., the administrator and registered nurse (RN)-B who had recently served as the interim director of nursing, were interviewed. The administrator stated she had been brought in as the new administrator in 1/14, and had conducted her first QAA committee meeting on 6/6/14. When asked to provide the dates of all of the QAA meetings for the last year, the administrator was only able to find one other documented meeting on 5/10/13. The administrator acknowledged that the facility hadn't been holding the required quarterly meetings. RN-B stated they were aware of the concerns with staffing, however, staffing was based on resident census. RN-B stated the staffing concerns had not been discussed at the QA meeting because the facility management felt	F 520	4. An informational memo will be posted in the employee break room regarding the purposes of monthly Quality Assurance Committee meetings, attached to the invitation for staff to attend these meetings and bring forth quality concerns and suggestions. Staff will also be reminded about the "Suggestions and Concerns" box located in the employee break room to serve as a means for all staff to offer suggestions and concerns, should they prefer to bring them forth anonymously.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	09/12/2014

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F 520	Continued From page 77 there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility's QAA committee, whether the committee was currently working on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee or what the purpose/role of the committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident cares. RN-A was unaware of any current quality improvement projects/action plans put into place by the QAA committee, and stated she was not aware what was discussed at the facility QA meetings. The facility's policy Quality Assessment and	F 520	These will be reviewed at the monthly QAC meetings and addressed as needed for ongoing quality improvement. The facility administrator is responsible for monitoring the effectiveness and success of the quarterly QA & A meetings, and will complete a QA & A Audit immediately following the completion of this meeting each month for the next 6 months. At that time Committee members will evaluate and determine if further monitoring of the effectiveness of the Committee remains necessary. 5. October 22, 2014	

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F 520	Continued From page 78 Assurance Committee dated 5/14, indicated the facility was to have an ongoing QAA committee that would meet at least quarterly, or more often as the facility deemed necessary, to fulfill committee functions and operate effectively. Further, the policy identified that the facility would implement action plans to address quality deficiencies which would include processes to revise plans that were not achieving or sustaining desired outcomes.	F 520		

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

F5497023

PRINTED: 10/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/15/2014

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.	K 000	POC OK TS 11-7-14	
	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, Fire Marshal Division on September 15, 2014. At the time of this survey, Haven Homes of Maple Plain was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to:		RECEIVED NOV - 6 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC's 10-22-14

EXIT: 9-12-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tolen Lyren	Administrator	10/22/14

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 Marian.Whitney@state.mn.us Haven Homes of Maple Plain is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(000) construction. In 1999, an addition was constructed to the southeast and was determined to be of Type II(000) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 67 and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	K 029	K029 As referenced in 19.3.2.1. we will apply approved fire resistive material to these spaces to prevent the passage of smoke into the other parts of this smoke compartment should there be an incident that would generate smoke. Work completed on 10/20/2014	

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K 029	Continued From page 2 doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient practice could affect 25 residents, staff and visitors as smoke from a fire in these rooms could enter the corridor making it untenable. Findings include:	K 029		
K 130 SS=F	On facility tour between 12:30 PM and 3:30 PM on 9/15/2014, it was observed that the nurse's storage room (which is over 50 sq.ft.) was not smoke resistant; where the wall and corrugated roof deck meet was installed with wool installation but was not sprayed with a fire rated material to prevent the passage of smoke not in accordance with 19.3.2.1. This deficient practice was verified by the Maintenance Supervisor at time of discovery. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	K130 As per requirement of section 2703.9.3 we will install posts to act as a protective barrier between possible vehicle and natural gas line impact. These posts were installed in accordance with section 312 as referenced here. Completion date 10/10/2014	

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K 130	Continued From page 3 This STANDARD is not met as evidenced by: Minnesota State Fire Code (07) Edition Section 312.1and 2703.9.3. Requires gas fuel piping be protected with guard posts from vehicle impact. This deficient practice could affect all patients, visitors, and staff in the event of a collision. Findings Include: On facility tour between 12:30 PM and 3:30 PM on 9/15/2014, it was observed that a dumpster were placed within 2ft. of the generator's natural gas piping with no guard post protection as required by MN State Fire Code section 312.1 and 2703.9.3. This deficient practice was verified by the facility's Maintenance Supervisor.	K 130	**SECTION 312** **VEHICLE IMPACT PROTECTION** **312.1 General.** Vehicle impact protection required by this code shall be provided by posts that comply with Section 312.2 or by other approved physical barriers that comply with Section 312.3. **312.2 Posts.** Guard posts shall comply with all of the following requirements: 1. Constructed of steel not less than 4 inches (102 mm) in diameter and concrete filled. 2. Spaced not more than 4 feet (1219 mm) between posts on center. 3. Set not less than 3 feet (914 mm) deep in a concrete footing of not less than a 15-inch (381 mm) diameter. 4. Set with the top of the posts not less than 3 feet (914 mm) above ground. 5. Located not less than 3 feet (914 mm) from the protected object. **312.3 Other barriers.** Physical barriers shall be a minimum of 36 inches (914 mm) in height and shall resist a force of 12,000 pounds (53 375 N) applied 36 inches (914 mm) above the adjacent ground surface.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 5008

October 1, 2014

Ms. Diane Lynch, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue, P.O. Box 369
Maple Plain, Minnesota 55359

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5497024

Dear Ms. Lynch:

The above facility was surveyed on September 8, 2014 through September 12, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 W Division, #212 St Cloud, MN 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner at (320) 223-7343.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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	00950	A. BUILDING: _____ B. WING _____	09/12/2014

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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: The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site	2 000	Accepted 10/14/14	

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2 000	Continued From page 1 revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required. In addition, the facility failed to develop and implement appropriate action plans for identified areas of concern related to resident care concerns in the facility. This had the potential to affect all 48 residents who currently resided in the facility. Findings include: Refer to F278 as the facility failed to ensure	2 255		

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2 255	Continued From page 2 accuracy of the minimum data set (MDS) assessment for 1 of 2 residents (R56) reviewed for pressure ulcers who had multiple unhealed pressure sores, failed to ensure transfer and mobility status was accurately coded for 2 of 2 residents (R20, R59) reviewed for rehabilitation services and failed to accurately code contractures for 2 of 5 residents (R7, R55) reviewed for range of motion. Refer to F310 as the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Refer to F312 as the facility failed to provide appropriate bathing and grooming assistance for 1 of 3 residents (R11) reviewed, who were dependent on staff for activities of daily living (ADL's). Refer to F314 as the facility failed to ensure 1 of 1 resident (R56), who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing, which resulted in actual harm for R56 related to the development of multiple pressure ulcers after admission to the facility. Refer to F317 as the facility failed to ensure range of motion (ROM) services were provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Refer to F318 as the facility failed to ensure range of motion and/ or ambulation services were provided to maintain current level of functioning for 3 of 5 residents (R31, R64, and R1) reviewed	2 255		

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2 255	Continued From page 3 for range of motion and/ or ambulation services. Refer to F353 as the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility. On 9/12/14, at 11:31 a.m., the administrator and registered nurse (RN)-B who had recently served as the interim director of nursing, were interviewed. The administrator stated she had been brought in as the new administrator in 1/14, and had conducted her first QAA committee meeting on 6/6/14. When asked to provide the dates of all of the QAA meetings for the last year, the administrator was only able to find one other documented meeting on 5/10/13. The administrator acknowledged that the facility hadn't been holding the required quarterly meetings. RN-B stated they were aware of the concerns with staffing, however, staffing was based on resident census. RN-B stated the staffing concerns had not been discussed at the QA meeting because the facility management felt there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the	2 255		

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2 255	Continued From page 4 discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility's QAA committee, whether the committee was currently working on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee or what the purpose/role of the committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident cares. RN-A was unaware of any current quality improvement projects/action plans put into place by the QAA committee, and stated she was not aware what was discussed at the facility QA meetings. The facility's policy Quality Assessment and Assurance Committee dated 5/14, indicated the facility was to have an ongoing QAA committee that would meet at least quarterly, or more often as the facility deemed necessary, to fulfill committee functions and operate effectively. Further, the policy identified that the facility would implement action plans to address quality deficiencies which would include processes to revise plans that were not achieving or sustaining desired outcomes.	2 255		

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2 255	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The administrator could work with the DON or designee, medical director, and governing body to update polices and procedures, identify issues, develop improvement plans, and ensure the committee meets quarterly. The administrator and DON could audit cares to ensure resident needs are met, audit charts for completion of restorative and range of motion programs, and report results to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was implemented for repositioning for 1 of 2 residents (R56), reviewed for pressure ulcers, for 1 of 1 residents bathing needs (R11), reviewed who required assistance with bathing, and for or 2 of 5 residents ROM programs (R31, R11) reviewed for range of motion services. Findings include: R56's quarterly Minimum data set dated 6/11/14, identified R56 had no cognitive impairments,	2 565		

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2 565	Continued From page 6 required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for pressure ulcer development, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's care plan dated 8/16/14, identified R56 had a unstageable pressure ulcer measuring 1.3 x 0.3 the coccyx. The care plan instructed R56 to be repositioned at no greater than 2 hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m. the resident was not repositioned and was unable to shift his weight independently in the wheelchair. During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up in his chair since approximately 6:00 a.m. that morning. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned at least every two hours, and should lie down after breakfast. LPN-B requested assistance to lay R56 down in bed. NA-B and LPN-B transfered R56 to his bed to lay down on 9/10/14, at 10:05 a.m. Although R56's care plan instructed staff to reposition R56 every two hours, the resident had been in his chair for a total of 2 hours and 47 minutes without being repositioned. R31's quarterly MDS dated 6/11/14, indicated R31 had no current functional losses of range of motion (contractures) in the upper or lower extremities.	2 565		

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2 565	Continued From page 7 R31s care plan dated 8/20/14, identified R31 was to receive passive range of motion daily to hips, knees, and ankles, 10-15 repetitions, as well as to bilateral shoulders, elbows, wrists and digits daily. Review of R31s ROM documentation indicated the resident recieved range of motion services 12 days in the last month (8/12/14 through 9/14/14). R31's restorative documentation for 7/2014, was not documented as being completed for 28 out of 31 days. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive any range of motion services other than routine dressing activities. During interview on 9/11/14, at 3:18 p.m. R31 stated he had a stroke a while back and did not walk anymore, but would like to use his legs and complete leg exercises. R11 quarterly MDS dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene and was able to provide partial physical help with bathing. The care plan dated 9/4/14, identified R11 needed the assist of one staff for bathing and preferred to have a bath versus a shower. Staff was directed to to honor resident's preferences and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated recently she had gone for a couple of weeks without a bath because the facility didn't have any bath aids. R11's point of care bathing record indicated R11	2 565		

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2 565	Continued From page 8 received a tub bath on 7/31/14, and the next entry was a partial bath on 8/28/14, which was 28 days later. During interview on 9/12/14, at 9:34 a.m. NA-B stated it was possible R11 went for weeks without a bath because there is not enough staff to assist residents with bathing. R1's quarterly MDS dated 6/25/14, indicated R1 had functional limitation in range of motion (ROM) to one side of the upper and lower extremities. R1 care plan dated 7/2/14, identified R1 was to receive passive range of motion (PROM) daily, 10-15 reps to bilateral shoulders, elbows, wrists, and digits. R1's PROM restorative nursing sheets were reviewed from April 2014 - September 2014. There was no documentation to determine if R1 was recieving PROM as directed by the care plan. During interview on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility no longer had a restorative aid, and the NAs are not able to complete R1's PROM as directed by the care plan. During interview on 9/11/14, at 9:25 a.m. R1 non-verbally indicated by motioning in a back and forth motion with her hand to indicate 'so-so,' when asked if staff were assisting her with PROM on a daily basis. When asked for a frequency of the PROM being done, R1 spelled out, "monthly," on her communication board. SUGGESTED METHOD OF CORRECTION:	2 565		

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2 565	Continued From page 9 The facility could develop a system which ensures that resident care plans are current and that all staff are delivering care according to the care plan and educate all care givers and nurse managers. The facility could monitor resident care for accurate delivery of care plan interventions and develop and auditing system to track ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility.	2 800		

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2 800	Continued From page 10 R7 was not being walked according to the assessed restorative nursing orders. During interview on 9/11/14, at 1:42 p.m. NA-F stated the facility did not have enough staff to walk R7, and as a result, she felt R7 had a decline in ambulation and possibly range of motion. NA-F reported R7 had difficulty with transferring now, and was unable to raise her feet up while in the wheelchair. R7's Annual minimum data set (MDS) dated 8/27/14, identified she had severe cognitive impairment, impairment (contractures) to one side of the upper extremity, and required extensive two person assistance with transfers/walking. Her balance was impaired and she could only stand with staff assistance. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57 feet with assistance of two staff, twice daily using a walker. R7's restorative nursing documentation from April 2014 - September 2014, lacked documentation that R7 had been walked/ambulated by staff from 4/2014 to 9/2014. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative program was in shambles right now, and she is trying to revamp the program. She verified there was no evidence that R7 was being walked. An interview on 9/10/14 at 1:00 p.m. was completed with NA-A who stated staff tries to ambulate residents, but it does not always happen because of the lack of staffing. NA-A stated staff is not able to complete ROM for resident either, and stated, "I feel sorry for the	2 800		

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2 800	Continued From page 11 residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. R47 stated during interview on 9/8/14, at 3:57 p.m., there was not sufficient staff at the present time. She stated she waited for over 20 minutes and all the way up to an hour for staff to respond to her call light and did not feel that was acceptable. She also reported that due to staffing shortage, she had to wait a long time to be served her food and by the time she gets her food it is cold. During a second interview on 9/8/14, at 7:02 p.m. R47 stated would transfer herself to the bathroom as staff does not respond to her call light. She stated she, "Refuses," to be incontinent of urine or stool because of having to wait for staff, and as a result will transfer herself. She stated she is aware she is not supposed to transfer herself to the bathroom because of previous falls, however, she can not wait for staff over 20 minutes for assistance. She reported the nursing assistants are aware she does this due to staff shortage. R47 stated she is supposed to be assisted with walking twice a day, however, staff is not able to do this as they just don't have time, and she didn't think she had been walked for about 10 days. A family member (FM)-B of R47 was interviewed on 9/10/14, at 1:15 p.m. and stated he had talked to staff a, "couple of time" that R47 was not being walked and he was concerned she would lose strength. FM-B stated R47 was to be walked twice each day, but it seldom happened. FM-B stated R47 had fallen a couple of times as she was not willing to be incontinent while waiting for assistance from staff when her call light is not answered for long periods of time. FM-B also	2 800		

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2 800	Continued From page 12 stated there were times when he visited and the call light was on for over 15 minutes and he would have to go out to the hall and try to find staff to assist her. R47's quarterly MDS dated 7/2/14, indicated R47 was cognitively intact with no signs or symptoms of delirium. She needed extensive assistance of two staff with bed mobility, extensive assistance of one staff for transfers, dressing, toilet use and personal hygiene. R47 needed extensive assistance of one staff with ambulation. R47's nursing assistant care sheet dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet twice per day with assistance of one staff, a transfer belt, rolling walker and wheelchair behind. Physician orders, signed 9/5/14, directed staff to complete passive range of motion to wrists, ankles, digits, knees, elbows, shoulder and hips daily. In addition, the physician ordered that R47 be walked 57-115 feet twice a daily with a wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets for August, 2014 to September, 2014 were reviewed and there was no documentation that R47 received any passive range of motion to extremities or ambulation. An interview with licensed practical nurse (LPN)-C was completed on 9/11/14 at 11:15 a.m. and she stated she was aware R47 was to be walked twice a day with staff assistance. LPN-C stated there was no documentation on the restorative nursing sheets to identify if R47 had been assisted with ambulation or any PROM in the prior months.	2 800		

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2 800	Continued From page 13 R1 reported on 9/9/14 at 1:10 p.m., she did not feel there were sufficient staff and she has been incontinent because the call light was not being answered fast enough. R1 also was concerned she had not been receiving ROM, and when asked how often she had been receiving ROM services, she spelt out,"monthly," using her communication board. R1's quarterly MDS, completed 6/25/14, indicated R1 had moderate cognitive ability, had no signs or symptoms of delirium/ psychosis, had no behavioral issues, and had limitations to one side of her upper and lower extremity (contractures). R1's care plan dated 7/2/14, and restorative nursing sheets from 4/2014- 9/2014, directed staff to provide passive range of motion daily to both shoulders, elbows, wrists, and fingers. R1's restorative nursing sheets for April, 2014 to September 12, 2014 lacked any documentation that passive range of motion was being done for R1. During an interview on 9/10/14, at 7:10 a.m. licensed practical nurse (LPN)-A stated a NA's did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14, at 1:25 p.m. NA-B stated the restorative aid position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to	2 800		

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2 800	Continued From page 14 residents. When interviewed on 9/11/14 at 10:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated NA's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to help him. R31's quarterly MDS dated 6/11/14, indicated R31 was cognitively impaired, totally dependent on two staff for all transfers, and needed extensive assistance of one staff for all locomotion. R31's care plan dated 8/20/14, indicated R31 was to receive PROM motion to hips, knees, and ankles 10-15 repetitions daily as well as to bilateral shoulders, elbows, wrists and fingers. A review of R31's restorative nursing sheets from 8/12/14, through 9/14/14, indicated R31 received PROM only 12 times. RN-A stated the facility did not currently offer formalized restorative programs at the present time due to lack of staffing. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive any range of motion services.	2 800		

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2 800	Continued From page 15 R55 was not receiving range of motion due to staff shortage. R55's quarterly MDS dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM, and was totally dependent on staff for transferring, toileting, dressing and all activities of daily living. R55 sheets from the restorative nursing book dated 1/1/14-6/30/14, instructed staff to ensure R55 received daily restorative treatments which included the following passive range of motion to shoulder, wrist, ankle, finger, elbows and knees. The 7/2014 MAR identified 3 restorative services were provided out of the 31 opportunities. The facility was unable to provide evidence that R55 had received passive range of motion from 8/14, to 9/11/14. During interview on 9/10/14, at 11:50 a.m., NA-B stated R55's ROM exercises were often not done because they didn't have enough staff to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises which the resident had been assessed as needing. During interview on 9/11/14, at 10:13 a.m., NA-H stated range of motion services were not being completed and R55 was becoming stiffer as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult so facility staff asked the residents family member to bring in different clothing. R56 stated on 9/8/14, at 3:50 p.m. he did not feel the facility had enough staff. He reported having to wait a long time to have his call light answered.	2 800		

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2 800	Continued From page 16 During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. The quarterly MDS dated 6/11/14, identified R56 was cognitively intact and he required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, and was at risk for developing pressure ulcers. He currently had one stage IV (Unstageable) pressure ulcer, that was present on admission over a year ago, and was unhealed. R56's admission care area assessment (CAA) dated 12/17/13, identified R56 was to be repositioned at no greater than two hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair and was unable to shift his weight independently, and was not approached by staff to assist the resident to reposition as assessed. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NA's did their best to assist residents to reposition as assessed but at times were unable to do so. NA-A verified R56 had not been repositioned every two hours as assessed because of the facility not having sufficient staffing to provide resident cares. R11 stated during an interview on 9/8/14, at 4:23 p.m. she had gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. In addition,	2 800		

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2 800	Continued From page 17 R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. She stated this happened a lot, and a few nights ago she had her call light on for over 40 minutes to go to the bathroom, no staff came to help her to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for toileting. R11's Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later. During interview on 9/9/14, at 3:03 p.m. NA-K stated there are not enough staff to provide residents a bath. NA-K stated she often is not able to complete all the resident cares because of the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to being short staffed. During interview on 9/10/14, at 2:23 p.m., NA-F stated it was possible that some residents had gone for weeks without getting a bath because the facility does not have enough staff to complete all the resident cares. NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected.	2 800		

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2 800	Continued From page 18 During interview on 9/11/14, at 10:13 a.m., NA-H stated there was not enough staff to accommodate baths for the residents, and resident baths are not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist residents. During interview on 9/12/14, at 9:34 a.m., NA-B stated resident baths are not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, the facility is still working on the staffing concerns. During dining observation on 9/8/14, at approximately 5:40 p.m. NA-P was observed sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident giving them a bite of food, and then rolling on the stool using her feet to the next resident. NA-P would give a resident a bite of food, set the fork or spoon down, and immediately roll over to the next resident, and continued rolling around the table on the stool the entire meal. R12's quarterly MDS dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and	2 800		

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2 800	Continued From page 19 required extensive staff assistance with dining. R66's quarterly MDS dated 8/6/14, identified R66 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/27/14, identified R7 had severe cognitive impairment and required extensive staff assistance with dining. During interview on 9/8/14, at 6:01 p.m. NA-P stated she was required to feed multiple residents at a time, and needed to use the rolling stool so she was able to go from resident to resident to ensure they all received their meal. NA-P stated there was not enough staff to ensure all the residents were being fed timely, so the NA's do what they have to so the residents receive their meals. When interviewed on 9/10/14, at 7:10 a.m. LPN-A stated sometimes the residents needed to wait for help because the facility is short staffed. LPN-A stated the managers are not typically assisting residents with dining, however, the week during the survey, they have been helping out. LPN-A stated residents have voiced concerns of the call lights not being answered and not having cares provided. LPN-A stated restorative nursing/ ambulation for the residents is not being completed, and residents have complained of not walking and feel they are losing strength. LPN-A stated on the weekends, the staff brings residents with behavioral issues to the lobby and this falls on the nurse to provide additional supervision,which makes it difficult to complete all the resident cares which need to be completed. When interviewed on 9/10/14, at 6:50 a.m. NA-L stated there were not enough staff on the night	2 800		

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2 800	Continued From page 20 shift and staff was struggling to provide the necessary care for over 2 months. NA-L stated residents have been complaining of waiting 45 - 60 minutes for help. NA-L stated when there is a sick call, the staff is not replaced and they work short, and there have been nights the facility had only one nurse working to take care of all the residents in the facility. When interviewed on 9/10/14, at 6:57 a.m. NA-M stated residents have voiced concerns about not having enough staff to complete the cares and she had reported this to the charge nurse on duty multiple times. NA-M stated nothing had changed with staffing, even after reporting residents are not receiving the cares they require. When interviewed on 9/10/14, at 7:01 a.m. NA-N stated the night shift, sick calls are not replaced, and they often work short staffed. When interviewed on 9/10/14 at 7:46 a.m. NA-H stated residents are not getting the quality care they need and deserve, and there had been no restorative services for 3 months. The restorative aid and bath aid positions were eliminated several months ago, and staff had quit due to short staffing. She stated residents not being helped in the dining room to eat, and during survey management had been helping in the dining room, which never happens on a regular week. NA-H stated residents have voiced concerns they are not receiving their baths because staff does not have time to do this extra task. NA-H also stated some residents are only assisted twice per shift to use the bathroom due to staffing, and residents are not getting walked so they get restless and then try to walk alone. When interviewed on 9/10/14, at 9:18 a.m. NA-E	2 800		

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2 800	Continued From page 21 stated she did not feel there were enough staff and nursing assistants were not able to provide all cares, including baths, shaving, ROM, and ambulation. NA-E stated residents have complained of the call lights not being answered, and R11 complained of having less strength due to ROM not being done. During an interview on 9/10/14, at 1:15 p.m., NA-F stated the NA's constantly feel rushed. She stated the NA's are supposed to do ROM, ambulation, and baths for residents, and the NA's are not able to complete this because of short staffing. When interviewed on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility did not have sufficient staff to complete resident cares. NA-B had tears in her eyes as she stated they are unable to complete resident cares, especially bathing, ROM, dining, and ambulation. When interviewed on 9/10/14, at 2:07 p.m. NA-O stated it is difficult to provide resident cares due to being short staffed. On 9/11/14, at 9:08 a.m. a print out of the call light times was requested from the DON, who stated they did not have the capability of printing out the report. She did not identify the process the facility was using to monitor call light response times. When interviewed on 9/11/14 at 10:30 a.m. RN-A verified there is no formal restorative program at this time. RN-A confirmed there have been complaints from NA's about not having enough staff to complete resident cares or ROM and ambulation. RN-A stated the NA's were asked to do ROM on residents while assisting to dress	2 800		

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2 800	Continued From page 22 them, and verified this was not a formal program and did not meet the intention of a restorative nursing program. During interview on 9/11/14, at 10:13 a.m., NA-H stated the facility was short staffed and the resident cares were not being completed. NA-H stated ROM was not being completed for residents, specifically R55 who was becoming stiffer as a result. NA-H stated there were not enough staff to accommodate baths for the residents and they were often skipped. NA-H stated the NA's had complained to the administration staff at the nurse meetings about short staffing, however, nothing had been done to correct the staffing issue. When interviewed on 9/12/14, at 10:34 a.m., the staffing coordinator (MR)-J stated when there was a sick call, replacement depended on the number of staff scheduled. She reported if a sick call resulted in staff working a shift with less than established minimums, she would consult with the director of nursing (DON). She indicated there is no policy on staffing. When interviewed on 9/12/14, at 11:04 a.m. the DON and administrator stated staffing was based on census, not necessarily on resident care levels. The goal was to have six nursing assistants on both the day and evening shift, and three nursing assistants on the night shift. If there is a call in, they have not been replacing the staff if it would require overtime. They stated they had not reduced the hours of staff, and there had not been layoffs, however, they would not replace staff if someone left or retired, until they met the right staff . They stated they felt the facility was significantly overstaffed, and did not believe their was an issue with lack of staffing.	2 800		

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2 800	Continued From page 23 They stated they had been trying to educate staff on being more efficient in providing residents cares. They NA's should have been able to complete all of the duties necessary with less staff and they felt the NA's were making a choice to not complete things such as baths or restorative nursing services. DON stated they used to have nine NA's working at a time and now they have six, because having nine, "Just didn't make good business sense." SUGGESTED METHOD OF CORRECTION: The facility could work with the Administrator to develop a system to ensure staffing levels are adequate to meet resident care needs. The facility could develop auditing tools to ensure the required resident care is being provided and report results to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

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2 830	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident falls were thoroughly assessed to ensure appropriate/pertinent interventions could be implemented or revised, for 2 of 2 residents (R64, R3), with multiple falls. Findings include: R64 admission face sheet, dated 2/24/12, indicated the resident had diagnoses including weakness, dementia, and incontinence. R64's quarterly Minimum Data Set (MDS) dated 8/13/14, indicated R64 had severe cognitive impairment, required extensive assistance for all activities of daily living (ADL), including bed mobility, transfer, walking, and toilet use. R64 was not steady, and only able to stabilize with staff assistance. R64's care plan dated 8/19/14, indicated R64 was at high risk for falls and had falls prior to and after admission to the the facility. Staff were directed to anticipate R64's toileting needs, place the floor mat on the floor when in bed, have the call light safety alarm system on while in bed, wear gripper socks while in bed, ensure safety alarm was on R64's wheelchair/chair, and ensure an anti-rollback device was on the residents wheelchair. R64's Fall Risk/Restraint Evaluation Review dated 5/20/14, indicated, "Resident remains high falls risk; [six] 6 falls in [three] 3 months. Resident attempts self transfers frequently. Confused and delusional reverting to his days of being a pastor... Gripper socks when in bed; W/C	2 830		

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2 830	Continued From page 25 [wheelchair] alarm; motion sensor; Bed alarm system remain appropriate. Floor mat added." R64's progress notes indicated the resident had a fall on 7/27/14. According to the progress notes, R64's alarm sounded, and the resident was observed sitting on the floor at his bedside and had no injuries. R64 was alert, and reported he wanted to go to school and rolled out of bed. R64 told staff he needed to go to the bathroom and staff assisted the resident to the bathroom and he urinated. Staff was unable to provide any further assessment or investigation of the fall to determine if current interventions were appropriate, new interventions were needed, and if R64's toileting plan was being implemented and was appropriate to prevent further falls. R64's progress notes indicated the resident had another fall on 8/24/14. According to the progress notes, R64's alarm sounded, and he was observed on the floor on his buttocks. No injuries were noted. R64 indicated he needed to clip his nails. Staff was unable to provide any further assessment or investigation of the fall to determine if current interventions were appropriate, if there were any trends with the residents falls, or if new interventions were needed to prevent further falls. During interview on 9/12/14, at 10:00 a.m., registered nurse (RN)-B stated she was in charge of conducting post fall investigations. RN-B stated there was no further information available regarding these falls, and post fall assessments were not completed to determine what may have caused the fall, if there were any trends noted, if the current interventions were appropriate, or if the interventions needed to be modified. RN-B stated, "We are working on that...I didn't even	2 830		

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2 830	Continued From page 26 know he [R64] had a fall last week." Although R64's fall assessment dated 5/20/14, indicated the resident had fallen six times in the prior three months while a resident in the facility , the facility was unable to provide progress notes, incident reports, or any documentation regarding the falls they had identified in the fall assessment. R3's diagnoses listed on the undated facesheet included visual loss, spasm of muscle, abnormal involuntary movements, lack of coordination, dementia, and frequency of urination. R3's quarterly MDS dated 7/2/14, indicated R3 was severely cognitively impaired, required extensive assistance with all ADL's, and was not steady when standing or transferring. During an interview on 9/8/14, at 4:20 p.m., RN-A stated R3 had three recent falls, on 8/20/14, 8/22/14, and 9/4/14. RN-A stated R3 was impulsive and leaned forward in her chair and often rolled out of her chair. RN-A stated R3 was not injured during these falls. During multiple observations on 9/10/14, R3 was seated in her wheelchair, in the area in front of the nurses station. R3 had a alarm clipped to the back of her blouse, and had a Safe-T-Mate anti-rollback device on her wheelchair. R3 attempted to stand many times and multiple staff members attempted to redirect R3 and assisted her to sit down. R3 was able to self propel her wheelchair and would often lean forward in her wheelchair which would sound the alarm which was attached to her. On one occasion, a staff member offered R3 a magazine, which R3 sat and read calmly in her wheelchair for several	2 830		

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2 830	Continued From page 27 minutes paging through the magazine and talking about each picture. R3's care plan dated 7/8/14, indicated R3 was at risk for additional falls due to a history of frequent falls. Staff were directed to observe for unsafe practices and to anticipate R3's needs, especially toileting needs. The care plan also directed staff to offer activities to keep her busy, to offer towels for folding, cloths to wipe surfaces she could reach, and dolls to dress and undress. R3's progress notes related to her recent falls, included the following: On 8/20/14, R3 stood up from her wheelchair outside of her room and fell to her knees. There were no injuries noted. R3 indicated she was going to get to her appointment. Staff noted increased confusion after lunchtime and R3 was toileted and laid down for nap. Staff was unable to provide any further assessment of the fall to determine the cause of the fall, if current interventions were appropriate, or if new interventions were needed. On 08/22/2014, R3's alarm sounded and she was observed slowly falling to the floor in the activity room. No injuries were noted. R3 stated she was attempting to get up and walk out of the activity room when she fell. R3 was assisted back into her wheelchair and promptly assisted to the restroom to be toileted. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. On 9/5/14, R3's alarm sounded and staff witnessed her standing and then falling by the desk in the main parlor. R3 stated she was standing to reach for the watermelon that was in front of her at the desk. R3 was assisted back into her wheelchair and the food was placed	2 830		

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2 830	Continued From page 28 closer to her. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. During an interview on 9/12/14, at 10:00 a.m., registered nurse (RN)-B indicated she was in charge of conducting post fall investigations. RN-B stated there was no further information available regarding R3's falls. Post fall assessments were not completed to determine what may have caused R3's falls, if there were any trends noted, if the current interventions were appropriate, or if the plan of care was being followed. The facility undated policy titled Fall Prevention and Risk/Restraint Evaluation included, "The Post Fall Evaluation will be completed by the DON [director of nursing] or her/his designee within 72 hours after a resident fall." SUGGESTED METHOD OF CORRECTION: The DON or desigee could work with the QA Committee to update policies and procedures for assessing causative factors for falls. The facility could also perform audits of post-fall documentation to ensure interventions were put into place and potential contributing factors were reviewed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program	2 890		

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2 890	Continued From page 29 that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Findings include: R47's quarterly Minimum Data Set (MDS) dated 7/2/14, indicated R47 had no cognitive impairment, needed extensive assistance of one staff for transfers and ambulation, and used a wheelchair or a walker to aid her ambulation. R47's balance was not steady during transfers and walking and she had no loss of upper and lower function range of motion (contractures). R47's Care Area Assessments (CAA) dated 10/9/13, identified R47 was alert and oriented,	2 890		

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2 890	Continued From page 30 had clear speech, and she was understood and able to understand others. R47 had an unsteady gait, was able to bear weight, and required a wheelchair behind her when she was involved in the restorative walking program. During interview on 9/8/14, at 7:11 p.m. R47 stated she was concerned she was going to lose her ability to walk because staff had not been assisting her to ambulate. She stated she was supposed to be walked twice a day but there was not enough staff to do this. She indicated she was, "Very rarely being walked." Another interview was completed on 9/11/14, at 11:00 a.m. R47 stated she was, "upset, " about not being walked twice a day due to staff shortage. She stated, "They just don't have time to walk me." R47 stated she had been involved in therapy and the therapist recommended she be walked. Because staff had not been assisting her to walk, R47 stated her joints are getting stiff and was not able to move as easily as she had in the recent past. She stated the last time she could remember she was walked was about 7-10 days ago. R47's care plan dated 7/9/14, indicated R47 was to be ambulated per the "Restorative program." The restorative program was not specified in the plan of care. R47's nursing assistant care sheet, dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet, twice per day with assistance of one staff, a transfer belt, rolling walker, and wheelchair behind. R47's physical therapy note dated 8/7/14, indicated the resident was able to ambulate up to	2 890		

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2 890	Continued From page 31 80 feet with a rolling walker and contact guard assistance. R47 was seen in the occupational therapy (OT) department from 7/14/14 to 8/14/14. R47 was considered to be alert and able to follow directions. R47's discharge from OT on 8/14/14, indicated she transferred with contact guard assistance (CGA- the therapist would hold a transfer belt for stabilization), tolerated standing for greater than three minutes while she maintained a safe balance while using a 4 wheeled walker, had an increase in her endurance while performing her activities of daily living, and reported no increase in fatigue while performing her exercises. R47's physician orders dated 9/5/14, directed staff to ambulate the resident 57-115 feet twice daily with a wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, were reviewed from April 2014, to September 11, 2014 identified the following: -April 1 to June 30, 2014, R47 was ambulating twice a day, walking 57 to 115 feet consistently. -July, 2014, R47 was walked 15 times on the day shift, and twice on the evening shift. The last documentation of R47 being ambulated was 7/23/14, when she walked 115 feet. -August 2014, to September 11 2014, there was no documentation regarding R47 ambulating. During interview on 9/11/14, at 9:44 a.m. nursing assistant (NA)-J stated he was aware R47 was to	2 890		

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2 890	Continued From page 32 be ambulated twice a day, however, he had never assisted R47 to ambulate. NA-J stated staff does not have time to complete R47 ambulation program because of short staff. During interview on 9/11/14, at 11:15 a.m. licensed practical nurse (LPN)-C stated R47 was to be ambulated twice a day, however, she stated there was no way to determine if R47 was being ambulated because there was no documentation. During interview on 9/11/14, at 2:39 p.m. physical therapy assistant (PTA)-E stated she had worked with R47 from 7/14/14, until her discharge from physical therapy on 8/12/14. PTA-E had recommended R47 be ambulated twice a day, 57-111 feet. PTA-E stated R47, "loved to be walked," and was able to consistently walk 80 feet when discharged from PT on 8/12/14. During interview on 9/11/14, at 3:24 p.m. registered nurse (RN)-A (who was identified as the person in charge of Rehab/Restorative Services), stated there was no record of staff efforts to walk R47. RN-A stated staff was to ambulate R47 twice a day, however, she was not sure if this was being done, and was unsure if R47 had declined in her ability to ambulate. RN-A stated there was no formal nursing assessment completed of R47's ambulation program to ensure it was appropriate and being implemented as ordered. During observation on 9/11/14, at 3:55 p.m. PTA-E assisted R47 to ambulate. R47 was able to walk 45-60 feet before becoming short of breath and needed to sit down. PTA-E stated R47's current ambulation ability was a decline from when the resident was discharged from physical therapy on 8/12/14.	2 890		

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2 890	Continued From page 33 Although the facility was aware R47 was not being ambulated as assessed by PT, the facility did not reassess and put interventions into place to ensure the resident did not decline in the ability to ambulate. R47's decline in ambulation ability related to the lack of the facility completing the ambulation program as assessed resulted in actual harm for R47. R7's annual MDS dated 8/27/14, identified R7 had severe cognitive impairment, had impairment (contracture) to one side of the upper extremity, required extensive two person assistance with transfers and walking in the corridor, was only able to stabilize when standing with staff assistance, and walking in the resident room, unit, and off the unit had not occurred during the 7 day prior look back period of the MDS completion date of 8/27/14. R7's CAAs dated 8/27/14, did not address R7's walking, transfer ability, or current contractures. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and both knees were bent and raised off the bed. R7's Physical Therapist Progress & Discharge Summary dated 3/4/14, indicated R7 was to ambulate 20-30 feet, using a four wheeled walker with assist of two staff, two times a day. R7 was able to hang onto the walker without hand support and did not need the platform walker on even services. PT also indicated R7's knee range of motion (ROM) was 26 degrees of left knee extension, and 22 degree of right knee extension. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57	2 890		

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2 890	Continued From page 34 feet with assistance of two staff, two times daily using a walker. R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, from April 2014 - September 2014, instructed two staff to walk the resident 29-57 feet, two times daily. There was no documentation identifying if staff was ambulating R7 from 4/2014- 9/2014. R7's care plan dated 9/3/14, indicated staff pushed R7 to all destinations in the wheelchair and transferred with assist of two with a transfer belt and walker. R7's care plan did not address if the resident was able to ambulate, nor did it instruct staff on R7's assessed ambulation program. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative/ ambulating program was in shambles right now, and she was trying to revamp the program to ensure residents were receiving their programs as assessed. RN-A was not aware R7 had not been ambulating or had a decline in transfer ability or ambulation. During interview on 9/11/14, at 1:42 p.m. NA-F stated R7 had a decline in ambulating as well as transfers, and staff was supposed to be walking her, however, R7 no longer walks, and staff did not have time to spend to try to assist her in walking prior. NA-F stated recently she had to order foot pedals for R7 because she could no longer raise her feet up when in the wheelchair when staff were pushing her to destinations. During interview on 9/11/14, at 1:57 p.m. RN-D	2 890		

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2 890	Continued From page 35 stated she had observed R7 ambulating and transferring a few months ago, and R7, "got to the point," of being unable to bear weight on the walker, so staff was transferring the resident using a hand in hand method. RN-D stated she had done no formal assessment of R7's ambulation program when it was noted R7's ambulation program was not being implemented as assessed and R7 was noted to be declining in her ability to transfer and ambulate. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, and stated R7 was resistive and had some contractures in her left hand and bilateral knees. PTA-E and COTA-D transferred R7 from the wheelchair to her bed. During the transfer, R7 did not take any steps, bear any weight on her feet, and was lifted into bed with heavy assist. During the evaluation, R7 stated, "ouch," on multiple occasions and grimaced when staff was attempting to straighten the resident's knees. PTA-E and COTA-D both verified R7 would benefit from therapy and should have been referred back to therapy when staff noted the resident was declining in transfers and no longer ambulating. COTA-D stated residents have expressed concerns with not being ambulated. Although the facility was aware R7's ambulation program was not being completed as assessed, and the resident was no longer ambulating and had a decline in transfers, the facility failed to reassess and refer the resident back to therapy. This resulted in actual harm for R7. SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of	2 890		

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2 890	Continued From page 36 motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, range of motion (ROM) services were not provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Findings include: R55's quarterly Minimum Data Set (MDS) dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM (contractures), and was totally dependent on staff for transferring,	2 895		

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2 895	Continued From page 37 toileting, dressing, and all activities of daily living. During interview on 9/8/14, at 5:55 p.m. registered nurse (RN)-A stated R55 had contractures (fixed high resistance to passive stretch of a muscle) in both knees only, did not utilize any splint devices, and was not receiving any formal ROM program. R55's care plan, last updated 6/9/14, did not identify the presence of any contractures nor did it instruct staff on the type of ROM exercises to be completed by staff. R55's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, was located in the restorative nursing book dated 1/1/14, through 6/30/14, and instructed staff R55 was to receive daily restorative nursing treatments which included the following: -Shoulder passive range of motion (PROM) 10-15 REPS-bilateral flexion/extension -Wrist PROM 10-15 reps bilateral flexion/extension -Ankle PROM 10-15 reps bilateral dorsiflexion/flexion -Digits PROM 10-15 reps bilateral flexion/extension -Elbow PROM 10-15 reps bilateral flexion/extension -Knee PROM 10-15 reps bilateral flexion/extension The 7/2014 restorative nursing sheet identified 3 restorative treatments were provided out of the 31 opportunities.	2 895		

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2 895	Continued From page 38 The facility was unable to provide any restorative nursing sheets for R55 for the months of 8/2014, or 9/2014. The facility had no documentation any ROM was done for R55 for 2 months. The facility was unable to verify when R55's ROM program was started, and if it had been reassessed at any time to determine if it was appropriate for R55. Review of R55's Electronic Point Of Care Record from 7/1/14, to 9/12/14, did not identify R55 received any ROM services, nor was there any assessment to ensure the ROM program was appropriate for R55. During observation on 9/10/14, at 7:18 a.m. R55 was observed being assisted with dressing. R55's legs would not fully extend and rest on the bed, and the residents knees stayed bent. Nursing assistant (NA)-B was unable to raise R55's arms above her head to put on her shirt, and instead needed to slide the shirt up R55's arms and then stretch it over her head. R55 was not able to lift up her arms or straighten her arms from the elbow. NA-B verified R55 was becoming more stiff. During interview on 9/10/14, at 11:50 a.m. NA-B stated R55's ROM exercises were not being completed because they didn't have enough staff to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises which the resident had been assessed as needing. During interview on 9/10/14, at 12:45 p.m., RN-C stated when restorative services or ROM was provided to the residents, the NAs should document in Point of Care when it was completed. RN-C was unable to provide any further documentation that R55 was receiving any	2 895		

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2 895	Continued From page 39 ROM services, and verified there was no documentation in Point of Care R55 was receiving any ROM services. During interview on 9/11/14, at 9:38 a.m. licensed practical nurse (LPN)-B stated the NAs were responsible for completing the ROM treatments for the residents as well as charting when it was completed in the residents electronic point of care record. LPN-B was not aware R55's ROM was not being completed. R55's Physical Therapy Discharge Summary dated 9/6/11, indicated R55 demonstrated passive stretching of the right knee to 22 degrees and 25 degrees of the left knee. R55 was noted to be pain free and would be discharged to continue bilateral lower extremity ROM program with staff. R55's Occupational Therapy Discharge Summary dated 7/17/12, indicated R55 exhibited proper hip/knee/ankle alignment while in the wheelchair. The summary did not note the presence of any upper extremity contractures. During interview on 9/10/14, at 2:03 p.m. certified occupational therapy assistant (COTA)-D examined R55's upper extremities and indicated R55 was somewhat resistant when attempting to evaluate total ROM, so she was unable to completely assess the degree of the shoulder, wrist, and finger contractures. However, COTA-D indicated R55 appeared to have bilateral upper extremity contractures, which she was not aware of prior. COTA-D stated R55 would definitely benefit from a splint device for the right thumb which was identified to be the most contracted joint during the exam. Physical therapy assistant (PTA)-E was also interviewed at this time and	2 895		

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2 895	Continued From page 40 completed an exam of R55's lower extremities. PTA-E stated when compared to the most recent physical therapy discharge summary dated 9/6/11, R55's knee contractures had worsened. PTA-E stated the right knee contractures had worsened to 55 degrees compared to 22 degrees before, and the left knee was now at 35 degrees compared to 25 degrees prior. COTA-D and PTA-E both verified R55 should be receiving ROM as had been assessed, and should have been referred back to OT/PT when staff noted R55's knees were becoming more contracted, and noted a decline in the resident's ability to move the upper extremities when being assisted with dressing. During interview on 9/11/14, at 9:09 a.m. family (FM)-A stated recently staff had asked him to purchase larger pants and different types of shirts so it would be easier to dress R55. FM-A stated R55 was becoming so stiff she was not able to lift her arms and straighten her knees so it was a struggle to get her dressed every day. FM-A stated staff asked for shirts that opened in the back, as well as larger pants, to make it slide on better. During interview on 9/11/14, at 10:13 a.m. NA-H stated range of motion services were not being completed and R55 was becoming stiff as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult, so staff asked the resident's family member to bring in different clothing. During interview on 9/11/14, at 11:10 a.m. RN-A confirmed there was no formal ROM assessment in place for R55 to ensure the current restorative program was being implemented as assessed,	2 895		

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2 895	Continued From page 41 nor to ensure the program is adequate to prevent further decrease in ROM. The facility failed to ensure R55's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R55 was having further difficulty with dressing related to decrease in ROM, the facility failed to provide further interventions and reassessment which resulted in actual harm to R55. R7's annual MDS dated 8/27/14, indicated R7 had severe cognitive impairment and had ROM impairment (contracture) to one side of the upper extremity. R7's clinic note dated 3/21/14, indicated the resident had a chronic right hand contracture which was released with surgery, had no pain, and was regaining muscular function back in the right hand. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and her left hand was in a fist. During observation on 9/10/14, at 6:53 a.m. R7 was sitting in her wheelchair in the activities room and her left hand was closed in a fist. During observation on 9/11/14, at 9:40 a.m. R7 was sitting in the activity room with her left hand closed in a fist. During observation on 9/12/14, at 8:40 a.m. R7 was sitting in the dining room with her left hand up to her face with her fingers bent inward.	2 895		

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2 895	Continued From page 42 During observation of R7 from 9/9/14- 9/12/14, R7 was not observed to release the fist of her left hand, nor did she attempt to use her left hand. R7's PT Progress and Discharge Summary dated 3/4/14, indicated the resident was able to hang onto the walker without hand support, and was to receive ROM. R7's current Physician Orders sheets for September 2014, instructed staff the resident was to receive the following restorative nursing program: · Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 · Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, indicated the resident had a right hand contracture. The restorative nursing sheets reviewed from April 2014, - September 2014,	2 895		

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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
2 895	Continued From page 43 noted the following program to be completed for R7 on the day shift: · Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x · Digits PROM 10-15 reps bilateral flexion/extension 1x · Elbow PROM 10-15 reps bilateral flexion/extension 1x · Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x · Knee PROM 10-15 reps bilateral flexion/extension 1x · Shoulder PROM 10-15 reps bilateral flexion/extension 1x · Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 · Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets for April 2014 - September 2014, noted the restorative nursing program to be completed for R7 on the day shift, however, there was no documentation R7 was receiving any ROM. R7's care plan dated 6/11/14, identified R7 had a right hand contracture. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, who both verified R7 was resistive and had some contracture(s) in her left hand and bilateral knees. During the evaluation R7 grimaced and stated, "Ouch" on multiple occasions when PTA-E and COTA-D were attempting ROM. COTA-D and PTA-E both stated R7 would benefit from therapy and possibly a splint or cone for the new contracture in her left hand.	2 895		

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2 895	Continued From page 44 During interview on 9/9/14, at 9:46 a.m. RN-A stated R7 had a contracture to her right hand and had surgery to release part of the contracture. RN-A stated the restorative program was not being completed for residents as assessed, and she was trying to revamp the program. RN-A stated R7 should be receiving the ROM services as had been assessed by PT. RN-A was not aware of R7's left hand or bilateral knee contractures. An interview on 9/10/14, at 1:00 p.m. was completed with NA-A who stated staff was not able to complete ROM for residents and stated, "I feel sorry for the residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. During interview on 9/11/14, at 1:57 p.m. RN-D stated R7 had a contracture to the right hand, which was repaired via surgery, and was the contracture identified on the resident's MDS. RN-D stated several months ago R7 got to the point of being unable to hang onto the walker with her hands, so staff was ambulating the resident hand in hand. RN-D stated R7 was noted at that time to have a decline in ROM in her left hand related to being unable to hang onto the walker, however, R7's restorative program was not reassessed, and the resident was not referred back to PT to prevent further decline in ROM ability. The facility failed to ensure R7's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R7 was no longer	2 895		

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2 895	Continued From page 45 able to hang onto the walker to ambulate, the facility failed to provide further interventions and reassessment which resulted in actual harm to R7. The facility policy titled Restorative Nursing, undated, identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff 5. Two Restorative programs must be provided a minimum of 6 days/week 6. Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy further identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned. The summary of the policy documented the following, "Restorative nursing was mandated by OBRA [Omnibus Budget Reconciliation Act] in	2 895		

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2 895	Continued From page 46 1987, as a means to keep residents at their highest possible practicable physical, mental and psychosocial level. Maintaining function enhances dignity and self-esteem. It is the primary reason for implementing effective restorative nursing programs. A comprehensive organized program guides staff to accurately identify restorative needs, implement restorative programs that assure residents receive the restorative services as planned and document to maintain a permanent record of the entire process. It does not feel good to lose function. Loss of function decreases a person's self-worth and one's ability to experience and enjoy quality of life. An organized restorative program that delivers systematic care based on the resident's individual needs increases self-esteem and worth and enhances well being." SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
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:	2 900		

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2 900	Continued From page 47 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 1 of 1 resident (R56) who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing. This resulted in actual harm for R56 related to the development of multiple pressure ulcers after admission to the facility. Findings include: R56's quarterly Minimum Data Set (MDS) dated 6/11/14, identified R56 had no cognitive impairment, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for developing pressure ulcers, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's most recent Care Area Assessment (CAA) dated 6/23/14, revealed R56 was at risk for pressure ulcer development, was on a turning and repositioning program, receiving pressure ulcer care with dressing application, and had a	2 900		

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2 900	Continued From page 48 pressure reducing device for the chair and bed. R56 was identified as being admitted with pressure ulcers both heels. R56's care plan dated 8/16/14, identified R56 had a 1.3 x 0.3 unstageable pressure ulcer on the coccyx, should be repositioned at no greater than 2 hour intervals, had a pressure redistribution mattress on the bed, and a pressure redistribution wheelchair cushion. R56's Skin Observation Reports dated 1/2/14, through 6/5/14, indicated the resident's skin was intact and had no pressure ulcers. R56's Braden Scale (a tool used to assess pressure ulcer risk) dated 6/8/14, indicated the resident had a mild risk of developing pressure ulcers. The Braden scale assessment indicated R56 had recently gotten a new wheelchair cushion related to the risk of developing pressure ulcers. R56's Tissue Tolerance Evaluation (assessment to determine skins ability to withstand pressure) dated 6/17/14, identified non-blanchable redness at the three hour mark in the lying position, and was unable to change position independently. The evaluation indicated R56 had no redness at the one, two or three hour mark in the sitting position and was unable to change position independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 6/23/14, identified no redness at the one or two hour mark in the lying position, and able to reposition independently. The evaluation indicated there was blanchable redness at the two hour mark while sitting and that R56 could reposition	2 900		

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2 900	Continued From page 49 independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 8/25/14, identified blanchable redness at the two hour mark in the wheelchair and the resident was unable to reposition independently. There was no further assessment of the tissue tolerance evaluation. R56's Skin Injury/Wound Report(s) dated 6/17/14, indicated R56 developed a pressure ulcer in the right gluteal fold measuring 0.5 centimeter (cm) x 0.8 cm with a pink wound bed, and was a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough). The area was cleansed and a protective cream applied, and the physician was faxed for further orders. Measurements of the pressure ulcer were documented weekly on the Skin Injury/ Wound Report. Review of the weekly monitoring from 6/17/14, through 9/10/14, indicated the pressure ulcer had worsened increasing in size and developing into an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough, yellow, tan, gray, green or brown, and/or eschar, tan, brown or black tissue, in the wound bed). On 9/10/14, the pressure ulcer was 1.5 cm x 2 cm, with a 70% slough yellow wound base and was unstageable. Another pressure ulcer was identified on a Skin Injury/Wound Report(s) dated 7/27/14, on the right buttock measuring 0.5 cm x 0.4 cm was identified by staff as, "trauma from the adhesive dressing being used on the gluteal fold." However, the area was identified as a "pressure ulcer," on the Skin Injury/Wound Report because it was located on a pressure area. On 8/29/14, the facility identified the pressure ulcer was a	2 900		

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2 900	Continued From page 50 stage 2. The documentation of the pressure ulcer on 9/10/14, identified the pressure ulcer had worsened to an unstageable pressure ulcer, and increased in size with a description of the pressure ulcer as 2.5 cm x 2 cm, with 50% white/ yellow slough wound bed, and was currently unstageable. R56's current physician orders dated 9/5/14, instructed staff to apply Tegaderm with foam dressing to reddened area on the sacrum, check every shift, and change every three days and as needed (PRN). Tegaderm with a foam dressing was to be applied to the right buttock, sacrum, and gluteal fold every 3 days and as needed (PRN). The physician orders also instructed staff that R56 was not appropriate to have three hour intervals ordered for repositioning programs due to skin issues, therefore, needed to be repositioned at no greater than every two hours. R56's Nurses notes dated 6/2/14. indicated the resident was admitted with two, stage 4 pressure ulcers on the right and left heel. R56 was being seen at the wound clinic for these wounds, and they had been debrided by the surgeon in the past. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair on a cushion, and was unable to shift his weight independently. Throughout the 2 hour and 28 minute observation, R56 was not approached by staff to reposition as assessed. During interview on 9/10/14, at 7:20 a.m., R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning.	2 900		

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2 900	Continued From page 51 During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NAs did their best to assist residents to reposition as assessed. NA-A stated she was aware of R56's pressure ulcers on his buttocks and, "They were pretty open," right now. NA-A verified R56 was to be repositioned every 2 hours. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned after 2 hours and should lie down after breakfast. LPN-B requested assistance from staff to lay R56 down. During observation on 9/10/14, at 10:05 a.m. NA-B entered R56's room to reposition him, which was 2 hours and 47 minutes after the initial constant observation began, and 4 hours and 5 minutes since R56 stated he had been up in his chair. NA-B lifted R56 out of his chair using a standing lift and removed his brief. R56's buttocks were dark red in color and had a foam dressing on the right buttock. During interview on 9/10/14, at 11:23 a.m. registered nurse (RN)-A stated LPN-B had been the wound nurse, however, there was a recent re-assignment of wound duties and she was delegating them out to the staff. RN-A was unsure of the current condition of R56's ulcers. During interview on 9/10/14, at 11:35 a.m. LPN-B stated R56 had gotten a new wheelchair cushion when the buttock pressure ulcers developed around 6/21/14, and she though the resident currently had three pressure ulcers, however, LPN-B was not clear on the current condition of the pressure ulcers. LPN-B stated nursing decided to get R56 a new wheelchair cushion	2 900		

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2 900	Continued From page 52 because the resident had complained he felt like he was sitting in a hole. LPN-B stated OT did not evaluate the resident to ensure the wheelchair cushion was appropriate. During observation of R56's current pressure ulcers on 9/10/14, at 1:58 p.m. the director of nursing (DON) and LPN-B verified R56 had two open areas on his buttocks, one on the upper gluteal cleft which was whitish at the wound base and was an unstageable pressure ulcer with 90% slough wound bed which currently measured 1.5 cm x 2 cm. The second pressure ulcer was on the right buttock and had 60-70% slough that was whitish in color at the wound base and measured 2.5 cm x 2 cm, and was also unstageable. LPN-B stated both pressure ulcers had increased in size and stage since the last time she had seen them, however, LPN-B was unable to verify the last time she had observed R56 pressure ulcers. During interview on 9/10/14, at 2:17 p.m. certified occupational therapy assistant (COTA)-D stated she had not been involved in assessing R56 for adequate wheelchair positioning or the wheelchair cushion. During interview on 9/11/14, at 1:07 p.m. director of nursing (DON) stated she was not aware of R56's worsening pressure ulcers. DON stated R56 repositioning schedule of every two hours should have been re-evaluated after the pressure ulcers developed and worsened to ensure the schedule was individualized and adequate to promote healing of the pressure ulcers. During interview on 9/11/14, at 1:10 p.m. RN-B stated she was not aware of R56's worsening pressure ulcers so she had not discussed interventions with OT, nor had she reassessed	2 900		

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2 900	Continued From page 53 the current interventions in place to ensure they were being implemented and were adequate to prevent further pressure ulcers. On 9/11/14, at 1:39 p.m., a call was placed to R56's medical doctor (MD)-C who was unable to be reached to discuss R56's pressure ulcers. The facility policy, titled Repositioning, undated, indicated it was the policy of the facility to have in place a system to identify repositioning programs for each resident and repositioning every two hours or more frequently depending upon the resident's condition and tolerance of the tissue load may be implemented, and more frequent repositioning (i.e. off loading hourly) may be warranted for individuals at high risk for pressure ulcer development. The policy indicated the therapy department assessed postural alignment, weight distribution, sitting balance, stability, and pressure redistribution along with cushion/mattress recommendations in coordination with the nursing department. The facility policy titled Wound/Skin Care Policy, last revised 12/01/97, indicated an at-risk resident who sits too long on a static surface may be more prone to get ischial ulcerations. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could assign the interdisciplinary team to review all residents with pressure sores to assure they are receiving the necessary treatment/services to prevent pressure sores from developing and to promote healing. The Director of Nursing could assign the Quality Assurance Committee to provide on-going monitoring of the delivery of care to residents to ensure that pressure sores do not develop unless the resident's clinical condition	2 900		

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2 900	Continued From page 54 demonstrates that they were unavoidable. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on interview and documentation review, the facility failed to provide bathing assistance for 1 of 3 residents (R11) reviewed who was dependent on staff for bathing. Findings include: R11 quarterly Minimum data set (MDS) dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene, and was able to provide partial physical help for bathing. R11 care plan dated 9/4/14, indicated R11 needed assist of one staff for bathing and preferred to have a bath versus a shower, and the goal was to respect the resident's wishes and maintain autonomy, and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11	2 920		

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2 920	Continued From page 55 stated she had recently gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. R11's Point of Care Bathing Record (where the nursing assistants (NA) document when a resident received a bath/shower), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath completed on 8/28/14, 28 days later. During interview on 9/11/14, at 10:13 a.m. NA-H stated there were not enough staff to assist residents with baths and they were not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist with bathing. During interview on 9/12/14, at 9:34 a.m., NA-B stated the facility used to have a bath aid to provide resident baths, however, a few months ago the bath aid left the facility, so resident baths were not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, RN-A stated the facility was still working on a staffing pattern to ensure resident cares are being completed. A policy on resident bathing was requested but not provided.	2 920		

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2 920	Continued From page 56 SUGGESTED METHOD OF CORRECTION: The director of nursing could provide education on the performance of providing activities of daily living and follow up with audits/observation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21426	MN St. Statute 144A.04 Subd. 4 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 facility failed to ensure 1 of 5 residents (R37), who was reviewed for tuberculosis screening,	21426		

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	00950	A. BUILDING: _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359

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21426	Continued From page 57 received a two-step mantoux or a baseline tuberculosis symptom screen. Findings include: R37 was admitted to the facility on 5/22/14. R37's medical record lacked any documentation of a tuberculosis symptom screen or baseline mantoux testing. Copies of any further information were requested from the DON on 9/12/14, at 10:12 a.m., none were provided. DON verified there was no record of R37 receiving a tuberculosis symtpom screen or baseline mantoux testing. A facility policy on resident tuberculosis testing was requested but not provided. SUGGESTED METHOD OF CORRECTION: The facility could develop an auditing system to ensure all residents receive a baseline tuberculosis symptom screen and appropriate testing. The facility could report findings to the QA Committee to develop a system for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		

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21695	Continued From page 58 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 48 residents (R46) bathrooms had bathroom equipment in good repair. In addition, the facility failed to ensure 2 of 48 residents (R46, R24) were provided adequate water pressure to their bathroom sink. Findings include: R46's annual minimum data set (MDS) dated 8/6/14, identified the resident had no cognitive impairment. During interview on 9/8/14, at 4:30 p.m. R46 stated her bathroom sink was cracked and she had very little water pressure in her bathroom sink. She stated she had talked to several of the staff about both issues with her bathroom sink, and no one did anything about it. R46 stated the low water pressure and cracked sink had been like this since her admission to the facility which was over a year ago. During a tour of the facility on 9/12/14, at 1:00 p.m. maintenance supervisor (MS)-F verified R46's sink had two large cracks, one extending from the faucet knob down the entire sink almost to the drain, and a second crack on the left edge of the sink. MS-F also verified the water pressure in R46's bathroom sink was very low and the water trickled out of the faucet. MS-F stated he had not been informed of the cracked sink, which he stated had the potential to, "Scratch" the resident, and he was not aware of the low water pressure in R46's room. MS-F stated he did daily	21695		

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21695	Continued From page 59 rounds of the facility looking for damaged equipment, however, he did not go into any of the resident rooms or bathrooms during the inspection. He stated it was the expectation nursing staff inform him of broken items so maintence could repair them. R24's quarterly MDS dated 6/24/14, identified the resident had severe cognitive impairment and required extensive assistance of two staff for personal cares. During observations on 9/8/14, at 7:14 p.m. and 9/11/14, at 11:00 a.m. R24's water flowed out of the bathroom sink faucet slowly and took a long time for the temperature of the water to heat up to get warm. During the tour of the facility on 9/12/14, at 1:00 p.m. MS-F verified R24's bathroom sink water pressure was very low. MS-F stated he was not aware of the R24's low water pressure until now, and it was an easy fix if he had been informed of the problem for his department to address the issue. MS-F stated nursing staff are to notify him of any maintenance problems. A facility maintence policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rooms and bathrooms are in functional working order. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance.	21695		

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21695	Continued From page 60 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced	21800		

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21800	Continued From page 61 by: Based on interview and document review, the facility failed to ensure 2 of 3 residents (R11, R57) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, informing them of their right to an appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services. Findings include: R11 was admitted to the facility with skilled medicare coverage on 2/13/14. On 4/22/14, the facility determined R11 no longer met medicare coverage criteria and issued a notice of medicare non-coverage on continued stay, with the first non-covered day listed as 4/25/14. The facility did not have record R11 received the CMS 10123, informing her of her rights for an expedited appeal. R57 was admitted to the facility with skilled medicare coverage on 1/17/14. R57's denial letters contained only the CMS 10123, indicating R57's last covered day was 3/19/14. R57 records did not contain the required notice of medicare coverage on continued stay. R57 remained in the facility after her medicare coverage was discontinued. During interview on 9/11/14, at approximately 10:00 a.m. director of nursing (DON) stated the facility did not have a policy specific to how to issue medicare denials, and verified there were no other denial letters on file for R11 or R57. DON provided copies of a Haven Homes Medicare Assessment Tool and a blank notice of medicare coverage on continued stay, however,	21800		

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21800	Continued From page 62 these did not address the facility process on how to inform residents of medicare appeal rights or for required denial letters the residents must receive. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents receive proper documentation regarding liability and demand bill notices in a timely manner. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		