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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KOXR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245544**

2. STATE VENDOR OR MEDICAID NO. (L2) **699435200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMDEN CARE CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **11/12/2015**

6. DATE OF SURVEY **05/2/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **87** (L18)

13.Total Certified Beds **87** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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 :
Jacob Mabera, HFE NE II 06/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 0715/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1991
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/09/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5544

On May 3rd and May 5, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify your facility had achieved and maintain compliance with Federal certification deficiencies issued pursuant to the LSC and FMS surveys completed on January 26, 2015 and March 10, 2016. Based on our PCR, we have determined that your facility has corrected deficiencies pursuant to the LSC and FMS surveys effective May 2, 2016.

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245544

June 16, 2016

Ms. Mary Hamer, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

Dear Ms. Hamer:

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 2, 2016 the above facility is certified for or recommended for:

87 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 87 skilled nursing facility beds.

Your request for the following waivers has been approved based on the submitted documentation: K18, K25, K27, K51 and K56.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1036

June 2, 2016

Ms. Mary Hamer, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

RE: Project Number S5544026

Dear Ms. Hamer:

On February 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016. 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.

March 10, 2016, a surveyor representing the Region V Office of the Centers for Medicare and 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 most serious deficiencies at the time of the FMS were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

March 24, 2016, CMS forwarded the results of the FMS completed on March 10, 2016 and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 28, 2016 (42 CFR 488.417(b))

Also, the CMS Region V Office notified you in their letter of March 24, 2016, 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 April 28, 2016.

On May 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 3, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 28, 2016 and the Federal Monitoring Survey (FMS) completed on March 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 2, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant

to our standard survey, completed on January 28, 2016 and FMS completed March 10, 2016, effective May 2, 2016.

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 the CMS letter of March 24, 2016. 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 April 28, 2016, be discontinued, effective May 2, 2016. (42 CFR 488.417(b))

Also, 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 April 28, 2016.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 28, 2016, is to be discontinued, effective May 2, 2016. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 28, 2016, is to be discontinued, effective May 2, 2016.

Correction of the Life Safety Code (LSC) deficiencies cited under K18, K25, K27, K51 and K56 at the time of the March 10, 2016 Federal Monitoring Survey (FMS), had not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of May 31, 2016 for LSC deficiency cited at K25, date of completion of June 10, 2016 for LSC deficiencies cited at K18, K27, K56 and date of completion of December 31, 2016 for LSC deficiency cited at K51, have been approved.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

REVISED 7/7/2016

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245544 Y1	A. Building B. Wing Y2	5/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0246	Correction	ID Prefix	F0254	Correction
Reg. #	483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. #	483.15(e)(1)	Completed	Reg. #	483.15(h)(3)	Completed
LSC		05/02/2016	LSC		05/02/2016	LSC		05/02/2016
ID Prefix	F0257	Correction	ID Prefix	F0279	Correction	ID Prefix	F0280	Correction
Reg. #	483.15(h)(6)	Completed	Reg. #	483.20(d), 483.20(k)(1)	Completed	Reg. #	483.20(d)(3), 483.10(k)(2)	Completed
LSC		05/02/2016	LSC		05/02/2016	LSC		05/02/2016
ID Prefix	F0282	Correction	ID Prefix	F0309	Correction	ID Prefix	F0314	Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	Completed	Reg. #	483.25(c)	Completed
LSC		05/02/2016	LSC		05/02/2016	LSC		05/02/2016
ID Prefix	F0315	Correction	ID Prefix	F0323	Correction	ID Prefix	F0334	Correction
Reg. #	483.25(d)	Completed	Reg. #	483.25(h)	Completed	Reg. #	483.25(n)	Completed
LSC		05/02/2016	LSC		05/02/2016	LSC		05/02/2016
ID Prefix	F0353	Correction	ID Prefix	F0354	Correction	ID Prefix	F0356	Correction
Reg. #	483.30(a)	Completed	Reg. #	483.30(b)	Completed	Reg. #	483.30(e)	Completed
LSC		05/02/2016	LSC		03/08/2016	LSC		05/02/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	7/7/2016	35456	5/2/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245544 Y1	A. Building B. Wing Y2	5/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0431	Correction	ID Prefix F0465	Correction		
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.70(h)	Completed		
LSC	05/02/2016	LSC	05/02/2016		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	7/7/2016	35456	5/2/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/28/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245544 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/3/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0022	04/18/2016	LSC K0029	04/18/2016	LSC K0033	03/11/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	04/05/2016	LSC K0048	04/06/2016	LSC K0050	03/14/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	04/18/2016	LSC K0054	04/18/2016	LSC K0062	04/18/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0067	03/11/2016	LSC K0069	04/08/2016	LSC K0076	04/14/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0144	03/11/2016	LSC K0147	03/11/2016	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	6/2/2016	19251	5/3/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/10/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245544	A. Building 01 - MAIN BUILDING 01 B. Wing	5/3/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 02/29/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 03/08/2016	ID Prefix Reg. # NFPA 101 LSC K0074	Correction Completed 01/28/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 6/2/2016	SIGNATURE OF SURVEYOR 19251	DATE 5/3/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1036

June 2, 2016

Ms. Mary Hamer, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

Re: Enclosed Reinspection Results - Project Number S5544026

Dear Ms. Hamer:

On May 2, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 2, 2016. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00166 Y1	A. Building B. Wing Y2	5/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20555	Correction	ID Prefix 20565	Correction	ID Prefix 20570	Correction
Reg. # MN Rule 4658.0405 Subp. 1	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0405 Subp. 4	Completed
LSC	05/02/2016	LSC	05/02/2016	LSC	05/02/2016
ID Prefix 20800	Correction	ID Prefix 20830	Correction	ID Prefix 20840	Correction
Reg. # MN Rule 4658.0510 Subp. 1	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0520 Subp. 2 B	Completed
LSC	05/02/2016	LSC	05/02/2016	LSC	05/02/2016
ID Prefix 20865	Correction	ID Prefix 20900	Correction	ID Prefix 20905	Correction
Reg. # MN Rule 4658.0520 Subp. 2 G	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.0525 Subp. 4	Completed
LSC	05/02/2016	LSC	05/02/2016	LSC	05/02/2016
ID Prefix 21426	Correction	ID Prefix 21610	Correction	ID Prefix 21695	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1340 Subp. 1	Completed	Reg. # MN Rule 4658.1415 Subp. 4	Completed
LSC	05/02/2016	LSC	05/02/2016	LSC	05/02/2016
ID Prefix 21705	Correction	ID Prefix 21800	Correction	ID Prefix 21810	Correction
Reg. # MN Rule 4658.1415 Subp. 6	Completed	Reg. # MN St. Statute144.651 Subd. 4	Completed	Reg. # MN St. Statute 144.651 Subd. 6	Completed
LSC	05/02/2016	LSC	05/02/2016	LSC	05/02/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	6/2/2016	35456	5/2/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/28/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KOXR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245544**

2. STATE VENDOR OR MEDICAID NO. (L2) **699435200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMDEN CARE CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **11/12/2015**

6. DATE OF SURVEY **01/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **87** (L18)

13.Total Certified Beds **87** (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
	87			
(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 :
Kathy Sass, HPR-Dietary Specialist 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/25/2016 (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 **01/01/1991** (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. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **03/09/2016** (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0732

February 16, 2016

Ms. Mary Hamer, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

RE: Project Number S5544026

Dear Ms. Hamer:

On January 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

<u>Potential Consequences</u> - 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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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 March 8, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 8, 2016 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 April 28, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Received 3-2-16

PRINTED: 02/17/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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	**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.**	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156	F156(C) R43 discharged from facility on 8/11/2015. All residents are at risk of not knowing rights as pertain to payer source upon changes in treatment plan (not receiving Advanced Beneficiary Notices timely). Leadership staff including therapy were educated on Medicare Compliance, Expedited Review, timeliness of issuing Denial Letters and the Appeals Process on 2/22/16.	

Received 3-4-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Ann Hamer LNHA | TITLE: Executive Director | (X6) DATE: 3-2-16

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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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156	Audits to assure the timeliness of the delivery of Advanced Beneficiary Notices to residents will be completed weekly x 3 month. Audits will be reviewed at QAA x 3 months with follow-up to Committee recommendations. Corrections to deficient practice will be made by March 8, 2016.	

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or uniform denial letter upon termination of all Medicare (MC) Part A skilled services for 1 of 5 residents (R43) reviewed for liability notice and beneficiary appeal rights. In addition, the facility failed to provide R43 with the Notice of Medicare Non-coverage CMS-010123 when R43 remained in the facility until discharge. Findings include: R43's closed record was reviewed and indicated R43 had been admitted to the facility on 7/29/15, and had been discharged 8/11/15. In addition, the record indicated R43 had received skilled physical and occupational therapy. The record	F 156		

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F 156	Continued From page 3 indicated R43's payment source had been MC. When questioned on 1/28/16 at 8:50 a.m., about the MC denial notice for R43, the business office manager stated she was unable to locate the notice(s) provided. After looking through R43's closed record, the business office manager stated, "I can't find it." On 1/28/16, at 2:35 p.m., the registered nurse (RN)-B responsible for Minimum Data Set assessments stated, "Typically we would give the Medicare notices two days before the end of therapy." When asked whether R43 had been given a notice prior to the end of the skilled therapy services, RN-B stated the resident had left before the notice could be provided. RN-B stated she didn't have any other information, because the person responsible for giving the resident the notice no longer worked at the facility. On 1/28/16, at 2:48 p.m. the director of nursing stated she would expect residents to be given appropriate and timely MC denial notice as required by MC. On 1/28/16, at 3:17 p.m., the physical therapy assistant (PTA) stated after having reviewed the therapy notes, the therapy department had held weekly therapy meetings and during the 8/7/15, meeting which was a week before the end of the skilled services it had been discussed resident was going to be discharged from therapy. PTA stated the resident had made good progress and had met their maximum potential. PTA stated the resident had been provided therapy from 7/29/15 through 8/10/15, when R43 was discharged from therapy. The resident had then stayed in the	F 156		

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	245544	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 4 facility for another night not eligible for MC coverage. The facility provided their current policy entitled, Medicare Compliance: Expedited Review, Denial Letter, Appeals Process, Consolidated Billing-HDGR (Health Dimensions Group) policy revised January 2013; ..."2. This notice must be given at least two (2) days prior to the end of skilled services for the resident."	F 156		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were accessible for 2 of 2 residents (R15, R10) reviewed who utilized call lights to summon staff assistance. Findings include: R15 was observed on 1/25/16, at 11:45 a.m. in her room sitting in the wheelchair. R15's call light was observed on the floor next to R15's wheelchair, and was out of R15's reach. When interviewed, R15 stated she needed her call light so she could call for help. R15 also stated it had	F 246	F246 (D) – All call lights were examined for appropriate length for resident use. All residents are at risk when call lights are not accessible. Nursing staff were educated on the need for call lights to be accessible to residents. Call light accessibility will be audited 3 x weekly x 12 weeks on alternating shifts. Findings will be reported at QAA x 3 months with follow-up to Committee recommendations. Corrections to deficient practice will be made by March 8, 2016.	

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F 246	Continued From page 5 happened in the past that the call light was not left within reach, and she needed to remind staff before leaving the room to place the call light within reach. At that point the nursing assistant (NA)-I entered the room, verified the call light was not within R15's reach, picked up the call light and handed it to R15. NA-I stated the call lights supposed to be placed always within residents reach. R15's admission Minimum Data Set (MDS) dated 12/30/15, indicated R15 was cognitively intact. R10 was observed on 1/26/16, at 11:17 a.m. and interviewed in her room. R10 was laying in her bed, and stated she routinely used the call light when she needed help. R10 then looked for the call light but could not find it. Registered nurse (RN)-A nurse manger was interviewed on 1/26/16, at 11:25 a.m. and verified R10 was capable of using the call light. RN-A confirmed R10's call light was not within reach, and looked for the call light. RN-A located the call light which was wrapped up in the bedding at the foot of the resident's bed. RN-A stated staff were expected to place the call light within the reach of the resident when they left the room. R10's admission MDS dated 10/27/15, indicated R10 had moderate cognitive impairment. On 1/28/16, at 9:43 a.m. the director of nursing stated staff were expected to make sure call light were placed within residents' reach all the time. The facility's call light policy was requested, but not provided.	F 246		
F 254	483.15(h)(3) CLEAN BED/BATH LINENS IN	F 254		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 254 SS=D	Continued From page 6 GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate bedding was provided for 1 of 1 resident (R15) in the sample who utilized a bariatric bed. Findings include: R15 was observed on 1/25/16, at 4:58 p.m. to be laying in her bed. There was no sheet on the oversized bariatric mattress, only a bed spread, which did not cover the top of the mattress and R15's head and neck were on the bare mattress. R15 stated the staff had told her for the last three days that there were no bed sheets available for her mattress. On 1/25/16, at 5:14 p.m. the director of nursing (DON) was interviewed, and stated the facility just received a shipment of bariatric bedding last Saturday (1/23/16). The DON stated the facility had six bariatric beds in use, and staff were expected to make the beds appropriately using sheets. The DON said she was unaware staff did not have an adequate supply of linens. The DON then went to R15's room and when she returned at 5:20 p.m., stated the lack of linens of R15's bed was "not acceptable." The DON also stated she would have expected the staff to inform her about missing resident care supplies including bedding.	F 254	F254 (D) Fitted sheets fitting bariatric beds were obtained and placed on R15's bed on 1/25/16. Six other bariatric beds in use in facility were checked for appropriate use of clean bariatric bedding on 1/25/16. Bariatric residents are at risk for lack of appropriate supply and use of clean fitting bed linens. Staff was educated regarding the need to provide for clean well-fitting linens and notifying administration when supply of linens is low. Bariatric linen supply will be audited weekly x 12 weeks for a par supply of 3 bariatric bottom sheets for each bariatric bed. Findings will be reviewed monthly by the QAPI Committee x 3 months, with follow-up to Committee for recommendations.	

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	245544	A. BUILDING _____ B. WING _____	01/28/2016

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F 257 F 257 SS=D	Continued From page 7 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81°F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comfortable temperatures were maintained in a shared room for 2 of 5 residents (R46, R12) reviewed for environment with room temperature concerns. Findings include: R46's quarterly Minimum Data Set (MDS) dated 11/26/15, indicated resident had intact cognition. On 1/26/16, at 9:37 a.m. when asked during interview if there was any problems with the temperature, lighting, noise or anything else in the building that affected his comfort, R46 stated "It was not warm enough." During the interview R46's bed was observed right next to the heat radiator on the wall and was also covered with three heavy blankets on top of him which were not facility blankets. On 1/28/15, at 7:40 a.m. R46 stated he had reported the cold room temperature to the staff but was not sure when it was going to be addressed and in the meantime was using heavy blankets to keep warm. R12's annual MDS dated 11/3/15, indicated	F 257 F 257	Corrections deficient practice will be made by March 8th. 2016 F257 (D) Room temperatures for R46 and R12 were assessed by maintenance on 1/28/16 and proper adjustments made to increase room temperature to a comfortable level were done. All residents are at risk for uncomfortable room temperatures. Staff were educated on assessing for and reporting uncomfortable room temperatures for residents. Random room temperatures x 5 will be audited 5 days a week x 4 weeks and monthly x 2 months. Findings will be reported monthly x 3 months to the QAPI Committee with follow-up to recommendation of Committee. Deficient practice will be corrected by March 8, 2016	

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F 257	Continued From page 8 resident severely impaired cognition skills and family was involved in care decisions as a result. On 1/26/16, at 11:28 a.m. during a family interview with R12's family when asked if there were any problems with the temperature, lighting, noise or anything else in the building that affected R12's comfort, family member stated during visits to the facility the room was always cold which R12 was not able to verbalize. On 1/28/16, from 12:04 p.m. to 12:32 p.m., an environmental tour was conducted with the regional manager (RM) and the administrator. During the tour the RM checked the room temperatures twice. The first temperature reading registered and observed at 68 degrees Fahrenheit, and the second reading registered at 69 degrees Fahrenheit. Both the administrator and the RM verified the readings and stated they would adjust the thermostat located by the door to the room. The administrator also stated she would educate staff about ensuring maintenance were aware of resident concerns about room temperatures. The facility's policy, Environment - Quality of Life (General) dated April 1, 2008, indicated "Comfortable and safe temperature levels (71-81 degrees F)..."	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	F 279 (D) R15 has been discharged to home since the survey. Care plans and NAR (Nursing Assistants Registered) care guides for those residents with indwelling catheters and assistive breathing devices, i.e.	

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F 279	Continued From page 9 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a plan of care to ensure individualized interventions were in place to meet resident needs for 1 of 1 resident (R15) who had an Indwelling Foley catheter and respiratory concerns. Findings include: Catheter care: R15 was observed on 1/27/16, at 8:23 a.m. laying in the bed. During interview R15 stated she felt staff did not always clean her properly in the morning, and she received cares only when she requested them, which included a partial bath in the morning and peri care. R15 had an indwelling Foley catheter, with a 2000 milliliter (ml) bag attached to it. R15 stated she used to have urinary tract infections (UTI) in the past, and did not know when staff supposed to care for her	F 279	Cpaps, were reviewed and revised to include care interventions for indwelling catheters and assistive breathing equip; i.e. Cpaps. All residents are at risk due to incomplete care planning and communication of care needs. Staff were educated on comprehensive care planning and timely communication of care needs and the need for proper care of indwelling catheters and the monitoring of residents using assistive breathing equipment; i.e. Cpaps. All new residents' records will be audited x 12 weeks to assure an individualized care plan is completed by day 21 and care interventions are communicated through the NAR care guide. Findings will be reported monthly to AQPI committee x 3 months with follow-up to Committee recommendations.	

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F 279	Continued From page 10 catheter. R15 also stated she preferred to use the bedpan when she had bowel movements, but staff have not always had a bed pan available to use. On 1/27/16, at 1:35 p.m. R15 was interviewed again, stated she have not received grooming cares, pericare or catheter care yet today, no staff checked in with her yet today related to her grooming needs. R15 also stated she had the catheter for a long time, and had seen the urologist when in trouble with kidney failure. R15's Hospital Discharge Summary dated 12/1/15, indicated R15 had been hospitalized for UTI, worsening renal function, and a diagnosis of pyelonephritis (a specific type of urinary tract infection that generally begins in the urethra or bladder and travels up into the kidneys), and chronic kidney disease. The discharge summary also indicated R15 had a Foley catheter in place prior to admission. The facility's Admission Nursing assessment dated 12/1/15, identified the use of a catheter and history of UTI's. However, the temporary care plan dated 12/1/15, noted toileting assist of one or two staff and failed to identify presence of Foley catheter, any medical conditions related to the urinary tract, and failed to identify interventions to care for the catheter. On 12/2/15, the Physician Order read "Change foley cath [catheter] monthly. Catheter cares q [every] shift." Review of R15's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 12/1/15 through 12/5/15, identified catheter cares and to change the Foley	F 279	Corrections to deficient practice will be made by March 8, 2016.	

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F 279	Continued From page 11 catheter every month, however, the plan care was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of pyelonephritis and worsening kidney disease. R15 was hospitalized and readmitted on 12/23/15, per the Admission Nursing Assessment. The form indicated history of UTI's, however the form was left incomplete, did not indicate presence of the Foley catheter, urinary tract related medical conditions or interventions. The Temporary care plan dated 12/23/15, indicated toileting assist of two staff, and pad use. Review of R15's MAR and TAR from 12/23/15 going forward; lacked the identification of catheter cares and to change the Foley catheter every month. In addition, the plan care was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of UTIs, pyelonephritis and worsening kidney disease. R15's admission Minimum Data Set (MDS) dated 12/30/15, indicated R15 had indwelling catheter, was frequently incontinent of bowel, and was dependent of two staff's assistance with bed mobility, transfers and toilet use. The MDS also depicted R15 as being cognitively intact and able to have clear comprehension of others and able to clearly state needs. The Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 1/4/16, indicated the facility would proceed to care plan for Foley catheter care and monitoring of adverse outcomes associated with the Foley catheter use. The comprehensive plan of care dated 12/23/15, for bowel and bladder needs, activities of daily	F 279		

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F 279	Continued From page 12 living needs and catheter use was not developed nor was there any interventions identified to assist R15 with cares. The care plan did not include presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter. R15's care plan revised on 1/5/16, indicated R15 was a vulnerable adult and staff were to monitor and investigate any concerns. The care plan was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of UTIs, pyelonephritis and worsening kidney disease. The Physician's Progress notes dated 1/14/16, indicated R15 had chronic kidney disease and chronic indwelling Foley catheter for the past six years due to immobility, and had history of UTI's. The note also indicated R15 had complaints recently of bladder spasm, started on oxybutynin, had urine analysis with mixed flora (more than one organism isolated from urine culture), and ordered a three day course of Levaquin (antibiotic). The newly diagnosed bladder spasms was not added to the plan of care nor was there monitoring and interventions put into place on the plan of care other than the medication to relieve the spasms. The nursing assistant (NA) care sheet (undated) indicated assist of two with grooming, dressing, toileting, and transfer with Hoyer to commode. However, the sheet did not indicate presence of indwelling Foley catheter, or related cares. On 1/27/16, the NA who was assigned to take care of R15 or registered nurse (RN)-A (also nurse manager were not available for interview.	F 279		

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F 279	Continued From page 13 On 1/27/16, at 2:09 p.m. the licensed practical nurse (LPN)-B was interviewed and stated the nursing assistants were expected to complete twice daily pericare, "wipe the catheter every morning", get resident cleaned up in the morning, and nurses were responsible to make sure "everything is done" (meaning cares). LPN-B stated she was not told R15 did not receive cares that morning. On 1/27/16, at 3:22 p.m. the director of nursing (DON) stated she would expect staff to complete morning cares, such as partial baths, and if a resident had Foley catheter to complete catheter care along with the pericare. The DON was not aware R15 did not receive those cares this morning. On 1/28/16, at 10:11 a.m. the DON stated by day 21 of admission she would expect to see a comprehensive care plan written by the MDS nurse. The DON reviewed R15's record and stated she would expect R15 to have care plan developed for activities of daily living care needs (include grooming, toileting) and Foley catheter care. Respiratory care: R15's Admission Record indicate she had been admitted to the facility on 12/1/15, with diagnoses including anxiety and depression. The Admission Nursing Assessment, dated 12/1/15, noted there was no indication the resident utilized a continuous positive airway pressure (CPAP) machine (to help a person who has obstructive sleep apnea [OSA] breathe more easily during sleep) at night. In addition, the assessment	F 279		

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F 279	Continued From page 14 lacked evidence of oxygen use and if the resident required oxygen saturation levels (O2 sats) due to the oxygen use. On 12/1/15, the Physician Order read "Whatever she use [sic] at home for oxygen is fine and resident states she uses 2 L [liters] with CPAP at night." The resident's Initial/Temporary Care Plan dated 12/1/15, indicated R15 needed one staff assist with dressing/grooming, needed assist of one-two staff with toileting, and two staff assist with transferring. The Temporary Care Plan did not include any information regarding O2 use or CPAP machine use. An undated nursing assistant assignment sheet did not include indwelling catheter use, O2 use or CPAP machine use. On 12/4/15, the Physician Order noted the physician ordered a chest xray, blood draws and to keep the oxygen levels between 2 to 4 L, and keep the O2 Sats over 90%. The information was not added to the plan of care nor was the information found on the MAR/TARs. Review of R15's MAR and TAR from 12/1/15 through 12/15/15, had no indication of the CPAP machine/O2 use, or monitoring of R15's breathing. The discharge MDS dated 12/4/15, indicated R15 received oxygen therapy at the facility, had a diagnosis of respiratory failure, but did not indicate R15 utilized CPAP, nor that she utilized an indwelling catheter. The MDS information contraindicated what the Admission Nursing Assessment, dated 12/1/15.	F 279		

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F 279	Continued From page 15 The H&P (history and physical) Summary dated 12/5/15, indicated the resident was admitted with "ID/Sepsis/Severe Sepsis: Possible pneumonia with sepsis; cultures have been sent and empiric abx [antibiotic] started." The Hospital Discharge Summary indicated R15 had been sent to the hospital on 12/5/15, and readmitted to the nursing home 12/9/15. The principal diagnoses listed for the hospitalization included: "acute hypoxic respiratory arrest." The Discharge Summary indicated R15 had required treatment with "intubation, steroids, oxygen, antibiotics," had been extubated after one day, and needed a low dose of O2 which was different than before. The Summary also indicated, "[R15] was observed to take off her BIPAP [bilevel positive airway pressure] at times when sleeping, and combined with her obesity could cause obstructive respiratory arrest." The facility's Admission Nursing Assessment dated 12/9/15, indicated R15's lungs were clear and that she was breathing easier however, there was no indication of CPAP use. The medical record lacked evidence of a temporary care plan from readmission on 12/9/15, and after multiple requests the facility failed to provide the document for review. A discharge MDS dated 12/14/15, indicated R15 had been re-admitted with a diagnosis of septicemia (a bacterial infection spread through the entire vascular system of the body), did not use any oxygen in the facility nor did R15 utilize the CPAP, and had a diagnosis of respiratory failure.	F 279		

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F 279	Continued From page 16 R15's MAR/TARs review dated 12/9/15, through 12/15/15, indicated no use of the CPAP machine/O2 use, or monitoring of R15's breathing. The TAR dated 12/23/15 going forward to 12/13/15, identified the staff were monitoring the oxygen sats as they were to keep the sat level over 92% and monitoring the BiPAP usage. R15's plan of care dated 12/23/15, was reviewed and noted the care plan did not identify any interventions that were put into place to monitor R15's recent diagnosis of pneumonia related sepsis with recent hospitalization dated 12/14/15, monitoring for lung sounds, changes in breathing, shortness of breath, and changes in vital signs. In fact R15's plan of care was revised on 1/5/16, and still the plan of care did not identify either hospitalizations or the recent diagnoses, nor were there any interventions identified to minimize potential and/or prevent future hospital readmissions regarding her breathing status, pneumonia related sepsis, CPAP machine use, O2 use. RN-B was interviewed on 1/26/16, at 4:07 p.m. about the plans of care for R15. He verified the care plans lacked any information for the dates of the hospitalization, or the reasons of the hospitalization, and any new interventions for staff to implement cares for R15 to minimize and or prevent future hospitalizations for R15. He also commented the care plans should have been written by day 21 after resident admission, and verified the comprehensive care plan for R15 should have been completed by 1/14/16 (approximately two weeks ago).	F 279		

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F 279	Continued From page 17 The DON was interviewed on 1/28/16, at 10:11 a.m. The DON indicated when the resident was re-admitted back to the facility she expected the staff to complete the assessments, treat the residents as a new admission, monitor vital signs, note what diagnosis(es) they came back with, note what the medical doctor (MD) ordered, update the nurse practitioner and MD, and document circumstances of hospitalization. The DON also verified the temporary care plan from 12/1/15, and 12/23/15, had "minimum information", and should have include all relevant information related to R15's medical conditions, and interventions put in place to address them. The DON also verified the lack of temporary care plan from 12/9/15. The DON also stated RN-B was responsible for developing residents' comprehensive care plans by day 21, and verified R15's should have been completed approximately two weeks ago. The facility's undated Resident Care Planning policy indicated "The care plan is initiated within 24 hours from the time of admission and fully developed within 21 days following the resident's arrival to the facility. All disciplines are responsible for adding their portion to the 24 hour care plan and the permanent care plan."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F280(D) Comprehensive skin assessments including Braden risk assessments and tissue tolerance tests were completed for R10 and R34. Care plans, Treatment Administration	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	01/28/2016

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CAMDEN CARE CENTER	612 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 280	Continued From page 18 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 2 of 3 residents (R10, R34) reviewed for pressure ulcers and/or non-pressure related skin conditions. Findings include: R10 was observed on 1/26/16 at 8:07 a.m. to be transferred into the wheelchair. During the period of continuous observation, the resident was transferred to bed with a mechanical lift at 10:23 a.m. Registered nurse (RN)-A, nurse consultant (NC)-A, and licensed practical nurse (LPN)-D were present to assess R10's skin. During the observation R10 stated, "my skin is falling apart, it hurts when I sit in the wheel chair." R10's bed was observed to have an air mattress in place over the mattress and a thick white pillow was observed in place over a cushion in the wheel chair. Nursing assistant (NA)-J turned R10 and	F 280	Records (TARs), wound care sheets and NAR care guides for R10 and R34 were reviewed and revised to include interventions towards healing of current and prevention of future skin breakdown. Skin checks were completed on all facility residents and continue on a weekly schedule. All residents requiring assistance are at risk for skin breakdown due to untimely/incomplete assessments, care planning, communication and monitoring of interventions. Staff were educated on need for timely reporting of identified skin impairment, timely skin assessments and appropriate care planning interventions and communication of interventions; the need to follow care planned interventions and follow-up monitoring.	

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F 280	Continued From page 19 removed her incontinent brief. There was a moderate amount of bright red blood on the incontinent brief. LPN-D stated there should have been a dressing over a wound on the resident's buttock and that no one had reported the dressing had come off. A wound on the right buttocks was observed to be localized on scar tissue and RN-A measured the area to be 4 centimeter (cm) long, 2 cm wide, and to have no depth. There was 100 % red bleeding over the wound bed. When LPN-D touched R10's wound to clean it, R10 retracted. RN-A stated the wound "could have been caused by pressure, or more likely friction." NC-A stated it appeared "friction and shearing played a big role in the development of the wound since the brief [incontinent brief] line was right there. I don't think it is a pressure ulcer." R10's record was reviewed. According to the Admission Record documentation dated 12/8/15, R10 had been admitted to the facility on 10/21/15, with diagnoses including: unspecified kidney failure, hypertension, peripheral vascular disease, and diabetes. An Admission Nursing Assessment document dated 10/21/15, indicated R10's left side was paralyzed, and the resident's skin risks included incontinence, impaired mobility, and being chair fast. A diagram of R10's body was marked to identify skin issues in three areas: on the coccyx, and on each buttock. The documented description noted for the left and right buttocks indicated, "Scarring from old pressure sore." A Temporary Care Plan dated 10/26/15, did not include a detailed plan to prevent pressure ulcer development, including a repositioning schedule. However, the treatment administration records	F 280	DON/Designee will audit residents with skin breakdown weekly x 12 weeks for appropriate assessments, monitoring and treatment, and care plan and care guide interventions. Findings will be reported monthly to QAPI committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be made by March 8, 2016.	

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F 280	Continued From page 20 (TARs) for December 2015 and January 2016, identified an approach initiated 10/19/15 that directed "reposition every two hours in the chair..." The admission Minimum Data Set (MDS) assessment dated 10/27/15, indicated R10 was dependent on two staff for assistance with bed mobility, transfers, and toilet use; did not have any unhealed pressure ulcers, but was at risk for developing pressure ulcers; had functional limitation of range of motion impairment on one side; and used a wheel chair for mobility. The corresponding Care Area Assessment (CAA) dated 11/9/15, indicated "PLACE INTERVENTIONS THAT ASSIST IN DECREASING THE POTENTIAL FOR PRESSURE AREA AND OR OTHER SKIN BREAKDOWN." A Braden scale (tool used to determine pressure ulcer risk) assessment dated 11/13/15, identified the resident's pressure ulcer risk at a score of 16, indicating mild risk for development of pressure ulcers. A Progress Note dated 11/24/15, included, "abrasion noted on LF [left] buttocks, sm [small] amount of blood dripping from area". The note also indicated the resident was laid down after meals, and repositioned/offloaded every two hours. A Physician's Order dated 11/24/15, identified a treatment order of: "apply silverstatin cream [a cream used to treat wounds] to Lt [left] buttocks and apply foam dressing and change q [every] am [morning] and PRN [as needed]. Reposition q	F 280		

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F 280	Continued From page 21 2 hrs [every two hours]." A Physician's Order dated 12/16/15, included, "apply silverstatin cream to left buttock and apply foam dressing and change q 3 days + PRN [as needed]." The Physical Therapy (PT) Daily Notes dated 12/28/15, indicated R10 had complained of right buttocks pain, and indicated PT had educated nursing staff to "perform position change every hour to decrease pain and take pressure off coccyx ulcer," and had recommended ROHO cushion (specialty pressure reduction cushion for wheel chair use). R10's care plan, and Treatment Administration Records (TARs) were not updated to include the recommendations for hourly repositioning. During interview with the director of nursing (DON) on 1/28/16 at 9:46 a.m., the DON stated she would expect resident care plans to be updated. The facility's undated Resident Care Planning policy included: "Between Interdisciplinary Conferences, each discipline is responsible for adding/deleting problems, goals, and approaches to the individual care plan as changes occur." R34 was observed continuously on 1/27/16, from 7:05 a.m. until 8:42 a.m. the following was observed: At 7:27 a.m. nursing assistant (NA)-A and entered R34's room and obtained permission to observe cares. At 7:30 a.m. during morning care there was a pink dressing observed in place on the top outer side of R34's left breast. NA-A removed the resident's incontinence brief and washed under R34's abdominal fold. R34 said that "hurts." NA-A told R34 there was a tear under left abdomen	F 280		

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F 280	Continued From page 22 fold, and verified there was no gauze dressing between R34's abdominal fold and groin. At 8:09 a.m. registered nurse (RN)-A arrived to perform wound care. The measurements and descriptions of wounds were as followed: 1) Left breast: A crescent shaped wound that looked like a ruptured blister measured 3.5 centimeters (cm.) x 1 cm. x 0 cm. There was no drainage. The wound was cleansed, and an Island dressing (sterile pad or compress applied to a wound to promote healing) was applied. 2) Abdominal slits: a) slit in left groin fold 9.2 cm long. b) 0.5 cm long slit to the right of the left groin slit c) slit in right groin fold 2.8 cm long. 3) Right ischial tuberosity: Stage 3 pressure ulcer measuring 1cm. x 0.8 cm. x 0 cm. Wound bed had 20 percent (%) granulation tissue and 50% slough. No drainage was observed. RN-A stated, "I will cover it with a border dressing until I can obtain orders from the MD [medical doctor]." 4) Coccyx: Slit between buttocks measuring 8 cm. in length. R34's care plan printed 6/3/15, indicated R34 was at risk for impaired skin integrity and had a history of resolved pressure ulcers related to incontinence, immobility diabetes, pain, neuropathy, chronic issues of open areas to the sacral coccyx area related to scar tissue from previously healed ulcers and multiple ulcers on stomach related to R34 picking at skin. The interventions instructed staff to assist R34 with repositioning as needed and with each check and change, encourage R34 to make frequent position changes when R34 was able when in the chair or in bed, report skin issues to physician as they arise and skin checks per facility protocol with bath and as needed. The care plan indicated R34 was incontinent of bowel and bladder and	F 280		

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F 280	Continued From page 23 required extensive assistance to total assistance with toileting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after lunch and during the night on rounds or as needed. The care plan with print date of 11/30/15, did not address skin or incontinence issues. A Pressure Ulcer Care Area Assessment dated 8/5/15, indicated R34 was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning. R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). The MDS further indicated R34 was always incontinent of bowel and bladder and was at risk for developing pressure ulcers. The quarterly MDS identified diagnoses including: diabetes mellitus, chronic kidney disease and hypertension. The Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff that [R34] required total assist of two to check and change before breakfast after lunch and during the night on rounds or as needed, and encourage repositioning. A Progress Note dated 12/31/15, at 10:51 a.m. indicated, "Resident has an o/a [open area] on right inner buttock, measures 1 cm x 1 cm. Resident has pain in area, 7 % slough 25% granulation. Protective barrier cream applied to site." This information was not updated on the care plan.	F 280		

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F 280	Continued From page 24 The Treatment Administration Record dated January 2016, instructed staff to "WASH AND DRY ABDOMINAL FOLDS AND GROIN, APPLY 4X4 TO SKIN FOLDS [initiated 1/20/15]." Although the treatment was set up for every shift, this information was not updated on the care plan or NA Assignment Sheet. During interview on 1/27/16, at 9:00 a.m. RN-A stated, "I was not aware of the slits on her abdomen. There are no wound sheets because the wounds developed in December while I was on vacation. The nurse who found the wounds should have called the MD (medical doctor). I am not a wound nurse the director is a wound nurse. I don't know if the information is on the weekly skin sheets. It should be. The nurse should have updated the care plan." RN-B was interviewed at 11:00 a.m. on 1/27/16, RN-B stated, "I don't care plan turning and repositioning schedules because it is a compliance issue, you cannot get the staff to follow the schedule." On 1/27/15, at 11:09 am RN-A was asked how frequently a resident should be repositioned and stated, "I would need to check the care plan." When asked how frequently a resident with a wound like R34's should be repositioned RN-A stated, "at least every two hours." During interview on 1/27/16, at 2:31 p.m. the director of nurses stated, "...My expectation is that the aides would tell the nurse right away when they find an open area. The nurse needs to chart on it and tell the wound nurse about it [RN-A]. The nurses need to put the appropriate interventions for the open area in place and	F 280		

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F 280	Continued From page 25 document. The nurse needs to update the care plan...The individualized turning/repositioning schedule should be on the assignment sheets and care plans." The facility's Repositioning of resident's policy dated July 2012, included: "3. Residents will be repositioned every 2 hours unless otherwise documented on care plan and NA (nursing assistant) assignment sheets." The facility's Skin Care Protocol revised 6/28/05 indicated: "...a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrated that they were unavoidable" and "a resident having pressure sores receives necessary treatment and services, as the facility is able to provide, to promote healing, prevent infection, and prevent new sores from developing."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care (POC) for 1 of 3 residents (R12) who were observed for repositioning.	F 282	F282(D) - R12 was re-assessed for skin issues through completion of a Braden risk assessment and bowel and bladder assessment. R12's TAR, care plan and NAR care guide were reviewed and revised to address and include preventive skin breakdown measures. All residents requiring assistance with mobility and cares are at risk for decline.	

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F 282	Continued From page 26 Findings include: R12 was observed continuously on 1/27/16, from 8:54 a.m. to 11:22 a.m. - At 8:54 a.m. R12 was sitting in a Broda chair in the dining room, - At 8:59 a.m. nursing assistant (NA)-G took R12 to room and put upper dentures in R12's mouth without adhesive. NA-G returned R12 to the dining room, - At 9:15 a.m. R12 sitting in the television (TV) room, - At 10:37 a.m. R12 remained sitting in the TV room asleep, - At 10:53 a.m. R12 sitting in the TV room awake and, - At 11:22 a.m. R12 still sitting in TV room sleeping. The observation was resumed on 1/27/16, at 12:45 p.m. R12 sitting in TV room sleeping - At 12:57 p.m. asked licensed practical nurse (LPN)-A if R12 had been toileted and repositioned since R12 got up that morning. LPN-A verified R12 had not been laid down or repositioned yet since R12 got up that morning. LPN-A stated, "[R12] had just eaten lunch staff were going to lay [R12] down." R12 went for four hours and 15 minutes without being repositioned. - At 1:10 p.m. NA-G wheeled R12 to bedroom and, - At 1:16 p.m. NA-G and NA-H placed R12 in EZ stand (a mechanical standing lift) and stood R12 up. NA-H pulled R12's pants down and said "he is dry in back and he is dry in front." Requested NA-H remove R12's incontinence brief. R12's skin intact was intact, cocoyx was red but blanchable. R12 had been incontinent of stool. NA-G and NA-H washed R12's bottom and applied a new incontinence brief.	F 282	Staff were educated on need follow resident's plan of care in accordance with their assessed needs and risks, particularly those residents at high risk for skin breakdown. DON/Designee will perform random audits of 5 residents care plans with focus on residents with or at risk for skin breakdown, and will monitor care planned interventions weekly x 12 weeks. Findings will be reported monthly to QAPI Committee with follow-up to recommendations by Committee. Results will be reviewed at QAA monthly x 3 months with follow-up to Committee recommendations. Corrections to deficient practice will be made by March 8, 2016.	

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F 282	Continued From page 27 During continuous observation on 1/28/16, from 7:30 a.m. to 10:46 a.m. R12 went for three hours and 16 minutes without being repositioned. - At 7:15 a.m. R12 was lying in bed, - At 7:30 a.m. up in Broda chair in the hallway, - At 7:45 a.m. R12 in dining room, - At 8:52 a.m. NA-A assisting R12 to eat breakfast, - At 9:15 a.m. R12 sitting in TV room, - At 10:30 a.m. R12 remained in TV room, - At 10:40 a.m. R12 taken to shower room by NA-A to be repositioned and checked and, - At 10:46 a.m. R12 stood up in standing lift. NA-C and NA-F pulled pants down and removed incontinence brief. Incontinence brief was wet. R12's right gluteal fold was red. LPN-A verified that R12 had not been repositioned since R12 got up. LPN-A checked R12's skin and indicated it was blanchable. R12's Minimum Data Set dated 11/3/15, indicated R12 was severely cognitively impaired, required assistance with all activities of daily living, was incontinent of bowel and bladder and at risk for development of pressure ulcers. The Pressure Ulcer Care Area Assessment dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, frequent urinary and bowel incontinence, and identified risk for pressure ulcer development. Care plan printed 1/28/16, instructed staff R12 continues to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility psychotropic drug use and diuretic use. Interventions instructed staff follow repositioning	F 282		

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F 282	Continued From page 28 schedule per nursing, provide moisture barrier and perform peri-care during each check and change and as needed, wound care as ordered, check and change before breakfast after lunch and on rounds through night and as needed. The Physician Orders signed by doctor on 1/6/16, instructed staff to reposition R12 in wheelchair every two hours and house barrier cream to skin over right buttock twice a day. The Treatment Administration Record (TAR) dated Jan 16, indicated R12 was to be "REPOSITION IN WHEELCHAIR EVERY 2 HOURS (Started 10/13/14)." The box for the AM shift was left blank on 1/27/16, and signed 1/28/16. The undated Group 3 NA Assignment Sheet instructed staff check and change before breakfast after lunch before bed and on rounds through night as needed. Reposition during check and changes. During interview on 1/27/16, at 12:57 p.m. LPN-A stated, "[R12] has not been laid down or repositioned yet since he got up this morning." During interview on 1/28/16, at 10:21 a.m. NA-A said I got [R12] up at 7:30 a.m. [R12]'s skin is intact. NA-A stated, "[R12] has not been repositioned today. We are so short we cannot get people up or toileted or repositioned." During interview on 1/27/16, at 2:31 p.m. the director of nursing stated, "...To determine how often the residents need to be repositioned we look at tissue tolerance and comorbidities. Residents need to be turned at baseline, every	F 282		

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F 282	Continued From page 29 two hours minimum. If there is a wound every 1 hour. If the wound is nasty, the resident should only be up for meals. The individualized turning/repositioning schedule should be on the assignment sheets and care plans." The facility's Repositioning of resident's policy dated July 2012, instructed staff: "3. Residents' will be repositioned every 2 hours unless otherwise documented on care plan and NAR [nursing assistant registered] assignment sheets." R12 was not repositioned according to the plan of care which instructed staff to turn and reposition every two hours per the TAR.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care and services including assessment, care plan development and implementation of interventions, for 1 of 2 residents (R34) who had non pressure related skin issues. Findings include: R34 was observed continuously on 1/27/16, from	F 309	F309 (D) –R34's attending physician was contacted on 1/27/16 and wound treatment orders obtained for R 34. A comprehensive skin assessment, completion of a Braden risk assessment and tissue tolerance test were completed for R34. R34's TAR, care plan and NAR care guide were reviewed and revised according to M.D. orders and assessment findings. Weekly wound care monitoring was implemented for R34. All residents requiring assistance are at risk for skin	

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F 309	Continued From page 30 7:05 a.m. until 8:42 a.m. the following was observed: At 7:27 a.m. nursing assistant (NA)-A and entered R34's room and obtained permission to observe cares. At 7:30 a.m. during morning care there was a pink dressing observed in place on the top outer side of R34's left breast. NA-A removed the resident's incontinence brief and washed under R34's abdominal fold. R34 said that "hurts." NA-A told R34 there was a tear under left abdomen fold, and verified there was no gauze dressing between R34's abdominal fold and groin. At 8:09 a.m. registered nurse (RN)-A arrived to perform wound care. The measurements and descriptions of wounds were as followed: 1) Left breast: A crescent shaped wound that looked like a ruptured blister measured 3.5 centimeters (cm.) x 1 cm. x 0 cm. There was no drainage. The wound was cleansed, and an Island dressing (sterile pad or compress applied to a wound to promote healing) was applied. 2) Abdominal slits: a) slit in left groin fold 9.2 cm long. b) 0.5 cm long slit to the right of the left groin slit c) slit in right groin fold 2.8 cm long. R34's care plan printed 6/3/15, indicated R34 was at risk for impaired skin integrity and had a history of resolved pressure ulcers related to incontinence, immobility diabetes, pain, neuropathy, chronic issues of open areas to the sacral coccyx area related to scar tissue from previously healed ulcers and multiple ulcers on stomach related to R34 picking at skin. The interventions instructed staff to assist R34 with repositioning as needed and with each check and change, encourage R34 to make frequent position changes when R34 was able when in the chair or in bed, report skin issues to physician as they arise and skin checks per facility protocol	F 309	breakdown due to lack of appropriate assessment, interventions, communication, and monitoring. Staff were educated on reporting skin issues immediately and follow-up interventions to be put into place and followed to treat as well as to prevent declining skin condition, stressing the importance of timely incontinence care and repositioning per the care plan. DON/Designee will monitor all skin sheets, wound sheets, TARs and care plans of residents with wounds weekly x 12 weeks. Findings will be reported monthly to QAPI Committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be made by March 8, 2016.	

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F 309	Continued From page 31 with bath and as needed. The care plan indicated R34 was incontinent of bowel and bladder and required extensive assistance to total assistance with toileting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after lunch and during the night on rounds or as needed. In addition, the care plan provided by facility with print date of 11/30/15, did not address skin or incontinence issues. Pressure Ulcer Care Area Assessment dated 8/5/15, indicated [R34] was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning. R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). R34 was always incontinent of bowel and bladder. R34's quarterly MDS indicated R34 was at risk for developing pressure ulcers. R34's quarterly MDS diagnoses included diabetes mellitus, chronic kidney disease and hypertension. Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff that [R34] required total assist of two to check and change before breakfast after lunch and during the night on rounds or as needed, and encourage repositioning. The Treatment Administration Record dated January 2016, instructed staff to "WASH AND DRY ABDOMINAL FOLDS AND GROIN, APPLY 4X4 TO SKIN FOLDS [Started 01/20/15]." The treatment was set up for every shift. The	F 309		

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F 309	Continued From page 32 information was not on care plan or nursing assistant assignment sheet. During interview on 1/27/16, at 9:00 a.m. RN-A stated, "I was not aware of the slits on her abdomen. There are no wound sheets because the wounds developed in December while I was on vacation. The nurse who found the wounds should have called the MD (medical doctor). I am not a wound nurse the director is a wound nurse. I don't know if the information is on the weekly skin sheets. It should be. The nurse should have updated the care plan." On 1/27/16 at 11:00 a.m. RN-B was interviewed and stated, "I don't care plan turning and repositioning schedules because it is a compliance issue, you cannot get the staff to follow the schedule." On 1/27/15, at 11:09 am RN-A was asked how frequently a resident should be repositioned and stated, "I would need to check the care plan." When asked how frequently a resident with a wound like R34's should be repositioned RN-A stated, "at least every two hours." During interview on 1/27/16, at 2:31 p.m. the director of nurses stated, "[NA-A] told me about the slit on R34's right groin this morning. No one told me about the other wounds or that there was not a treatment for [R34]. My expectation is that the aides would tell the nurse right away when they find an open area. The nurse needs to chart on it and tell the wound nurse about it [RN-A]. The nurses need to put the appropriate interventions for the open area in place and document. The nurse needs to update the care plan. The nurse needs to get a treatment	F 309		

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F 309	Continued From page 33 immediately from the doctor. The nurse would follow up weekly and as needed until resolved. I would expect a comprehensive skin assessment to be completed. There should be a tissue tolerance. There should be weekly skin checks for all residents. To determine how often the residents need to be repositioned we look at tissue tolerance and comorbidities. Residents need to be turned at baseline, every two hours minimum. If there is a wound every one hour. If the wound is nasty, the resident should only be up for meals. The individualized turning/repositioning schedule should be on the assignment sheets and care plans." The facility's Skin Care Protocol revised 6/28/05, indicated: "Skin assessments will be completed on a weekly basis."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and provide care and services to promote healing for a facility acquired pressure	F 314	F314 (D) A current comprehensive skin assessment, Braden risk assessment, nutritional assessment and tissue tolerance test were completed for R10. R10's TAR was reviewed for accuracy according to M.D. orders. R10's care plan and NAR care guide were reviewed and revised to include interventions to promote healing of skin breakdown and prevent further breakdown. Weekly wound	

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F 314	Continued From page 34 ulcer for 1 of 3 residents (R10) reviewed with pressure ulcers; In addition, the facility failed to provide repositioning for 2 of 2 residents (R34, R12) identified at risk for pressure ulcers. Findings include: R10 was not comprehensively reassessed to identify risk factors in order to prevent potential further skin breakdown, and to promote healing after a pressure ulcer was identified by staff on R10's buttocks on 11/24/15 (33 days after nursing home admission). On 1/26/16, during continuous observation the following was observed: At 8:07 a.m. R10 was transferred into the wheel chair, and brought to the dining room, At 8:30 a.m. R10 was observed still sitting in the wheel chair. At 9:22 a.m. R10 was wheeled to the activity room. At 10:18 a.m. R10 was brought back to her room where a nursing assistant (NA)-J put her coat on her. R10 stated she was going out for lunch to a 50's Style Grill with other residents and activity staff. At approximately 10:23 a.m. R10's skin was assessed by registered nurse (RN)-A. The nurse consultant/RN (NC)-A was present during assessment along with licensed practical nurse (LPN)-D. When interviewed R10 stated, "my skin is falling apart" and also stated, "it hurts when I sit in the wheel chair." R10 was transferred from the wheel chair to the bed with a mechanical lift. The bed had an air mattress on it. There was a thick white pillow on the top of the cushion in the wheel chair. When NA-J removed R10's pad, there was a moderate amount of bright red blood on the pad. LPN-D stated there should have been a dressing on the wound, and stated she had not	F 314	assessments were completed for R10; R10's sacral wound has healed since survey. Weekly wound assessments were initiated for R34. A current comprehensive skin assessment, Braden risk assessment and tissue tolerance test were completed for R34 with updates made to care plan, TAR (per M.D. orders) and NAR care guide. R12 was reassessed for skin breakdown through a new skin check and Braden risk assessment; R12's TAR, care plan and NAR care guide were reviewed and revisions made to include repositioning every 2 hours. All residents requiring assistance with cares and mobility are at risk for skin breakdown and require appropriate interventions are taken to prevent skin breakdown	

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F 314	Continued From page 35 been informed by staff that the previous dressing had come off. The right buttocks wound was localized on the scar tissue, and RN-A measured it to be 4 centimeter (cm) long and 2 cm wide, with no depth, and 100 % bleeding in the wound bed. When LPN-D touched R10's wound to clean it, R10 retracted in pain. RN-A stated the wound could have been caused by pressure, but was more likely friction. NC-A also stated, "Friction and shearing played a big role in the development of the wound since the brief line was right there. I didn't think it was a pressure ulcer." R10 went for two hours and 16 minutes without being repositioned. The Admission Record dated 12/8/15, indicated R10 was admitted to the facility on 10/21/15, with diagnoses including unspecified kidney failure, hypertension, peripheral vascular disease, diabetes. The Admission Nursing Assessment dated 10/21/15, indicated R10's left side was "paralyzed", at skin risk included incontinence, impaired mobility, chair fast. The body diagram had three circles on coccyx, and bilateral buttocks, and the description noted for left and right buttocks "Scarring from old pressure sore." The Temporary Care Plan dated 10/26/15, indicated R10 transferred with Hoyer lift (mechanical lift used to transfer residents), however did not include detailed plan to prevent pressure ulcer development, including repositioning schedule. The admission Minimum Data Set (MDS) dated 10/27/15, indicated R10 was dependent on two staff member's assistance with bed mobility,	F 314	Staff were educated on risks for skin breakdown, the standard for assessing residents for skin breakdown, implementing and following care planned interventions for healing or prevention of skin breakdown. DON/Designee will audit skin assessments, wound sheets, TARs, care plans, NAR care guides and visual monitoring of interventions for all residents with wounds weekly x 12 week. Findings will be reported monthly to QAPI committee x 3 months with follow-up according to committee recommendations Corrections to deficient practice will be made by March 8, 2016.	

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F 314	Continued From page 36 transfers, and toilet use; R10 did not have any unhealed pressure ulcers and was at risk for developing pressure ulcer; R10 had had functional limitation of range of motion impairment on one side; and used wheel chair for mobility. R10 did not have a skin comprehensive care plan developed after the MDS had been completed. The Braden scale (tool used to determine pressure ulcer risk) dated 11/13/15, had score of 16, indicating mild risk for developing pressure ulcer. However, accuracy of the result was questionable due to staff indicating no sensory perception impairment even though R10 had left sided paralysis, and also due to staff indicating friction and shear being only potential problem even though R10 required maximum assistance in moving. No additional Braden assessment was found in the medical record. The Nutritional Assessment was completed on 11/3/15, the record lacked evidence of a new assessment after buttocks wound developed on 11/24/15. The Care Area Assessment (CAA) worksheet dated 11/9/15, indicated "PLACE INTERVENTIONS THAT ASSIST IN DECREASING THE POTENTIAL FOR PRESSURE AREA AND FOR OTHER SKIN BREAKDOWN." The Progress Note dated 11/24/15, indicated "abrasion noted on LF [left] buttocks, sm [small] amount of blood dripping from area." The note also indicated resident was laid down after meals, and repositioned/offloaded every two hours. The nurse practitioner was updated. All progress	F 314		

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F 314	Continued From page 37 notes dated between 10/21/15, and 1/26/15, were reviewed, no other entries found related R10's buttocks wound. The Physician Order dated 11/24/15, indicated treatment order: "apply silverstatin cream [a cream used to treat wounds] to Lt [left] buttocks and apply foam dressing and change q [every] am [sic- morning] and PRN [as needed]. Reposition q 2 hrs [every two hours]." The Physician Order dated 12/16/15, indicated "apply silverstatin cream to left buttock and apply foam dressing and change q 3 days + PRN." The Physician/Nurse Practitioner (NP) Progress Notes dated 12/9/15, 12/15/15, 12/23/15, 1/12/15, all indicated "SKIN: normal, no rash." The Physical Therapy Daily Notes dated 12/28/15, noted R10 complained of right buttocks pain, and nursing staff was educated "to perform position change every hour to decrease pain and take pressure off coccyx ulcer", and recommended ROHO cushion (specialty pressure reduction cushion for wheel chair use). The Hospital Discharge Orders dated printed 12/29/15, indicated R10 had a history of pressure ulcers: "Wound buttocks pressure ulcer 9/17/13." The January 2016 Treatment Administration Record (TAR) indicated the Physician Order from: 11/24/15, (R10 to be repositioned every two hours) and 12/16/16, (for dressing change). The PT/OT/ST (physical therapy/occupational therapy/speech therapy) Resident Referral and Recommendations dated 1/8/16, indicated "Do not put pillow on top of ROHO cushion in	F 314		

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F 314	Continued From page 38 wheelchair." The undated NA Assignment Sheet dated 1/22/16, indicated for R10, "do not put pillow on top of ROHO cushion in wheel chair", however, did not indicate frequency of the repositioning, or presence of buttocks wound. The medical record lacked evidence of weekly assessments, or any measurements of the buttocks wound. The medical record also lacked evidence of comprehensive reassessment to determine causative factor, evaluate risk and changes in R10's condition that caused the development of the buttocks wound. On 1/26/16, at 9:30 a.m. the licensed practical nurse (LPN)-D stated R10 had a wound on the right buttocks, more than likely pressure related since 11/24/15. When inquired about the progress notes dated 11/24/15, LPN-D stated R10 had one pressure ulcer only, documenting left side versus right side must have been a mistake. On 1/26/16 at 9:45 a.m., RN-A and the director of nursing (DON) were interviewed, RN-A stated R10 did not have any pressure ulcers or wounds or her buttocks or coccyx. Both stated they were not aware R10 had a facility acquired wound on the right buttocks. On 1/26/16 10:29 a.m., the DON was informed about the observation, and stated R10 should have been repositioned at least every two hours, and before going out to outings. On 1/26/26 at 10:32 a.m., NA-J was interviewed, and could not remember when she had last	F 314		

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F 314	Continued From page 39 repositioned R10. NA-J acknowledged R10 was not repositioned or offloaded since she was transferred into her wheel chair before breakfast that morning. NA-J stated R10 should have been repositioned at least every two hours. During interview on 1/28/16, at 9:46 a.m. the DON (director of nursing) stated residents were supposed to be comprehensively reassessed when they developed a new wound, to determine causative factors; would expect staff to do Braden scale, tissue perfusion test, and she would expect to see a comprehensive note in the record with all contributing factors included. She would also expect dietary staff to be informed, care plan updated, and weekly wound measurements started to monitor healing process. DON stated RN-A was responsible making sure all these were put in place. The DON stated she could not find any assessments from 11/24/16, when R10 developed new wound on the buttocks crease, there was no comprehensive care plan written, which the MDS coordinator was responsible for. At 9:55 a.m. RN-B (also MDS coordinator) joined the conversation, and stated "didn't believe" a comprehensive care plan was written for R10, after she transferred from the other facility. R34 was observed continuously on 1/27/16, from 7:05 a.m. until 8:42 a.m. the following was observed: At 7:27 a.m. nursing assistant (NA)-A and entered R34's room and obtained permission to observe cares. At 7:30 a.m. during morning care there was a pink dressing observed in place on the top outer side of R34's left breast. NA-A removed the resident's incontinence brief and washed under R34's abdominal fold. R34 said that "hurts." NA-A told R34 there was a tear under left abdomen	F 314		

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F 314	Continued From page 40 fold, and verified there was no gauze dressing between R34's abdominal fold and groin. At 8:09 a.m. registered nurse (RN)-A arrived to perform wound care. The measurements and descriptions of pressure ulcers were as followed: 1) Right ischial tuberosity: Stage 3 pressure ulcer measuring 1cm. x 0.8 cm. x 0 cm. Wound bed had 20 percent (%) granulation tissue and 50% slough. No drainage was observed. RN-A stated, "I will cover it with a border dressing until I can obtain orders from the MD [medical doctor]." 2) Coccyx: Slit between buttocks measuring 8 cm. in length. During interview with NA-A at 9:16 a.m. on 1/27/16, NA-A stated, "The sore on [R34's] right leg has been there since I started here, about three weeks. They normally put cream on it but it is getting worse. I first saw the slit on [R34's] bottom and on [R34's] abdomen Monday morning. I told the nurse Monday. I think LPN (licensed practical nurse)-B was the nurse Monday morning. LPN-B told me to put barrier cream on and watch it. It looks worse that is why I asked for the nurse." R34's care plan printed 6/3/15, indicated R34 was at risk for impaired skin integrity and had a history of resolved pressure ulcers related to incontinence, immobility diabetes, pain, neuropathy, chronic issues of open areas to the sacral coccyx area related to scar tissue from previously healed ulcers and multiple ulcers on stomach related to R34 picking at skin. The interventions instructed staff to assist R34 with repositioning as needed and with each check and change, encourage R34 to make frequent position changes when R34 was able when in the chair or in bed, report skin issues to physician as	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 314	Continued From page 41 they arise and skin checks per facility protocol with bath and as needed. The care plan indicated R34 was incontinent of bowel and bladder and required extensive assistance to total assistance with tolleting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after lunch and during the night on rounds or as needed. The care plan with print date of 11/30/15, did not address skin or incontinence issues. A Pressure Ulcer Care Area Assessment dated 8/5/15, indicated R34 was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning. R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). The MDS further indicated R34 was always incontinent of bowel and bladder and was at risk for developing pressure ulcers. The quarterly MDS identified diagnoses including: diabetes mellitus, chronic kidney disease and hypertension. The Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff that [R34] required total assist of two to check and change before breakfast after lunch and during the night on rounds or as needed, and encourage repositioning. A Progress Note dated 12/31/15, at 10:51 a.m. indicated, "Resident has an o/a [open area] on right inner buttock, measures 1 cm x 1 cm. Resident has pain in area, 7 % slough 25% granulation. Protective barrier cream applied to	F 314		

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F 314	Continued From page 42 site." This information was not updated on the care plan. During interview on 1/27/16, at 9:00 a.m. RN-A stated, "...There are no wound sheets because the wounds developed in December while I was on vacation. The nurse who found the wounds should have called the MD (medical doctor). I am not a wound nurse the director is a wound nurse. I don't know if the information is on the weekly skin sheets. It should be." RN-A further described the wound on R34's bottom as a stage 3, (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) and stated, "The nurse should have updated the care plan." RN-B was interviewed at 11:00 a.m. on 1/27/16, RN-B stated, "I don't care plan turning and repositioning schedules because it is a compliance issue, you cannot get the staff to follow the schedule." On 1/27/15, at 11:09 am RN-A was asked how frequently a resident should be repositioned and stated, "I would need to check the care plan." When asked how frequently a resident with a wound like R34's should be repositioned RN-A stated, "at least every two hours." During interview on 1/27/16, at 2:31 p.m. the director of nurses stated, "I did not know about the slit on R34's coccyx or the wound on R34's right ischial tuberosity. [NA-A] told me about the slit on R34's right groin this morning. No one told me about the other wounds or that there was not	F 314		

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F 314	Continued From page 43 a treatment for R34. My expectation is that the aides would tell the nurse right away when they find an open area. The nurse needs to chart on it and tell the wound nurse about it [RN-A]. The nurses need to put the appropriate interventions for the open area in place and document. The nurse needs to update the care plan. The nurse needs to get a treatment immediately from the doctor. The nurse would follow up weekly and as needed until resolved. I would expect a comprehensive skin assessment to be completed. There should be a tissue tolerance. There should be weekly skin checks for all residents. To determine how often the residents need to be repositioned we look at tissue tolerance and comorbidities. Residents need to be turned at baseline, every two hours minimum. If there is a wound every one hour. If the wound is nasty, the resident should only be up for meals. The individualized turning/repositioning schedule should be on the assignment sheets and care plans." R12 was observed continuously on 1/27/16, from 8:54 a.m. to 11:22 a.m. At 8:54 a.m. R12 was sitting in a Broda chair in the dining room. At 8:59 a.m. NA-G took R12 to his room to put upper dentures in the resident's mouth. NA-G then returned R12 to the dining room. At 9:15 a.m. R12 was taken to the television (TV) room. At 10:37 a.m. R12 remained sitting in the TV room and appeared to have fallen asleep. R12 remained seated in the TV room until 11:22 a.m. when the surveyor left the area. At 12:45 p.m. R12 was again observed sitting in TV room. At 12:57 p.m. LPN-A was interviewed to determine whether R12 had been toileted or repositioned since having gotten up that morning. LPN-A verified R12 had not been laid down or	F 314		

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F 314	Continued From page 44 repositioned yet since having been gotten up that morning. (Four hours and 15 minutes without being repositioned). LPN-A then stated, "[R12] has just eaten lunch and staff were going to lay him down." At 1:10 p.m. NA-G wheeled R12 to the bedroom and at 1:16 p.m. NA-G and NA-H transferred R12 with the EZ stand (a mechanical standing lift) and stood R12 up. NA-H pulled R12's pants down and said, "he is dry in back and dry in front." R12's skin was observed to be intact, his coccyx area was red but blanchable. It was noted R12 had been incontinent of stool. NA-G and NA-H washed R12's bottom and applied a new incontinence brief. During continuous observation on 1/28/16, from 7:30 a.m. to 10:46 a.m. R12 went for three hours and 16 minutes without being repositioned: At 7:30 a.m. R12 was observed in his Broda chair in the hallway. At 7:45 a.m. R12 was seated in the dining room in the Broda chair. At 9:15 a.m. R12 was taken to the TV room. During interview on 1/28/16, at 10:21 a.m. NA-A said I got (R12) up at 7:30 a.m. [R12]'s skin is intact. NA-A stated, "[R12] has not been repositioned today. We are so short we cannot get people up or toileted or repositioned." At 10:30 a.m. R12 remained in TV room seated in the Broada chair. At 10:46 a.m. R12 was taken to the bathroom where he was stood using a standing lift. NA-C and NA-F pulled R12's pants down and removed his incontinence brief which was observed to be wet. R12's right gluteal fold was observed to be red. LPN-A, also present during the observation, stated R12 had not been repositioned since he'd been gotten up that morning. LPN-A checked R12's skin and stated it was blanchable.	F 314		

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F 314	Continued From page 45 R12's MDS dated 11/3/15, indicated R12 was severely cognitively impaired, required assistance with all activities of daily living, was incontinent of bowel and bladder and at risk for development of pressure ulcers. The Pressure Ulcer CAA dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, frequent urinary and bowel incontinence, and identified risk for pressure ulcer development. R12's care plan printed 1/28/16, instructed staff that R12 continued to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility psychotropic drug use and diuretic use. Interventions included for staff to follow repositioning schedule per nursing, provide moisture barrier and perform peri-care during each check and change and as needed, wound care as ordered, check and change before breakfast after lunch and on rounds through night and as needed. The NA Assignment Sheet instructed staff check and change before breakfast after lunch before bed and on rounds through night as needed. Reposition during check and changes. The Physician Orders signed by doctor on 1/6/16, instructed staff to reposition R12 in wheelchair every two hours and house barrier cream to skin over right buttock twice a day. The Treatment Administration Record for January 2016, indicated for R12 "REPOSITION IN WHEELCHAIR EVERY 2 HOURS (Started 10/13/14)."	F 314		

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F 314	Continued From page 46 During interview on 1/27/16, at 2:31 p.m. the DON stated, ...". The nurse needs to chart on it and tell the wound nurse about it [RN-A]. The nurses need to put the appropriate interventions for the open area in place and document. The nurse needs to update the care plan. The nurse needs to get a treatment immediately from the doctor. The nurse would follow up weekly and as needed until resolved. I would expect a comprehensive skin assessment to be completed. There should be a tissue tolerance. There should be weekly skin checks for all residents. To determine how often the residents need to be repositioned we look at tissue tolerance and comorbidities. Residents need to be turned at baseline, every two hours minimum. If there is a wound every 1 hour. If the wound is nasty, the resident should only be up for meals. The individualized turning/repositioning schedule should be on the assignment sheets and care plans." The facility's Repositioning of resident's policy dated July 2012, included: "3. Residents will be repositioned every 2 hours unless otherwise documented on care plan and NA (nursing assistant) assignment sheets." The facility's Skin Care Protocol revised 6/28/05 indicated: "...a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrated that they were unavoidable" and "a resident having pressure sores receives necessary treatment and services, as the facility is able to provide, to promote healing, prevent infection, and prevent new sores from developing."	F 314		

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F 315 F 315 SS=D	Continued From page 47 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate indwelling Foley catheter care to 1 of 2 residents (R15) in the sample reviewed with indwelling Foley catheter. Findings include: R15 was observed on 1/27/16, at 8:23 a.m. laying in the bed. During interview R15 stated she felt staff did not always clean her properly in the morning, and she received cares only when she requested them, which included a partial bath in the morning and peri care. R15 had an indwelling Foley catheter, with a 2000 milliliter (ml) bag attached to it. R15 stated she used to have urinary tract infections (UTI) in the past, and did not know when staff supposed to care for her catheter. R15 also stated she preferred to use the bedpan when she had bowel movements, but staff have not always had bed pan available to use. On 1/27/16, at 1:35 p.m. R15 was	F 315 F 315	F315 (D) R15 has been discharged to home from facility since survey. All residents requiring assistance with elimination and grooming including those residents with indwelling foley catheters are at risk due to lack of adequate care planning and interventions. Staff were educated on the standard of delivery of peri-care to a resident with an indwelling foley catheter and on the standard of providing assistance with elimination and grooming (peri-care) based on resident's identified needs. DON/Designee will audit 5 residents weekly who have an indwelling catheter or require assistance with per-cares for proper delivery of assistance with elimination and grooming according to residents' care plan. Findings will be reported	

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F 315	Continued From page 48 interviewed again, stated she have not received grooming cares, pericare or catheter care yet today, no staff checked in with her yet today related to her grooming needs. R15 also stated she had the catheter for a long time, and saw the urologist when in trouble with kidney failure. The Admission Nursing assessment dated 12/1/15, indicated catheter use, and history of UTI's. The temporary care plan dated 12/1/15, noted toileting assist of one or two staff. The care plan did not indicate presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter. The Admission Nursing assessment (first re-admission) dated 12/9/15, also indicated use of Foley catheter, with no additional information. The Admission Nursing Assessment dated 12/23/15 (second re-admission), indicated history of UTI's, however the form was left incomplete, did not indicate presence of the Foley catheter, urinary tract related medical conditions or interventions. The Temporary care plan dated 12/23/15, indicated toileting assist of two staff, and pad use. The care plan did not include presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter. R15's admission Minimum Data Set (MDS) dated 12/30/15, indicated R15 had indwelling catheter, was frequently incontinent of bowel, and was dependent of two staff's assistance with bed mobility, transfers and toilet use. The MDS also depicted R15 as being cognitively intact and able to have clear comprehension of others and able to clearly state needs.	F 315	monthly to QAPI committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be made by March 8, 2016.	

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F 315	Continued From page 49 The Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 1/4/16, indicated the facility would proceed to care plan for Foley catheter care and monitoring of adverse outcomes associated with the Foley catheter use. The comprehensive care plan 12/23/15, for bowel and bladder needs, activities of daily living needs and catheter use was not developed nor was there any interventions identified to assist R15 with cares. The nursing assistant (NA) care sheet (undated) indicated assist of two with grooming, dressing, toileting, and transfer with Hoyer to commode. However, the sheet did not indicate presence of indwelling Foley catheter, or related cares. The Physician's Progress Notes dated 1/14/16, indicated R15 had chronic kidney disease and chronic indwelling Foley catheter for the past six years due to immobility, and had history of UTI's. The note also indicated R15 had complaints recently of bladder spasm, started on oxybutynin, had urine analysis with mixed flora (more than one organism isolated from urine culture), and ordered a three day course of Levaquin (antibiotic). Additional diagnoses included diabetes, osteoarthritis, and depression. On 1/27/16, the NA who was assigned to take care of R15 nor registered nurse (RN)-A (also nurse manager) were not available for interview. On 1/27/16, at 2:09 p.m. the licensed practical nurse (LPN)-B was interviewed and stated the nursing assistants were expected to complete twice daily pericare, "wipe the catheter every	F 315		

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F 315	Continued From page 50 morning", get resident cleaned up in the morning, and nurses were responsible to make sure "everything is done" (meaning cares). LPN-B stated she was not told R15 did not receive cares that morning. On 1/27/16, at 3:22 p.m. the director of nursing (DON) stated she would expect staff to complete morning cares, such as partial baths, and if a resident had Foley catheter to complete catheter care along with the pericare. The DON was not aware R15 did not receive those cares that morning. On 1/28/16, at 10:11 a.m. the DON also stated by day 21 of admission she would expect to see a comprehensive care plan written by the MDS nurse. The DON reviewed R15's record and stated she would expect R15 to have care plan developed for activities of daily living care needs (include grooming, toileting) and Foley catheter care. The facility's undated Resident Care Planning policy indicated "The care plan is initiated within 24 hours from the time of admission and fully developed within 21 days following the resident's arrival to the facility. All disciplines are responsible for adding their portion to the 24 hour care plan and the permanent care plan."	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 (D) Assist bar on bed of R12 was examined and repaired by maintenance on 1/27/16. All assist bars/side rails were checked by maintenance on 1/28/16. Maintenance	

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F 323	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure assist bar for positioning and transfers was properly secured to resident bed to assure safe use for 1 of 1 resident (R12) who utilized assist bars. Findings include: During initial tour on 1/25/16, at 4:09 p.m. the right assist rail which was attached to the bed, nearest the door, was noted to bow outward. R12 was in the day room sitting in a wheelchair. On 1/27/16, at 7:07 a.m. R12 was observed lying in bed with head turned to the left. The right assist rail was bowing outward. R12's Minimum Data Set dated 11/3/15, identified diagnosis of right sided hemiplegia, stroke and dementia. R12's Fall Care Area Assessment dated 11/3/15, indicated R12 had balance problems during transfers between bed and wheelchair. The care plan printed 1/28/16, indicated R12 was at risk for fall related to hemiplegia, dementia, impaired mobility and urinary and fecal incontinence. Interventions included call light within reach, perimeter mattress on bed to reduce the potential of falls, extensive to total assistance with transfers and bed mobility to decrease the potential for falls, and resident uses enabler bars	F 323	maintains a weekly record of checks of all assist bars and side rails in facility. All residents using assist bars or side rails are at risk for injury due to improperly maintained equipment. Maintenance was educated on performing and documenting weekly checks of assist bars and side rails, and to perform any necessary repairs immediately. Maintenance will audit the security of assist bars and side rails weekly x 12 weeks with findings reported monthly to the QAPI committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be completed by March 8, 2016.	

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	245544	A. BUILDING _____ B. WING _____	01/28/2016

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F 323	Continued From page 52 when in bed. On 1/27/16, at 9:22 a.m. the regional manager verified the enabler bar was loose. The regional manager stated the assist bar should be taken off, ensure the holes have not been rounded off, tightened and then replaced. The regional manager stated the maintenance technicians are to audit all assist rails every week. They are to check every bar in the building. Work history report indicated that Facility Safety: Check assist rails was done on 1/25/16, 1/22/16, not recorded for the week of 1/9/16 and was last done on 12/31/15. On 1/27/16, at 12:57 p.m. licensed practical nurse-A stated [R12] will grab the bar and help to roll from side to side.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 334	F334 (D) Facility immunization policy was reviewed. R63 was offered and declined both the influenza and pneumococcal vaccines as well declined the Vaccine Information Sheet (VIS). Review of records for R 46 and R9 and interview of administering RN indicate that R46 and R9 received the flu vaccine in 2015 and the pneumococcal vaccine previously. All resident records were reviewed for immunization status and those	

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F 334	Continued From page 53 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5	F 334	residents who did not have an annual flu shot or did not have a previous pneumococcal vaccination were offered the influenza and pneumococcal vaccines. Residents that refuse immunizations are given VIS education sheets provided by the CDC and re-offered the vaccinations. All residents are at a greater risk for contracting communicable infections of influenza and pneumonia due to lack of immunizations Education of Infection Control Nurse and nursing staff done regarding the policy of identifying immunization status upon admission to facility, offering influenza and pneumococcal vaccinations as indicated and providing education using the Vaccine Information Sheet (VIS) upon request or refusal and vaccinations and to re-offer	

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F 334	Continued From page 54 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R63, R9, R46) were offered and/or received both influenza and pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: R63 was admitted to the facility on 11/12/15, according to the admission face sheet. After review of R63's records, there was no indication R63 had been offered, refused, received and/or had contraindications for receipt of the influenza or pneumococcal vaccinations. R9 was admitted to the facility on 11/5/15, according to the admission face sheet. After review of R9's records, there was no indication R47 had been offered and/or received an influenza vaccination during the 2015/16 influenza season. R46 was admitted to the facility on 8/24/15, according to the admission face sheet. After review of R46's records, there was no indication R46 had been offered, refused, received and/or had contraindications for receipt of the influenza or pneumococcal vaccinations.	F 334	vaccinations following resident education. DNS/Designee will audit all newly admitted residents' immunization records for consents and completion of flu and pneumococcal immunizations per resident consent including the use of Vaccine Information Sheets (VIS) upon refusals of vaccine(s). Findings will be reported monthly to the QAPI committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be completed by March 8, 2016.	

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F 334	Continued From page 55 On 1/28/16, at 10:23 a.m. consultant registered nurse (CN)-A and CN-B verified R63, R9 and R46 were missing immunization documentation. Both stated they would continue to look however had not found any documentation of the residents' immunizations. An undated facility policy, Influenza Vaccination of Residents directed, "It is the policy of this facility that annually, in the fall, residents will be offered immunizations against influenza. The time for immunization will follow the recommendations of the CDC (centers for disease control) and the state department of health." An undated facility policy, Pneumococcal Vaccination of Residents directed, "It is the policy of this facility that each resident or their responsible party will be asked on admission if they have previously had the pneumococcal vaccination and their age at the time of vaccination. The records that accompany the resident also will be used to determine immunization status. If there is no prior evidence of vaccination, the vaccine will be offered to the resident at that time." On 1/28/16, at 2:42 p.m. the director of nursing (DON) stated all residents were supposed to have an immunization sheet in their individual charts with documentation of Pneumovax and influenza vaccine history. The DON further stated residents who did not have proof pnuemovax were supposed to be asked on admission and if resident had not received the immunization then resident was supposed to be offered vaccination or be provided a consent to sign before receiving it or if they refused would be	F 334		

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F 334	Continued From page 56 made to sign a statement that risks and benefits had been reviewed.	F 334		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficent staffing was provided to meet the individual needs of 5 of 6 residents (R34, R10, R15, R12, R21) who required assistance with repositioning, skin care, pressure ulcer, catheter care. This had the potential to affect all 52 residents who resided in the facility.	F 353	F353 (F) Staffing numbers are reviewed daily for adequate staffing levels. PRN staff as well as scheduled staff are utilized to fill absences. Readjustments to staff assignments are made in accordance with resident needs. All residents are at risk due to deficient staff numbers. Staff were educated on policy and procedure for sufficient staffing. Staffing numbers are reviewed daily for adequacy and appropriateness of assignment. Corporate HR representative met with CNA staff on 2/25/16 and 2/26/16 and conducted an open staff forum to address staffing concerns; findings were reported to facility	

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F 353	Continued From page 57 Findings include: Refer to F309: The facility failed to provide appropriate care and services including assessment, care plan development and implementation of interventions, for 1 of 2 residents (R34) who had non pressure related skin issues. Refer to F314: The facility failed to comprehensively reassess and provide care and services to promote healing for a facility acquired pressure ulcer for 1 of 3 residents (R10) reviewed with pressure ulcers. Refer F315: The facility failed to provide appropriate indwelling Foley catheter care to 1 of 2 residents (R15) in the sample reviewed with indwelling Foley catheter. Resident Observation: R12 was observed continuously on 1/27/16, from 8:54 a.m. to 11:22 a.m. - At 8:54 a.m. R12 was sitting in a Broda chair in the dining room, - At 8:59 a.m. nursing assistant (NA)-G took R12 to room and put upper dentures in R12's mouth without adhesive. NA-G returned R12 to the dining room, - At 9:15 a.m. R12 sitting in the television (TV) room, - At 10:37 a.m. R12 remained sitting in the TV room asleep, - At 10:53 a.m. R12 sitting in the TV room awake and, - At 11:22 a.m. R12 still sitting in TV room sleeping. The observation was resumed on 1/27/16, at	F 353	administration. A family council meeting continues to be held annually. Findings will be reported monthly to QAPI committee with follow-up to committee recommendations. Corrections to deficient practice will be made by March 8, 2016.	

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F 353	Continued From page 58 12:45 p.m. R12 sitting in TV room sleeping - At 12:57 p.m. asked licensed practical nurse (LPN)-A if R12 had been toileted and repositioned. Since R12 got up that morning. LPN-A verified R12 had not been laid down or repositioned yet since R12 got up that morning. LPN-A stated, "[R12] had just eaten lunch staff were going to lay [R12] down." R12 went for four hours and 15 minutes without being repositioned. - At 1:10 p.m. NA-G wheeled R12 to bedroom and, - At 1:16 p.m. NA-G and NA-H placed R12 in EZ stand (a mechanical standing lift) and stood R12 up. NA-H pulled R12's pants down and said "he is dry in back and he is dry in front." Requested NA-H remove R12's incontinence brief. R12's skin intact was intact, coccyx was red but blanchable. R12 had been incontinent of stool. NA-G and NA-H washed R12's bottom and applied a new incontinence brief. During continuous observation on 1/28/16, from 7:30 a.m. to 10:46 a.m. R12 went for three hours and 16 minutes without being repositioned. - At 7:15 a.m. R12 was lying in bed, - At 7:30 a.m. up in Broda chair in the hallway, - At 7:45 a.m. R12 in dining room, - At 8:52 a.m. NA-A assisting R12 to eat breakfast, - At 9:15 a.m. R12 sitting in TV room, - At 10:30 a.m. R12 remained in TV room, - At 10:40 a.m. R12 taken to shower room by NA-A to be repositioned and checked and, - At 10:46 a.m. R12 stood up in standing lift. NA-C and NA-F pulled pants down and removed incontinence brief. Incontinence brief was wet. R12's right gluteal fold was red. LPN-A verified R12 had not been repositioned since R12 got up. LPN-A checked R12's skin and indicated it was	F 353		

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F 353	Continued From page 59 blanchable. R12's Minimum Data Set (MDS) dated 11/3/15, indicated R12 was severely cognitively impaired, required assistance with all activities of daily living, was incontinent of bowel and bladder and at risk for development of pressure ulcers. The Pressure Ulcer Care Area Assessment dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, frequent urinary and bowel incontinence, and identified risk for pressure ulcer development. Care plan printed 1/28/16, instructed staff R12 continues to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility psychotropic drug use and diuretic use. Interventions instructed staff follow repositioning schedule per nursing, provide moisture barrier and perform peri-care during each check and change and as needed, wound care as ordered, check and change before breakfast after lunch and on rounds through night and as needed. The undated Nursing Assistant Assignment Sheet instructed staff check and change before breakfast after lunch before bed and on rounds through night as needed. Reposition during check and changes. The Physician Orders signed by doctor on 1/6/16, instructed staff to reposition R12 in wheelchair every two hours and house barrier cream to skin over right buttock twice a day. The Treatment Administration Record dated Jan 16, indicated R12 was to be "REPOSITION IN	F 353		

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F 353	Continued From page 60 WHEELCHAIR EVERY 2 HOURS (Started 10/13/14)." The box for the AM shift was left blank on 1/27/16, and signed 1/28/16. Copy of R12's tissue tolerance requested but not received. During interview on 1/27/16, at 12:57 p.m. LPN-A stated, "[R12] has not been laid down or repositioned yet since he got up this morning." During interview on 1/28/16, at 10:21 a.m. NA-A said, "I got [R12] up at 7:30 a.m. [R12]'s skin is intact." NA-A further stated, "[R12] has not been repositioned today. We are so short we cannot get people up or toileted or repositioned." Resident Interview: R21's admission MDS dated 11/13/15, indicated cognition was intact and R21 required extensive physical assistance of two staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R21 used a wheelchair for mobility. On 1/25/16, at 4:48 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, either Friday or Saturday of the previous week, when she had the light on at around 10:00 p.m., someone had come into the room turned the light off at 10:25 p.m. and had told her the night shift would take care of it. The night staff did not come back until about 11:30 p.m. Resident indicated she had reported the concern to the director of nursing.	F 353		

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F 353	Continued From page 61 R13's admission MDS dated 11/9/15, indicated cognition was severely impaired and required extensive physical assistance of one to two staff with bed mobility, dressing, toileting and personal hygiene. In addition, the MDS indicated R13 used a wheelchair for mobility. On 1/25/16, at 6:31 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "You wait for when they are ready for things." R18's quarterly MDS dated 10/22/15, indicated resident had intact cognition and required extensive physical assistance of two staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R49 used a wheelchair for mobility. On 1/26/16, at 9:11 a.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, the facility was understaffed and at time would hear other resident hollering for help as their call lights were not being answered. R46's quarterly MDS dated 11/26/15, indicated cognition was intact and required extensive physical assistance of two staff with bed mobility, dressing, toileting and personal hygiene. In addition, the MDS indicated R46 used both a wheelchair and walker for mobility. On 1/26/16, at 9:40 a.m. during interview when	F 353		

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F 353	Continued From page 62 asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "sometimes have to wait. I have wet myself because I had to wait. Weekends are the worse." R34's quarterly MDS dated 10/30/15, indicated R34 had moderately impaired cognition, required total dependence to extensive physical assistance of one to two staff with activities of daily living. In addition, the MDS indicated R34 used a wheelchair for mobility. On 1/26/16, at 2:50 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "I wait for 1 hour to get out of bed." R15's scheduled 14 day MDS dated 1/6/16, indicated cognition was intact and resident required extensive physical assistance of two staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R15 used a wheelchair for mobility and had a functional limitation in range of motion on both the upper and lower extremities. On 1/26/16, at 4:49 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated one of the NA's would leave the tray in the room. When NA had been asked to remove the tray would state, "I don't have time. I need to help other people." Resident also stated some of the	F 353		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 353	Continued From page 63 aides at the facility were quite mean and thought a couple had been fired. Family interview R12's annual MDS dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a wheelchair for mobility. On 1/26/16, at 11:20 a.m. during interview with a family member, when asked if they felt there was enough staff available to make sure resident get the care and assistance he needed without having to wait a long time family member stated "I never see staff at shift change. I am here every afternoon. They need to re-think the way they do it. They have good aides. They have started switching aides every month. This causes him to swing at them when they approach him wrong he likes to know what is going to happen." Staff interviews On 1/27/16, at 7:19 am registered nurse (RN)-B, was working the North medication cart, and stated, "Hopefully not for long, I have to fill in once in a while, but, it takes me a long time because I have to read everything, and I wasn't planning on this today." -At 10:30 a.m. LPN-C, verified she had been called in to cover short staff. On 1/28/16, at 8:29 a.m. LPN-D stated "Usually we are not short staff here but today we are short staff." - At 8:33 a.m. the staffing coordinator (SC) was observed passing medications. When	F 353		

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F 353	Continued From page 64 approached and asked SC who also was a trained medication aide (TMA) stated "today we are short of one nurse and I am passing medications and the nurses are doing the treatments." When asked if staffing was a problem SC stated "Usually on PM's we have a problem with nurse shifts but we are able to cover them as the other nurses would either work doubles or pick up as we are giving bonuses so it's always covered." - At 8:50 a.m. LPN-A stated he had worked both hallways yesterday and it was big mess, because they were short. -At 9:00 p.m. NA-C, stated there was no aide assigned to the West hallway today, she was just floating around and helping everyone who needs help, because those two aides called in sick. - At 10:21 a.m. NA-A stated, "[R34] has not been repositioned today. We are so short, we cannot get people up or toileted or repositioned. I told you yesterday it was not too bad here. It is bad." - At 10:36 a.m. NA-F stated, "It is so hard working with just four people we cannot get everything done. We cannot reposition people or toilet them as we should. An entire hallway called in. I am tired of every one calling in. I work hard and try to do what I can but it makes the residents life miserable when we are short." - At 10:40 a.m. NA-C stated, "We are so short. We are down three people. We normally have six to seven aides. I am making beds on the other hallways and we are trying to make sure everyone is turned and toileted. It is not working. We are late on just about everyone." - At 1:00 p.m. NA-A stated, "I'm just taking a break As you know when you guys are here, it's crazy, it'd be different if you did it this way 365." - At 2:30 p.m. NA-C stated the facility was always short staffed and it was even hard to make sure	F 353		

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F 353	Continued From page 65 all resident cares, toileting and answering call lights was done. NA-C stated at times it is even hard to get all the call lights answered because it was heavy and a lot of resident's had a lot of needs yet there was not enough staff in the facility to meet resident needs. NA- further stated even taking break was a problem and had not even taken a break for the shift and that was not good. - At 2:30 p.m. other-D, stated the facility no longer had restorative here, because they do not have enough staff, but stated they were talking about bringing it back. - At 3:06 a.m. NA-D stated she did not work a lot at the facility but at times when someone called in the staffing would try to replace the staff and at times, would just end up splitting the group. When asked if resident care needs were able to be completed NA-D stated "sometimes we do the best we can." - At 3:10 p.m. NA-E stated since the new administrator and director of nursing (DON) came to the facility, they had come with staff from the other facility and that staff were always reporting the aides and staff who had been at the facility to management and staff had decided to quit because of the issues and that was why the facility had staffing issues. NA-E stated most of the time the facility was under staffed and management did not care about the resident care needs like for example some resident's required extensive assistance and needed two to three staff for cares yet was cutting the hours. NA-E gave an example of when an activity was still going on and staff were asked to leave at around 9:00 p.m. and at that time there were many residents still up waiting to go to bed and two staff were asked to leave for the night yet one staff in the wing was not able to met the resident needs.	F 353		

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F 353	Continued From page 66 When asked if staff was able to meet resident needs timely, NA-E stated not all the time and residents had to wait for a while for staff to come provide cares and at times residents were not toileted or repositioned on a timely manner as directed by the plan of care. During conversation NA-E appeared upset and stated resident care was more important than the money yet management did not see it the same way. - At 3:22 p.m. an outside agency hospice RN stated, "There has been so much turn over and it is hard to know who to go to with concerns and to ensure continuity of care." Document review: The following was noted during a review of the actual staffing and staff postings. On 1/25/16, day shift, group 1 was a "split group." On 1/26/16, evening shift, group 1 was a "split group" as there was one NA call in, On 1/27/16, day shift, RN/MDS nurse and health unit coordinator (HUC)/LPN pulled to medication cart due to nurse call in, Evening shift - two NAs called in so the evening shift split group 1. On 1/28/16, day HUC/LPN call in, Receptionist/TMA pulled to medication cart on West, LPN on West pulled to medication cart North/East, split group 1, and two NAs called in from West hallway (not replaced), working three NAs short "everyone sharing everyone in building." The facility failed to provide the requested actual staffing sheets for 11/11 through 11/15/15 requested on 1/29/16, at 3:02 p.m. On 11/10/15, indicated 8 RN hours (not recorded in RN manager or LPN manager hours) that are not reflected in the actual daily staffing sheet. On Sunday 11/15/15, there was no RN coverage listed on the 24 hours actual staffing sheet.	F 353		

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F 353	Continued From page 67 On 11/125/15, no RN coverage. On Saturday 11/28/15, no RN coverage. On Sunday 11/29/15, no RN coverage. On Sunday 12/27/15, no RN coverage and LPN double shift, On Sunday 1/17/16, planned split group 1 on both a.m. and p.m. shifts. On Sunday 1/24/16, MDS RN planned as South hallway nurse. The staffing pattern could not be reviewed as the staffing sheets for 11/16 through 11/24/15, were missing as well as the staff postings. In addition, the staffing schedule and postings were missing for 11/25 through 11/28/15. On 1/28/16, at 2:57 p.m. the staffing coordinator, human resources person and the DON were interviewed for staffing. The staffing coordinator explained the usual staffing: South - Day shift: one nurse and three NAs, South/East Evening shift: one nurse and three NAs, West - Day shift: one nurse and two NAs, North/West Evening shift: one nurse and two to three NAs (+ pick up residents on EAST), North/East - Days: one nurse and two NAs, Evenings: one TMA and two NAs and, Night shift: one to two nurses and two to three NAs for the building. Further explanation of a split group, indicated when there was not enough staff to fill the staffing plan, so staff assigned to other groups would split group 1 (residents in addition to their assignment). On 1/28/16, at 1:20 p.m. the HR director was interviewed and indicated the facility had a turnover rate of 4% last month and that they are actively advertising.	F 353		

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F 353	Continued From page 68 On 1/28/16, at 2:30 p.m. a staffing interview with the director of nursing, revealed they currently are hiring, as a lot of nurses have called and asked if the facility was hiring but they did not show for the interview process. Per the DON the facility currently pays less than other facilities.	F 353		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a registered nurse (RN) eight consecutive hours per day, seven days a week, and did not have an RN waiver. Findings include: On 1/28/16, at 2:30 p.m. a staffing interview with the director of nursing, staffing coordinator and human resources person revealed the scheduler and human resources coordinator were not aware	F 354	F354 (F) RN coverage 8 hours daily 7 days a week is provided All residents are at risk due to lack of professional nurse coverage. RN managerial staff and staffing coordinators were educated on the regulation requiring RN coverage at least 8 hours daily 7 days per week Staffing schedules are reviewed daily to ensure adequate RN coverage is maintained within facility. Findings will be reported monthly to QAPI committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be completed by March 8, 2016.	

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F 354	Continued From page 69 that RN coverage was required at least eight hours a day. The facility did not have a staffing waiver. Review of the actual staffing and the staff postings revealed: -Staff posting dated Saturday 11/10/15, indicated eight RN hours (not recorded in RN manager or LPN manager hours) that are not reflected in the actual daily staffing sheet, - On Sunday 11/15/15, there was no RN coverage listed on the 24 hours actual staffing sheet, - On Saturday 11/28/15, no RN coverage, - On Sunday 11/29/15, no RN coverage and, - On Sunday 12/27/15, no RN coverage. All three facility staff verified no RN coverage was provided on those days.	F 354		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356	F356 (C) Facility maintains records of daily posted staffing All residents, families and visitors have the potential to be affected by missing posted staffing data. Schedulers were educated on the requirement for daily staffing posting within facility and the retention of schedules for a minimum of 18 months.	

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F 356	Continued From page 70 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to retain records of staffing for the 18 month period required. This had the potential to affect all of the 52 residents, families and visitors to the facility. Findings include: On 1/28/16, at 2:30 p.m. a staff interview with the director of nursing, staffing coordinator and human resources person was completed. A review of the actual staffing and the staff postings revealed: Staff posting sheets were missing from 11/16/15 through 11/24/15. In addition, the staff postings were missing for 11/25 through 11/28/15. The above three facility staff verified the staff posting sheets were missing on those days and the facility did not maintain the full 18 months.	F 356	Staffing data will be reviewed daily for posting and records maintained for 18 months. Findings will be reported monthly to QAPI committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be completed by March 8, 2016.	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=E	Continued From page 71 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	F431 (E) Temperature storage guidelines for medications housed in medication room refrigerator were verified with suppliers and pharmacists on 1/27/16. Medications stored in refrigerator on 1/27/16 were relabeled for expiration dates or removed from refrigerator according to manufacturers' guidelines and destroyed. Refrigerator located in medication room was replaced on 1/27/16 and new refrigerator temp is monitored to maintain the acceptable temperature range between 36 and 46 degrees F. R62's self-administered insulin without an 'opened/expiration' date was removed and destroyed and insulin was replaced in resident's room with an expiration date label affixed. R62 was educated on need to keep all medications in room securely locked when not in use.	

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F 431	Continued From page 72 review, the facility failed to ensure the medication refrigerator temperature was kept within manufacturer's recommendation range, and the facility failed to ensure the refrigerator temperature was monitored. This had the potential to affect 12 of 52 residents (R39, R45, R15, R62, R14, R34, R70, R36, R10, R21, R69, R53) currently resided in the facility. In addition R62's medications kept in the room were not locked and secured, and insulin vial was not dated when opened. Findings include: During medication room observation in the presence of the licensed practical nurse (LPN)-D on 1/28/16, at 9:08 a.m. the medication refrigerator was at 55 degrees Fahrenheit (F). LPN-D stated resident's extra medication supply such as insulin was stored in this refrigerator, and temperature was too high. The temperature log above the refrigerator was from July 2015 (from 6 months ago) and had only four temperature results recorded. When asked for the current temperature log, LPN-D stated she could not find any for the past 6 months. The following unopened medications were observed stored in the refrigerator: - Afluria 5 milliliter (ml) (influenza virus vaccine) - Nine vials of Infuvite (multiple vitamins for intravenous infusion) for R39 - One Novolog insulin pen (used to treat diabetes) for R45, - Two Novolog insulin vials for R15, - Three Novolog insulin pens for R62, - One vial of Lantus insulin (also used to treat diabetes) for R34, - One Lantus insulin vial for R70, - One Lantus insulin vial for R36,	F 431	All residents receiving medications requiring refrigeration are at risk due to inadequate daily monitoring of medication refrigerator temperature. All residents are at risk if medications are not labeled with opened/expiration dates as well as unsecure medications stored within facility. Nursing staff were educated on the need for the maintenance of 36 - 46 degrees F temperature range for refrigerator containing medications, the labeling of medications with 'opened/expiration' dates and the need for locking all medications in facility including those in resident rooms being self-administered by resident. A revised medication refrigerator temp log was implemented immediately and is monitored daily for	

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F 431	Continued From page 73 - Two Lantus insulin pens for R10, - Three Lantus insulin pens for R21, - One Humalog insulin (also used to treat diabetes) pen for R69, - One bottle of Latanoprost 0.005 percent (%) (eye drops) for R53, - One vial of Lorazepam injection (with no resident name on) LPN-Z was not sure if the thermometer was accurate or not, suggested to recheck temperature with another thermometer. On 1/28/16, at 9:12 a.m. the director of nursing (DON) verified the refrigerator temperature should have been between 36 and 46 degree F, and stated night staff were responsible for checking the refrigerator temperature daily at night. The DON also verified the last temperature checks were done 6 months ago in July 2015. On 1/28/16, at 10:55 a.m. the medication refrigerator temperature was checked again by LPN-A, and it was at 48 degrees (still too high). On 1/28/16, the nurse consultant (NC)-C was interviewed and stated the refrigerator temperature should have been kept between 36 and 46 degrees F, and the refrigerator temperature monitored daily. The undated manufacturer's recommendation for unopened Latanoprost eye drops, Lantus, Novolog, Infuvite, Humalog, and Lorazepam storage was to be stored at 36 F- 46 F. The pharmacy consultant (PC) was interview via phone call on 1/28/16, at 3:10 p.m., and stated the medication refrigerator temperature should have been kept between 36 and 46 degrees F,	F 431	completion and the appropriateness of temperatures. DNS/Designee will monitor resident rooms weekly x 12 weeks where self-administered medications are stored for inclusion of labeling of 'open/expiration' dates on medications, removal and replacement of expired medications and to monitor that medications are securely locked when not in use by resident. Findings will be reported monthly to QAPI committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be completed by March 8, 2016.	

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F 431	Continued From page 74 and the above listed medications also should have been kept between these temperature ranges. PC also stated refrigerator monitoring should include daily temperature checks. PC further stated he had many conversations in the past with staff about refrigerator temperature monitoring, but was not aware the refrigerator temperature was running so high. The undated Medication Storage in the Facility policy indicated "Medications requiring "refrigeration" are kept at temperatures ranging from 2/36 degrees C/F [Celsius/Fahrenheit] to 8/46 degrees C/F in a refrigerator not accessible to patients". The facility's Monitoring of Refrigerator Temperatures dated 4/12, indicated "Night Charge Nurse will check refrigerator temp [sic-temperature] and record on monitoring sheet on the front of the fridge". The policy did not clearly indicate frequency of temperature checks. R62 On 1/25/16, at 1:47 p.m. R62 was observed and interviewed in his room. There was plastic container with blood sugar check supplies and insulin observed on the top of the nightstand. When interviewed R62 stated he did his own blood sugar checks, and self-administered the insulin, and showed the content of the box. There was a Novolog pen dated opened on 1/17/16, another Novolog pen dated opened on 1/24/16, and an opened Lantus vial not dated when it was opened (with pharmacy delivery dated 1/11/16). R62 also showed two medication carts with Metformin 1000 mg, each with 30 tablets. R62 stated he kept his medication supply usually on	F 431		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 431	Continued From page 75 the bedside table, did not lock them in the drawer if he went to the dining room, only if he left the facility and went out. On 1/28/16, at 8:23 a.m. R62 was observed eating breakfast in the dining room. At this time the plastic container with the insulin was observed again unattended/ unlocked in R62's room on the bedside table. On 1/28/16, at 8:24 a.m. the DON verified the medication box with insulin supply was on the bedside table, and stated medications in residents rooms supposed to be kept locked in the top drawer of the dresser. DON also stated the Lantus insulin should have been dated with the date when opened. On 01/28/16, at 9:08 a.m. LPN-D also stated R62's medications should have been locked in his room in the top drawer of the dresser. The undated Medication Storage in the Facility policy did not include instructions for medication storage requirements in resident's rooms.	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a chair was	F 465	F465 (D) Wheelchair and room chair for R 27 was cleaned. Wheelchairs for R12 and R41 were examined, cleaned and repaired. R 21's personal electric wheelchair has been scheduled for repair. All chairs in resident rooms and wheelchairs were checked for cleanliness; a wheelchair	

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	246544	A. BUILDING _____ B. WING _____	01/28/2016

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F 465	Continued From page 76 maintained in a clean and sanitary manner for 1 of 1 resident (R27). In addition failed to ensure 3 of 3 residents (R12, R41, R21) had their wheelchairs maintained in good repair reviewed for environmental concerns. Findings include: R27 lazy boy recliner chair was observed on 1/26/16, at 8:57 a.m. during room observation with spots on the arm and sitting part perhaps secretions from trach and suctioning. On 1/28/16, at 12:04 p.m. to 12:32 p.m. during the environmental tour with the regional manager (RM) verified the lazy boy which was covered with spots of perhaps secretions stated would have to bring a spot cleaner and use disinfectant to clean the chair when resident was not up on it. During the tour resident was observed seated on the chair and was able to acknowledge all the spots and stated he would not blame anyone for it and gave surveyor thumbs up when surveyor indicated RM was going to clean it. R12's Broda wheelchair right armrest on 1/25/16, at 11:46 a.m. during room observation was observed broken and was missing front edge of foam. On 1/28/16, at 12:04 p.m. to 12:32 p.m. during the environmental tour R12 was observed seated on his Broda wheelchair in the North dining room both the administrator and the regional manager (RM) verified the wheelchair had simmers of what appeared to be dry food on the side. In addition the regional manager verified foam was missing on the right armrest and was exposing gray foam	F 465	cleaning schedule has been established.. All residents with chairs in rooms and who use wheelchairs are at a safety risk due to unclean or equipment in ill repair. Maintenance staff were educated on need to check the cleanliness and status of chairs in rooms and resident wheelchairs. Maintenance/Designee will perform random audits by inspecting 5 wheelchairs and 5 room chairs for cleanliness and need for repair daily x 12 weeks. Findings will be reported monthly to QAPI committee x 3 months with follow-up to committee recommendations. Corrections to deficient practice will be completed by March 8, 2016.	

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F 465	Continued From page 77 underneath making it not a cleanable surface. RM stated thought was due to staff probably shaving the wheelchair under the tables. RM was overheard indicated to the administrator the armrest was going to be replaced. R12's annual Minimum Data Set (MDS) dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a wheelchair for mobility. R41's wheelchair was observed to be in ill repair On 1/28/16, at 12:25 p.m. during the environment tour R41 was seated on the wheelchair at the dining table waiting for lunch and the left armrest was observed cracked and the vinyl was peeled off and was exposing the foam underneath making it an uncleanable surface. RM verified it. R41's annual MDS dated 11/13/15, indicated R41 had severely impaired cognition skills, required total dependence for locomotion on and off the unit and used a wheelchair for locomotion. R21's wheelchair was observed to be in ill repair On 1/26/16, at 12:01 p.m. R21's left armrest of the electric wheelchair was observed with vinyl cracked, peeled off and was exposing the yellow foam underneath making it an uncleanable surface. On 1/28/16, at 12:44 p.m. during the environmental tour the RM stated the electric wheelchair was resident own personal	F 465		

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F 465	Continued From page 78 wheelchair. RM stated staff were supposed to call family member if they noticed any concerns so family would provide replacement parts. RM verified the wheelchair was with ill repair and acknowledged staff should have reported the concern immediately to his department to be addressed to prevent causing skin issues. R21's admission MDS dated 11/13/15, indicated R21 had intact cognition, required extensive physical assistance with transfers, had a functional limitation of both lower extremities and used a wheelchair for locomotion. Environmental- Cleaning of Equipment policy dated April 1, 2008 indicated "All unit equipment (e.g., refrigerator, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and enteral equipment) is cleaned on a routine basis."	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety Fire Marshal Division on January 26, 2016. At the time of this survey, Camden Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	APPROVED Tom Linhoff By Tom Linhoff at 3:03 pm, Mar 15, 2016 RECEIVED MAR - 7 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maryann Hamer LNHA	Executive Director	3-2-16

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 By email to: Marlan.Whitney@state.mn.us, 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. Camden Care Center is a 1-story building with a partial basement. The 1 story building was constructed in 1990 and was determined to be of Type II(222) construction. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 73 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	K 052	**K052F** Testing of the digital alarm communicator tester was done on 2-29-16 by maintenance. Digital alarm communicator tester is tested and logged monthly by maintenance.	

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K 052	Continued From page 2 requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based upon a review of available records and staff interview, testing of the digital alarm communicator transmitter (DACT) had not been conducted during each month of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.6.1.4, and NFPA 70 (1999) and NFPA 72 (1999) and CMS policy. This deficient practice could adversely affect 52 residents. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:30 PM on 01/26/2016, during a review of available records no documentation could be provided verifying the digital alarm communicator transmitter (DACT) was tested during the months of Jan, Apr, Jul, Aug, Oct and Nov in 2015 in accordance with NFPA 70 and 72., 9.6.1.4 This deficient practice was verified by the Maintenance Superintendent.	K 052		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	K062E Corroded sprinkler heads in kitchen will be replaced along with 401 style plate by Tyco by March 8, 2016.	

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K 062	Continued From page 3 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and observation, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 25 residents. Findings include: During the facility tour between the hours of 9:00 AM and 12:30 PM on 1/26/2016, during documentation review it was revealed through the sprinkler company report that the kitchen has 3 corroded sprinkler heads and has a 401 style plate that should be replaced in accordance with NFPA 13(99) and NFPA 25(98). This deficient practice was verified by the Maintenance Superintendent.	K 062		
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower	K 074	**K074** Cubicle curtains in rooms 189, 155 and 148 were replaced on 1-28-16 with curtains meeting ½ inch diagonal mesh requirement to allow for adequate sprinkler coverage.	

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K 074	Continued From page 4 curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has cubicle curtains that does not meet the requirements in accordance with NFPA 25 (98) and NFPA 701 (99). This deficient practice could affect 52 residents by hampering proper sprinkler coverage. Findings include: On facility tour between 9:00 AM and 12:30 PM on 1/26/2016, it was found that the cubicle curtain in patient rooms 189, 155, and 148 did not meet the 1/2 inch diagonal mesh requirement in accordance with NFPA 25 (98) and NFPA 701. This deficient practice was verified by the Maintenance Superintendent.	K 074		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0732
February 16, 2016

Ms. Mary Hamer, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5544026

Dear Ms. Hamer:

The above facility was surveyed on January 25, 2016 through January 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,
"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES

ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	01/28/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 25th to January 28th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000		

Minnesota Department of Health

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Executive Director		3-2-16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide develop a plan of care for 1 of 2 residents (R15) in the sample reviewed with indwelling Foley catheter and oxygen /CPAP use. Findings include: Catheter care: R15 was observed on 1/27/16, at 8:23 a.m. laying in the bed. During interview R15 stated she felt staff did not always clean her properly in the morning, and she received cares only when she requested them, which included a partial bath in	2 555		

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2 555	Continued From page 2	2 555		

the morning and peri care. R15 had an indwelling Foley catheter, with a 2000 milliliter (ml) bag attached to it. R15 stated she used to have urinary tract infections (UTI) in the past, and did not know when staff supposed to care for her catheter. R15 also stated she preferred to use the bedpan when she had bowel movements, but staff have not always had bed pan available to use. On 1/27/16, at 1:35 p.m. R15 was interviewed again, stated she have not received grooming cares, pericare or catheter care yet today, no staff checked in with her yet today related to her grooming needs. R15 also stated she had the catheter for a long time, and saw the urologist when in trouble with kidney failure.

R15's Hospital Discharge Summary dated 12/1/15, noted R15 was hospitalized for UTI and worsening renal function and a diagnoses of pyelonephritis (inflammation of the substance of the kidney as a result of bacterial infection) and chronic kidney disease. The note also reveal R15 has had a Foley catheter in place prior to admission.

The Admission Nursing assessment dated 12/1/15, indicated catheter use, and history of UTI's. The temporary care plan dated 12/1/15, noted toileting assist of one or two staff. The care plan did not indicate presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter.

On 12/2/15, the Physician Order read "Change foley cath [catheter] monthly. Catheter cares q [every] shift."

Review of R15's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 12/1/15 through 12/5/15,

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2 555	Continued From page 3 identified catheter cares and to change the Foley catheter every month, however, the plan of care was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of pyelonephritis and worsening kidney disease. R15 was hospitalized and readmitted on 12/23/15, per the Admission Nursing Assessment. The form indicated history of UTI's, however the form was left incomplete, did not indicate presence of the Foley catheter, urinary tract related medical conditions or interventions. The Temporary care plan dated 12/23/15, indicated toileting assist of two staff, and pad use. Review of R15's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 12/23/15 going forward, lacked the identification of catheter cares and to change the Foley catheter every month. In addition, the plan of care was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of UTIs, pyelonephritis and worsening kidney disease. R15's admission Minimum Data Set (MDS) dated 12/30/15, indicated R15 had indwelling catheter, was frequently incontinent of bowel, and was dependent of two staff's assistance with bed mobility, transfers and toilet use. The MDS also depicted R15 as being cognitively intact and able to have clear comprehension of others and able to clearly state needs. The Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 1/4/16, indicated the facility would proceed to care plan for Foley catheter care and monitoring of adverse outcomes associated with the Foley catheter use.	2 555		

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2 555	Continued From page 4 The comprehensive plan of care dated 12/23/15, for bowel and bladder needs, activities of daily living needs and catheter use was not developed nor was there any interventions identified to assist R15 with cares. The care plan did not include presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter. R15's care plan revised on 1/5/16, indicated R15 was a vulnerable adult and staff were to monitor and investigate any concerns. The care plan was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of UTIs, pyelonephritis and worsening kidney disease. The Physician's Progress notes dated 1/14/16, indicated R15 had chronic kidney disease and chronic indwelling Foley catheter for the past six years due to immobility, and had history of UTI's. The note also indicated R15 had complaints recently of bladder spasm, started on oxybutynin, had urine analysis with mixed flora (more than one organism isolated from urine culture), and ordered a three day course of Levaquin (antibiotic). The newly diagnosed bladder spasms was not added to the plan of care nor was there monitoring and interventions put into place on the plan of care other than the medication to relieve the spasms. The nursing assistant (NA) care sheet (undated) indicated assist of two with grooming, dressing, toileting, and transfer with Hoyer to commode. However, the sheet did not indicate presence of indwelling Foley catheter, or related cares. On 1/27/16, the NA who was assigned to take care of R15 or registered nurse (RN)-A (also	2 555		

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2 555	Continued From page 5 nurse manager were not available for interview. On 1/27/16, at 2:09 p.m. the licensed practical nurse (LPN)-B was interviewed and stated the nursing assistants were expected to complete twice daily pericare, "wipe the catheter every morning", get resident cleaned up in the morning, and nurses were responsible to make sure "everything is done" (meaning cares). LPN-B stated she was not told R15 did not receive cares that morning. LPN-B than stated "my brain is dead", and preferred to conclude interview. On 1/27/16, at 3:22 p.m. the director of nursing (DON) stated she would expect staff to complete morning cares, such as partial baths, and if a resident had Foley catheter to complete catheter care along with the pericare. The DON was not aware R15 did not receive those cares this morning. On 1/28/16, at 10:11 a.m. the DON also stated by day 21 of admission she would expect to see a comprehensive care plan written by the MDS nurse. The DON reviewed R15's record and stated she would expect R15 to have care plan developed for activities of daily living care needs (include grooming, toileting) and Foley catheter care. Respiratory care: R15's Admission Record indicate she had been admitted to the facility on 12/1/15, with diagnoses including anxiety and depression. The Admission Nursing Assessment, dated 12/1/15, noted there was no indication the resident utilized a continuous positive airway pressure (CPAP) machine (to help a person who has obstructive sleep apnea [OSA] breathe more easily during	2 555		

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2 555	Continued From page 6 sleep) at night. In addition, the assessment lacked evidence of oxygen use and if the resident required oxygen saturation levels (O2 sats) due to the oxygen use. On 12/1/15, the Physician Order read "Whatever she use [sic] at home for oxygen is fine and resident states she uses 2 L [liters] with CPAP at night." The resident's Initial/Temporary Care Plan dated 12/1/15, indicated R15 needed one staff assist with dressing/grooming, needed assist of one-two staff with toileting, and two staff assist with transferring. The Temporary Care Plan did not include any information regarding O2 use or CPAP machine use. An undated nursing assistant assignment sheet did not include indwelling catheter use, O2 use or CPAP machine use. On 12/4/15, the Physician Order noted the physician ordered a chest xray, blood draws and to keep the oxygen levels between 2 to 4 L, and keep the O2 Sats over 90%. The information was not added to the plan of care nor was the information found on the MAR/TARs. Review of R15's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 12/1/15, through 12/15/15, had no indication of the CPAP machine/O2 use, or monitoring of R15's breathing. The discharge Minimum Data Set (MDS) dated 12/4/15, indicated R15 received oxygen therapy at the facility, had a diagnosis of respiratory failure, but did not indicate R15 utilized CPAP, nor that she utilized an indwelling catheter. The MDS information contraindicated what the Admission Nursing Assessment, dated 12/1/15.	2 555		

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2 555	Continued From page 7	2 555		

The H&P (history and physical) Summary dated 12/5/15, indicated the resident was admitted with "ID/Sepsis/Severe Sepsis: Possible pneumonia with sepsis; cultures have been sent and empiric abx [antibiotic] started."

The Hospital Discharge Summary indicated R15 had been sent to the hospital on 12/5/15, and readmitted to the nursing home 12/9/15. The principal diagnoses listed for the hospitalization included: "acute hypoxic respiratory arrest." The Discharge Summary indicated R15 had required treatment with "intubation, steroids, oxygen, antibiotics," had been extubated after one day, and needed a low dose of O2 which was different than before. The Summary also indicated, "[R15] was observed to take off her BIPAP [bilevel positive airway pressure] at times when sleeping, and combined with her obesity could cause obstructive respiratory arrest."

The facility's Admission Nursing Assessment dated 12/9/15, indicated R15's lungs were clear and that she was breathing easier however, there was no indication of CPAP use.

The medical record lacked evidence of a temporary care plan from readmission on 12/9/15, and after multiple requests the facility failed to provide the document for review.

A discharge MDS dated 12/14/15, indicated R15 had been re-admitted with a diagnosis of septicemia (a bacterial infection spread through the entire vascular system of the body), did not use any oxygen in the facility nor did R15 utilize the CPAP, and had a diagnosis of respiratory failure.

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2 555	Continued From page 8 R15's MAR/TARs review dated 12/9/15, through 12/15/15, indicated no use of the CPAP machine/O2 use, or monitoring of R15's breathing. The TAR dated 12/23/15 going forward to 12/13/15, identified the staff were monitoring the oxygen sats as they were to keep the sat level over 92% and monitoring the BiPAP usage. R15's plan of care dated 12/23/15, was reviewed and noted the care plan did not identify any interventions that were put into place to monitor R15's recent diagnosis of pneumonia related sepsis with recent hospitalization dated 12/14/15, monitoring for lung sounds, changes in breathing, shortness of breath, and changes in vital signs. In fact R15's plan of care was revised on 1/5/16, and still the plan of care did not identify either hospitalizations or the recent diagnoses, nor were there any interventions identified to minimize potential and/or prevent future hospital readmissions regarding her breathing status, pneumonia related sepsis, CPAP machine use, O2 use. The Minimum Data Set registered nurse (RN)-B was interviewed on 1/26/16, at 4:07 p.m. about the plans of care for R15. He verified the care plans lacked any information for the dates of the hospitalization, or the reasons of the hospitalization, and any new interventions for staff to implement cares for R15 to minimize and or prevent future hospitalizations for R15. He also commented the care plans should have been written by day 21 after resident admission, and verified the comprehensive care plan for R15 should have been completed by 1/14/16 (approximately two weeks ago).	2 555		

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2 555	Continued From page 9 The director of nursing (DON) was interviewed on 1/28/16, at 10:11 a.m. The DON indicated when the resident was re-admitted back to the facility she expected the staff to complete the assessments, treat the residents as a new admission, monitor vital signs, note what diagnosis(es) they came back with, note what the medical doctor (MD) ordered, update the NP and MD, and document circumstances of hospitalization. The DON also verified the temporary care plan from 12/1/15, and 12/23/15, had "minimum information", and should have include all relevant information related to R15's medical conditions, and interventions put in place to address them. The DON also verified the lack of temporary care plan from 12/9/15. The DON also stated RN-B was responsible for developing residents' comprehensive care plans by day 21, and verified R15's should have been completed approximately two weeks ago. The facility's undated Resident Care Planning policy indicated "The care plan is initiated within 24 hours from the time of admission and fully developed within 21 days following the resident's arrival to the facility. All disciplines are responsible for adding their portion to the 24 hour care plan and the permanent care plan." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure a care plan is developed to reflect each residents' current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 555		

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2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care (POC) for 1 of 3 residents (R12) who were observed for repositioning. Findings include: R12 was observed continuously on 1/27/16, from 8:54 a.m. to 11:22 a.m. - At 8:54 a.m. R12 was sitting in a Broda chair in the dining room, - At 8:59 a.m. nursing assistant (NA)-G took R12 to room and put upper dentures in R12's mouth without adhesive. NA-G returned R12 to the dining room, - At 9:15 a.m. R12 sitting in the television (TV) room, - At 10:37 a.m. R12 remained sitting in the TV room asleep, - At 10:53 a.m. R12 sitting in the TV room awake and, - At 11:22 a.m. R12 still sitting in TV room sleeping. The observation was resumed on 1/27/16, at 12:45 p.m. R12 sitting in TV room sleeping - At 12:57 p.m. asked licensed practical nurse (LPN)-A if R12 had been toileted and repositioned	2 565		

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2 565	Continued From page 11	2 565		

since R12 got up that morning. LPN-A verified R12 had not been laid down or repositioned yet since R12 got up that morning. LPN-A stated, "[R12] had just eaten lunch staff were going to lay [R12] down." R12 went for four hours and 15 minutes without being repositioned.
- At 1:10 p.m. NA-G wheeled R12 to bedroom and,
- At 1:16 p.m. NA-G and NA-H placed R12 in EZ stand (a mechanical standing lift) and stood R12 up. NA-H pulled R12's pants down and said "he is dry in back and he is dry in front." Requested NA-H remove R12's incontinence brief. R12's skin intact was intact, coccyx was red but blanchable. R12 had been incontinent of stool. NA-G and NA-H washed R12's bottom and applied a new incontinence brief.

During continuous observation on 1/28/16, from 7:30 a.m. to 10:46 a.m. R12 went for three hours and 16 minutes without being repositioned.
- At 7:15 a.m. R12 was lying in bed,
- At 7:30 a.m. up in Broda chair in the hallway,
- At 7:45 a.m. R12 in dining room,
- At 8:52 a.m. NA-A assisting R12 to eat breakfast,
- At 9:15 a.m. R12 sitting in TV room,
- At 10:30 a.m. R12 remained in TV room,
- At 10:40 a.m. R12 taken to shower room by NA-A to be repositioned and checked and,
- At 10:46 a.m. R12 stood up in standing lift. NA-C and NA-F pulled pants down and removed incontinence brief. Incontinence brief was wet. R12's right gluteal fold was red. LPN-A verified that R12 had not been repositioned since R12 got up. LPN-A checked R12's skin and indicated it was blanchable.

R12's Minimum Data Set dated 11/3/15, indicated R12 was severely cognitively impaired, required

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2 565	Continued From page 12 assistance with all activities of daily living, was incontinent of bowel and bladder and at risk for development of pressure ulcers. The Pressure Ulcer Care Area Assessment dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, frequent urinary and bowel incontinence, and identified risk for pressure ulcer development. Care plan printed 1/28/16, instructed staff R12 continues to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility psychotropic drug use and diuretic use. Interventions instructed staff follow repositioning schedule per nursing, provide moisture barrier and perform peri-care during each check and change and as needed, wound care as ordered, check and change before breakfast after lunch and on rounds through night and as needed. The Physician Orders signed by doctor on 1/6/16, instructed staff to reposition R12 in wheelchair every two hours and house barrier cream to skin over right buttock twice a day. The Treatment Administration Record (TAR) dated Jan 16, indicated R12 was to be "REPOSITION IN WHEELCHAIR EVERY 2 HOURS (Started 10/13/14)." The box for the AM shift was left blank on 1/27/16, and signed 1/28/16. The undated Group 3 Nursing Assistant Assignment Sheet instructed staff check and change before breakfast after lunch before bed and on rounds through night as needed. Reposition during check and changes.	2 565		

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2 565	Continued From page 13 During interview on 1/27/16, at 12:57 p.m. LPN-A stated, "[R12] has not been laid down or repositioned yet since he got up this morning." During interview on 1/28/16, at 10:21 a.m. NA-A said I got [R12] up at 7:30 a.m. [R12]'s skin is intact. Na-A stated, "[R12] has not been repositioned today. We are so short we cannot get people up or toileted or repositioned." During interview on 1/27/16, at 2:31 p.m. the director of nurses (DON) stated, "...To determine how often the residents need to be repositioned we look at tissue tolerance and comorbidities. Residents need to be turned at baseline, every two hours minimum. If there is a wound every 1 hour. If the wound is nasty, the resident should only be up for meals. The individualized turning/repositioning schedule should be on the assignment sheets and care plans." The facility's Repositioning of resident's policy dated July 2012, instructed staff: "3. Residents' will be repositioned every 2 hours unless otherwise documented on care plan and NAR [nursing assistant registered] assignment sheets." R12 was not repositioned according to the plan of care which instructed staff to turn and reposition every two hours per the TAR. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff to follow care plans in regards to specific resident cares and services. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 570	Continued From page 14	2 570		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 2 of 3 residents (R10, R34) reviewed for pressure ulcers and/or non-pressure related skin conditions. Findings include: R10 was observed on 1/26/16 at 8:07 a.m. to be transferred into the wheelchair. During the period of continuous observation, the resident was transferred to bed with a mechanical lift at 10:23 a.m. Registered nurse (RN)-A, nurse consultant (NC)-A, and licensed practical nurse (LPN)-D were present to assess R10's skin. During the observation R10 stated, "my skin is falling apart, it hurts when I sit in the wheel chair." R10's bed was observed to have an air mattress in place over the mattress and a thick white pillow was observed in place over a cushion in the wheel chair. Nursing assistant (NA)-J turned R10 and	2 570		

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	00166	A. BUILDING: _____ B. WING _____	01/28/2016

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2 570	Continued From page 15	2 570		

removed her incontinent brief. There was a moderate amount of bright red blood on the incontinent brief. LPN-D stated there should have been a dressing over a wound on the resident's buttock and that no one had reported the dressing had come off. A wound on the right buttocks was observed to be localized on scar tissue and RN-A measured the area to be 4 centimeter (cm) long, 2 cm wide, and to have no depth. There was 100 % red bleeding over the wound bed. When LPN-D touched R10's wound to clean it, R10 retracted. RN-A stated the wound "could have been caused by pressure, or more likely friction." NC-A stated it appeared "friction and shearing played a big role in the development of the wound since the brief [incontinent brief] line was right there. I don't think it is a pressure ulcer."

R10's record was reviewed. According to the Admission Record documentation dated 12/8/15, R10 had been admitted to the facility on 10/21/15 with diagnoses including: unspecified kidney failure, hypertension, peripheral vascular disease, and diabetes.

An Admission Nursing Assessment document dated 10/21/15, indicated R10's left side was paralyzed, and the resident's skin risks included incontinence, impaired mobility, and being chair fast. A diagram of R10's body was marked to identify skin issues in three areas: on the coccyx, and on each buttock. The documented description noted for the left and right buttocks indicated, "Scarring from old pressure sore."

A Temporary Care Plan dated 10/26/15, did not include a detailed plan to prevent pressure ulcer development, including a repositioning schedule. However, the treatment administration records (TARs) for December 2015 and January 2016,

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2 570	Continued From page 16 identified an approach initiated 10/19/15 that directed "reposition every two hours in the chair..." The admission Minimum Data Set (MDS) assessment dated 10/27/15, indicated R10 was dependent on two staff for assistance with bed mobility, transfers, and toilet use; did not have any unhealed pressure ulcers, but was at risk for developing pressure ulcers; had functional limitation of range of motion impairment on one side; and used a wheel chair for mobility. The corresponding Care Area Assessment (CAA) dated 11/9/15, indicated "PLACE INTERVENTIONS THAT ASSIST IN DECREASING THE POTENTIAL FOR PRESSURE AREA AND OR OTHER SKIN BREAKDOWN. " A Braden scale (tool used to determine pressure ulcer risk) assessment dated 11/13/15, identified the resident's pressure ulcer risk at a score of 16, indicating mild risk for development of pressure ulcers. A Progress Note dated 11/24/15 included, "abrasion noted on LF [left] buttocks, sm [small] amount of blood dripping from area". The note also indicated the resident was laid down after meals, and repositioned/offloaded every two hours. A Physician's Order dated 11/24/15, identified a treatment order of: "apply silverstatin cream [a cream used to treat wounds] to Lt [left] buttocks and apply foam dressing and change q [every] am [morning] and PRN [as needed]. Reposition q 2 hrs [every two hours]." A Physician's Order dated 12/16/15, included, "apply silverstatin cream to left buttock and apply foam dressing	2 570		

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2 570	Continued From page 17 and change q 3 days + PRN [as needed]." The Physical Therapy Daily Notes dated 12/28/15, indicated R10 had complained of right buttocks pain, and indicated PT had educated nursing staff to "perform position change every hour to decrease pain and take pressure off coccyx ulcer," and had recommended ROHO cushion (specialty pressure reduction cushion for wheel chair use). R10's care plan, and TARs were not updated to include the recommendations for hourly repositioning. During interview with the director of nursing (DON) on 1/28/16 at 9:46 a.m., the DON stated she would expect resident care plans to be updated. The facility's undated Resident Care Planning policy included: "Between Interdisciplinary Conferences, each discipline is responsible for adding/deleting problems, goals, and approaches to the individual care plan as changes occur." R34's was observed on 1/27/16 to receive wound care from RN-A for the following wounds: 1) Left breast: crescent shaped wound that looked like a ruptured blister, measured as 3.5 centimeters (cm.) x1 cm. x 0 cm. There was no drainage. 2) Abdominal slits: a) slit in left groin fold 9.2 cm long. b) 0.5 cm long slit to the right of the left groin slit c) slit in right groin fold 2.8 cm long. 3) Right ischial tuberosity: Stage 3 pressure ulcer measuring 1 cm. x 0.8 cm. x 0 cm. Wound bed was 20 percent (%) granulation tissue and 50%	2 570		

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2 570	Continued From page 18 slough. No drainage observed. RN-A stated, "I will cover it with border dressing until I can obtain orders from the MD [medical doctor]." 4) Coccyx: Slit between buttocks measuring 8 cm. in length. R34's care plan dated 6/3/15, indicated R34 was at risk for impaired skin integrity and had a history of resolved pressure ulcers related to incontinence, immobility, diabetes, pain, neuropathy, chronic issues of open areas to the sacral coccyx area related to scar tissue from previously healed ulcers, and multiple ulcers on stomach related to R34 picking at skin. Care plan interventions instructed staff to assist R34 with repositioning as needed, and with each check and change, to encourage R34 to make frequent position changes as able when in the chair or in bed, to report skin issues to MD as they arise, and to conduct skin checks per facility protocol with bath and as needed. The care plan also indicated R34 was incontinent of bowel and bladder and required extensive to total assistance with toileting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after lunch and during the night on rounds or as needed. A Pressure Ulcer Care Area Assessment (CAA) dated 8/5/15, indicated R34 was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning. R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). The MDS further indicated R34 was incontinent of bowel and bladder, and was at risk for developing	2 570		

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2 570	Continued From page 19 pressure ulcers. The Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff that R34 required total assist of two to check and change before breakfast, after lunch, and during the night on rounds/or as needed, and to encourage repositioning. A Progress Note dated 12/31/15, at 10:51 a.m. indicated, "Resident has an o/a [open area] on right inner buttock, measures 1 cm x 1 cm. Resident has pain in area, 7 % slough 25% granulation. Protective barrier cream applied to site." The information was not updated on the care plan. During interview on 1/27/16, at 9:00 a.m. RN-A stated, "I was not aware of the slits on her abdomen or coccyx. There are no wound sheets because the wounds developed in December while I was on vacation. The nurse who found the wounds should have called the MD. I am not a wound nurse the director is a wound nurse. I don't know if the information is on the weekly skin sheets. It should be. The nurse should have updated the care plan with a new pressure ulcer. The wound on R34's bottom is a stage 3." RN-B was interviewed at 11:00 a.m. on 1/27/16, RN-B stated, "I don't care plan turning and repositioning schedules because it is a compliance issue. You cannot get the staff to follow the schedule." On 1/27/16, at 11:09 a.m. when RN-A was asked how frequently a resident should be repositioned stated I would need to check the care plan. When asked how frequently a resident with a wound like R34 should be repositioned RN-A stated, "at least	2 570		

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2 570	Continued From page 20 every two hours." During interview on 1/27/16, at 2:31 p.m. the director of nurses stated, "...My expectation is that the aides would tell the nurse right away when they find an open area. The nurse needs to chart on it and tell the wound nurse about it [RN-A]. The nurses need to put the appropriate interventions for the open area in place and document. The nurse needs to update the care plan." The facility's Repositioning of resident's policy dated July 2012, included: "3. Residents will be repositioned every 2 hours unless otherwise documented on care plan and NAR (nursing assistant) assignment sheets." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for accuracy of care plans to add resident cares and services when a change is warranted. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.	2 800		

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2 800	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficent staffing was provided to meet the individual needs of 5 of 6 residents (R34, R10, R15, R12, R21) who required assistance with repositioning, skin care, pressure ulcer, catheter care. This had the potential to affect all 52 residents who resided in the facility. Findings include: Refer to F309: The facility failed to provide appropriate care and services including assessment, care plan development and implementation of interventions, for 1 of 2 residents (R34) who had non pressure related skin issues. Refer to F314: The facility failed to comprehensively reassess and provide care and services to promote healing for a facility acquired pressure ulcer for 1 of 3 residents (R10) reviewed with pressure ulcers. Refer F315: The facility failed to provide appropriate indwelling Foley catheter care to 1 of 2 residents (R15) in the sample reviewed with indwelling Foley catheter. Resident Observation: R12 was observed continuously on 1/27/16, from 8:54 a.m. to 11:22 a.m. - At 8:54 a.m. R12 was sitting in a Broda chair in the dining room, - At 8:59 a.m. nursing assistant (NA)-G took R12 to room and put upper dentures in R12's mouth	2 800		

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2 800	Continued From page 22 without adhesive. NA-G returned R12 to the dining room, - At 9:15 a.m. R12 sitting in the television (TV) room, - At 10:37 a.m. R12 remained sitting in the TV room asleep, - At 10:53 a.m. R12 sitting in the TV room awake and, - At 11:22 a.m. R12 still sitting in TV room sleeping. The observation was resumed on 1/27/16, at 12:45 p.m. R12 sitting in TV room sleeping - At 12:57 p.m. asked licensed practical nurse (LPN)-A if R12 had been toileted and repositioned. Since R12 got up that morning. LPN-A verified R12 had not been laid down or repositioned yet since R12 got up that morning. LPN-A stated, "[R12] had just eaten lunch staff were going to lay [R12] down." R12 went for four hours and 15 minutes without being repositioned. - At 1:10 p.m. NA-G wheeled R12 to bedroom and, - At 1:16 p.m. NA-G and NA-H placed R12 in EZ stand (a mechanical standing lift) and stood R12 up. NA-H pulled R12's pants down and said "he is dry in back and he is dry in front." Requested NA-H remove R12's incontinence brief. R12's skin intact was intact, coccyx was red but blanchable. R12 had been incontinent of stool. NA-G and NA-H washed R12's bottom and applied a new incontinence brief. During continuous observation on 1/28/16, from 7:30 a.m. to 10:46 a.m. R12 went for three hours and 16 minutes without being repositioned. - At 7:15 a.m. R12 was lying in bed, - At 7:30 a.m. up in Broda chair in the hallway, - At 7:45 a.m. R12 in dining room, - At 8:52 a.m. NA-A assisting R12 to eat breakfast,	2 800		

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2 800	Continued From page 23 - At 9:15 a.m. R12 sitting in TV room, - At 10:30 a.m. R12 remained in TV room, - At 10:40 a.m. R12 taken to shower room by NA-A to be repositioned and checked and, - At 10:46 a.m. R12 stood up in standing lift. NA-C and NA-F pulled pants down and removed incontinence brief. Incontinence brief was wet. R12's right gluteal fold was red. LPN-A verified that R12 had not been repositioned since R12 got up. LPN-A checked R12's skin and indicated it was blanchable. R12's Minimum Data Set (MDS) dated 11/3/15, indicated R12 was severely cognitively impaired, required assistance with all activities of daily living, was incontinent of bowel and bladder and at risk for development of pressure ulcers. The Pressure Ulcer Care Area Assessment dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, frequent urinary and bowel incontinence, and identified risk for pressure ulcer development. Care plan printed 1/28/16, instructed staff R12 continues to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility psychotropic drug use and diuretic use. Interventions instructed staff follow repositioning schedule per nursing, provide moisture barrier and perform peri-care during each check and change and as needed, wound care as ordered, check and change before breakfast after lunch and on rounds through night and as needed. The undated Nursing Assistant Assignment Sheet instructed staff check and change before breakfast after lunch before bed and on rounds through night as needed. Reposition during check	2 800		

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2 800	Continued From page 24 and changes. The Physician Orders signed by doctor on 1/6/16, instructed staff to reposition R12 in wheelchair every two hours and house barrier cream to skin over right buttock twice a day. The Treatment Administration Record dated Jan 16, indicated R12 was to be "REPOSITION IN WHEELCHAIR EVERY 2 HOURS (Started 10/13/14)." The box for the AM shift was left blank on 1/27/16, and signed 1/28/16. Copy of R12's tissue tolerance requested but not received. During interview on 1/27/16, at 12:57 p.m. LPN-A stated, "[R12] has not been laid down or repositioned yet since he got up this morning." During interview on 1/28/16, at 10:21 a.m. NA-A said, "I got [R12] up at 7:30 a.m. [R12]'s skin is intact." NA-A further stated, "[R12] has not been repositioned today. We are so short we cannot get people up or toileted or repositioned." Resident Interview: R21's admission MDS dated 11/13/15, indicated cognition was intact and R21 required extensive physical assistance of two staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R21 used a wheelchair for mobility. On 1/25/16, at 4:48 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident	2 800		

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2 800	Continued From page 25 stated, either Friday or Saturday of the previous week, when she had the light on at around 10:00 p.m., someone had come into the room turned the light off at 10:25 p.m. and had told her the night shift would take care of it. The night staff did not come back until about 11:30 p.m. Resident indicated she had reported the concern to the director of nursing. R13's admission MDS dated 11/9/15, indicated cognition was severely impaired and required extensive physical assistance of one to two staff with bed mobility, dressing, toileting and personal hygiene. In addition, the MDS indicated R13 used a wheelchair for mobility. On 1/25/16, at 6:31 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "You wait for when they are ready for things." R18's quarterly MDS dated 10/22/15, indicated resident had intact cognition and required extensive physical assistance of two staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R49 used a wheelchair for mobility. On 1/26/16, at 9:11 a.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, the facility was understaffed and at time would hear other resident hollering for help as their call lights were not being answered.	2 800		

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2 800	Continued From page 26 R46's quarterly MDS dated 11/26/15, indicated cognition was intact and required extensive physical assistance of two staff with bed mobility, dressing, toileting and personal hygiene. In addition, the MDS indicated R46 used both a wheelchair and walker for mobility. On 1/26/16, at 9:40 a.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "sometimes have to wait. I have wet myself because I had to wait. Weekends are the worse." R34's quarterly MDS dated 10/30/15, indicated R34 had moderately impaired cognition, required total dependence to extensive physical assistance of one to two staff with activities of daily living. In addition, the MDS indicated R34 used a wheelchair for mobility. On 1/26/16, at 2:50 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "I wait for 1 hour to get out of bed." R15's scheduled 14 day MDS dated 1/6/16, indicated cognition was intact and resident required extensive physical assistance of two staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R15 used a wheelchair for mobility and had a functional limitation in range of motion on both the upper and lower extremities.	2 800		

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2 800	Continued From page 27 On 1/26/16, at 4:49 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated one of the NA's would leave the tray in the room. When NA had been asked to remove the tray would state, "I don't have time. I need to help other people." Resident also stated some of the aides at the facility were quite mean and thought a couple had been fired. Family interview R12's annual MDS dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a wheelchair for mobility. On 1/26/16, at 11:20 a.m. during interview with a family member, when asked if they felt there was enough staff available to make sure resident get the care and assistance he needed without having to wait a long time family member stated "I never see staff at shift change. I am here every afternoon. They need to re-think the way they do it. They have good aides. They have started switching aides every month. This causes him to swing at them when they approach him wrong he likes to know what is going to happen." Staff interviews On 1/27/16, at 7:19 am registered nurse (RN)-B, was working the North medication cart, and stated, "Hopefully not for long, I have to fill in once in a while, but, it takes me a long time because I have to read everything, and I wasn't planning on this today." -At 10:30 a.m. LPN-C, verified she had been	2 800		

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2 800	Continued From page 28 called in to cover short staff. On 1/28/16, at 8:29 a.m. LPN-D stated "Usually we are not short staff here but today we are short staff." - At 8:33 a.m. the staffing coordinator (SC) was observed passing medications. When approached and asked SC who also was a trained medication aide (TMA) stated "today we are short of one nurse and I am passing medications and the nurses are doing the treatments." When asked if staffing was a problem SC stated "Usually on PM's we have a problem with nurse shifts but we are able to cover them as the other nurses would either work doubles or pick up as we are giving bonuses so it's always covered." - At 8:50 a.m. LPN-A stated he had worked both hallways yesterday and it was big mess, because they were short. -At 9:00 p.m. NA-C, stated there was no aide assigned to the West hallway today, she was just floating around and helping everyone who needs help, because those two aides called in sick. - At 10:21 a.m. NA-A stated, "[R34] has not been repositioned today. We are so short, we cannot get people up or toileted or repositioned. I told you yesterday it was not too bad here. It is bad." - At 10:36 a.m. NA-F stated, "It is so hard working with just four people we cannot get everything done. We cannot reposition people or toilet them as we should. An entire hallway called in. I am tired of every one calling in. I work hard and try to do what I can but it makes the residents life miserable when we are short." - At 10:40 a.m. NA-C stated, "We are so short. We are down three people. We normally have six to seven aides. I am making beds on the other hallways and we are trying to make sure everyone is turned and toileted. It is not working.	2 800		

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2 800	Continued From page 29 We are late on just about everyone." - At 1:00 p.m. NA-A stated, "I'm just taking a break As you know when you guys are here, it's crazy, it'd be different if you did it this way 365." - At 2:30 p.m. NA-C stated the facility was always short staffed and it was even hard to make sure all resident cares, toileting and answering call lights was done. NA-C stated at times it is even hard to get all the call lights answered because it was heavy and a lot of resident's had a lot of needs yet there was not enough staff in the facility to meet resident needs. NA- further stated even taking break was a problem and had not even taken a break for the shift and that was not good. - At 2:30 p.m. other-D, stated the facility no longer had restorative here, because they do not have enough staff, but stated they were talking about bringing it back. - At 3:06 a.m. NA-D stated she did not work a lot at the facility but at times when someone called in the staffing would try to replace the staff and at times, would just end up splitting the group. When asked if resident care needs were able to be completed NA-D stated "sometimes we do the best we can." - At 3:10 p.m. NA-E stated since the new administrator and director of nursing (DON) came to the facility, they had come with staff from the other facility and that staff were always reporting the aides and staff who had been at the facility to management and staff had decided to quit because of the issues and that was why the facility had staffing issues. NA-E stated most of the time the facility was under staffed and management did not care about the resident care needs like for example some resident's required extensive assistance and needed two to three staff for cares yet was cutting the hours. NA-E gave an example of when an activity was still	2 800		

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2 800	Continued From page 30 going on and staff were asked to leave at around 9:00 p.m. and at that time there were many residents still up waiting to go to bed and two staff were asked to leave for the night yet one staff in the wing was not able to met the resident needs. When asked if staff was able to meet resident needs timely, NA-E stated not all the time and residents had to wait for a while for staff to come provide cares and at times residents were not toileted or repositioned on a timely manner as directed by the plan of care. During conversation NA-E appeared upset and stated resident care was more important than the money yet management did not see it the same way. - At 3:22 p.m. an outside agency hospice RN stated, "There has been so much turn over and it is hard to know who to go to with concerns and to ensure continuity of care." Document review: The following was noted during a review of the actual staffing and staff postings. On 1/25/16, day shift, group 1 was a "split group," On 1/26/16, evening shift, group 1 was a "split group" as there was one NA call in, On 1/27/16, day shift, RN/MDS nurse and health unit coordinator (HUC)/LPN pulled to medication cart due to nurse call in, Evening shift - two NAs called in so the evening shift split group 1. On 1/28/16, day HUC/LPN call in, Receptionist/TMA pulled to medication cart on West, LPN on West pulled to medication cart North/East, split group 1, and two NAs called in from West hallway (not replaced), working three NAs short "everyone sharing everyone in building." The facility failed to provide the requested actual staffing sheets for 11/11 through 11/15/15 requested on 1/29/16, at 3:02 p.m.	2 800		

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2 800	Continued From page 31 On 11/10/15, indicated 8 RN hours (not recorded in RN manager or LPN manager hours) that are not reflected in the actual daily staffing sheet. On Sunday 11/15/15, there was no RN coverage listed on the 24 hours actual staffing sheet. On 11/125/15, no RN coverage. On Saturday 11/28/15, no RN coverage. On Sunday 11/29/15, no RN coverage. On Sunday 12/27/15, no RN coverage and LPN double shift, On Sunday 1/17/16, planned split group 1 on both a.m. and p.m. shifts. On Sunday 1/24/16, MDS RN planned as South hallway nurse. The staffing pattern could not be reviewed as the staffing sheets for 11/16 through 11/24/15, were missing as well as the staff postings. In addition, the staffing schedule and postings were missing for 11/25 through 11/28/15. On 1/28/16, at 2:57 p.m. the staffing coordinator, human resources (HR) person and the DON were interviewed for staffing. The staffing coordinator explained the usual staffing: South - Day shift: one nurse and three NAs, South/East Evening shift: one nurse and three NAs, West - Day shift: one nurse and two NAs, North/West Evening shift: one nurse and two to three NAs (+ pick up residents on EAST), North/East - Days: one nurse and two NAs, Evenings: one TMA and two NAs and, Night shift: one to two nurses and two to three NAs for the building. Further explanation of a split group, indicated when there was not enough staff to fill the staffing plan, so staff assigned to other groups would split group 1 (residents in addition to their assignment).	2 800		

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2 800	Continued From page 32 On 1/28/16, at 1:20 p.m. the HR director was interviewed and indicated the facility had a turnover rate of 4% last month and that they are actively advertising. On 1/28/16, at 2:30 p.m. a staffing interview with the director of nursing, revealed they currently are hiring, as a lot of nurses have called and asked if the facility was hiring but they did not show for the interview process. Per the DON the facility currently pays less than other facilities. SUGGESTED METHOD OF CORRECTION: Facility administration and the director of nursing could utilize employee, resident and family input to evaluate staffing patterns and identify times/ places where those staffing patterns could/should be adjusted and implement those adjustments in order to meet all resident needs in a timely manner. Facility policies and procedures for sufficient staffing could be reviewed/ revised. Pertinent employees could be retrained on those policies/ practices. Audit tools could be developed to observe for timely and complete care, meeting all resident needs as identified in their care plan. The facility's Quality Assessment & Assurance committee could review those findings and develop/ implement corrective actions for any patterns or root/cause determinations for on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		

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2 830	Continued From page 33 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care and services including assessment, care plan development and implementation of interventions, for 1 of 2 residents (R34) who had non pressure related skin issues. Findings include: R34 was observed continuously on 1/27/16, from 7:05 a.m. until 8:42 a.m. the following was observed: At 7:27 a.m. nursing assistant (NA)-A and entered R34's room and obtained permission to observe cares. At 7:30 a.m. during morning care there was a pink dressing observed in place on the top outer side of R34's left breast. NA-A removed the resident's incontinence brief and washed under R34's abdominal fold. R34 said that "hurts." NA-A told R34 there was a tear under left abdomen fold, and verified there was no gauze dressing between R34's abdominal fold and groin. At 8:09 a.m. registered nurse (RN)-A arrived to perform wound care. The measurements and descriptions of wounds were as followed:	2 830		

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2 830	Continued From page 34 1) Left breast: A crescent shaped wound that looked like a ruptured blister measured 3.5 centimeters (cm.) x 1 cm. x 0 cm. There was no drainage. The wound was cleansed, and an Island dressing (sterile pad or compress applied to a wound to promote healing) was applied. 2) Abdominal slits: a) slit in left groin fold 9.2 cm long. b) 0.5 cm long slit to the right of the left groin slit c) slit in right groin fold 2.8 cm long. R34's care plan printed 6/3/15, indicated R34 was at risk for impaired skin integrity and had a history of resolved pressure ulcers related to incontinence, immobility diabetes, pain, neuropathy, chronic issues of open areas to the sacral coccyx area related to scar tissue from previously healed ulcers and multiple ulcers on stomach related to R34 picking at skin. The interventions instructed staff to assist R34 with repositioning as needed and with each check and change, encourage R34 to make frequent position changes when R34 was able when in the chair or in bed, report skin issues to physician as they arise and skin checks per facility protocol with bath and as needed. The care plan indicated R34 was incontinent of bowel and bladder and required extensive assistance to total assistance with toileting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after lunch and during the night on rounds or as needed. In addition, the care plan provided by facility with print date of 11/30/15, did not address skin or incontinence issues. Pressure Ulcer Care Area Assessment dated 8/5/15, indicated [R34] was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning.	2 830		

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2 830	Continued From page 35 R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). R34 was always incontinent of bowel and bladder. R34's quarterly MDS indicated R34 was at risk for developing pressure ulcers. R34's quarterly MDS diagnoses included diabetes mellitus, chronic kidney disease and hypertension. Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff that [R34] required total assist of two to check and change before breakfast after lunch and during the night on rounds or as needed, and encourage repositioning. The Treatment Administration Record dated January 2016, instructed staff to "WASH AND DRY ABDOMINAL FOLDS AND GROIN, APPLY 4X4 TO SKIN FOLDS [Started 01/20/15]." The treatment was set up for every shift. The information was not on care plan or nursing assistant assignment sheet. During interview on 1/27/16, at 9:00 a.m. RN-A stated, "I was not aware of the slits on her abdomen. There are no wound sheets because the wounds developed in December while I was on vacation. The nurse who found the wounds should have called the MD (medical doctor). I am not a wound nurse the director is a wound nurse. I don't know if the information is on the weekly skin sheets. It should be. The nurse should have updated the care plan." On 1/27/16 at 11:00 a.m. RN-B was interviewed and stated, "I don't care plan turning and repositioning schedules because it is a	2 830		

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2 830	Continued From page 36 compliance issue, you cannot get the staff to follow the schedule." On 1/27/15, at 11:09 am RN-A was asked how frequently a resident should be repositioned and stated, "I would need to check the care plan." When asked how frequently a resident with a wound like R34's should be repositioned RN-A stated, "at least every two hours." During interview on 1/27/16, at 2:31 p.m. the director of nurses stated, "[NA-A] told me about the slit on R34's right groin this morning. No one told me about the other wounds or that there was not a treatment for [R34]. My expectation is that the aides would tell the nurse right away when they find an open area. The nurse needs to chart on it and tell the wound nurse about it [RN-A]. The nurses need to put the appropriate interventions for the open area in place and document. The nurse needs to update the care plan. The nurse needs to get a treatment immediately from the doctor. The nurse would follow up weekly and as needed until resolved. I would expect a comprehensive skin assessment to be completed. There should be a tissue tolerance. There should be weekly skin checks for all residents. To determine how often the residents need to be repositioned we look at tissue tolerance and comorbidities. Residents need to be turned at baseline, every two hours minimum. If there is a wound every one hour. If the wound is nasty, the resident should only be up for meals. The individualized turning/repositioning schedule should be on the assignment sheets and care plans." The facility's Skin Care Protocol revised 6/28/05, indicated: "Skin assessments will be completed on a weekly basis."	2 830		

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2 830	Continued From page 37 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin conditions. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty One (21) Days	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally	2 840		

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2 840	Continued From page 38 appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate indwelling Foley catheter care to 1 of 2 residents (R15) in the sample reviewed with indwelling Foley catheter. Findings include: R15 was observed on 1/27/16, at 8:23 a.m. laying in the bed. During interview R15 stated she felt staff did not always clean her properly in the morning, and she received cares only when she requested them, which included a partial bath in the morning and peri care. R15 had an indwelling Foley catheter, with a 2000 milliliter (ml) bag attached to it. R15 stated she used to have urinary tract infections (UTI) in the past, and did	2 840		

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2 840	Continued From page 39	2 840		

not know when staff supposed to care for her catheter. R15 also stated she preferred to use the bedpan when she had bowel movements, but staff have not always had bed pan available to use. On 1/27/16, at 1:35 p.m. R15 was interviewed again, stated she have not received grooming cares, pericare or catheter care yet today, no staff checked in with her yet today related to her grooming needs. R15 also stated she had the catheter for a long time, and saw the urologist when in trouble with kidney failure.

The Admission Nursing assessment dated 12/1/15, indicated catheter use, and history of UTI's. The temporary care plan dated 12/1/15, noted toileting assist of one or two staff. The care plan did not indicate presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter.

The Admission Nursing assessment (first re-admission) dated 12/9/15, also indicated use of Foley catheter, with no additional information.

The Admission Nursing Assessment dated 12/23/15 (second re-admission), indicated history of UTI's, however the form was left incomplete, did not indicate presence of the Foley catheter, urinary tract related medical conditions or interventions. The Temporary care plan dated 12/23/15, indicated toileting assist of two staff, and pad use. The care plan did not include presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter.

R15's admission Minimum Data Set (MDS) dated 12/30/15, indicated R15 had indwelling catheter, was frequently incontinent of bowel, and was dependent of two staff's assistance with bed

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 40 mobility, transfers and toilet use. The MDS also depicted R15 as being cognitively intact and able to have clear comprehension of others and able to clearly state needs. The Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 1/4/16, indicated the facility would proceed to care plan for Foley catheter care and monitoring of adverse outcomes associated with the Foley catheter use. The comprehensive care plan 12/23/15, for bowel and bladder needs, activities of daily living needs and catheter use was not developed nor was there any interventions identified to assist R15 with cares. The nursing assistant (NA) care sheet (undated) indicated assist of two with grooming, dressing, toileting, and transfer with Hoyer to commode. However, the sheet did not indicate presence of indwelling Foley catheter, or related cares. The Physician's Progress Notes dated 1/14/16, indicated R15 had chronic kidney disease and chronic indwelling Foley catheter for the past six years due to immobility, and had history of UTI's. The note also indicated R15 had complaints recently of bladder spasm, started on oxybutynin, had urine analysis with mixed flora (more than one organism isolated from urine culture), and ordered a three day course of Levaquin (antibiotic). Additional diagnoses included diabetes, osteoarthritis, and depression. On 1/27/16, the NA who was assigned to take care of R15 or registered nurse (RN)-A (also nurse manager were not available for interview. On 1/27/16, at 2:09 p.m. the licensed practical	2 840		

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2 840	Continued From page 41 nurse (LPN)-B was interviewed and stated the nursing assistants were expected to complete twice daily pericare, "wipe the catheter every morning", get resident cleaned up in the morning, and nurses were responsible to make sure "everything is done" (meaning cares). LPN-B stated she was not told R15 did not receive cares that morning. LPN-B than stated "my brain is dead", and preferred to conclude interview. On 1/27/16, at 3:22 p.m. the director of nursing (DON) stated she would expect staff to complete morning cares, such as partial baths, and if a resident had Foley catheter to complete catheter care along with the pericare. The DON was not aware R15 did not receive those cares this morning. On 1/28/16, at 10:11 a.m. the DON also stated by day 21 of admission she would expect to see a comprehensive care plan written by the MDS nurse. The DON reviewed R15's record and stated she would expect R15 to have care plan developed for activities of daily living care needs (include grooming, toileting) and Foley catheter care. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents who require assistance with catheter care receive timely services; educate staff as appropriate; then develop monitoring systems or audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 840		

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2 865	Continued From page 42	2 865		
2 865	MN Rule 4658.0520 Subp. 2 G Adequate and Proper Nursing Care; Bed Linen Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Bed linen must be changed weekly, or more often as needed. Beds must be made daily and straightened as necessary. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate bedding was provided for 1 of 1 resident (R15) in the sample who utilized a bariatric bed. Findings include: R15 was observed on 1/25/16, at 4:58 p.m. to be laying in her bed. There was no sheet on the oversized bariatric mattress, only a bed spread, which did not cover the top of the mattress and R15's head and neck were on the bare mattress. R15 stated the staff had told her for the last three days that there were no bed sheets available for her mattress. On 1/25/16, at 5:14 p.m. the director of nursing (DON) was interviewed, and stated the facility just received a shipment of bariatric bedding last Saturday (1/23/16). The DON stated the facility had six bariatric beds in use, and staff were expected to make the beds appropriately using sheets. The DON said she was unaware staff did not have an adequate supply of linens. The DON then went to R15's room and when she returned at 5:20 p.m., stated the lack of linens of R15's bed was "not acceptable." The DON also stated	2 865		

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2 865	Continued From page 43 she would have expected the staff to inform her about missing resident care supplies including bedding. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure bariatric beds are made with appropriate bed linens. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 865		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		

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2 900	Continued From page 44 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively reassess and provide care and services to promote healing for a facility acquired pressure ulcer for 1 of 3 residents (R10) reviewed with pressure ulcers; In addition, the facility failed to provide repositioning for 2 of 2 residents (R34, R12) identified at risk for pressure ulcers. Findings include: R10 was not comprehensively reassessed to identify risk factors in order to prevent potential further skin breakdown, and to promote healing after a pressure ulcer was identified by staff on R10's buttocks on 11/24/15 (33 days after nursing home admission). On 1/26/16, during continuous observation the following was observed: At 8:07 a.m. R10 was transferred into the wheel chair, and brought to the dining room, At 8:30 a.m. R10 was observed still sitting in the wheel chair. At 9:22 a.m. R10 was wheeled to the activity room. At 10:18 a.m. R10 was brought back to her room where a nursing assistant (NA)-J put her coat on her. R10 stated she was going out for lunch to a 50's Style Grill with other residents and activity staff. At approximately 10:23 a.m. R10's skin was assessed by registered nurse (RN)-A. The nurse consultant/RN (NC)-A was present during assessment along with licensed practical nurse (LPN)-D. When interviewed R10 stated, "my skin is falling apart" and also stated, "it hurts when I sit in the wheel chair." R10 was transferred from the wheel chair to the bed with a mechanical lift. The bed had an air mattress on it. There was a thick	2 900		

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2 900	Continued From page 45 white pillow on the top of the cushion in the wheel chair. When NA-J removed R10's pad, there was a moderate amount of bright red blood on the pad. LPN-D stated there should have been a dressing on the wound, and stated she had not been informed by staff that the previous dressing had come off. The right buttocks wound was localized on the scar tissue, and RN-A measured it to be 4 centimeter (cm) long and 2 cm wide, with no depth, and 100 % bleeding in the wound bed. When LPN-D touched R10's wound to clean it, R10 retracted in pain. RN-A stated the wound could have been caused by pressure, but was more likely friction. NC-A also stated, "Friction and shearing played a big role in the development of the wound since the brief line was right there. I didn't think it was a pressure ulcer." R10 went for two hours and 16 minutes without being repositioned. The Admission Record dated 12/8/15, indicated R10 was admitted to the facility on 10/21/15, with diagnoses including unspecified kidney failure, hypertension, peripheral vascular disease, diabetes. The Admission Nursing Assessment dated 10/21/15, indicated R10's left side was "paralyzed", at skin risk included incontinence, impaired mobility, chair fast. The body diagram had three circles on coccyx, and bilateral buttocks, and the description noted for left and right buttocks "Scarring from old pressure sore." The Temporary Care Plan dated 10/26/15, indicated R10 transferred with Hoyer lift (mechanical lift used to transfer residents), however did not include detailed plan to prevent pressure ulcer development, including repositioning schedule.	2 900		

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2 900	Continued From page 46 The admission Minimum Data Set (MDS) dated 10/27/15, indicated R10 was dependent on two staff member's assistance with bed mobility, transfers, and toilet use; R10 did not have any unhealed pressure ulcers and was at risk for developing pressure ulcer; R10 had had functional limitation of range of motion impairment on one side; and used wheel chair for mobility. R10 did not have a skin comprehensive care plan developed after the MDS had been completed. The Braden scale (tool used to determine pressure ulcer risk) dated 11/13/15, had score of 16, indicating mild risk for developing pressure ulcer. However, accuracy of the result was questionable due to staff indicating no sensory perception impairment even though R10 had left sided paralysis, and also due to staff indicating friction and shear being only potential problem even though R10 required maximum assistance in moving. No additional Braden assessment was found in the medical record. The Nutritional Assessment was completed on 11/3/15, the record lacked evidence of a new assessment after buttocks wound developed on 11/24/15. The Care Area Assessment (CAA) worksheet dated 11/9/15, indicated "PLACE INTERVENTIONS THAT ASSIST IN DECREASING THE POTENTIAL FOR PRESSURE AREA AND FOR OTHER SKIN BREAKDOWN." The Progress Note dated 11/24/15, indicated "abrasion noted on LF [left] buttocks, sm [small] amount of blood dripping from area." The note	2 900		

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2 900	Continued From page 47 also indicated resident was laid down after meals, and repositioned/offloaded every two hours. The nurse practitioner was updated. All progress notes dated between 10/21/15, and 1/26/15, were reviewed, no other entries found related R10's buttocks wound. The Physician Order dated 11/24/15, indicated treatment order: "apply silverstatin cream [a cream used to treat wounds] to Lt [left] buttocks and apply foam dressing and change q [every] am [sic- morning] and PRN [as needed]. Reposition q 2 hrs [every two hours]." The Physician Order dated 12/16/15, indicated "apply silverstatin cream to left buttock and apply foam dressing and change q 3 days + PRN." The Physician/Nurse Practitioner (NP) Progress Notes dated 12/9/15, 12/15/15, 12/23/15, 1/12/15, all indicated "SKIN: normal, no rash." The Physical Therapy Daily Notes dated 12/28/15, noted R10 complained of right buttocks pain, and nursing staff was educated "to perform position change every hour to decrease pain and take pressure off coccyx ulcer", and recommended ROHO cushion (specialty pressure reduction cushion for wheel chair use). The Hospital Discharge Orders dated printed 12/29/15, indicated R10 had a history of pressure ulcers: "Wound buttocks pressure ulcer 9/17/13." The January 2016 Treatment Administration Record (TAR) indicated the Physician Order from: 11/24/15, (R10 to be repositioned every two hours) and 12/16/16, (for dressing change). The PT/OT/ST (physical therapy/occupational therapy/speech therapy) Resident Referral and	2 900		

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2 900	Continued From page 48 Recommendations dated 1/8/16, indicated "Do not put pillow on top of ROHO cushion in wheelchair." The undated NA Assignment Sheet dated 1/22/16, indicated for R10, "do not put pillow on top of ROHO cushion in wheel chair", however, did not indicate frequency of the repositioning, or presence of buttocks wound. The medical record lacked evidence of weekly assessments, or any measurements of the buttocks wound. The medical record also lacked evidence of comprehensive reassessment to determine causative factor, evaluate risk and changes in R10's condition that caused the development of the buttocks wound. On 1/26/16, at 9:30 a.m. the licensed practical nurse (LPN)-D stated R10 had a wound on the right buttocks, more than likely pressure related since 11/24/15. When inquired about the progress notes dated 11/24/15, LPN-D stated R10 had one pressure ulcer only, documenting left side versus right side must have been a mistake. On 1/26/16 at 9:45 a.m., RN-A and the director of nursing (DON) were interviewed, RN-A stated R10 did not have any pressure ulcers or wounds or her buttocks or coccyx. Both stated they were not aware R10 had a facility acquired wound on the right buttocks. On 1/26/16 10:29 a.m., the DON was informed about the observation, and stated R10 should have been repositioned at least every two hours, and before going out to outings. On 1/26/26 at 10:32 a.m., NA-J was interviewed,	2 900		

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2 900	Continued From page 49 and could not remember when she had last repositioned R10. NA-J acknowledged R10 was not repositioned or offloaded since she was transferred into her wheel chair before breakfast that morning. NA-J stated R10 should have been repositioned at least every two hours. During interview on 1/28/16, at 9:46 a.m. the DON (director of nursing) stated residents were supposed to be comprehensively reassessed when they developed a new wound, to determine causative factors; would expect staff to do Braden scale, tissue perfusion test, and she would expect to see a comprehensive note in the record with all contributing factors included. She would also expect dietary staff to be informed, care plan updated, and weekly wound measurements started to monitor healing process. DON stated RN-A was responsible making sure all these were put in place. The DON stated she could not find any assessments from 11/24/16, when R10 developed new wound on the buttocks crease, there was no comprehensive care plan written, which the MDS coordinator was responsible for. At 9:55 a.m. RN-B (also MDS coordinator) joined the conversation, and stated "didn't believe" a comprehensive care plan was written for R10, after she transferred from the other facility. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing	2 900		

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2 900	Continued From page 50 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide repositioning for 2 of 2 residents (R34, R12) identified at risk for pressure ulcers. Findings include: R34 was observed continuously on 1/27/16, from 7:05 a.m. until 8:42 a.m. the following was observed: - At 7:27 a.m. NA-A and surveyor entered R34's room and obtained permission to observe cares. - At 7:30 a.m. during morning cares observed a pink dressing in place on the top outer side of R34's left breast. -NA-A removed incontinence brief and washed under R34's abdominal fold. -NA-A verified there were no folded 4X4's gauze dressings between R34's abdominal fold and	2 905		

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2 905	Continued From page 51 groin. R34 said that "hurts." NA-A told R34 there was a tear under left abdomen fold. NA-A applied barrier cream and washed R34's bottom. -NA-A requested NA-G ask a nurse to come and check R34's bottom. - At 8:09 a.m. registered nurse (RN)-A arrived to perform wound care. The measurements and descriptions of wounds were as followed: 1) Right ischial tuberosity: Stage 3 pressure ulcer measuring 1 cm. x 0.8 cm. x 0 cm. Wound bed was 20 percent (%) granulation tissue and 50% slough. No drainage observed. RN-A stated, "I will cover it with border dressing until I can obtain orders from the MD [medical doctor]." 4) Coccyx: Slit between buttocks measuring 8 cm. in length. -8:42 a.m. observation of wound treatments stopped. R34's care plan printed 6/3/15, indicated R34 was at risk for impaired skin integrity and had a history of resolved pressure ulcers related to incontinence, immobility diabetes, pain, neuropathy, chronic issues of open areas to the sacral coccyx area related to scar tissue from previously healed ulcers and multiple ulcers on stomach related to R34 picking at skin. The interventions instructed staff to assist R34 with repositioning as needed and with each check and change, encourage R34 to make frequent position changes when R34 was able when in the chair or in bed, report skin issues to MD as they arise and skin checks per facility protocol with bath and as needed. The care plan indicated R34 was incontinent of bowel and bladder and required extensive assistance to total assistance with toileting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after lunch and during the night on rounds or as needed. In addition,	2 905		

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2 905	Continued From page 52	2 905		

incomplete care plan (pages 8-14) provided by facility with print date of 11/30/15, did not address skin or incontinence issues.

Pressure Ulcer Care Area Assessment (CAA) dated 8/5/15, indicated [R34] was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning.

R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). R34 was always incontinent of bowel and bladder. R34's quarterly MDS indicated R34 was at risk for developing pressure ulcers. R34's quarterly MDS diagnoses included diabetes mellitus, chronic kidney disease and hypertension.

Group 2 Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff that (R34) required total assist of two to check and change before breakfast after lunch and during the night on rounds or as needed, and encourage repositioning.

The Progress Note dated 12/31/15, at 10:51 a.m. "Resident has an o/a [open area] on right inner buttock, measures 1 cm x 1 cm. Resident has pain in area, 7 % slough 25% granulation. Protective barrier cream applied to site." The information was not updated on the care plan.

During interview on 1/27/16, at 9:00 a.m. RN-A stated, "I was not aware of the slits on her abdomen or coccyx. There are no wound sheets because the wounds developed in December while I was on vacation. The nurse who found the wounds should have called the MD. I am not a

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2 905	Continued From page 53	2 905		

wound nurse the director is a wound nurse. I don't know if the information is on the weekly skin sheets. It should be. The nurse should have updated the care plan with a new pressure ulcer. The wound on R34's bottom is a stage 3 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue)."
- At 9:16 a.m. NA-A stated, "The sore on [R34's] right leg has been there since I started here, about three weeks. They normally put cream on it but it is getting worse. I first saw the slit on [R34's] bottom and on [R34's] abdomen Monday morning. I told the nurse Monday. I think [Licensed practical nurse (LPN)-B] was the nurse Monday morning. [LPN-B] told me to put barrier cream on and watch it. It looks worse that is why I asked for the nurse."
- At 11:00 a.m. RN-B said, "I don't care plan turning and repositioning schedules because it is a compliance issue. You cannot get the staff to follow the schedule."

On 1/27/16, at 11:09 a.m. when RN-A was asked how frequently a resident should be repositioned stated I would need to check the care plan. When asked how frequently a resident with a wound like R34 should be repositioned RN-A stated, "at least every two hours."

During interview on 1/27/16, at 2:31 p.m. the director of nurses stated, "I did not know about the slit on R34's coccyx or the wound on R34's right ischial tuberosity. [NA-A] told me about the slit on R34's right groin this morning. No one told me about the other wounds or that there was not a treatment for [R34]. My expectation is that the aides would tell the nurse right away when they

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2 905	Continued From page 54 find an open area. The nurse needs to chart on it and tell the wound nurse about it [RN-A]. The nurses need to put the appropriate interventions for the open area in place and document. The nurse needs to update the care plan. The nurse needs to get a treatment immediately from the doctor. The nurse would follow up weekly and as needed until resolved. I would expect a comprehensive skin assessment to be completed. There should be a tissue tolerance. There should be weekly skin checks for all residents. To determine how often the residents need to be repositioned we look at tissue tolerance and comorbidities. Residents need to be turned at baseline, every two hours minimum. If there is a wound every one hour. If the wound is nasty, the resident should only be up for meals. The individualized turning/repositioning schedule should be on the assignment sheets and care plans." R12 was observed continuously on 1/27/16, from 8:54 a.m. to 11:22 a.m. - At 8:54 a.m. R12 was sitting in a Broda chair in the dining room, - At 8:59 a.m. nursing assistant (NA)-G took R12 to room and put upper dentures in R12's mouth without adhesive. NA-G returned R12 to the dining room, - At 9:15 a.m. R12 sitting in the television (TV) room, - At 10:37 a.m. R12 remained sitting in the TV room asleep, - At 10:53 a.m. R12 sitting in the TV room awake and, - At 11:22 a.m. R12 still sitting in TV room sleeping. The observation was resumed on 1/27/16, at 12:45 p.m. R12 sitting in TV room sleeping	2 905		

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2 905	Continued From page 55 - At 12:57 p.m. asked licensed practical nurse (LPN)-A if R12 had been toileted and repositioned since R12 got up that morning. LPN-A verified R12 had not been laid down or repositioned yet since R12 got up that morning. LPN-A stated, "[R12] had just eaten lunch staff were going to lay [R12] down." R12 went for four hours and 15 minutes without being repositioned. - At 1:10 p.m. NA-G wheeled R12 to bedroom and, - At 1:16 p.m. NA-G and NA-H placed R12 in EZ stand (a mechanical standing lift) and stood R12 up. NA-H pulled R12's pants down and said "he is dry in back and he is dry in front." Requested NA-H remove R12's incontinence brief. R12's skin intact was intact, coccyx was red but blanchable. R12 had been incontinent of stool. NA-G and NA-H washed R12's bottom and applied a new incontinence brief. During continuous observation on 1/28/16, from 7:30 a.m. to 10:46 a.m. R12 went for three hours and 16 minutes without being repositioned. - At 7:15 a.m. R12 was lying in bed, - At 7:30 a.m. up in Broda chair in the hallway, - At 7:45 a.m. R12 in dining room, - At 8:52 a.m. NA-A assisting R12 to eat breakfast, - At 9:15 a.m. R12 sitting in TV room, - At 10:30 a.m. R12 remained in TV room, - At 10:40 a.m. R12 taken to shower room by NA-A to be repositioned and checked and, - At 10:46 a.m. R12 stood up in standing lift. NA-C and NA-F pulled pants down and removed incontinence brief. Incontinence brief was wet. R12's right gluteal fold was red. LPN-A verified that R12 had not been repositioned since R12 got up. LPN-A checked R12's skin and indicated it was blanchable.	2 905		

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2 905	Continued From page 56 R12's MDS dated 11/3/15, indicated R12 was severely cognitively impaired, required assistance with all activities of daily living, was incontinent of bowel and bladder and at risk for development of pressure ulcers. The Pressure Ulcer CAA dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, frequent urinary and bowel incontinence, and identified risk for pressure ulcer development. Care plan printed 1/28/16, instructed staff R12 continues to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility psychotropic drug use and diuretic use. Interventions instructed staff follow repositioning schedule per nursing, provide moisture barrier and perform peri-care during each check and change and as needed, wound care as ordered, check and change before breakfast after lunch and on rounds through night and as needed. The undated Group 3 Nursing Assistant Assignment Sheet instructed staff check and change before breakfast after lunch before bed and on rounds through night as needed. Reposition during check and changes. The Physician Orders signed by doctor on 1/6/16, instructed staff to reposition R12 in wheelchair every two hours and house barrier cream to skin over right buttock twice a day. The Treatment Administration Record dated Jan 16, indicated R12 was to be "REPOSITION IN WHEELCHAIR EVERY 2 HOURS (Started 10/13/14)." The box for the AM shift was left blank on 1/27/16, and signed 1/28/16.	2 905		

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2 905	Continued From page 57 Copy of R12's tissue tolerance requested but not received. During interview on 1/27/16, at 12:57 p.m. LPN-A stated, "[R12] has not been laid down or repositioned yet since he got up this morning." During interview on 1/28/16, at 10:21 a.m. NA-A said I got (R12) up at 7:30 a.m. [R12]'s skin is intact. Na-A stated, "[R12] has not been repositioned today. We are so short we cannot get people up or toileted or repositioned." During interview on 1/27/16, at 2:31 p.m. the director of nurses (DON) stated, ...". The nurse needs to chart on it and tell the wound nurse about it [RN-A]. The nurses need to put the appropriate interventions for the open area in place and document. The nurse needs to update the care plan. The nurse needs to get a treatment immediately from the doctor. The nurse would follow up weekly and as needed until resolved. I would expect a comprehensive skin assessment to be completed. There should be a tissue tolerance. There should be weekly skin checks for all residents. To determine how often the residents need to be repositioned we look at tissue tolerance and comorbidities. Residents need to be turned at baseline, every two hours minimum. If there is a wound every 1 hour. If the wound is nasty, the resident should only be up for meals. The individualized turning/repositioning schedule should be on the assignment sheets and care plans." The facility's Skin Care Protocol dated revised on 6/28/05, indicated "That a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrated that they were	2 905		

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2 905	Continued From page 58 unavoidable; and a resident having pressure sores receive necessary treatment and services, as the facility is able to provide, to promote healing, prevent infection, and prevent new sores from developing." The facility's Repositioning of resident's policy dated July 2012, instructed staff: "3. Residents' will be repositioned every 2 hours unless otherwise documented on care plan and NAR assignment sheets." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff on ensuring each resident receives turning and repositioning assistance according to their assessed need. The DON or designee could then perform observational audits to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance	21426		

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21426	Continued From page 59 regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 1 of 5 employees (E-3) had proper interpretation for Tuberculin Skin Test (TST) result. In addition failed to ensure 5 of 5 resident (R46, R32, R33, R9, R63) had TST's and a symptom screening completed as recommended per State guidelines. Findings include: Employees E-3's personnel file revealed a hire date of 7/7/15. E-3's file indicated a step one Tuberculin Skin Test (TST) had been administered on 7/9/15, and read 7/11/15, with 0 millimeters (mm) no interpretation either "Positive or Negative." Residents R46 was admitted to the facility on 8/24/15. R46's medical record indicted resident had TB symptom screening on 11/15/15, however had not received either the step one or step two TST's. R32 was admitted to the facility on 10/5/15. R32's medical record indicted resident had not had the TB symptom screening, step one and step two TST.	21426		

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21426	Continued From page 60 R33 was admitted to the facility on 10/29/15, and was re-admitted again 12/29/15. R33's medical record indicted resident had a TB symptom screen done 12/29/15, however had not received either the step one or step two TST's since being admitted to the facility. R9 was admitted to the facility on 11/5/15. R9's medical record indicted a TB symptom screening had been completed on the same day. The medical record revealed even though R9 had received step one TST on 11/5/15, read 11/7/15, as 0 mm with a "Negative" interpretation, R9 had not received step two. R63 was admitted to the facility on 11/2/15. R63's medical record indicted a TB symptom screening had been completed on the same day and a step one TST was given on 11/3/15, however was never read and a step two TST was never administered. Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening Health Care Workers (HCW's) directed: "TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative)... In addition the regulation directed "Screening should be initiated within 72 hours of admission and "Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing for TB risk factors and TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering	21426		

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21426	Continued From page 61 either a two-step TST or single IGRA..." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure tuberculin screening procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medication refrigerator temperature was kept within manufacturer's recommendation range, and the facility failed to ensure the refrigerator temperature was monitored. This had the potential to affect 12 of 52 residents (R39, R45, R15, R62, R14, R34, R70, R36, R10, R21, R69, R53) currently resided in the facility. In addition R62's medications kept in the room were not locked and secured, and insulin vial was not dated when opened. Findings include: During medication room observation in the	21610		

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21610	Continued From page 62	21610		

presence of the licensed practical nurse (LPN)-D on 1/28/16, at 9:08 a.m. the medication refrigerator was at 55 degrees Fahrenheit (F). LPN-D stated resident's extra medication supply such as insulin was stored in this refrigerator, and temperature was too high. The temperature log above the refrigerator was from July 2015 (from 6 months ago) and had only four temperature results recorded. When asked for the current temperature log, LPN-D stated she could not find any for the past 6 months. The following unopened medications were observed stored in the refrigerator:
- Afluria 5 milliliter (ml) (influenza virus vaccine)
- Nine vials of Infuvite (multiple vitamins for intravenous infusion) for R39
- One Novolog insulin pen (used to treat diabetes) for R45,
- Two Novolog insulin vials for R15,
- Three Novolog insulin pens for R62,
- One vial of Lantus insulin (also used to treat diabetes) for R34,
- One Lantus insulin vial for R70,
- One Lantus insulin vial for R36,
- Two Lantus insulin pens for R10,
- Three Lantus insulin pens for R21,
- One Humalog insulin (also used to treat diabetes) pen for R69,
- One bottle of Latanoprost 0.005 percent (%) (eye drops) for R53,
- One vial of Lorazepam injection (with no resident name on)

LPN-Z was not sure if the thermometer was accurate or not, suggested to recheck temperature with another thermometer.

On 1/28/16, at 9:12 a.m. the director of nursing (DON) verified the refrigerator temperature should have been between 36 and 46 degree F, and stated night staff were responsible for

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21610	Continued From page 63 checking the refrigerator temperature daily at night. The DON also verified the last temperature checks were done 6 months ago in July 2015. On 1/28/16, at 10:55 a.m. the medication refrigerator temperature was checked again by LPN-A, and it was at 48 degrees (still too high). On 1/28/16, the nurse consultant (NC)-C was interviewed and stated the refrigerator temperature should have been kept between 36 and 46 degrees F, and the refrigerator temperature monitored daily. The undated manufacturer's recommendation for unopened Latanoprost eye drops, Lantus, Novolog, Infuvite, Humalog, and Lorazepam storage was to be stored at 36 F- 46 F. The pharmacy consultant (PC) was interview via phone call on 1/28/16, at 3:10 p.m., and stated the medication refrigerator temperature should have been kept between 36 and 46 degrees F, and the above listed medications also should have been kept between these temperature ranges. PC also stated refrigerator monitoring should include daily temperature checks. PC further stated he had many conversations in the past with staff about refrigerator temperature monitoring, but was not aware the refrigerator temperature was running so high. The undated Medication Storage in the Facility policy indicated "Medications requiring "refrigeration" are kept at temperatures ranging from 2/36 degrees C/F [Celsius/Fahrenheit] to 8/46 degrees C/F in a refrigerator not accessible to patients". The facility's Monitoring of Refrigerator	21610		

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21610	Continued From page 64 Temperatures dated 4/12, indicated "Night Charge Nurse will check refrigerator temp [sic-temperature] and record on monitoring sheet on the front of the fridge". The policy did not clearly indicate frequency of temperature checks. R62 On 1/25/16, at 1:47 p.m. R62 was observed and interviewed in his room. There was plastic container with blood sugar check supplies and insulin observed on the top of the nightstand. When interviewed R62 stated he did his own blood sugar checks, and self-administered the insulin, and showed the content of the box. There was a Novolog pen dated opened on 1/17/16, another Novolog pen dated opened on 1/24/16, and an opened Lantus vial not dated when it was opened (with pharmacy delivery dated 1/11/16). R62 also showed two medication carts with Metformin 1000 mg, each with 30 tablets. R62 stated he kept his medication supply usually on the bedside table, did not lock them in the drawer if he went to the dining room, only if he left the facility and went out. On 1/28/16, at 8:23 a.m. R62 was observed eating breakfast in the dining room. At this time the plastic container with the insulin was observed again unattended/ unlocked in R62's room on the bedside table. On 1/28/16, at 8:24 a.m. the DON verified the medication box with insulin supply was on the bedside table, and stated medications in residents rooms supposed to be kept locked in the top drawer of the dresser. DON also stated the Lantus insulin should have been dated with the date when opened.	21610		

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21610	Continued From page 65 On 01/28/16, at 9:08 a.m. LPN-D also stated R62's medications should have been locked in his room in the top drawer of the dresser. The undated Medication Storage in the Facility policy did not include instructions for medication storage requirements in resident's rooms. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that medications are stored appropriately. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty - one (21) days.	21610		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a chair was maintained in a clean and sanitary manner for 1 of 1 resident (R27). In addition failed to ensure 3 of 3 residents (R12, R41, R21) had their wheelchairs maintained in good repair reviewed for environmental concerns. In addition, the	21695		

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21695	Continued From page 66 facility failed to ensure assist bar for positioning and transfers was properly secured to resident bed to assure safe use for 1 of 1 resident (R12) who utilized assist bars. Findings include: R27 lazy boy recliner chair was observed on 1/26/16, at 8:57 a.m. during room observation with spots on the arm and sitting part perhaps secretions from trach and suctioning. On 1/28/16, at 12:04 p.m. to 12:32 p.m. during the environmental tour with the regional manager (RM) verified the lazy boy which was covered with spots of perhaps secretions stated would have to bring a spot cleaner and use disinfectant to clean the chair when resident was not up on it. During the tour resident was observed seated on the chair and was able to acknowledge all the spots and stated he would not blame anyone for it and gave surveyor thumbs up when surveyor indicated RM was going to clean it. R12's Broda wheelchair right armrest on 1/25/16, at 11:46 a.m. during room observation was observed broken and was missing front edge of foam. On 1/28/16, at 12:04 p.m. to 12:32 p.m. during the environmental tour R12 was observed seated on his Broda wheelchair in the North dining room both the administrator and the regional manager (RM) verified the wheelchair had simmers of what appeared to be dry food on the side. In addition the regional manager verified foam was missing on the right armrest and was exposing gray foam underneath making it not a cleanable surface. RM stated thought was due to staff probably	21695		

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21695	Continued From page 67 shaving the wheelchair under the tables. RM was overheard indicated to the administrator the armrest was going to be replaced. R12's annual Minimum Data Set (MDS) dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a wheelchair for mobility. R41's wheelchair was observed to be in ill repair On 1/28/16, at 12:25 p.m. during the environment tour R41 was seated on the wheelchair at the dining table waiting for lunch and the left armrest was observed cracked and the vinyl was peeled off and was exposing the foam underneath making it an uncleanable surface. RM verified it. R41's annual MDS dated 11/13/15, indicated R41 had severely impaired cognition skills, required total dependence for locomotion on and off the unit and used a wheelchair for locomotion. R21's wheelchair was observed to be in ill repair On 1/26/16, at 12:01 p.m. R21's left armrest of the electric wheelchair was observed with vinyl cracked, peeled off and was exposing the yellow foam underneath making it an uncleanable surface. On 1/28/16, at 12:44 p.m. during the environmental tour the RM stated the electric wheelchair was resident own personal wheelchair. RM stated staff were supposed to call family member if they noticed any concerns so family would provide replacement parts. RM	21695		

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21695	Continued From page 68 verified the wheelchair was with ill repair and acknowledged staff should have reported the concern immediately to his department to be addressed to prevent causing skin issues. R21's admission MDS dated 11/13/15, indicated R21 had intact cognition, required extensive physical assistance with transfers, had a functional limitation of both lower extremities and used a wheelchair for locomotion. Environmental- Cleaning of Equipment policy dated April 1, 2008 indicated "All unit equipment (e.g., refrigerator, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and enteral equipment) is cleaned on a routine basis." R12's Enabler bar: During initial tour on 1/25/16, at 4:09 p.m. the right assist rail which was attached to the bed, nearest the door, was noted to bow outward. R12 was in the day room sitting in a wheelchair. On 1/27/16, at 7:07 a.m. R12 was observed lying in bed with head turned to the left. The right assist rail was bowing outward. R12's Minimum Data Set (MDS) dated 11/3/15, identified diagnosis of right sided hemiplegia, stroke and dementia. R12's Fall Care Area Assessment dated 11/3/15, indicated R12 had balance problems during transfers between bed and wheelchair. Care plan printed 1/28/16, indicated R12 was at risk for fall related to hemiplegia, dementia, impaired mobility and urinary and fecal incontinence. Interventions included call light	21695		

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21695	Continued From page 69 within reach, perimeter mattress on bed to reduce the potential of falls, extensive to total assistance with transfers and bed mobility to decrease the potential for falls, and resident uses enabler bars when in bed. On 1/27/16, at 9:22 a.m. the regional manager verified the enabler bar was loose. The regional manager stated the assist bar should be taken off, ensure the holes have not been rounded off, tightened and then replaced. The regional manager stated the maintenance technicians are to audit all assist rails every week. They are to check every bar in the building. Work history report indicated that Facility Safety: Check assist rails was done on 1/25/16, 1/22/16, not recorded for the week of 1/9/16 and was last done on 12/31/15. On 1/27/16, at 12:57 p.m. licensed practical nurse (LPN)-A stated [R12] will grab the bar and help to roll from side to side. SUGGESTED METHOD OF CORRECTION: The administrator, environmental director or designee (s) could revise policies and procedures to ensure that the environment for the residents is free from hazards, safe, functional, sanitary, and comfortable for the residents, staff and the public. The administrator, environmental director or designee (s) could provide in-servicing to all staff related how to ensure the environment the policies and procedures are followed. The administrator, environmental director or designee (s) could monitor the status of physical plant conditions periodically to ensure that a routine maintenance plan in place is being effectively instituted.	21695		

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21695	Continued From page 70 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21695		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comfortable temperatures were maintained in a shared room for 2 of 5 residents (R46, R12) reviewed for environment with room temperature concerns. Findings include: R46's quarterly Minimum Data Set (MDS) dated 11/26/15, indicated resident had intact cognition. On 1/26/16, at 9:37 a.m. when asked during interview if there was any problems with the	21705		

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21705	Continued From page 71 temperature, lighting, noise or anything else in the building that affected his comfort, R46 stated "It was not warm enough." During the interview R46's bed was observed right next to the heat radiator on the wall and was also covered with three heavy blankets on top of him which were not facility blankets. On 1/28/15, at 7:40 a.m. R46 stated he had reported the cold room temperature to the staff but was not sure when it was going to be addressed and in the meantime was using heavy blankets to keep warm. R12's annual MDS dated 11/3/15, indicated resident severely impaired cognition skills and family was involved in care decisions as a result. On 1/26/16, at 11:28 a.m. during a family interview with R12's family when asked if there were any problems with the temperature, lighting, noise or anything else in the building that affected R12's comfort, family member stated during visits to the facility the room was always cold which R12 was not able to verbalize. On 1/28/16, from 12:04 p.m. to 12:32 p.m., an environmental tour was conducted with the regional manager (RM) and the administrator. During the tour the RM checked the room temperatures twice. The first temperature reading registered at 68 degrees Fahrenheit, and the second reading registered at 69 degrees Fahrenheit. Both the administrator and the RM verified the readings and stated they would adjust the thermostat located by the door to the room. The administrator also stated she would educate staff about ensuring maintenance were aware of resident concerns about room temperatures.	21705		

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21705	Continued From page 72 The facility's policy, Environment - Quality of Life (General) dated April 1, 2008, indicated "Comfortable and safe temperature levels (71-81 degrees F)..." SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop and implement policies and procedures to ensure resident rooms are maintained at a comfortable temperatures; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21705		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who	21800		

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21800	Continued From page 73 speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or uniform denial letter upon termination of all Medicare (MC) Part A skilled services for 1 of 5 residents (R43) reviewed for liability notice and beneficiary appeal rights. In addition, the facility failed to provide R43 with the Notice of Medicare Non-coverage CMS-010123 when R43 remained in the facility until discharge. Findings include: R43's closed record was reviewed and indicated R43 had been admitted to the facility on 7/29/15, and had been discharged 8/11/15. In addition, the record indicated R43 had received skilled physical and occupational therapy. The record indicated R43's payment source had been MC. When questioned on 1/28/16 at 8:50 a.m., about the MC denial notice for R43, the business office manager stated she was unable to locate the notice(s) provided. After looking through R43's closed record, the business office manager	21800		

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21800	Continued From page 74 stated, "I can't find it." On 1/28/16, at 2:35 p.m., the registered nurse (RN)-B responsible for Minimum Data Set assessments stated, "Typically we would give the Medicare notices two days before the end of therapy." When asked whether R43 had been given a notice prior to the end of the skilled therapy services, RN-B stated the resident had left before the notice could be provided. RN-B stated she didn't have any other information, because the person responsible for giving the resident the notice no longer worked at the facility. On 1/28/16, at 2:48 p.m. the director of nursing stated she would expect residents to be given appropriate and timely MC denial notice as required by MC. On 1/28/16, at 3:17 p.m., the physical therapy assistant (PTA) stated after having reviewed the therapy notes, the therapy department had held weekly therapy meetings and during the 8/7/15, meeting which was a week before the end of the skilled services it had been discussed resident was going to be discharged from therapy. PTA stated the resident had made good progress and had met their maximum potential. PTA stated the resident had been provided therapy from 7/29/15 through 8/10/15, when R43 was discharged from therapy. The resident had then stayed in the facility for another night not eligible for MC coverage. The facility provided their current policy entitled, Medicare Compliance: Expedited Review, Denial Letter, Appeals Process, Consolidated Billing-HDGR (Health Dimensions Group) policy revised January 2013; ..."2. This notice must be	21800		

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21800	Continued From page 75 given at least two (2) days prior to the end of skilled services for the resident." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21800		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were accessible for 2 of 2 residents (R15, R10) reviewed who utilized call lights to summon staff	21810		

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21810	Continued From page 76 assistance. Findings include: R15 was observed on 1/25/16, at 11:45 a.m. in her room sitting in the wheelchair. R15's call light was observed on the floor next to R15's wheelchair, and was out of R15's reach. When interviewed, R15 stated she needed her call light so she could call for help. R15 also stated it had happened in the past that the call light was not left within reach, and she needed to remind staff before leaving the room to place the call light within reach. At that point the nursing assistant (NA)-I entered the room, verified the call light was not within R15's reach, picked up the call light and handed it to R15. NA-I stated the call lights supposed to be placed always within residents reach. R15's admission Minimum Data Set (MDS) dated 12/30/15, indicated R15 was cognitively intact. R10 was observed on 1/26/16, at 11:17 a.m. and interviewed in her room. R10 was laying in her bed, and stated she routinely used the call light when she needed help. R10 then looked for the call light but could not find it. Registered nurse (RN)-A nurse manger was interviewed on 1/26/16, at 11:25 a.m. and verified R10 was capable of using the call light. RN-A confirmed R10's call light was not within reach, and looked for the call light. RN-A located the call light which was wrapped up in the bedding at the foot of the resident's bed. RN-A stated staff were expected to place the call light within the reach of the resident when they left the room. R10's admission MDS dated 10/27/15, indicated R10 had moderate cognitive impairment.	21810		

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21810	Continued From page 77 On 1/28/16, at 9:43 a.m. the director of nursing stated staff were expected to make sure call light were placed within residents' reach all the time. The facility's call light policy was requested, but not provided. The call light policy was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure call lights are kept within resident reach. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		