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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JUHK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00669

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245585**

2.STATE VENDOR OR MEDICAID NO.
(L2) **145240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRAVERSE CARE CENTER**
(L4) **303 SEVENTH STREET SOUTH**
(L5) **WHEATON, MN** (L6) **56296**

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) **12/01/2010**

6. DATE OF SURVEY **05/30/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Gail Anderson, Unit Supervisor — 09/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 09/21/2017 (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
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/06/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5585

On May 30, 2017, the Department of Health completed a revisit by review of the facilty's plan of correction. On May 17, 2017 and September 19, 2017, the Department of Public Safet completed revisits to verify the facility achieved and maintained compliance with Federal certification deficiencies issued pursuant to the standard survey completed on April 6, 2017 FMS completed on April 24, 2017. Based on our visits, we have deteremined the facility has corrected the deficiencies issued pursuant to the standardy survey completed April 6, 2017 and FMS completed April 24, 2017, effective May 16, 2017.

As a result of finding the facility achieved compliance, we recommended and CMS concurred and authorized the Department to notify the facility of the following action:

- Mandatory denail of payment for new Medicare and Medicaid Admissions (DPNA), effective July 6, 2017, be rescinded

Since DPNA did not go into effect, the two year loss of NATCEP, which was to begin, July 6, 2017, is also rescinded.

Effective May 16, 2017, the facility is certified for 49 skilled nursing facility beds.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245585

September 21, 2017

Ms. Calista Taffe, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Dear Ms. Taffe:

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 May 16, 2017 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Electronically delivered
September 21, 2017

Ms. Calista Taffe, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: Project Number S5585027, F5585028

Dear Ms. Taffe:

On April 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 6, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 24, 2017, a surveyor representing the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found the most serious deficiencies 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), whereby corrections were required.

On May 8, 2017, CMS forwarded the results of the FMS to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 6, 2017. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of May 8, 2017, 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 July 6, 2017.

On May 30, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction. On May 17, 2017 and September 19, 2017, the Minnesota Department of Public Safety completed revisits to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 6, 2017 and an FMS completed on April 24, 2017. We presumed, based on your plan of

correction, that your facility had corrected these deficiencies as of May 16, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 6, 2017 and FMS completed on April 24, 2017, effective May 16, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of May 8, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 6, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 6, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 6, 2017, is to be rescinded.

In their letter of May 8, 2017, CMS advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 6, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 16, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH** **WHEATON, MN 56296**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 4/24/17 following a Minnesota Department of Health Survey on 4/10/17. At this Comparative Federal Monitoring Survey, Traverse Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.90(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. Traverse Health Care Center is comprised of the original building which is one story with a partial basement construction Type II (111) and an addition which is one story of Type V (111) construction. The entire facility is fully sprinklered and there is supervised smoke detection located in the corridors, spaces open to the corridors and some of the resident rooms. The facility has 49 certified beds and all beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 47. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT	K 222		5/16/17

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

Electronically Signed | 05/10/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH** **WHEATON, MN 56296**

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K 222	Continued From page 1 LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH** **WHEATON, MN 56296**

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K 222	Continued From page 2 installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure all exit doors with a delayed egress lock had signs indicating the presence of a delayed egress system in accordance with NFPA 101-2012 Edition, Section 7.2.1.6.1.1. This deficient practice could potentially affect 25 of 47 residents in the facility. Findings include: Observations by the laundry exit corridor on 4/24/17 at 12:45pm, revealed a placarded exit door that included a delayed egress locking system. There was no signage indicating the presence of the delayed egress system or how to operate the locking mechanism. The finding was confirmed by the Maintenance Director at the time of discovery who stated he was unsure why there was no signage present to indicate the delayed egress lock was on the exit door.	K 222	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. K222 The signage was installed on the laundry exit door properly per the requirements of NFPA 101, Life Safety Code , 2010 edition section 7.2.1.6.1.1. The Maintenance Director/ Designee will audit all delayed egress doors for proper signage to indicate the presence of a delayed egress one time per month for 3 months. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH** **WHEATON, MN 56296**

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K 226 SS=E	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure the means of egress from the exit door to the public way was clear of obstruction in accordance with NFPA 101-2012 Edition, Sections 7.2.4 and 7.3.4.1.1 This deficient practice could potentially affect 25 of 47 residents in the facility. Findings include: Observations outside the 200 wing exit corridor on 4/24/17 at 12:50pm, revealed the presence of a picnic table intruding that reduced the egress pathway to the public way to less than 24 inches. The finding was confirmed by the Maintenance Director at the time of discovery who stated he was unsure who put the table there but it needed to be moved.	K 226	K226 The picnic table that obstructed the exit door was relocated as to not obstruct the egress from that exit at the time of the survey. The Maintenance Director/ Designee will audit all exits 2 times a week for 3 months to ensure staff and visitors are aware that there can not be any obstructions to any egress. Staff will be educated not to block in any way any public egress. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed.	5/16/17
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		5/16/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH** **WHEATON, MN 56296**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinklers were maintained free of foreign materials in accordance with NFPA 101 - 2012 edition, Section 9.7.5 and NFPA 25 2011 edition, Section 5.2.1. This had the potential to affect approximately 35 of the 47 residents in the facility. Findings include: 1.) On 4/24/17 at 2:10pm, observation in the dryer utility closet revealed two sprinklers with visible evidence of an accumulation of dirt and debris that could affect the normal operation of the sprinklers. 2.) On 4/24/17 at 2:20pm, observation in the main tub hall janitor closet revealed a sprinkler with visible evidence of an accumulation of dirt and debris that could affect the normal operation of the sprinkler. 3.) On 4/24/17 at 2:40pm, observation in soiled utility closet number 509 revealed two sprinklers with visible evidence of an accumulation of dirt	K 353	K353 The Maintenance Director/ Designee will ensure that sprinklers will be maintained free from foreign materials in accordance with NFPA 101-2012 edition, section 9.7.5 and NFPA 25 2011 edition sectioin5.2.1. The Maintenance Director/ Designee will audit montly for 3 months to ensure there is no foreign material on the sprinkler heads and will incorporate this in the preventative maintenance system on or before 5/16/17. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 5 and debris that could affect the normal operation of the sprinklers. 4.) On 4/24/17 at 3:10pm, observation in the attic space above closet number 515 revealed a sprinkler with visible evidence of an accumulation of dirt, debris and insulation material that could affect the normal operation of the sprinkler. These findings were confirmed by the Maintenance Director at the time of discovery who stated the sprinklers need maintenance.	K 353		
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920		5/16/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2017**

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TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH** **WHEATON, MN 56296**

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K 920	Continued From page 6 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly utilize Underwriters Laboratory (UL) approved power strips and plug multipliers in accordance with the requirements of NFPA 101 - 2012 edition, Sections 9.1.2 and NFPA 70, 2011 Edition, Sections 400-8 and 590.3. This deficient practice could potentially affect 30 of the 47 residents in the facility. Findings include: On 4/24/17 at 2:05pm, observation in the Nursing Manager office revealed a refrigerator plugged into a non-UL approved power strip. The finding was confirmed by the Maintenance Director at the time of discovery who stated the power strip should not be used in that way.	K 920	K920 The Maintenance Director/ Designee will remove all unapproved and improperly utilized power strips and plug multipliers peer NFPA 101-2012 edition sections 9.1.2 and NFPA 70 2011 edition sections 400-8 and 590.3. The Maintenance Director / Designee will educate staff, on unapproved power strips and pug multipliers and audit 2 times a month for 3 months to ensure they are not in use, Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JUHK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00669

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245585**

2.STATE VENDOR OR MEDICAID NO.
(L2) **145240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRAVERSE CARE CENTER**
(L4) **303 SEVENTH STREET SOUTH**
(L5) **WHEATON, MN** (L6) **56296**

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) **12/01/2010**

6. DATE OF SURVEY **04/06/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Christina Martinson, HFE NE II 05/16/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/05/2017 (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
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 26, 2017

Mr. Edward Brady, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, Minnesota 56296

RE: Project Number S5585027

Dear Mr. Brady:

On April 10, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 May 16, 2017, 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 May 16, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 6, 2017 (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 October 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

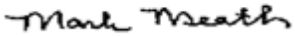
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

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

Sincerely,



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

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
	245585	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		5/16/17

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

Electronically Signed | 05/04/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 3 (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must 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. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) 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	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 4 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) 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 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) 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/ Medicaid or by the	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 2 of 3 residents (R55, R56) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services	F 156	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of	

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F 156	Continued From page 6 (CMS) Form 10123, which informed residents of their rights to an appeal, and expedited review of their Medicare coverage, 48 hours prior to discontinuation of the skilled services which were covered by the Medicare Part A benefit. Findings include: Review of R55's progress notes dated from 12/19/16 to 3/3/17, indicated R55 was admitted to the facility for skilled rehabilitation services covered by Medicare Part A that began on 12/19/16, and was discharged from physical therapy (PT) services on 1/13/17 and occupation therapy (OT) services on 1/12/17. R55 was discharged from the facility on 3/3/17. R55 had not received the required notice, CMS Form 10123, 48 hours prior to the discontinuation of the skilled services which were covered by the Medicare Part A benefit. Review of R55's CMS 10123 Form, was signed by R55 on 1/12/17. Review of R56's progress notes dated from 1/20/17 to 2/21/17, indicated R56 was admitted to the facility for skilled rehabilitation services covered by Medicare Part A that began on 1/20/17, and was discharged from PT and OT services on 2/21/17, with a planned discharge from the facility to home on 2/22/17. R56 discharged from the facility on 2/21/17. R56's medical record lacked the required CMS Form 10123, to be given 48 hours prior to discontinuation of the skilled services which were covered by the Medicare Part A benefit. On 4/6/17, at 3:40 p.m. registered nurse (RN)-A verified R55 had received Medicare part A benefits, and confirmed R55 had not received the required CMS Form 10123, 48 hours prior to	F 156	Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. • F156 Resident #55 has been discharged to another facility and Resident #56 has been discharged to home. All other residents who had a Medicare A benefit since survey will be reviewed to ensure they have received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services Form 10123, which informs the residents of their rights to an appeal, and expedited review of their Medicare Coverage, 48 hours prior to discontinuation of the skilled services which were covered by the Medicare Part A benefit. Education on Medicare letters of denial will be given to the MDS Nurse/Social Worker Designee to ensure procedure is properly followed. MDS coordinator will audit weekly all residents whose Medicare A benefits are ending to ensure a liability notice was given timely. Audits will be conducted weekly and reviewed at QAPI for three months to ensure adherence to policy is being followed.	

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	245585	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 156	Continued From page 7 discontinuation of the skilled services which were covered by the Medicare Part A benefit. RN-A confirmed R56 had not received the required CMS Form 10123, 48 hours prior to discontinuation of the skilled services which were covered by the Medicare Part A benefit. RN-A confirmed both R55 and R56 had remaining Medicare Part A benefit days at the time of discharge from skilled rehabilitation services. On 04/6/17, at 4:12 p.m. business office coordinator (BOC) confirmed both R55 and R56 should have received the required CMS Form 10123, 2 days prior to discharge from skilled therapy services. The BOC confirmed R55's required CMS Form 10123 was not given timely, and confirmed R56 had planned to discharge home on 2/22/17, then decided to discharge home on 2/21/17 after being discharged from therapy. BOC confirmed both R55 and R56 had remaining Medicare Part A benefit days at the time of discharge from skilled rehabilitation services. The facility's admission, transfer and discharge policy, revised 11/2016, indicated the facility would issue a written notice to all Medicare residents at the end of their skilled service. The policy did not address the specific required forms or timeline requirements prior to discontinuation of skilled services.	F 156	Deficient practice to be corrected by 5/16/2017 • F225 Resident #5 care plan has been reviewed and updated on Elopement Risk. Resident #5 assessments have been reviewed and updated on Elopement Risk. Resident #5 has a Secure Care Band in Place on left ankle. Orders are in place to check Secure Care Band Placement every shift and check workability of Secure Care Band every evening. Resident #5 has been added to the Elopement Book. All doors have been checked to ensure the Secure Care Alarms are working. All staff educated on Policy and Procedure of Vulnerable Adult Reporting, and Policy and Procedure of residents having Freedom from Abuse, Neglect, and Exploitation. Staff educated on door system and how the door system works. Audits will be conducted by DON/Designee on three residents per week for 3 months to ensure proper plan of care is present for those at risk of eloping from the facility and to ensure resident safety, making sure Secure Care Bands are in the care plan and on the	

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F 156	Continued From page 8	F 156	order sheets for checking placement every shift as well as workability of the Secure Care Band in the evenings. Audits will be conducted by Maintenance/Designee on all the doors three times per week for 3 months to ensure the Secure Care Alarms are working properly. Audits will be reviewed at QAPI for three months to ensure adherence to policy is being followed. Deficient practice to be corrected by 5-16-17.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225		5/16/17

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F 225	Continued From page 9 (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey	F 225		

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F 225	Continued From page 10 Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately notify the State Agency (SA) of an elopement for 1 of 3 residents (R5) reviewed for abuse prohibition. Findings include: R5's quarterly Minimum Data Set (MDS) dated 3/21/17, indicated R5 had diagnoses which included Alzheimer's disease, dementia, depression, hypertension (HTN) and heart failure. The MDS identified R5 was severely cognitively impaired and required extensive staff assistance for activities of daily living (ADL's) with the exception of eating. Elopement Risk Assessment dated 3/21/17, indicated R5 had seeking behaviors. The assessment indicated R5 would look for his wife frequently when she was not near him. The assessment indicated R5 was not at risk for elopement, was at the facility with his wife and wanted to be near her, and indicated R5 did not talk of leaving the facility. Elopement Risk Assessment dated 3/25/17, indicated R5 had a one time elopement event, the secure care band did not alarm when R5 exited out the back door, and R5 was noted to have increased confusion, short-term and long-term memory loss and intermittent confusion and impaired decision making skills. The assessment identified R5 was at an increased risk of eloping from the facility.	F 225	" F225 Resident #5 care plan has been reviewed and updated on Elopement Risk. Resident #5 assessments have been reviewed and updated on Elopement Risk. Resident #5 has a Secure Care Band in Place on left ankle. Orders are in place to check Secure Care Band Placement every shift and check workability of Secure Care Band every evening. Resident #5 has been added to the Elopement Book. All doors have been checked to ensure the Secure Care Alarms are working. All staff educated on Policy and Procedure of Vulnerable Adult Reporting, and Policy and Procedure of residents having Freedom from Abuse, Neglect, and Exploitation. Staff educated on door system and how the door system works. Audits will be conducted by DON/Designee on three residents per week for 3 months to ensure proper plan of care is present for those at risk of eloping from the facility and to ensure	

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F 225	Continued From page 11 R5's nursing progress noted dated 3/25/17, indicated R5 had been found outside of the facility by the big dumpster. R5 had stated he wanted to go home. R5 had been brought back into the facility, and the wander guard had not sounded the alarm coming back in. Registered nurse (RN)-A was notified in person, and a message was left for the administrator. R5's elopement incident form #2231 dated 3/25/17, at 3:50 p.m. indicated staff went out for break and found R5 seated outside in front of the big garbage can, R5 had stated I want to go home. The report indicated R5 was forgetful and oriented to person. Interventions put into place: education to staff, wander guard/secure care band care planned for left ankle, orders for checking secure band every shift and workability every evening, added R5 to the elopement book and checked all doors to ensure the secure care alarms worked. The vulnerable adult incident report regarding R5's elopement was submitted to the SA on 3/29/17, 4 days after the incident, and the investigation was submitted to the SA on 3/30/17. During interview on 4/3/17, at 7:23 p.m. RN-A reported R5 eloped out of the back delivery door, and had been found by an employee out back. RN-A confirmed the alarm had not activated when R5 exited the facility, but alarmed when R5 came back into the facility. RN-A had not reported she submitted the event to the SA. RN-A confirmed the elopement on 3/25/17 was R5's first elopement, and stated R5 had not attempted to elope since then.	F 225	resident safety, making sure Secure Care Bands are in the care plan and on the order sheets for checking placement every shift as well as workability of the Secure Care Band in the evenings. Audits of nursing notes, incident reports, and 24 hour communication board will be audited for immediate reporting to the SA. Audits will be done five days per week for one month. If no trends are found, this will be audited three times per week for two additional months. Audits will be conducted by Maintenance/Designee on all the doors three times per week for 3 months to ensure the Secure Care Alarms are working properly. Audits will be reviewed at QAPI for three months to ensure adherence to policy is being followed. Deficient practice to be corrected by 5-16-17.	

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F 225	Continued From page 12	F 225		

During interview on 4/5/17, at 2:06 p.m. registered nurse (RN)-B reported she was the staff member who found R5 outside by the garbage can while on her break. RN-B stated R5 had not received any injuries, but had been ready to come back inside. RN-B reported R5 had been observed in the dining room 20 minutes prior to her finding him outside. RN-B stated R5 had times he would verbalize he wanted to go home, stated R5 had worn a wander guard prior to leaving the facility and indicated no alarm was heard when he went out the door. RN-B stated the alarm had sounded when she brought R5 back in through the same door he had exited. RN-B reported R5 had not had any elopements since 3/25/17. RN-B reported the nurse who was working was expected to file the initial incident report online to the SA, reported staff do not wait and error on the side of caution. Incidents such as large bruises, sexual contact, bruises in suspicious areas, injury of unknown origin were all reportable events to the SA. RN-B verified she was educated and was instructed to report elopements right away also.

During interview on 4/6/17, at 10:57 a.m. the director of nursing (DON) confirmed R5's elopement on 3/25/17 was the only elopement and stated the door had not alarmed when R5 exited the facility, the door had been found to be out of range. The DON confirmed R5 had worn a wander guard prior to the elopement on 3/25/17 and nursing management had not been aware of the wander guard placement. The DON confirmed she had been updated when the elopement happened, and had not notified the interim administrator until 3/27/17. The DON reported that she was unaware of the fact that

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F 225	Continued From page 13 elopements were required incident for which to file a vulnerable adult report to the SA, and stated "I needed education as well". The DON confirmed the elopement had not been submitted to the SA until 3/29/17. During interview on 4/6/17, at 12:13 p.m. the interim administrator confirmed 3/25/17 had been his first day at the facility, and reported the DON, who would have been his designee at the time of the incident, was not informed of R5's elopement until 3/27/17. The interim administrator verified the DON and administrator are expected to be updated immediately of all vulnerable adult situations, including elopements. The interim administrator stated education was provided to all staff regarding reporting elopements to the administrator immediately, and submitting the incident to the SA immediately after safety is secured. The facility's Freedom from Abuse, Neglect and Exploitation policy, dated 11/2016 indicated all abuse, neglect and misappropriation of resident property would be reported to the administrator and state agencies immediately.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 226		5/16/17

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F 226	Continued From page 14 (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse prevention policy for 1 of 3 residents (5) reviewed for abuse prohibition. Findings include: The facility's Freedom from Abuse, Neglect and Exploitation policy, dated 11/2016 indicated all abuse, neglect and misappropriation of resident property would be reported to the administrator and state agencies immediately. R5's quarterly Minimum Data Set (MDS) dated	F 226	" F226 Resident #5 care plan has been reviewed and updated on Elopement Risk. Resident #5 assessments have been reviewed and updated on Elopement Risk. Resident #5 has a Secure Care Band in Place on left ankle. Orders are in place to check Secure Care Band Placement every shift and check workability of Secure Care Band every evening.	

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F 226	Continued From page 15 3/21/17, indicated R5 had diagnoses which included Alzheimer's disease, dementia, depression, hypertension (HTN) and heart failure. The MDS identified R5 was severely cognitively impaired and required extensive staff assistance for activities of daily living (ADL's) with the exception of eating. Elopement Risk Assessment dated 3/21/17, indicated R5 had seeking behaviors. The assessment indicated R5 would look for his wife frequently when she was not near him. The assessment indicated R5 was not at risk for elopement, was at the facility with his wife and wanted to be near her, and indicated R5 did not talk of leaving the facility. Elopement Risk Assessment dated 3/25/17, indicated R5 had a one time elopement event, the secure care band did not alarm when R5 exited out the back door, and R5 was noted to have increased confusion, short-term and long-term memory loss and intermittent confusion and impaired decision making skills. The assessment identified R5 was at an increased risk of eloping from the facility. R5's nursing progress noted dated 3/25/17, indicated R5 had been found outside of the facility by the big dumpster. R5 had stated he wanted to go home. R5 had been brought back into the facility, and the wander guard had not sounded the alarm coming back in. Registered nurse (RN)-A was notified in person, and a message was left for the administrator. R5's elopement incident form #2231 dated 3/25/17, at 3:50 p.m. indicated staff went out for	F 226	Resident #5 has been added to the Elopement Book. All doors have been checked to ensure the Secure Care Alarms are working. All staff educated on Policy and Procedure of Vulnerable Adult Reporting, and Policy and Procedure of residents having Freedom from Abuse, Neglect, and Exploitation. Staff will be educated on door system and how the door system works. Audits will be conducted by DON/Designee on three residents per week for 3 months to ensure proper plan of care is present for those at risk of eloping from the facility and to ensure resident safety, making sure Secure Care Bands are in the care plan and on the order sheets for checking placement every shift as well as workability of the Secure Care Band in the evenings. Audits of nursing notes, incident reports, and 24 hour communication board will be audited for immediate reporting to the SA. Audits will be done five days per week for one month. If no trends are found, this will be audited three times per week for two additional months. Audits will be conducted by Maintenance/Designee on all the doors three days per week for 3 months to ensure Secure Care Alarms are working properly.	

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F 226	Continued From page 16 break and found R5 seated outside in front of the big garbage can, R5 had stated I want to go home. The report indicated R5 was forgetful and oriented to person. Interventions put into place: education to staff, wander guard/secure care band care planned for left ankle, orders for checking secure band every shift and workability every evening, added R5 to the elopement book and checked all doors to ensure the secure care alarms worked. The vulnerable adult incident report regarding R5's elopement was submitted to the SA on 3/29/17, 4 days after the incident, and the investigation was submitted to the SA on 3/30/17. During interview on 4/3/17, at 7:23 p.m. RN-A reported R5 eloped out of the back delivery door, and had been found by an employee out back. RN-A confirmed the alarm had not activated when R5 exited the facility, but alarmed when R5 came back into the facility. RN-A had not reported she submitted the event to the SA. RN-A confirmed the elopement on 3/25/17 was R5's first elopement, and stated R5 had not attempted to elope since then. During interview on 4/5/17, at 2:06 p.m. registered nurse (RN)-B reported she was the staff member who found R5 outside by the garbage can while on her break. RN-B stated R5 had not received any injuries, but had been ready to come back inside. RN-B reported R5 had been observed in the dining room 20 minutes prior to her finding him outside. RN-B stated R5 had times he would verbalize he wanted to go home, stated R5 had worn a wander guard prior to leaving the facility and indicated no alarm was heard when he went out the door. RN-B stated	F 226	Audits will be reviewed at QAPI for three months to ensure adherence to policy is being followed. Deficient practice to be corrected by 5-16-17.	

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F 226	Continued From page 17	F 226		

the alarm had sounded when she brought R5 back in through the same door he had exited. RN-B reported R5 had not had any elopements since 3/25/17. RN-B reported the nurse who was working was expected to file the initial incident report online to the SA, reported staff do not wait and error on the side of caution. Incidents such as large bruises, sexual contact, bruises in suspicious areas, injury of unknown origin were all reportable events to the SA. RN-B verified she was educated and was instructed to report elopements right away also.

During interview on 4/6/17, at 10:57 a.m. the director of nursing (DON) confirmed R5's elopement on 3/25/17 was the only elopement and stated the door had not alarmed when R5 exited the facility, the door had been found to be out of range. The DON confirmed R5 had worn a wander guard prior to the elopement on 3/25/17 and nursing management had not been aware of the wander guard placement. The DON confirmed she had been updated when the elopement happened, and had not notified the interim administrator until 3/27/17. The DON reported that she was unaware of the fact that elopements were required incident for which to file a vulnerable adult report to the SA, and stated "I needed education as well". The DON confirmed the elopement had not been submitted to the SA until 3/29/17.

During interview on 4/6/17, at 12:13 p.m. the interim administrator confirmed 3/25/17 had been his first day at the facility, and reported the DON, who would have been his designee at the time of the incident, was not informed of R5's elopement until 3/27/17. The interim administrator verified the DON and administrator are expected to be

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F 226	Continued From page 18 updated immediately of all vulnerable adult situations, including elopements. The interim administrator stated education was provided to all staff regarding reporting elopements to the administrator immediately, and submitting the incident to the SA immediately after safety is secured.	F 226		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents reviewed, (R17, R38) were provided bathing preferences according to previous life routines. Findings include: When interviewed on 4/3/17, at 3:40 p.m. R17 stated he was not given a choice on how many baths he preferred to receive. R17 stated he gets one bath every Friday and it was not his choice.	F 242	" F242 Resident # 17 and 38 have been asked their preference of how many baths a week they would like to have, type of bath they choose, and what time of the day they would like his bath, care plan and bath list updated. All other residents will be interviewed to determine their bathing preferences.	5/16/17

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F 242	Continued From page 19 R17 stated he would prefer 3 showers per week. R17 indicated he was not asked about his bathing preference, it was just set up. R17's Diagnosis Report dated 4/6/17, indicated R17 had diagnoses which included displaced fracture of left femur, major depressive disorder and traumatic amputation of right lower leg. The admission Minimum Data Set (MDS) dated 3/13/17, indicated R17 had moderate cognitive impairment and required physical assistance with bathing. The MDS further indicated it was very important for R17 to choose between a tub bath, shower, bed bath or sponge bath. R17's current care plan printed 4/6/17, directed 1 staff to participate with bathing. However, the care plan did not list the number or type of bath/shower to provide. The facility form titled Group 2 care sheet updated 3/31/17, instructed staff to provide R17 a bath Friday a.m. R17's Quarterly Care Conference Multidisciplinary documentation indicated R17's care conference was held 3/22/17. R17 and his spouse attended the care conference. The ADL (activities of daily living) section indicated "see care plan". No further documentation indicated bathing was discussed. R17's Admit/Readmit Assessment-HDGR completed 3/6/17, indicated bathing activity did not occur and identified R17 required assistance to complete ADLs. No preference to bathing was documented on the form. When interviewed on 4/5/17, at 9:53 a.m. certified	F 242	Nursing staff will be educated on creating plan of care to include resident preferences in bathing. LSW educated to add personal preferences to plan of care. Admission process will be updated to include bathing preference, how often they would like a bath, and what time of day they would like a bath. Quarterly Care Conference sheet will be updated to include preferences of bathing for the residents. DON/Designee will update Care Plans/Care Guides and Bath List on how many baths resident prefers to take during the week, type of bath resident prefers, and time of day they prefer their bath quarterly. Audits will be developed to monitor all residents are satisfied with their bathing schedule. Audits will be completed 1 time per week for three months. Audits will be reviewed at QAPI for three months to ensure adherence to policy is being followed. Deficient practice to be corrected by 5-16-17.	

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F 242	Continued From page 20 nursing assistant (CNA)-A confirmed R17 received one bath a week, on Fridays. CNA-A stated all residents were started with one tub bath per week. When interviewed on 4/5/17, at 9:50 a.m. R17 confirmed he received one tub bath per week, would have liked more, but stated it did not work out that way. R17 confirmed he was not given a choice on the number or type of bath he would receive. R17 indicated he had not requested more and did not know that he could. Even though staff were aware R17 found it very important to choose what type of bathing activity he received, the facility failed to ask R17's preference for bathing. When interviewed on 4/4/17, at 10:17 a.m. R38 confirmed she received one tub bath per week. R38 confirmed she was not given a choice on how many baths she received. During a follow up interview on 4/5/17, at 1:35 p.m. R38 confirmed no one had asked her what type of bath she would have liked or how many. R38 stated she would have preferred to also have a shower instead of a bath once a week also. R38's Diagnosis Report dated 4/6/17, indicated R38 had diagnoses which included major depressive disorder, polyarthritis and chronic low back pain. R38's quarterly MDS dated 1/12/17, indicated R38 had moderate cognitive impairment and required physical assistance with bathing.	F 242		

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R38's current care plan printed 4/6/17, directed 1 staff to participate with bathing, with no indication on number or type of bath to provide.

The Group 2 untitled care sheet updated 3/31/17, instructed staff to provide R38 a bath Wednesday a.m.

R38's Quarterly Care Conference Multidisciplinary documentation indicated R38's care conferences were held 7/26/16, 10/19/16 , and 1/18/17. R38 attended the care conferences 7/27/16, and 10/19/16. The ADL section indicated "see care plan." No further documentation indicated bathing was discussed.

R38's Admit/Readmit Assessment-HDGR completed 4/8/16, indicated R38 required physical help limited to transfer only, for bathing. No preference to bathing was documented on the form.

When interviewed on 4/05/17, at 1:56 p.m. registered nurse (RN)-B indicated the nurses completed the head to toe assessment, but the bath aide would have had a conversation with the new residents regarding their baths. If any problem with bathing was identified, this would be discussed by the nurse who admitted the resident. This would then have been entered on the care plan by the director of nursing (DON) or the nurse who admitted the resident if the DON was not available.

When interviewed on 4/6/17, at 9:31 a.m. CNA-C confirmed she scheduled resident baths. She indicated she looked at how many residents were

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scheduled in a column each day. If one resident left, the next resident was put in that spot. CNA-C stated sometimes the charge nurse would let her know what a resident wanted.

When interviewed on 4/6/17, at 10:16 a.m. registered nurse (RN)-A indicated she gave the nurses the assessment forms to be completed when a resident was admitted. RN-A stated she didn't ask new residents questions, unless the nurses were busy, then she would help.

When interviewed on 4/6/17, at 10:43 a.m. the social service designee (SSD)-A reviewed the usual facility practice for admission process of new residents. SSD-A indicated she did not ask residents any questions regarding their baths. SSD stated she had understood the nursing staff did this.

When interviewed on 4/6/17, at 11:13 a.m. LPN-A confirmed the admission form they used did not include an area for choices on bathing; only what type of assistance the resident would require. LPN-A indicated when a new resident was admitted they were assigned days for their bath into the spot that was assigned for the resident previously in the room they were admitted into. LPN-A stated she would tell the resident what day their bath was scheduled, and if they wanted a different day they would accommodate this. LPN-A stated R17 and R38 had not requested more baths to her. LPN-A stated care conferences were attended by the DON.

When interviewed on 4/6/17, at 2:10 p.m. DON confirmed bathing preferences were not included on the admission form used by the nurses. DON indicated she would expect the bath aide to ask

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F 242	Continued From page 23 bathing preferences of the residents. DON indicated that if a resident would prefer more baths or a different type they would accommodate their preferences. DON confirmed they had no formal process to assure bathing preferences were asked of the residents. A policy related to bathing preferences was requested, and no policy was provided.	F 242		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 provide services as directed by the care plan for removal of facial hair for 2 of 3 residents (R7, R15) observed to have long facial hair which was not removed by staff, for oral hygiene for 1 of 3 residents (R42) who required assistance with oral hygiene, and for toileting assistance or incontinence care for 2 of 3 residents (R5, R7) reviewed for activities of daily living (ADLs). Furthermore, the facility failed to ensure care plan interventions were implemented for 2 of 2 resident (R7, R52) identified with current pressure ulcers. Findings include:	F 282	• F282 Residents #7 and #15 have been shaved per care plan and care plan was reviewed and updated to reflect current care needed and match care guide. Nursing staff educated on providing assistance with shaving and grooming per plan of care. Audits will be conducted by DON/Designee three times per week for three months to ensure that residents are being shaved per plan of care. Resident #42 has been provided with oral	5/16/17

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F 282	Continued From page 24 R7 was not provided personal hygiene to remove facial hair as directed by the care plan. R7's care plan, revised on 4/4/17, identified R7 had ADL self care performance deficit related to decreased mobility secondary to arthritis. R7's care plan indicated R7 required staff assistance with personal hygiene care. Review of the nursing aid care plan undated, identified R7 was independent with ADL's and received a bath on Thursdays in the a.m. During observations on 4/3/17 at 5:01 p.m. R7 was in her room, laying in bed and was noted to have several long, thick white facial hairs on her cheeks and chin area. During observation on 4/5/17 at 9:20 a.m. R7 was laying in her bed after her dressing change to her right foot and was noted to have several long, thick white facial hairs on her lower chin area. R7 continued to have several long, thick white facial hairs on her lower chin area all day. During observation on 4/6/17 at 8:46 a.m. R7 was laying bed resting and was noted to have several long, thick white facial hairs on her lower chin area. R7 continued to have several long, thick white facial hairs on her lower chin area. At 10:00 a.m. R7 was out in the dining room area drinking orange juice independently and continued to have several long, thick white facial hairs on her lower chin area, and continued to have facial hair until she had her bath at approximately 11:00 a.m. On 4/6/17 at 8:59 a.m. NA-A confirmed R7	F 282	cares as he will allow per plan of care and care plan/care guide were reviewed and updated to reflect current care needed. Nursing staff educated on providing assistance with oral cares and grooming per plan of care. Audits will be conducted by DON/Designee three times per week for three months to ensure that resident's oral cares are being done per plan of care. Resident #5 and #7 have been toileted and incontinence care provided per care plan and Bowel and Bladder assessments were reviewed and updated. Additionally, care plan was reviewed and updated to reflect current plan of care needed and match care guide. Nursing staff has been educated on providing residents care per their care plan to minimize urinary incontinence. Audits will be conducted by DON/Designee on three residents per week for three months to review Bowel and Bladder Assessments, Care Plan, and Care Guide to ensure residents receive appropriate treatment and services regarding elimination needs. Resident #7 care plan was reviewed and updated to reflect current care needed to promote healing of a pressure ulcer. Resident #7 Occupational Therapy Screen was done to evaluate appropriate	

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F 282	Continued From page 25 required staff assistance with personal hygiene and indicated the bath aid shaved the residents on their bath day. NA-A also indicated that staff were supposed to be shaving the residents as well because the DON had told staff that they needed to start doing this and not just on their bath days. On 4/6/17 at 1:20 p.m. DON confirmed R7 required staff assistance with ADL's and stated staff should be offering (shaving) it to her and help if needed. The DON also indicated she had told staff that it is everybody's responsibility to make sure residents were getting shaved. R15 was not provided with personal hygiene to remove facial hair as directed by the care plan. R15's care plan dated 4/12/17, indicated R15 required extensive assist of one staff for personal hygiene related to the inability to remember the need for sequencing of ADL's. The care plan indicated R15 could be resistive to care related to dementia and Alzheimer's disease; staff were directed to reapproach or have a different staff member attempt to provide the ADL's. On 4/4/17, at 11:06 a.m. R15 was observed in the dining room, seated in a wheelchair. R15 was noted to have numerous long, white facial hairs above and below her lips and in the center of her chin. On 4/5/17, at 7:12 a.m. R15 was observed in bed and continued to have white, long facial hair above and below lips and in the center of her chin. At 1:58 p.m. R15 was in her room, seated in a wheelchair, and was again noted to have	F 282	positioning interventions are in place. Resident #52 care plan was reviewed and updated to reflect current care needed to promote healing of a pressure ulcer. Resident #52 Occupational Therapy Screen was done to evaluate appropriateness of Functional Maintenance Program and to provide clarification of appropriate positioning interventions. Residents who are at risk for developing pressure ulcers were reviewed to ensure care plan/care guide is reflective of services needed to promote healing or prevent pressure ulcers. Nursing staff has been educated on providing the necessary treatment and services to prevent pressure ulcers and promote healing. Audits will be conducted three times weekly by DON/Designee to ensure appropriate care and services are in place and care is being delivered to promote and or heal pressure ulcers. Audits to be reviewed at QAPI for the next 3 months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 5-16-17.	

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long facial hair. R15 was unable to answer if her long facial hair bothered her.

On 4/6/17, at 8:54 a.m. R15 was in the resident lobby, seated in a wheelchair. R15 was again noted to have numerous white, long facial hair above and below her lips and in the center of her chin. At 8:56 a.m. licensed practical nurse (LPN)-A assisted R15 to a private area and administered eye drop medication to both eyes. LPN-A assisted R15 back to the resident lobby. LPN-A did not assist R15 with shaving, or request staff to provide the care for R15.

During review of R15's progress notes and bathing schedule, R15 was identified to have her bath on Thursday of each week. The progress notes indicated R15 required total staff assistance of cares during bathing. Further, the progress notes did not indicate R15 had refused staff assistance for ADL's including shaving.

On 4/6/17, at 8:59 a.m. LPN-A reported R15 required staff assistance of one for ADL's including shaving. LPN-A reported staff provide shaving on bath day and as needed. LPN-A confirmed R15 had multiple long facial hairs on her upper and lower lip and in the center of her chin, and stated staff should have shaved R15's face before waiting until bath day. LPN-A reported R15 did have a history of resisting care assistance, then confirmed staff were expected to report the refusal and it would be documented in R15's medical record. LPN-A confirmed no staff had reported R15 refused shaving on 4/6/17.

On 4/6/17, at 9:35 a.m. nursing assistant (NA)-A confirmed she assisted R15 with morning cares on 4/6/17. NA-A verified R15 required staff

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assistance of one for all cares including shaving. NA-A reported R15 would refuse cares at times, such as toileting, then stated R15 was redirectable if another staff member attempted. NA-A reported all residents get shaved on bath days, then stated it was not only the bathing staff responsibility to ensure facial hair was removed. NA-A indicated staff were to report any refusals of care to the nurse and should also be documented. NA-A confirmed R15's had numerous white, long facial hairs above and below her lips and on her chin. NA-A confirmed she had not attempted to shave R15 on 4/6/17, and stated staff are expected to shave residents prior to their bath day if facial hair was present. NA-A reported razor availability was short in the facility, and stated R15 did not have a personal razor. NA-A indicated the only razor available was in the bathing area, and was usually being used by another resident.

On 4/6/17, at 10:50 a.m. the director of nursing (DON) confirmed R15 required extensive assistance of one staff to complete ADL's, which included shaving. The DON reported all residents are expected to be shaved on their bath day, and anytime someone noticed residents with facial hair. The DON confirmed staff were expected to document resident refusal of cares, including refusal of shaving. The DON stated staff had been trained to reapproach at a later time, or have another staff member attempt cares if a resident refused care assistance. The DON confirmed it was not acceptable for R15 to have facial hair growing on her face, and stated shaving was part of the bathing routine.

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R42 did not receive assistance with oral hygiene as directed by the care plan.

R42's care plan, dated 11/22/16, identified R42 had problems of self performance deficit related to cellulitis in right arm and decline in cognition. R42's care plan indicated R42 had an upper denture, lower partial and a few lower teeth.

Review of the nursing aid care plan undated, identified R42 required total assist for cares and staff were to swab for oral cares.

During observations on 4/5/17, at 7:33 a.m. R42 was laying in bed on his left side and NA-A and NA-E were assisting R42 to get dressed for the day. At 7:39 a.m. NA-A and NA-E transferred R42 via mechanical standing lift from his bed to the bathroom area and lowered R42 onto the toilet. At 7:42 a.m. NA-E lifted R42 off the toilet via mechanical standing lift and NA-A provided pericares, placed clean incontinent brief, and pull up R42's pants. At 7:46 a.m. NA-A and NA-E transferred R42 via mechanical standing lift back to his room and lowered R42 in his wheelchair. At 7:48 a.m. NA-E left R42's room after making his bed, collecting the dirty linen and garbage from NA-A while NA-A continued to work with R42, combing his hair. At 7:49 a.m. NA-A wheeled R42 down to the main dining for breakfast. At 9:24 a.m. R42 was done eating all of his breakfast and continued to sit in the main dining room area. R42 had upper teeth and had several missing, worn down teeth on the bottom of his mouth, which were very discolored and dirty. During the observation R42 was not offered or provided oral cares by NA-A or NA-E during this time.

On 4/6/17, at 8:52 a.m. NA-A confirmed R42

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required total assistance from two staff for all of his ADL's, including oral hygiene. NA-A indicated R42 had upper and lower dentures and which needed to be cleaned by staff. NA-A confirmed she did not provide R42 with oral cares and stated "I did not provide oral cares yesterday, I should have, but I didn't." NA-A also indicated staff on the night shift could not get R42's dentures out and stated "so I did not try to remove his dentures."

On 4/6/17 at 1:37 p.m. DON confirmed R42 required total assistance with ADL's from staff and she would expect staff to provide oral cares/brush his dentures in the morning and at night. The DON verified staff should be following the plan of care and indicated staff needed to offer dental care even if R42 refused at times.

R5 was not provided incontinence care as directed by the care plan.

R5's care plan dated 5/5/17, identified R5 had incontinence related to dementia and directed staff to check every two hours and as required for incontinence. R5's care plan directed staff to wash, rinse and dry perineum, and change clothes as needed after incontinence episodes.

R5's nursing assistant care guide dated 3/31/17, directed staff to assist R5 with toileting per his request only, and as needed. The care guide indicated R5 was occasionally incontinent, and required staff assist of one to provide personal cares and toileting.

During continuous observation on 4/5/17, from 7:05 a.m. to 10:42 a.m. the following was

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revealed:

- At 7:05 a.m. R5 was seated in a wheelchair by the nurses station

-At 7:13 a.m. R5 remained seated in his wheelchair, and was observed propelling self throughout the 200 hallway.

-At 7:19 a.m. R5 was directed by staff to the resident lobby, next to the dining room.

-At 7:30 a.m. the dining room doors open, then the dietary manager (DM) assisted R5 to the breakfast table and served him coffee.

-At 7:51 a.m. registered nurse (RN)-B administered R5 medications while he was seated at the dining room table.

-At 8:13 a.m. R5 finished the breakfast meal, remained at the dining room table, seated in his wheelchair.

-At 8:15 a.m. nursing assistant (NA)-F came into the dining room and asked R5 if he was ready for therapy. At 8:18 NA-F assisted R5 out of the dining room and into the therapy room.

-From 8:21 a.m.-9:19 a.m. R5 completed his restorative nursing program which included upper and lower extremity exercises. NA-F assisted R5 to the adjoining room, R5 looked out the window.

-At 9:35 a.m. nursing assistant (NA)-B entered the therapy room and asked R5 if he needed to go to the bathroom, R5 stated, no. NA-B did not check R5 for incontinence. R5 remained seated in the wheelchair while looking out the window,

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F 282	Continued From page 31 NA-B exited the therapy room. -From 9:37 a.m. to 10:13 a.m. R5 participated in a group exercise activity with other residents. -At 10:26 a.m. R5's wife assisted R5 out of the therapy room and into the resident lobby to watch television. -At 10:42 a.m. NA-B entered the resident lobby and assisted R5 to his room. NA-B asked R5 if he did his exercises today, R5 stated, no. NA-B assisted R5 to the bathroom, instructed R5 to stand up, then pulled down R5's incontinent brief. R5's buttocks and back of upper legs were red with multiple creases in his skin. NA-B used her gloved hand to feel R5's brief, then told R5 to go to the bathroom. -R5 was not checked for incontinence from 7:05 a.m. to 10:42 a.m. a total of 3 hours and 37 minutes. During interview on 4/5/17, at 10:52 a.m. NA-B confirmed she was assigned to provide cares for R5 on 4/5/17. NA-B reported R5 required extensive assistance of one staff member for all ADL's, and stated R5 was occasionally incontinent of urine. NA-B reported staff were only directed to check R5 for incontinence as needed or when R5 would request to use the bathroom. NA-B confirmed R5 wore an incontinence brief at all times. NA-B verified the care guide directed staff to only check brief as needed or when R5 requested to use the bathroom, and stated the nurse updated the care guides with any changes. NA-B confirmed R5 was not on a scheduled check and change program.	F 282		

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During interview on 4/5/17, at 1:46 p.m. trained medication aide (TMA)-A reported R5 needed staff assist of one for all ADL's, reported R5 was incontinent of urine but not bowel, and was not cognitively intact. TMA-A reported R5 wore an incontinence brief at all times, and stated R5 would let staff know when he needed to have a bowel movement, but was unable to notify staff about the need to urinate. TMA-A reported staff usually asked R5 every two hours if he needed to use the toilet. TMA-A confirmed R5's brief was often wet when she took him to the bathroom. TMA-A indicated staff are expected to check on R5 every two hours for toileting and incontinence cares.

During interview on 4/5/17, at 2:06 p.m. RN-B reported R5 was dependent on staff assist of one for all ADLs, except for eating. RN-B confirmed R5 wore a brief at all times and staff were expected to check on R5 every two hours. RN-B stated staff need to check every two hours due to R5 not capable of using the call light or informing staff of his toileting needs.

During interview on 4/6/17, at 10:58 a.m. the DON confirmed R5 required extensive assistance of one for ADL's, including toileting. The DON confirmed staff were expected to check on R5 every two hours, and as needed for incontinence needs as identified in R5's bowel and bladder assessment and care plan. The DON confirmed the nursing assistant care guides did not match R5's care plan, and stated, "We need to get that updated".

R7 did not receive timely toileting assistance as

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F 282	Continued From page 33 directed by the care plan R7's current care plan revised 4/4/17, identified R7 had impaired urinary elimination related to urge incontinence and used disposable briefs. The care plan directed staff to encourage fluids during the day to promote prompted voiding responses, establish voiding patterns, and ensure an unobstructed path to the bathroom. The care plan also indicated R7 had moisture associated skin damage on coccyx/sacral area related to urinary incontinence and decreased mobility. The care plan listed various interventions and directed staff to encourage R7 to toilet every two hours to remain dry. Review of the Group one nursing aid care plan updated 3/31/17, identified R7 was independent with ADL's and wore a brief at night. However, the care plan did not identify to encourage R7 to toilet every two hours. On 4/5/17, at 7:11 a.m. R7 was observed on her back, with her eyes closed in bed, with the head of bed (HOB) elevated. R7 remained in the same position in bed with her eyes closed until 8:30 a.m. Continual observations were conducted on 4/5/17, from 9:11 a.m. to 11:43 a.m. -At 9:11 a.m. R7 was observed in her bed, on her back, with the head of bed (HOB) elevated. Licensed practical nurse (LPN)-B entered R7's room and provided a dressing change to R7's right heel. LPN-B then applied a blue pressure relieving padded boot to R7's right foot, tucked her legs under the covers, covered her upper body with covers, put the bed in low position and call light within reach, and proceeded to leave the	F 282		

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room at 9:20 a.m. R7 was wearing a white incontinent brief with a white cloth pad underneath her. LPN-B did not offer to toilet or check R7 for incontinence before exiting the room.
-At 10:01 a.m. continued in same position.
-At 10:27 a.m. trained medication aid (TMA)-A entered R7's room, offered R7 assistance to get up, and R7 refused.
-At 10:31 a.m. TMA-A removed R7's blankets, inspected her incontinent brief, then covered R7 back up. TMA-A gathered supplies to change R7's incontinent brief, exited the room briefly and returned with additional supplies at 10:33 a.m. TMA-A uncovered R7 and proceeded to remove R7's incontinent brief which was moderately wet with urine and moderate amount of urine on the white cloth pad. TMA-A provided peri cares for R7.
-At 10:37 a.m. TMA-A offered R7 assistance to get up and R7 refused. TMA-A made R7 comfortable, put HOB up, bed in low position, call light within reach, wheel chair at end of bed and proceeded to leave the room with soiled linen and garbage in bags at 10:39 a.m.

On 4/5/17, at 9:19 a.m. LPN-B indicated that she had not assisted R7 with any of ADL's for the day and only gave R7 her medications this morning and did her dressing change. LPN-B also indicated that R7 usually got up later and she had not provided any cares for her this morning.

On 4/5/17, at 10:20 a.m. TMA-A confirmed R7 required assistance with ADL's off and on depending on the day. TMA-A indicated R7 wore an incontinent brief at night, a pad with underwear during the day and staff helped her with peri-cares. TMA-A indicated staff checked R7

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every two hours during the night for incontinence but there was nothing on her care plan which indicated she was supposed to check her every two hours during the day. TMA-A indicated she did not know the last time R7's incontinent brief was checked and she had not check her incontinent brief all morning since she arrived at work and stated she "was not aware she needed to be checked every two hours."

On 4/5/17 at 10:53 a.m. NA-A indicated she thought R7 required assistance from staff for ADL's but was not sure and indicated she had not worked with R7 that day and did not know the last time R7's incontinent brief was checked. NA-A verified R7 had incontinence of urine and was to be checked every two hours for incontinence.

On 4/5/17 at 2:11 p.m. LPN-B indicated R7 was incontinent of bowel and bladder and was to be checked every two or three hours. LPN-B verified she had not checked R7's brief for incontinence that morning. LPN-B confirmed R7's care plan and nursing assistance care plan and indicated staff should have followed the care plan and interventions in place.

On 4/6/17 at 1:01 p.m. R7 verified she had incontinence of urine and wore an incontinent brief. R7 indicated she did not worry about getting up because staff were to check it (meaning her incontinent brief).

On 4/6/17 at 1:20 p.m. director of nursing (DON) confirmed R7 required assistance from staff for ADL's. DON verified R7 was incontinent of urine, wore incontinent products and required assistance from staff to be checked or offered toileting every two hours and stated "to prevent

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her from breaking down and staying dry." The DON verified R7's current care plan and her nursing assistant care plan and indicated staff should have followed the care plans. The DON indicated the nursing assistants care plans were not accurate and did not match R7's written care plan. The DON indicated this was a problem of the care plans not getting updated with changes for the staff on the floor.

R7's care plan intervention for a pillow placed between the legs to prevent pressure and rubbing was not implemented.

R7's current care plan revised 4/4/17, identified R7 had a stage two ulcer on her right inner ankle related to ankles pressing together when in bed. The care plan listed various interventions and directed staff to apply pillow in-between legs to prevent pressure and rubbing. The care plan further directed staff to monitor/report and document any skin redness or breakdown.

Review of the Group one nursing aid care plan updated 3/31/17,, identified R7 was independent with ADL's, and directed staff to place a pillow between legs/ankles when in bed.

Continual observations were conducted on 4/5/17, from 9:11 a.m. to 11:43 a.m.
-At 9:11 a.m. R7 was lying on her back in her bed with the head of bed (HOB) elevated. Licensed practical nurse (LPN)-B was present in the room and removed a blue pressure relieving boot from R7's right foot. LPN-B proceeded to remove the dressing from R7's right inner heel and began a dressing change. The area measured 0.4 centimeters (cm) x 0.4 cm in the center of the

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ulcer with no open area and the outer edges of the ulcer were dry with flaky skin peeling. The entire ulcer area was pink. LPN-B proceeded to complete a dressing change of Aquacel (highly absorbent, nonadherent wound dressing) to wound area, covered with 4 x 4 gauze and wrapped with kerlix gauze, then applied her sock to her foot per R7's request. LPN-B then applied a blue pressure relieving padded boot to R7's right foot, tucked her legs under the covers, pulled the covers up to her chest. LPN-B exited the room and had not placed a pillow between R7's legs/ankles.

-at 9:20 a.m. R7 was noted to have her right leg crossed over her left leg with her right foot resting across her left foot in bed. A pillow was not present between R7's ankles, or near the end of the bed.
-At 10:01 a.m. continued in same position.
-At 10:27 a.m. R7 remained in the same position in bed. Trained medication aid (TMA)-A entered R7's room, offered R7 assistance to get up, and R7 refused. At 10:31 a.m. TMA-A removed R7's blankets, inspected her incontinent brief, then covered R7 back up. A pillow was not present between R7's ankles or near the end of the bed. TMA-A exited the room.
-At 10:33 a.m. TMA-A again entered R7's room, and proceeded to assist R7 with personal cares. R7 had a blue pressure relieving boot on her right foot and had no pillow in-between her legs/ankles when she was in bed. TMA-A proceeded to provide personal cares for R7. R7's buttocks had a small white area in the crease of the buttocks, and and no open areas noted to R7's buttocks or coccyx area, skin pink.
-At 10:39 a.m. TMA-A completed personal cares and exited the room. R7 remained in bed, with

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her right leg crossed over her left leg with her right foot resting across her left foot. TMA-A had not placed a pillow in-between R7's legs/ankles before leaving the room.
-At 11:25 a.m. R7 remained in same position.
-At 11:41 a.m. TMA-A entered R7's room, R7 stated her heel hurt a little bit. R7's right leg was crossed over her left leg with her right foot resting across her left foot. R7 continued to have blue pressure relieving boot on her right foot, but no pillow in-between her legs/ankles. TMA-A removed R7's covers and proceed to assist R7 to reposition up in her bed. TMA-A did not place a pillow in-between R7's legs/ankles before exiting the room at 11:43 a.m..

On 4/5/17 at 10:20 a.m., TMA-A confirmed R7 required assistance with ADL's off and on depending on the day. TMA-A verified R7 had an ulcer on her right heel and wore a pressure relieving boot when she was in bed. TMA-A indicated that she was not aware R7 was to have a pillow between her legs/ankles. She confirmed she had not placed a pillow to prevent pressure to her legs/ankles and after review of the nursing aid care plan for R7, confirmed the use of a pillow between her legs/ankles was to be done when she was in bed.

On 4/5/17 at 2:11 p.m., LPN-B confirmed R7 had a stage two ulcer on her right heel and wore a pressure relieving boot while in bed. She indicated R7 moved her feet around in bed and crossed her legs all the time. LPN-B indicated she was not sure if R7 was to have a pillow in-between her legs or not. LPN-B verified R7 did not have a pillow in-between her legs and stated "I did not even think of placing a pillow, I just put her boot back on." LPN-B confirmed R7's care

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F 282	Continued From page 39 plan and nursing assistance care plan and indicated staff should have followed the care plan. On 4/6/17 at 1:20 p.m., director of nursing (DON) confirmed R7 required assistance from staff for ADL's and was at risk for pressure ulcer. DON also indicated R7 was to have a pillow in-between her legs/ankles so they were not rubbing together. The DON verified R7's current care plan and nursing assistant care plan and indicated staff should have followed R7's care plan to prevent further breakdown. R52's care plan interventions for pressure ulcer were not implemented. R52's care plan dated 4/5/17, identified R52 had a pressure area to her right heel which was covered in black eschar (a slough or piece of dead tissue that is cast off from the surface of the skin) which developed 1/28/17, and a pressure ulcer to her right ankle which developed 2/10/17, related to immobility and shoes being too tight. The care planned interventions included trial of a soft, ankle high slipper to her right foot, extended leg rest, protective boot or float heels when in bed and reposition every 2 hours. The care plan also indicated R52 was to be evaluated by OT [occupational therapy] for wheelchair and bed positioning and was to complete restorative exercises as ordered. On 4/5/17, at 7:26 a.m. nursing assistant (NA-A) wheeled R52 out of her room and down the hallway towards the dining room. R52 wore a	F 282		

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navy blue, thin sock covered with a blue protective boot to her right foot. R52's right foot rested on her wheelchair foot pedal and R52's right leg rested on an extended leg rest which had black padding under her right calf.

-7:48 a.m. R52 was seated at the dining room table with R24 for the breakfast meal. The blue boot remained on R52's right foot in the leg rest.

-8:05 a.m. R52 self propelled her wheelchair, utilizing both arms and her left leg, from the aviary outside the therapy room into the therapy room doorway.

-8:14 a.m. trained medication assistant (TMA-A) wheeled R52 from her room to therapy department, R52 wore black moccasin style shoes on both feet and the blue boot was not present.

-8:22 a.m. R52 was seated in front of the arm bike, attempting to use the arm bike with a staff member along side of her. R52's right heel rested directly on the foot pedal of her wheelchair in the moccasin.

-8:38 a.m. restorative therapy supervisor (RTS) removed R52's foot pedal from her wheelchair and assisted R52 to put her right heel rested directly on floor. RTS assisted R52 to stand from her wheelchair and then into the seat of the Nu-step exercise machine. R52 had a slow, hunched over gait and grimaced during transfer to the Nu-step machine. RTS assisted R52 to place both feet onto the foot pedals of the Nu-step and R52 began to slowly utilize the machine. R52's right heel rested directly on the foot pedal of the machine while she was

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propelling the machine. RTS offered verbal encouragement for R52 to continue to pedal the machine.

-9:00 a.m. NA-F walked up to R52 and told her she was done. R52 had completed 52 steps with her feet on the pedals. NA-F assisted R52 from the Nu-step back into her wheelchair without the foot rest, and stated R52 had to wait for exercise class. R52's right heel rested directly on the floor.

-9:12 a.m. NA-F wheeled R52 to the back of the therapy room and positioned her wheelchair between R9 and R24. R52's right heel dragged across the floor surface during the move, and then rested directly on the floor.

-9:33 a.m. R52's continued to wear the moccasin style shoes, and the bottom of the foot rested directly on the floor. NA-E entered the therapy room, stated she was going to toilet R52 before exercise class started at 9:45 a.m. NA-E pushed R52 out the room, and R52's leg rest was not attached to the wheelchair.

-9:50 a.m. NA-E wheeled R52 from her room back to therapy, with the moccasin style shoes on both feet, and leg rest not attached to wheelchair. RTS applied leg weights to both R52's ankles and proceeded to place R52's right heel rested directly on floor with moccasin style shoes still on both feet.

From 9:51 a.m. to 10:26 a.m. RTS conducted the resident exercise class and R52 completed all of the exercises as instructed by RTS while wearing leg weights to both her ankles. R52 was encouraged by staff to participate in the various exercises. R52's right heel either rested directly

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on the floor or completed the exercises which applies pressure or friction to the heel.

The following exercises were done with ankle weights to both ankles and moccasin style shoes:

-R52 swept her right foot back and forth on the floor from side to side

-R52 lifted her foot up by the toes repeatedly and rested her heels flat on the floor

-R52 rocked back on her heels and tapped heel on the floor

-R52 marched and lifted both feet up and down with force

-R52 kicked her feet up and down and in between kicks, kept both feet flat on the floor

-R52 kicked out her right leg and dragged the foot/heel back under her chair. R52 dragged her right heel back and forth repeatedly

-10:26 a.m. RTS removed the ankle weights from R52's ankles and again rested R52's right heel directly on floor. RTS applied right foot pedal to R52's wheelchair, placed R52's right foot directly on the pedal and wheeled R52 from therapy to common area outside of the dining room.

-10:40 a.m. during observation of R52's right heel with licensed practical nurse (LPN)-B and registered nurse (RN)-A present, LPN-B measured R52's pressure ulcers. She stated the measurement of the right outer heel pressure ulcer was 0.3 centimeter (cm) x 0.3 cm area with a light brown superficial scab covering the area.

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F 282	Continued From page 43 The unstageable pressure ulcer which was located on the bottom of R52's right foot measured 0.7 cm x 0.4 cm with a 0.3 cm indented, hard light brown scab. RN-A confirmed the ulcer on the bottom of R52's heel was an unstageable pressure ulcer and stated if the scab came off, the wound may be deeper. She indicated she did not know the depth of the wound underneath the scab. On 4/5/2017, at 2:02 p.m. certified occupational therapy assistant (COTA) confirmed she was aware R52 had pressure ulcers on her right heel. She stated she was not aware of what caused R52's ulcers on her heel and indicated the ulcers may have been caused from R52 propelling her wheelchair with her heels or from the foot pedal of her wheelchair. She stated in the past R52 had worn a large protective boot all the time on her right foot and at present the boot was changed to bedtime only because therapy felt her sores were healing. She stated R52 was to wear slippers that protected her foot above the ankle. She stated the facility had not made any adaptations for her restorative exercises when she no longer wore the protective boot. COTA stated she felt R52 could rest her right foot on the floor because it was protected by the slipper and stated she felt use of the Nu-step was acceptable because pedaling put an equal amount of pressure on both of R52's heels. On 4/5/17, at 2:09 p.m. NA-F stated she was not sure what caused R52's sores on her foot. She stated R52 used a protective boot and kept her leg rests off most of the time in therapy. NA-F stated R52 wore a slipper or moccasin on her right foot to protect R52's heel.	F 282		

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F 282	Continued From page 44 On 4/5/17 2:18:04 PM RTS stated she did not know what caused R52's ulcers to her right heel and stated she thought the ulcers may have developed from poor circulation, from lying in her bed or from an ill fitting shoe. She stated she felt when R52 wore the leg weights and resting her right heel on the floor it would not cause any problems with R52's skin. She stated there were no other adaptations for R52's exercises or therapy. On 4/6/17, at 8:41 a.m. RTS confirmed R52's Restorative Therapy Administration records. She stated R52 was scheduled 5 days per week for both restorative therapy and exercise class. Stated R52 was a faithful attendee and attended both 3-4 times per week. On 4/6/17, at 8:53 a.m. RN-A stated R52 developed an unstageable pressure ulcer to her right heel caused from her brown shoes. She stated R52 had developed another pressure ulcer on 2/10/17, to the side of her right heel and stated she was unsure of what caused it. RN-A confirmed R52's care plan and confirmed R52's positioning requirements which included not resting her heel on the foot rest of her wheelchair. She stated staff floated R52's heels when she was in bed, used a padded dressing to cover her heel, and tried to keep pressure away from R52's right heel. RN-A confirmed she was not aware of R52's restorative therapy program and stated there were no special accommodations for her exercises. On 4/6/17, at 9:39 a.m. director of nurses (DON) confirmed R52's skin assessments, which identified R52 as having low risk for developing	F 282		

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pressure ulcers. She stated R52 developed an unstageable pressure ulcer to the bottom of her heel on 1/28/17, and developed a stage II pressure ulcer to the side of her right heel 2/10/17. She stated therapy recommended R52 wear a soft, ankle high slipper during the day and the protective boot at night.

On 4/06/17, at 10:16 a.m. R52 was observed seated in her wheelchair, with moccasin style shoes on both feet. RN-A and DON were present and both indicated it was not clear how to interpret what R52 was supposed to wear on her feet on R52's care plan and OT documentation.

On 4/6/17, at 11:18 a.m. occupational therapist (OT) stated she had ordered the ankle high slipper on 4/4/17, and stated R52 was to wear the moccasin type shoe on her left foot only for grip with transfers and propelling in her wheelchair. She stated she felt the Nu-step was not a concern because it applied equal pressure to both R52's heels. She stated whenever R52 was seated in her wheelchair she was supposed to have her foot rest on to protect her right heel and keep it from resting on the floor. OT stated there were had been no accommodations for R52's therapy/exercise program and stated the facility would need to have evaluation from physical therapy to make changes to protect R52's right heel.

On 4/06/17, at 3:15 p.m. R52's physician (MD) stated he was aware R52 had an unstageable pressure ulcer on the right heel, but was not aware that R52 developed a stage 2 pressure ulcer to her right outer heel. He stated he had last seen R52's pressure ulcer on 4/2/17 and felt it was stable at that time, with the use of the

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F 282	Continued From page 46 protective boot at all times. He stated he had not been consulted for approval to discontinue the protective boot to R52's right heel during the day. MD stated he felt it was not acceptable for R52 to use the Nu-step,attend exercise class with leg weights and applying direct pressure and shearing to right heel during exercises, without protection of right foot. The facility's Person-Centered Plan of Care-Comprehensive policy dated 11/2016, indicated residents would receive the services and/or items included in the plan of care.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services related to removal of facial hair for 2 of 3 residents (R7, R15) observed to have long facial hair which was not removed by staff, failed to provide the necessary care and services to maintain oral hygiene for 1 of 3 residents (R42), and failed to provide timely incontinence care for 1 of 3 residents (R5) reviewed for activities of daily living (ADLs). Findings include: R7 was not provided personal hygiene to remove facial hair.	F 312	• F312 Residents #7 and #15 have been shaved per care plan and care plan was reviewed and updated to reflect current care needed and match care guide. Nursing staff educated on providing assistance with shaving and grooming per plan of care. Audits will be conducted by DON/Designee three times per week for three months to ensure that residents are being shaved per plan of care.	5/16/17

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F 312	Continued From page 47 R7's quarterly MDS dated 2/15/17, identified R7 had diagnoses which included cancer, diabetes, and cerebrovascular accident (stroke). The MDS identified R7 was moderately cognitively impaired, and required extensive assistance of one staff for ADL's including personal hygiene. R7's care plan, revised on 4/4/17, identified R7 had ADL self care performance deficit related to decreased mobility secondary to arthritis. R7's care plan indicated R7 required staff assistance with personal hygiene care. Review of the nursing aid care plan undated, identified R7 was independent with ADL's and received a bath on Thursdays in the a.m. During observations on 4/3/17 at 5:01 p.m. R7 was in her room, laying in bed and was noted to have several long, thick white facial hairs on her cheeks and chin area. During observation on 4/5/17 at 9:20 a.m. R7 was laying in her bed after her dressing change to her right foot and was noted to have several long, thick white facial hairs on her lower chin area. R7 continued to have several long, thick white facial hairs on her lower chin area all day. During observation on 4/6/17 at 8:46 a.m. R7 was laying bed resting and was noted to have several long, thick white facial hairs on her lower chin area. R7 continued to have several long, thick white facial hairs on her lower chin area. At 10:00 a.m. R7 was out in the dining room area drinking orange juice independently and continued to have several long, thick white facial hairs on her lower chin area, and continued to	F 312	Resident #42 has been provided with oral cares as he will allow per plan of care and care plan/care guide was reviewed and updated to reflect current care needed. Nursing staff has been educated on providing assistance with oral cares and grooming per plan of care. Audits will be conducted by DON/Designee three times per week for three months to ensure that resident's oral cares are being done per plan of care. Residents #5 and #7 have been toileted and incontinence care provided per care plan and Bowel and Bladder assessments were reviewed and updated. Additionally, care plan was reviewed and updated to reflect current plan of care needed and match care guide. Nursing staff has been educated on providing residents care per their care plan to minimize urinary incontinence. Audits will be conducted by DON/Designee on three residents per week for three months to review Bowel and Bladder Assessments, Care Plan, and Care Guide to ensure all are matching. Audits to be reviewed at QAPI for the three months to ensure adherence to this policy is being followed. Deficient practice to be corrected by	

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F 312	Continued From page 48 have facial hair until she had her bath at approximately 11:00 a.m. On 4/6/17 at 8:59 a.m. NA-A confirmed R7 required staff assistance with personal hygiene and indicated the bath aid shaved the residents on their bath day. NA-A also indicated that staff were supposed to be shaving the residents as well because the DON had told staff that they needed to start doing this and not just on their bath days. On 4/6/17 at 1:20 p.m. DON confirmed R7 required staff assistance with ADL's and stated staff should be offering (shaving) it to her and help if needed. The DON also indicated she had told staff that it is everybody's responsibility to make sure residents were getting shaved. R15 was not provided personal hygiene to remove facial hair. R15's quarterly MDS dated 2/12/17, indicated R15's diagnoses included: Alzheimer's disease, dementia and depression. Further, the MDS indicated R15 had moderate impaired cognition and required extensive assist of one staff for completing personal hygiene including shaving. R15's care plan dated 4/12/17, indicated R15 required extensive assist of one staff for personal hygiene related to the inability to remember the need for sequencing of ADL's. The care plan indicated R15 could be resistive to care related to dementia and Alzheimer's disease; staff were directed to reapproach or have a different staff member attempt to provide the ADL's.	F 312	5-16-17.	

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On 4/4/17, at 11:06 a.m. R15 was observed in the dining room, seated in a wheelchair. R15 was noted to have numerous long, white facial hairs above and below her lips and in the center of her chin.

On 4/5/17, at 7:12 a.m. R15 was observed in bed and continued to have white, long facial hair above and below lips and in the center of her chin. At 1:58 p.m. R15 was in her room, seated in a wheelchair, and was again noted to have long facial hair. R15 was unable to answer if her long facial hair bothered her.

On 4/6/17, at 8:54 a.m. R15 was in the resident lobby, seated in a wheelchair. R15 was again noted to have numerous white, long facial hair above and below her lips and in the center of her chin. At 8:56 a.m. licensed practical nurse (LPN)-A assisted R15 to a private area and administered eye drop medication to both eyes. LPN-A assisted R15 back to the resident lobby. LPN-A did not assist R15 with shaving, or request staff to provide the care for R15.

During review of R15's progress notes and bathing schedule, R15 was identified to have her bath on Thursday of each week. The progress notes indicated R15 required total staff assistance of cares during bathing. Further, the progress notes did not indicate R15 had refused staff assistance for ADL's including shaving.

On 4/6/17, at 8:59 a.m. LPN-A reported R15 required staff assistance of one for ADL's including shaving. LPN-A reported staff provide shaving on bath day and as needed. LPN-A confirmed R15 had multiple long facial hairs on

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her upper and lower lip and in the center of her chin, and stated staff should have shaved R15's face before waiting until bath day. LPN-A reported R15 did have a history of resisting care assistance, then confirmed staff were expected to report the refusal and it would be documented in R15's medical record. LPN-A confirmed no staff had reported R15 refused shaving on 4/6/17.

On 4/6/17, at 9:35 a.m. nursing assistant (NA)-A confirmed she assisted R15 with morning cares on 4/6/17. NA-A verified R15 required staff assistance of one for all cares including shaving. NA-A reported R15 would refuse cares at times, such as toileting, then stated R15 was redirectable if another staff member attempted. NA-A reported all residents get shaved on bath days, then stated it was not only the bathing staff responsibility to ensure facial hair was removed. NA-A indicated staff were to report any refusals of care to the nurse and should also be documented. NA-A confirmed R15's had numerous white, long facial hairs above and below her lips and on her chin. NA-A confirmed she had not attempted to shave R15 on 4/6/17, and stated staff are expected to shave residents prior to their bath day if facial hair was present. NA-A reported razor availability was short in the facility, and stated R15 did not have a personal razor. NA-A indicated the only razor available was in the bathing area, and was usually being used by another resident.

On 4/6/17, at 10:50 a.m. the director of nursing (DON) confirmed R15 required extensive assistance of one staff to complete ADL's, which included shaving. The DON reported all residents are expected to be shaved on their bath day, and anytime someone noticed residents with

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facial hair. The DON confirmed staff were expected to document resident refusal of cares, including refusal of shaving. The DON stated staff had been trained to reapproach at a later time, or have another staff member attempt cares if a resident refused care assistance. The DON confirmed it was not acceptable for R15 to have facial hair growing on her face, and stated shaving was part of the bathing routine.

R42 was not provided oral cares by staff.

R42's quarterly MDS dated 1/17/17, identified R42 had diagnoses which included dementia, depression and hypertension. The MDS identified R42 had severe cognitive impairment, and was totally dependent on staff to perform personal hygiene including oral hygiene.

R42's care plan, dated 11/22/16, identified R42 had problems of self performance deficit related to cellulitis in right arm and decline in cognition. R42's care plan indicated R42 had an upper denture, lower partial and a few lower teeth.

Review of the nursing aid care plan undated, identified R42 required total assist for cares and staff were to swab for oral cares.

During observations on 4/5/17, at 7:33 a.m. R42 was laying in bed on his left side and NA-A and NA-E were assisting R42 to get dressed for the day. At 7:39 a.m. NA-A and NA-E transferred R42 via mechanical standing lift from his bed to the bathroom area and lowered R42 onto the toilet. At 7:42 a.m. NA-E lifted R42 off the toilet via mechanical standing lift and NA-A provided pericares, placed clean incontinent brief, and pull

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up R42's pants. At 7:46 a.m. NA-A and NA-E transferred R42 via mechanical standing lift back to his room and lowered R42 in his wheelchair. At 7:48 a.m. NA-E left R42's room after making his bed, collecting the dirty linen and garbage from NA-A while NA-A continued to work with R42, combing his hair. At 7:49 a.m. NA-A wheeled R42 down to the main dining for breakfast. At 9:24 a.m. R42 was done eating all of his breakfast and continued to sit in the main dining room area. R42 had upper teeth and had several missing, worn down teeth on the bottom of his mouth, which were very discolored and dirty. During the observation R42 was not offered or provided oral cares by NA-A or NA-E during this time.

On 4/6/17, at 8:52 a.m. NA-A confirmed R42 required total assistance from two staff for all of his ADL's, including oral hygiene. NA-A indicated R42 had upper and lower dentures and which needed to be cleaned by staff. NA-A confirmed she did not provide R42 with oral cares and stated "I did not provide oral cares yesterday, I should have, but I didn't." NA-A also indicated staff on the night shift could not get R42's dentures out and stated "so I did not try to remove his dentures."

On 4/6/17 at 1:37 p.m. DON confirmed R42 required total assistance with ADL's from staff and she would expect staff to provide oral cares/brush his dentures in the morning and at night. The DON verified staff should be following the plan of care and indicated staff needed to offer dental care even if R42 refused at times.

R5 was not provided timely incontinence care.

R5's quarterly MDS dated 3/21/17, indicated R5

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had diagnoses which included dementia, hypertension (HTN) and heart failure. The MDS identified R5 was severely cognitively impaired and required extensive assist of one staff for toileting. The MDS also indicated R5 was frequently incontinent of urine and occasionally incontinent of bowel.

R5's care area assessment (CAA) dated 10/24/16, indicated R5 was dependent on staff for for ADL's, including toileting. The CAA identified R5 was incontinent of bladder and did not seem to know when he needed to urinate. Further, the CAA identified R5 needed staff to provide assistance with transfers, and to toilet R5 every 2 hours and as needed if he requested.

R5's Bowel and Bladder Assessment dated 3/21/17, indicated R5 had an increase of bowel and bladder incontinence and required staff to check every two hours for incontinence. Further, the assessment indicated R5 dribbled urine constantly.

R5's care plan dated 5/5/17, identified R5 had incontinence related to dementia and directed staff to check every two hours and as required for incontinence. R5's care plan directed staff to wash, rinse and dry perineum, and change clothes as needed after incontinence episodes.

R5's nursing assistant care guide dated 3/31/17, directed staff to assist R5 with toileting per his request only, and as needed. The care guide indicated R5 was occasionally incontinent, and required staff assist of one to provide personal cares and toileting.

During continuous observation on 4/5/17, from

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F 312	Continued From page 54 7:05 a.m. to 10:42 a.m. the following was revealed: - At 7:05 a.m. R5 was seated in a wheelchair by the nurses station -At 7:13 a.m. R5 remained seated in his wheelchair, and was observed propelling self throughout the 200 hallway. -At 7:19 a.m. R5 was directed by staff to the resident lobby, next to the dining room. -At 7:30 a.m. the dining room doors open, then the dietary manager (DM) assisted R5 to the breakfast table and served him coffee. -At 7:51 a.m. registered nurse (RN)-B administered R5 medications while he was seated at the dining room table. -At 8:13 a.m. R5 finished the breakfast meal, remained at the dining room table, seated in his wheelchair. -At 8:15 a.m. nursing assistant (NA)-F came into the dining room and asked R5 if he was ready for therapy. At 8:18 NA-F assisted R5 out of the dining room and into the therapy room. -From 8:21 a.m.-9:19 a.m. R5 completed his restorative nursing program which included upper and lower extremity exercises. NA-F assisted R5 to the adjoining room, R5 looked out the window. -At 9:35 a.m. nursing assistant (NA)-B entered the therapy room and asked R5 if he needed to go to the bathroom, R5 stated, no. NA-B did not check R5 for incontinence. R5 remained seated	F 312		

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in the wheelchair while looking out the window, NA-B exited the therapy room.

-From 9:37 a.m. to 10:13 a.m. R5 participated in a group exercise activity with other residents.

-At 10:26 a.m. R5's wife assisted R5 out of the therapy room and into the resident lobby to watch television.

-At 10:42 a.m. NA-B entered the resident lobby and assisted R5 to his room. NA-B asked R5 if he did his exercises today, R5 stated, no. NA-B assisted R5 to the bathroom, instructed R5 to stand up, then pulled down R5's incontinent brief. R5's buttocks and back of upper legs were red with multiple creases in his skin. NA-B used her gloved hand to feel R5's brief, then told R5 to go to the bathroom.

-R5 was not checked for incontinence from 7:05 a.m. to 10:42 a.m. a total of 3 hours and 37 minutes.

During interview on 4/5/17, at 10:52 a.m. NA-B confirmed she was assigned to provide cares for R5 on 4/5/17. NA-B reported R5 required extensive assistance of one staff member for all ADL's, and stated R5 was occasionally incontinent of urine. NA-B reported staff were only directed to check R5 for incontinence as needed or when R5 would request to use the bathroom. NA-B confirmed R5 wore an incontinence brief at all times. NA-B verified the care guide directed staff to only check brief as needed or when R5 requested to use the bathroom, and stated the nurse updated the care guides with any changes. NA-B confirmed R5 was not on a scheduled check and change

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F 312	Continued From page 56 program. During interview on 4/5/17, at 1:46 p.m. trained medication aide (TMA)-A reported R5 needed staff assist of one for all ADL's, reported R5 was incontinent of urine but not bowel, and was not cognitively intact. TMA-A reported R5 wore an incontinence brief at all times, and stated R5 would let staff know when he needed to have a bowel movement, but was unable to notify staff about the need to urinate. TMA-A reported staff usually asked R5 every two hours if he needed to use the toilet. TMA-A confirmed R5's brief was often wet when she took him to the bathroom. TMA-A indicated staff are expected to check on R5 every two hours for toileting and incontinence cares. During interview on 4/5/17, at 2:06 p.m. RN-B reported R5 was dependent on staff assist of one for all ADLs, except for eating. RN-B confirmed R5 wore a brief at all times and staff were expected to check on R5 every two hours. RN-B stated staff need to check every two hours due to R5 not capable of using the call light or informing staff of his toileting needs. During interview on 4/6/17, at 10:58 a.m. the DON confirmed R5 required extensive assistance of one for ADL's, including toileting. The DON confirmed staff were expected to check on R5 every two hours, and as needed for incontinence needs as identified in R5's bowel and bladder assessment and care plan. The DON confirmed the nursing assistant care guides did not match R5's care plan, and stated "we need to get that updated".	F 312		

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F 312	Continued From page 57 Review of facility policy titled, Activities of Daily Living - ADL, revised 11/2016, indicated a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming and personal hygiene.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the necessary care and treatment to promote healing and prevent the further development of pressure ulcers for 2 of 2 residents (R7, R52) identified with current pressure ulcers. Findings include: R52 had not been provided the appropriate	F 314	• F314 Resident #52 care plan was reviewed and updated to reflect current care needed to promote healing of a pressure ulcer. Resident #52 Occupational Therapy Screen was done to evaluate appropriateness of Functional Maintenance Program and to provide clarification of appropriate positioning	5/16/17

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F 314	Continued From page 58 footwear and adaptations had not been made to her restorative program to promote healing of pressure ulcers to R52's right heel. R52's admission Minimum Data Set (MDS) dated 11/15/16, identified R52 had diagnoses which included anemia, hip fracture, and macular degeneration. The MDS identified R52 had severe cognitive impairment and required extensive assistance with activities of daily living (ADLs). The MDS further identified R52 was not at risk for developing pressure ulcers and had no pressure ulcer prevention interventions. R52's pressure ulcer care area assessment (CAA) dated 11/14/16, identified R52 was at risk for developing pressure ulcers related to the level of staff assistance R52 required for bed mobility and would be identified on R52's care plan. R52's quarterly MDS dated 2/14/17, identified R52 had diagnoses which included anemia, hip fracture, and macular degeneration. The MDS identified R52 had moderate cognitive impairment and required extensive assistance with ADLs. The MDS further identified R52 was at risk for developing pressure ulcers, had developed a stage 2 pressure ulcer on 1/28/17 and had a pressure reducing device on her bed, nutrition interventions and pressure ulcer care and dressings to feet. R52's care plan dated 4/5/17, identified R52 had a pressure area to her right heel which was covered in black eschar (a slough or piece of dead tissue that is cast off from the surface of the skin) which developed 1/28/17, and a pressure ulcer to her right ankle which developed 2/10/17, related to immobility and shoes being too tight.	F 314	interventions. Resident #7 care plan was reviewed and updated to reflect current care needed to promote healing of a pressure ulcer. Resident #7 Occupational Therapy Screen was done to evaluate appropriate positioning interventions are in place. Residents who are at risk for developing pressure ulcers were reviewed to ensure care plan/care guide is reflective of services needed to promote healing or prevent pressure ulcers. Nursing staff educated on providing the necessary treatment and services to prevent pressure ulcers and promote healing. Audits will be conducted three times weekly by DON/Designee to ensure appropriate care and services are in place and care is being delivered to promote and or heal pressure ulcers. Audits to be reviewed at QAPI for the next 3 months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 5-16-17	

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The care planned interventions included trial of a soft, ankle high slipper to her right foot, extended leg rest, protective boot or float heels when in bed and reposition every 2 hours. The care plan also indicated R52 was to be evaluated by OT [occupational therapy] for wheelchair and bed positioning and was to complete restorative exercises as ordered.

Review of R52's Braden-HDG (form used to determine risk pressure ulcer risk) dated 11/3/16, 1/28/17, 2/14/17, 2/18/17, and 2/24/17 revealed all forms identified R52 to be chairfast with slightly limited mobility. Friction and shear were identified as a potential problem. Each form determined R52 to be at low risk for developing a pressure ulcer, despite the development of an unstageable pressure ulcer on the bottom of the heel on 1/28/17 and the development of an stage 2 pressure ulcer on the side of the heel on 2/10/17.

On 4/5/17, at 7:26 a.m. nursing assistant (NA-A) wheeled R52 out of her room and down the hallway towards the dining room. R52 wore a navy blue, thin sock covered with a blue protective boot to her right foot. R52's right foot rested on her wheelchair foot pedal and R52's right leg rested on an extended leg rest which had black padding under her right calf.

-7:48 a.m. R52 was seated at the dining room table with R24 for the breakfast meal. The blue boot remained on R52's right foot in the leg rest.

-8:05 a.m. R52 self propelled her wheelchair, utilizing both arms and her left leg, from the aviary outside the therapy room into the therapy room doorway.

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-8:14 a.m. trained medication assistant (TMA-A) wheeled R52 from her room to therapy department, R52 wore black moccasin style shoes on both feet and the blue boot was not present.

-8:22 a.m. R52 was seated in front of the arm bike, attempting to use the arm bike with a staff member along side of her. R52's right heel rested directly on the foot pedal of her wheelchair in the moccasin.

-8:38 a.m. restorative therapy supervisor (RTS) removed R52's foot pedal from her wheelchair and assisted R52 to put her right heel rested directly on floor. RTS assisted R52 to stand from her wheelchair and then into the seat of the Nu-step exercise machine. R52 had a slow, hunched over gait and grimaced during transfer to the Nu-step machine. RTS assisted R52 to place both feet onto the foot pedals of the Nu-step and R52 began to slowly utilize the machine. R52's right heel rested directly on the foot pedal of the machine while she was propelling the machine. RTS offered verbal encouragement for R52 to continue to pedal the machine.

-9:00 a.m. NA-F walked up to R52 and told her she was done. R52 had completed 52 steps with her feet on the pedals. NA-F assisted R52 from the Nu-step back into her wheelchair without the foot rest, and stated R52 had to wait for exercise class. R52's right heel rested directly on the floor.

-9:12 a.m. NA-F wheeled R52 to the back of the therapy room and positioned her wheelchair between R9 and R24. R52's right heel dragged

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across the floor surface during the move, and then rested directly on the floor.

-9:33 a.m. R52's continued to wear the moccasin style shoes, and the bottom of the foot rested directly on the floor. NA-E entered the therapy room, stated she was going to toilet R52 before exercise class started at 9:45 a.m. NA-E pushed R52 out the room, and R52's leg rest was not attached to the wheelchair.

-9:50 a.m. NA-E wheeled R52 from her room back to therapy, with the moccasin style shoes on both feet, and leg rest not attached to wheelchair. RTS applied leg weights to both R52's ankles and proceeded to place R52's right heel rested directly on floor with moccasin style shoes still on both feet.

From 9:51 a.m. to 10:26 a.m. RTS conducted the resident exercise class and R52 completed all of the exercises as instructed by RTS while wearing leg weights to both her ankles. R52 was encouraged by staff to participate in the various exercises. R52's right heel either rested directly on the floor or completed the exercises which applies pressure or friction to the heel.

The following exercises were done with ankle weights to both ankles and moccasin style shoes:

-R52 swept her right foot back and forth on the floor from side to side

-R52 lifted her foot up by the toes repeatedly and rested her heels flat on the floor

-R52 rocked back on her heels and tapped heel on the floor

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F 314	Continued From page 62 -R52 marched and lifted both feet up and down with force -R52 kicked her feet up and down and in between kicks, kept both feet flat on the floor -R52 kicked out her right leg and dragged the foot/heel back under her chair. R52 dragged her right heel back and forth repeatedly -10:26 a.m. RTS removed the ankle weights from R52's ankles and again rested R52's right heel directly on floor. RTS applied right foot pedal to R52's wheelchair, placed R52's right foot directly on the pedal and wheeled R52 from therapy to common area outside of the dining room. -10:40 a.m. during observation of R52's right heel with licensed practical nurse (LPN)-B and registered nurse (RN)-A present, LPN-B measured R52's pressure ulcers. She stated the measurement of the right outer heel pressure ulcer was 0.3 centimeter (cm) x 0.3 cm area with a light brown superficial scab covering the area. The unstageable pressure ulcer which was located on the bottom of R52's right foot measured 0.7 cm x 0.4 cm with a 0.3 cm indented, hard light brown scab. RN-A confirmed the ulcer on the bottom of R52's heel was an unstageable pressure ulcer and stated if the scab came off, the wound may be deeper. She indicated she did not know the depth of the wound underneath the scab. On 4/5/2017, at 2:02 p.m. certified occupational therapy assistant (COTA) confirmed she was aware R52 had pressure ulcers on her right heel.	F 314		

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She stated she was not aware of what caused R52's ulcers on her heel and indicated the ulcers may have been caused from R52 propelling her wheelchair with her heels or from the foot pedal of her wheelchair. She stated in the past R52 had worn a large protective boot all the time on her right foot and at present the boot was changed to bedtime only because therapy felt her sores were healing. She stated R52 was to wear slippers that protected her foot above the ankle. She stated the facility had not made any adaptations for her restorative exercises when she no longer wore the protective boot. COTA stated she felt R52 could rest her right foot on the floor because it was protected by the slipper and stated she felt use of the Nu-step was acceptable because pedaling put an equal amount of pressure on both of R52's heels.

On 4/5/17, at 2:09 p.m. NA-F stated she was not sure what caused R52's sores on her foot. She stated R52 used a protective boot and kept her leg rests off most of the time in therapy. NA-F stated R52 wore a slipper or moccasin on her right foot to protect R52's heel.

On 4/5/17 2:18:04 PM RTS stated she did not know what caused R52's ulcers to her right heel and stated she thought the ulcers may have developed from poor circulation, from lying in her bed or from an ill fitting shoe. She stated she felt when R52 wore the leg weights and resting her right heel on the floor it would not cause any problems with R52's skin. She stated there were no other adaptations for R52's exercises or therapy.

On 4/6/17, at 8:41 a.m. RTS confirmed R52's Restorative Therapy Administration records. She

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stated R52 was scheduled 5 days per week for both restorative therapy and exercise class. Stated R52 was a faithful attendee and attended both 3-4 times per week.

On 4/6/17, at 8:53 a.m. RN-A stated R52 developed an unstageable pressure ulcer to her right heel caused from her brown shoes. She stated R52 had developed another pressure ulcer on 2/10/17, to the side of her right heel and stated she was unsure of what caused it. RN-A confirmed R52's care plan and confirmed R52's positioning requirements which included not resting her heel on the foot rest of her wheelchair. She stated staff floated R52's heels when she was in bed, used a padded dressing to cover her heel, and tried to keep pressure away from R52's right heel. RN-A confirmed she was not aware of R52's restorative therapy program and stated there were no special accommodations for her exercises.

On 4/6/17, at 9:39 a.m. director of nurses (DON) confirmed R52's skin assessments, which identified R52 as having low risk for developing pressure ulcers. She stated R52 developed an unstageable pressure ulcer to the bottom of her heel on 1/28/17, and developed a stage II pressure ulcer to the side of her right heel 2/10/17. She stated therapy recommended R52 wear a soft, ankle high slipper during the day and the protective boot at night.

On 4/06/17, at 10:16 a.m. R52 was observed seated in her wheelchair, with moccasin style shoes on both feet. RN-A and DON were present and both indicated it was not clear how to interpret what R52 was supposed to wear on her feet on R52's care plan and OT documentation.

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F 314	Continued From page 65 On 4/6/17, at 11:18 a.m. occupational therapist (OT) stated she had ordered the ankle high slipper on 4/4/17, and stated R52 was to wear the moccasin type shoe on her left foot only for grip with transfers and propelling in her wheelchair. She stated she felt the Nu-step was not a concern because it applied equal pressure to both R52's heels. She stated whenever R52 was seated in her wheelchair she was supposed to have her foot rest on to protect her right heel and keep it from resting on the floor. OT stated there were had been no accommodations for R52's therapy/exercise program and stated the facility would need to have evaluation from physical therapy to make changes to protect R52's right heel. On 4/06/17, at 3:15 p.m. R52's physician (MD) stated he was aware R52 had an unstageable pressure ulcer on the right heel, but was not aware that R52 developed a stage 2 pressure ulcer to her right outer heel. He stated he had last seen R52's pressure ulcer on 4/2/17 and felt it was stable at that time, with the use of the protective boot at all times. He stated he had not been consulted for approval to discontinue the protective boot to R52's right heel during the day. MD stated he felt it was not acceptable for R52 to use the Nu-step,attend exercise class with leg weights and applying direct pressure and shearing to right heel during exercises, without protection of right foot. Review of the facility Pressure Injury/Skin Integrity/Wound Management policy dated 11/16, identified residents with pressure injuries would receive the treatment and services to promote	F 314		

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F 314	Continued From page 66 healing and prevent new pressure injuries from developing. R7's care plan intervention for a pillow placed between the legs to prevent pressure and rubbing was not implemented. R7's quarterly MDS dated 2/15/17, identified R7 had diagnoses which included cancer, diabetes, and cerebrovascular accident (stroke). The MDS identified R7 was moderately cognitively impaired, and required extensive assistance of one staff for bed mobility, transfers and other activities of daily living (ADL's). The MDS also identified R27 was not at risk for the development of pressure ulcers. R7's Braden Scale for Predicting Pressure Sore Risk form, dated 3/22/17, identified R7 was at low risk for the development of pressure ulcers, skin was very moist, walked occasionally, mobility was very limited, and had a problem of friction and shearing. R7's current care plan revised 4/4/17, identified R7 had a stage two ulcer on her right inner ankle related to ankles pressing together when in bed. The care plan listed various interventions and directed staff to apply pillow in-between legs to prevent pressure and rubbing. The care plan further directed staff to monitor/report and document any skin redness or breakdown. Review of the Group one nursing aid care plan updated 3/31/17,, identified R7 was independent with ADL's, and directed staff to place a pillow between legs/ankles when in bed.	F 314		

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F 314	Continued From page 67 Continual observations were conducted on 4/5/17, from 9:11 a.m. to 11:43 a.m. -At 9:11 a.m. R7 was lying on her back in her bed with the head of bed (HOB) elevated. Licensed practical nurse (LPN)-B was present in the room and removed a blue pressure relieving boot from R7's right foot. LPN-B proceeded to remove the dressing from R7's right inner heel and began a dressing change. The area measured 0.4 centimeters (cm) x 0.4 cm in the center of the ulcer with no open area and the outer edges of the ulcer were dry with flaky skin peeling. The entire ulcer area was pink. LPN-B proceeded to complete a dressing change of Aquacel (highly absorbent, nonadherent wound dressing) to wound area, covered with 4 x 4 gauze and wrapped with kerlix gauze, then applied her sock to her foot per R7's request. LPN-B then applied a blue pressure relieving padded boot to R7's right foot, tucked her legs under the covers, pulled the covers up to her chest. LPN-B exited the room and had not placed a pillow between R7's legs/ankles. -at 9:20 a.m. R7 was noted to have her right leg crossed over her left leg with her right foot resting across her left foot in bed. A pillow was not present between R7's ankles, or near the end of the bed. -At 10:01 a.m. continued in same position. -At 10:27 a.m. R7 remained in the same position in bed. Trained medication aid (TMA)-A entered R7's room, offered R7 assistance to get up, and R7 refused. At 10:31 a.m. TMA-A removed R7's blankets, inspected her incontinent brief, then covered R7 back up. A pillow was not present between R7's ankles or near the end of the bed. TMA-A exited the room.	F 314		

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F 314	Continued From page 68 -At 10:33 a.m. TMA-A again entered R7's room, and proceeded to assist R7 with personal cares. R7 had a blue pressure relieving boot on her right foot and had no pillow in-between her legs/ankles when she was in bed. TMA-A proceeded to provide personal cares for R7. R7's buttocks had a small white area in the crease of the buttocks, and and no open areas noted to R7's buttocks or coccyx area, skin pink. -At 10:39 a.m. TMA-A completed personal cares and exited the room. R7 remained in bed, with her right leg crossed over her left leg with her right foot resting across her left foot. TMA-A had not placed a pillow in-between R7's legs/ankles before leaving the room. -At 11:25 a.m. R7 remained in same position. -At 11:41 a.m. TMA-A entered R7's room, R7 stated her heel hurt a little bit. R7's right leg was crossed over her left leg with her right foot resting across her left foot. R7 continued to have blue pressure relieving boot on her right foot, but no pillow in-between her legs/ankles. TMA-A removed R7's covers and proceed to assist R7 to reposition up in her bed. TMA-A did not place a pillow in-between R7's legs/ankles before exiting the room at 11:43 a.m.. On 4/5/17 at 10:20 a.m., TMA-A confirmed R7 required assistance with ADL's off and on depending on the day. TMA-A verified R7 had an ulcer on her right heel and wore a pressure relieving boot when she was in bed. TMA-A indicated that she was not aware R7 was to have a pillow between her legs/ankles. She confirmed she had not placed a pillow to prevent pressure to her legs/ankles and after review of the nursing aid care plan for R7, confirmed the use of a pillow between her legs/ankles was to be done when she was in bed.	F 314		

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F 314	Continued From page 69 On 4/5/17 at 2:11 p.m., LPN-B confirmed R7 had a stage two ulcer on her right heel and wore a pressure relieving boot while in bed. She indicated R7 moved her feet around in bed and crossed her legs all the time. LPN-B indicated she was not sure if R7 was to have a pillow in-between her legs or not. LPN-B verified R7 did not have a pillow in-between her legs and stated "I did not even think of placing a pillow, I just put her boot back on." LPN-B confirmed R7's care plan and nursing assistance care plan and indicated staff should have followed the care plan. On 4/6/17 at 1:20 p.m., director of nursing (DON) confirmed R7 required assistance from staff for ADL's and was at risk for pressure ulcer. DON also indicated R7 was to have a pillow in-between her legs/ankles so they were not rubbing together. The DON verified R7's current care plan and nursing assistant care plan and indicated staff should have followed R7's care plan to prevent further breakdown. Review of facility policy titled, Pressure Injury/Skin Integrity/Wound Management, revised on 11/16, indicated a resident with pressure injuries will receive treatment and services consistent with professional standards of practice to promote healing and prevent infection and prevent new pressure injuries from developing.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission	F 315		5/16/17

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F 315	Continued From page 70 receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely toileting assistance for 1 of 1 resident (R7) reviewed with bladder incontinence.	F 315	F315 Resident #7 has been toileted and incontinence care provided per care plan and Bowel and Bladder assessments were reviewed and updated. Additionally,	

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F 315	Continued From page 71 Findings include: R7's quarterly Minimum Data set (MDS) dated 2/15/17, identified R7 had diagnoses which included cancer, diabetes, and cerebrovascular accident (stroke). The MDS identified R7 had moderate cognitive impairment, and required extensive assistance of one staff for bed mobility, transfers and toilet use. Further, the MDS indicated R7 was frequently incontinent of urine. R7's current care plan revised 4/4/17, identified R7 had impaired urinary elimination related to urge incontinence and used disposable briefs. The care plan directed staff to encourage fluids during the day to promote prompted voiding responses, establish voiding patterns, and ensure an unobstructed path to the bathroom. The care plan also indicated R7 had moisture associated skin damage on coccyx/sacral area related to urinary incontinence and decreased mobility. The care plan listed various interventions and directed staff to encourage R7 to toilet every two hours to remain dry. Review of the Group one nursing aid care plan updated 3/31/17, identified R7 was independent with ADL's and wore a brief at night. However, the care plan did not identify to encourage R7 to toilet every two hours. On 4/5/17, at 7:11 a.m. R7 was observed on her back, with her eyes closed in bed, with the head of bed (HOB) elevated. R7 remained in the same position in bed with her eyes closed until 8:30 a.m. Continual observations were conducted on 4/5/17, from 9:11 a.m. to 11:43 a.m.	F 315	care plan was reviewed and updated to reflect current plan of care needed and match care guide. All current residents Bowel and Bladder assessments have been reviewed and updated, care plans and care guides have been updated to ensure all are matching to ensure residents receive appropriate treatment and services regarding elimination needs. Nursing staff has been educated on providing residents care per their care plan to minimize urinary incontinence. Audits will be conducted by DON/Designee on three residents per week for three months to review Bowel and Bladder Assessments, Care Plan, and Care Guide to ensure all are matching to ensure residents receive appropriate treatment and services regarding elimination needs. Audits to be reviewed at QAPI for the next 3 months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 5-16-17.	

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F 315	Continued From page 72 -At 9:11 a.m. R7 was observed in her bed, on her back, with the head of bed (HOB) elevated. Licensed practical nurse (LPN)-B entered R7's room and provided a dressing change to R7's right heel. LPN-B then applied a blue pressure relieving padded boot to R7's right foot, tucked her legs under the covers, covered her upper body with covers, put the bed in low position and call light within reach, and proceeded to leave the room at 9:20 a.m. R7 was wearing a white incontinent brief with a white cloth pad underneath her. LPN-B did not offer to toilet or check R7 for incontinence before exiting the room. -At 10:01 a.m. continued in same position. -At 10:27 a.m. trained medication aid (TMA)-A entered R7's room, offered R7 assistance to get up, and R7 refused. -At 10:31 a.m. TMA-A removed R7's blankets, inspected her incontinent brief, then covered R7 back up. TMA-A gathered supplies to change R7's incontinent brief, exited the room briefly and returned with additional supplies at 10:33 a.m. TMA-A uncovered R7 and proceeded to remove R7's incontinent brief which was moderately wet with urine and moderate amount of urine on the white cloth pad. TMA-A provided peri cares for R7. -At 10:37 a.m. TMA-A offered R7 assistance to get up and R7 refused. TMA-A made R7 comfortable, put HOB up, bed in low position, call light within reach, wheel chair at end of bed and proceeded to leave the room with soiled linen and garbage in bags at 10:39 a.m. On 4/5/17, at 9:19 a.m. LPN-B indicated that she had not assisted R7 with any of ADL's for the day and only gave R7 her medications this morning and did her dressing change. LPN-B also	F 315		

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F 315	Continued From page 73	F 315		

indicated that R7 usually got up later and she had not provided any cares for her this morning.

On 4/5/17, at 10:20 a.m. TMA-A confirmed R7 required assistance with ADL's off and on depending on the day. TMA-A indicated R7 wore an incontinent brief at night, a pad with underwear during the day and staff helped her with peri-cares. TMA-A indicated staff checked R7 every two hours during the night for incontinence but there was nothing on her care plan which indicated she was supposed to check her every two hours during the day. TMA-A indicated she did not know the last time R7's incontinent brief was checked and she had not check her incontinent brief all morning since she arrived at work and stated she "was not aware she needed to be checked every two hours."

On 4/5/17 at 10:53 a.m. NA-A indicated she thought R7 required assistance from staff for ADL's but was not sure and indicated she had not worked with R7 that day and did not know the last time R7's incontinent brief was checked. NA-A verified R7 had incontinence of urine and was to be checked every two hours for incontinence.

On 4/5/17 at 2:11 p.m. LPN-B indicated R7 was incontinent of bowel and bladder and was to be checked every two or three hours. LPN-B verified she had not checked R7's brief for incontinence that morning. LPN-B confirmed R7's care plan and nursing assistance care plan and indicated staff should have followed the care plan and interventions in place.

On 4/6/17 at 1:01 p.m. R7 verified she had incontinence of urine and wore an incontinent brief. R7 indicated she did not worry about getting

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F 315	Continued From page 74 up because staff were to check it (meaning her incontinent brief). On 4/6/17 at 1:20 p.m. director of nursing (DON) confirmed R7 required assistance from staff for ADL's. DON verified R7 was incontinent of urine, wore incontinent products and required assistance from staff to be checked or offered toileting every two hours and stated "to prevent her from breaking down and staying dry." The DON verified R7's current care plan and her nursing assistant care plan and indicated staff should have followed the care plans. The DON indicated the nursing assistants care plans were not accurate and did not match R7's written care plan. The DON indicated this was a problem of the care plans not getting updated with changes for the staff on the floor. The Bowel and Bladder Management-HDGR policy revised 11/2016, indicated each resident with bowel or bladder incontinence would receive appropriate treatment and services to achieve or maintain as much normal elimination function as possible.	F 315		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 334		5/16/17

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F 334	Continued From page 75 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 334		

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F 334	Continued From page 76 has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R13, R22) were offered and/or received the pneumovax vaccination. Findings include: R13 was admitted to the facility on 3/17/14, and remained in the facility. No documentation was provided to indicate R13 had been offered the pneumovax vaccination. R22 was admitted to the facility on 2/19/12, and remained in the facility. No documentation was provided to indicate R22 had been offered the pneumovax vaccination. During interview on 4/06/17, at 4:15 p.m. director of nursing (DON) confirmed no pneumovax vaccinations were recorded in R13 and R22's medical record as being administered or offered. DON stated she had completed audits of all	F 334	• F334 Resident #13 will receive the Prevnar 13 vaccine as previously requested. Resident's family had signed form that resident had received the PPSV 23 Vaccine on admission. Resident #22 will receive the Prevnar 13 vaccine as previously requested. Resident #22 had received her PPSV 23 Vaccine on 2-11-1997. All other resident's immunization records reviewed to determine if residents received the PPSV 23 Vaccine and the Prevnar 13 vaccine. Residents that request the Prevnar 13 will receive the vaccine.	

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F 334	Continued From page 77 facility resident vaccinations, but the vaccination process had not yet been completed. The facility's Immunizations: Pneumococcal Vaccine - HDGR Policy revised November 24, 2014, directed staff to offer, provide, and document pneumococcal PCV13 and PPSV23 vaccines for all residents.	F 334	Audits will be conducted at admission of new resident by DON/Designee to ensure that staff is offering the Prevnar 13 vaccine with each admission. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 5-16-17.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		5/16/17

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F 441	Continued From page 78 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 441		

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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 441	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were properly maintained while storing ice packs with ready to eat foods in 1 of 1 kitchenette. Findings include: During dining observation on 4/3/17, at 4:58 p.m. the refrigerator in the kitchenette across from the nurses station was noted to have several re-usable ice packs of different sizes and shapes located on the top and bottom shelf of the freezer. The re-usable freezer bags were laying directly on top of and mixed in with ready to eat foods such as: popsicles, berry and orange ice cream cups and assorted cookies in open plastic baggies. During observation on 4/4/17, at 9:42 a.m. the refrigerator in the kitchenette across from the nurses station was noted to have thirteen re-usable ice packs of different sizes and shapes located on the top and bottom shelf of the freezer. The re-usable freezer bags were laying directly on top of and mixed in with ready to eat foods such as: popsicles, berry and orange ice cream cups and assorted cookies. At 11:08 a.m. The re-usable ice packs continued to be mixed in with the ready to eat foods. During a tour on 4/4/17, at 3:34 p.m. with dietary manager (DM), the refrigerator in the kitchenette area across from the nurses station was noted to have five re-usable blue gel ice packs, one re-usable large dark blue ice pack, and one re-usable ice pack covered with a white cloth	F 441	• F441 Ice packs were immediately removed from freezer, and food that was in the freezer was disposed of and replaced. Staff educated to ensure appropriate infection control measures are properly maintained that ice packs are not to be stored with ready to eat foods. Audits will be conducted three times per week by Dietary Manager/Designee for three months to ensure that food is stored, prepared, distributed, and served in accordance with professional standards for food service safety. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 5-16-17.	

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	245585	A. BUILDING _____ B. WING _____	04/06/2017

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TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 441	Continued From page 80	F 441		

around it with Velcro attachable straps. The ice packs were located on the bottom shelf. The re-usable ice packs were mixed in and laying on top of ready to eat foods such as: cookies and popsicles. On the top shelf there were three blue re-usable ice packs laying on top of a tray of popsicles and some were note to be open with half of the popsicle missing. Several other re-usable ice packs were noted to be mixed in and laying on top of five cups of butter pecan ice cream cups, five cups of berry ice cream and twenty cartons of orange nutritional drinks. At 3:42 p.m. there was a total of thirteen re-usable ice packs in the freezer area.

On 4/4/17, at 3:34 p.m. DM confirmed findings and indicated dietary staff go through the refrigerator everyday to restock. The DM also indicated that she was not aware of the re-usable ice packs being stored in the freezer with ready to eat foods. The DM indicated that maybe they were used on someone's body, but she was not sure and stated "no this is not good, they should not be in the freezer." The DM indicated that she would expect staff to store the re-usable ice packs in the medication/treatment room freezer and stated "not where the food is stored".

On 4/4/17, at 3:42 p.m. trained medication aid (TMA)-B confirmed the re-usable ice packs were used when a resident in the facility had a fall with injuries or for any injury on a resident body. TMA-B also indicated they use a towel to cover the ice packs when they use them on residents but also indicated it was probably not a good idea to have the re-usable ice packs in with ready to eat foods. At 3:44 p.m. DM asked TMA-B to remove the re-usable ice packs from the freezer and put them in the medication room freezer and

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F 441	Continued From page 81 TMA-B stated "I can't believe there are so many." On 4/4/17, at 3:47 p.m. licensed practical nurse (LPN)-A confirmed findings and indicated the re-useable ice packs were in the freezer area to use on residents when they have migraines, sore knees or an injury that may require the use of ice. LPN-A indicated that she did not think that they needed that many ice packs and also indicated that staff was to put the re-usable ice packs back in the medication room freezer and not the kitchenette freezer. The LPN-A verified re-usable ice packs should not be mixed in with ready to eat foods and stated "I don't know how they got in there, they are not suppose to be in there, they should go in the med room." LPN-A also indicated this was not good infection control measures. Review of facility policy titled, Food, Sanitary Conditions (General), revised on 11/2016, indicated food is stored, prepared, distributed and served in accordance with professional standards for food service safety.	F 441		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.	F 465		5/16/17

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F 465	Continued From page 82 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain universal razors (defined as for the use of any facility resident) in a clean and sanitary condition for 2 of 2 universal razors in the facility. Findings include: During an observation on 4/6/17, at 2:30 p.m. of the facility tub room, with nursing assistant (NA)-D present, NA-D stated she routinely assisted residents with bathing. A black shaving razor was observed in the top drawer of cupboard near the sink. A second black razor rested on the top of the charger, which was plugged into an outlet near the tub outlet on the opposite wall. NA-D demonstrated her usual practice for cleaning the razor by striking the razor against the side of the garbage can. She then opened two alcohol wipes from the drawer, wiped the top and inside of the razor, then returned it back to the drawer. NA-C entered the bathing room at that time and NA-D confirmed NA-C also routinely completed baths for residents. NA-C unplugged the second razor, opened the top and a large amount of gray colored hair rested in the top cover and inside of the razor. NA-C took out a razor brush from the drawer and brushed out the hair from the top of the opened razor. NA-C opened the top drawer stating she was looking for alcohol wipes. NA-C indicated there were no alcohol wipes present in the tub room, immediately turned on the water faucet, and placed the top of the razor under the running water for a few seconds. She proceeded to dry off the razor with a paper towel and replaced the cover to the top of the razor. NA-C did not	F 465	• F465 Staff educated on the cleaning of electric razors. Universal razors will be cleaned and disinfected by removing the top cover of the razor over wastebasket and use the brush to remove hair. Clean razor with alcohol wipe and then disinfect razor head using a purple top Sani Wipe, and let sit for two minutes. Put the top cover of the razor back on. Will notify families during quarterly care conferences that they are being encouraged to bring in their residents their own individual electric razor if possible. Audits will be conducted three times per week for 3 months by DON/Designee on the proper cleaning and disinfecting of electric razors. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 5-16-17.	

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F 465	Continued From page 83 complete any further cleaning for the razor. When interviewed on 4/6/17, at 2:53 p.m. director of nursing (DON) stated universal razors were available for all residents to use. DON stated her expectation was for staff to use Sani wipes (germicidal disposable wipes) to cleanse the razors to kill blood-borne pathogens. DON acknowledged that correct disinfectant procedures had not been followed. The facility policy titled Shaving-Electric Razor, revised March 1, 2014, indicated to remove the top cover of the razor over wastebasket and use the brush to remove hair. No further cleaning instructions were specified. The facility policy titled Environment-Cleaning of Equipment (General) revised April 1, 2008 indicated all unit equipment is cleaned on a routine basis with no reference to razors.	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Traverse Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/04/2017

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

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K 000	Continued From page 1 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as one building due to no 2 hour fire barrier between the construction types and considered as the least fire resistive construction as per 8.2.1.3 (3) and with the adoption of the 2012 LSC, they are now considered existing buildings. Wings 100, 200. and 300 were constructed in 1967 and was determined to be of Type II(111) construction. It is 1 story with partial basement and is fully protected with fire sprinklers with smoke detectors in the corridors and spaces open to the corridors. Wings 300, 400 and 500 were constructed in 2005 and was determined to be of Type V(111) construction. It is 1 story with no basement and is fully protected with fire sprinkler with smoke detectors in the resident rooms and spaces open	K 000		

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K 000	Continued From page 2 to the corridors. The facility is separated by one two hour fire barrier and 4 smoke barriers The facility has a capacity of 49 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is	K 222		5/16/17

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K 222	Continued From page 3 constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the proper operation of exit door locking devices. NFPA 101, Life Safety Code, 2012 edition section 7.2.1.7. This deficient practice could cause the door not to open and affect all staff in the immediate area. Findings include:	K 222	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable	

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K 222	Continued From page 4 On the facility tour Between 8:45 am to 1:00 pm on 04/10/17, observations and staff interview revealed the panic hardware on the exit door by the laundry does not operate properly and hinders the door operation. This deficient condition was confirmed by the interim Facility Administrator and the Director of Maintenance.	K 222	state and federal regulatory requirements. K222 The panic hardware on the exit door by the laundry was repaired and is operating properly per the requirements of NFPA 101, Life Safety Code , 2010 edition section 7.2.1.7. The Maintenance Director/ Designee will Audit the operation 2 times per week for 3 months to assure operation. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed.	
K 371 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain smoke barriers for the purpose of subdivision of building spaces in accordance with NFPA 101, 2012 edition, sections 19.3.7 & 8.5. This deficient practice could allow for smoke to transfer from one compartment to another making evacuation more difficult. This condition could affect 16 of the 45	K 371	K371 The smoke barrier penetration in the 1967 building above the ceiling was sealed on both sides of the barrier with an approved sealant. An audit of the smoke barriers will be done whenever there is contractual work completed in the facility that could effect	5/16/17

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K 371	Continued From page 5 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:45 am to 1:00 pm on 04/10/17, observations and staff interview revealed a penetration in the smoke barrier in the 1967 building above the ceiling in the break room. This deficient condition was confirmed by the interim Facility Administrator and the Director of Maintenance.	K 371	smoke barriers in accordance with NFPA 101 , 2012 edition, in section 19.3.3 and 8.5 will be completed by the Maintenance Director/ Designee and any found penetrations will be sealed with the approved on both sides of the penetration to assure compliance. The Maintenance Director/ Designee will be responsible to audit and repair. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed.	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 45 residents and an undetermined amount of staff and visitors.	K 711	K771 The Evacuation plan will be revised to include all items required by the Life Safety Code, 2012 edition section 18.7.2.2. The Executive Director/Safety Director will train the staff in the revised evacuation plan and how to proper execute it in case	5/16/17

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K 711	Continued From page 6 Findings include: On the facility tour between 8:45 am to 1:00 pm on 04/10/17 record review and staff interview revealed the evacuation plan did not address all items required by the Life Safety Code. This deficient condition was confirmed by the interim Facility Administrator and the Director of Maintenance.	K 711	where an evacuation is necessary. Each fire drill will be audited for compliance so each shift will have four audits per year. Audits to be reviewed at QAPI whenever maintenance does an audit based on contractor work.	
K 741 SS=F	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		5/16/17

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TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH** **WHEATON, MN 56296**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 7 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide a smoking plan as required by NFPA 101, Life Safety Code, 2012 edition section 19.7.4. This deficient practice could allow for the ignition of fire and affect all 45 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:45 am to 1:00 pm on 04/10/17 record review and staff interview revealed there was no smoking policy. This deficient condition was confirmed by the interim Facility Administrator and the Director of Maintenance.	K 741	K741 A revised and adopted by the Quality Council, SMOKING POLICY was initiated. Staff will be trained in the revised smoking policy. The admission packet will contain the smoking policy and it will be posted visibly to inform visitors and guests as required by Life Safety Code 101, 2012 edition section 19.7.4 Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed.	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		5/16/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/10/2017**

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K 918	Continued From page 8 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all of the 45 residents and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: On the facility tour between 8:45 am to 1:00 pm on 04/10/17 record review and staff interview revealed the generator log did not cover all the items required for the monthly testing and maintenance. This deficient condition was confirmed by the	K 918	K918 A revised generator testing log has been put in place to conform with the Life Safety Code 101, 2012 edition section 9.1.3.1 and the 2010 edition of the NFPA 110 standard for Emergency and Standby Power Systems. The monitoring of the proper operation, testing and recording of the emergency generator will be done by the Maintenance Director/ Designee, and the Executive Director. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/10/2017**

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K 918	Continued From page 9 interim Facility Administrator and the Director of Maintenance.	K 918		