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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: L7J8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00951

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245364**

2.STATE VENDOR OR MEDICAID NO.
(L2) **244742800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANNANDALE CARE CENTER**
(L4) **500 PARK STREET EAST**
(L5) **ANNANDALE, MN** (L6) **55302**

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)

6. DATE OF SURVEY **07/06/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (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
	60			
(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 :
Timothy Rhonemus, HFE NE II 07/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 07/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/30/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245364
July 26, 2017

Ms. Debra Reitmeier, Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

Dear Ms. Reitmeier:

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 June 9, 2017 the above facility is certified for or recommended for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 26, 2017

Ms. Debra Reitmeier, Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

RE: Project Number S5364029

Dear Ms. Reitmeier:

On May 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 4, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 12, 2017 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 May 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 9, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2017, effective June 9, 2017 and therefore remedies outlined in our letter to you dated May 18, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245364 Y1	A. Building B. Wing Y2	7/6/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	500 PARK STREET EAST ANNANDALE, MN 55302

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 F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0315	Correction
Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24, 483.25(k)(l)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	06/09/2017	LSC	05/12/2017	LSC	06/05/2017
ID Prefix F0318	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(c)(2)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/09/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			T	7-6-17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE HFE nurse Eval II	DATE 7-6-17

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/4/2017	

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
245364 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/12/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	500 PARK STREET EAST ANNANDALE, MN 55302

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	K0341	05/02/2017	LSC	K0345	05/01/2017	LSC	K0353	06/06/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0374	05/02/2017	LSC	K0712	05/01/2017	LSC	K0920	05/08/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0923	05/30/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/1/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 26, 2017

Ms. Debra Reitmeier, Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

Re: Reinspection Results - Project Number S5364029

Dear Ms. Reitmeier:

On July 6, 2017 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 4, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00951 Y1	A. Building B. Wing Y2	7/6/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	500 PARK STREET EAST ANNANDALE, MN 55302

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 20565	Correction	ID Prefix 20830	Correction	ID Prefix 20895	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0525 Subp. 2.B	Completed
LSC	06/09/2017	LSC	05/12/2017	LSC	06/05/2017
ID Prefix 20910	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.0525 Subp. 5 A.B	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/09/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			[signature]	7-6-17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE HFE nurse Eval II	DATE 7-6-17

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/4/2017	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: L7J8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00951

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245364**

2.STATE VENDOR OR MEDICAID NO.
(L2) **244742800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANNANDALE CARE CENTER**
(L4) **500 PARK STREET EAST**
(L5) **ANNANDALE, MN** (L6) **55302**

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)

6. DATE OF SURVEY **05/04/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(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 :
Michelle Thompson, HFE NE II — 05/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/30/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 18, 2017

Ms. Debra Reitmeier, Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

RE: Project Number S5364029

Dear Ms. Reitmeier:

On May 4, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
brenda.fischer@state.mn.us
Telephone: (320)223-7338 Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 13, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 13, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 4, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 4, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	**500 PARK STREET EAST ANNANDALE, MN 55302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/1/17 to 5/4/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Annandale Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions as directed for 5 of 5 residents (R38, R18, R67, R15, and R36) who received	F 282	F282 SERVICES BY QAULIFIED PERSON/PER CARE PLAN 1) How corrective action will be	6/9/17

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

Electronically Signed | 05/26/2017

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F 282	Continued From page 1 range of motion (ROM) from restorative nursing. This had the potential to effect 28 residents identified as receiving a restorative nursing program. Findings include: R38's facesheet (undated) had diagnoses of Alzheimer's dementia with behaviors, major depression and Contractures of muscle, multiple sites. R38's Significant Change in Status Minimum Data Set (MDS), dated 4/14/2017, indicated the resident was severely cognitively impaired, was totally dependant with all activities of daily living (ADLs). The MDS identified R38 had functional limitations in ROM on one side of upper extremities which included shoulder, elbow, wrist and hand. The restorative nursing section identified no restorative programs were implemented. Review of R38's care plan (last reviewed 4/21/17), indicated that "R38 participates in a nursing rehab program to prevent contractures." The facility indicated in the care plan that R38 was to receive, "Nsg [nursing] rehab program: up to 3-5 x/wk has with ROM, LE [lower extremities] PROM [passive range of motion] 3/-5x/wk [3 to 5 times a week]. Complete bilateral upper extremity ROM. Wash left hand." During observations on 05/03/2017 at 9:10 a.m., nursing assistant rehabilitation (Rehab)-A entered R38's to provide ROM. Rehab-A positioned R38 on his back and wrapped a warm moist wash cloth around his left hand. Rehab-A completed ROM of R38's shoulder, elbow, and hand. She continued to provide ROM to R38's left leg, knee and foot, repeating the same on the right side,	F 282	accomplished for those residents found to be affected: The RN reassessed Resident R3's restorative nursing needs and discontinued the program due to an increase in behaviors; the care plan was updated to reflect current status. Resident R18 is currently working with physical therapy; when completed, the ROM program will be contracture prevention for bilateral lower extremities 3-5 times/ week. Resident R67 is currently working with occupational therapy and will have a shoulder ROM program upon completion with restorative nursing 3-5 times/week. R67 continues to decline attending exercise class daily so this was discontinued from her care plan. Resident R36 is currently working with occupational therapy and will have an upper ROM program with restorative nursing 3-5 times/week upon completion. Resident 15 had restorative nursing needs reassessed and the ROM program will be discontinued due to an anticipated health decline with hospice status. Care plan interventions have been updated to reflect current status. 2) How to identify other residents having the potential to be affected by the same practice: The RN continues to meet weekly with the	

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F 282	Continued From page 2 and finished with R38's right shoulder, arm and hand. Review of R38's monthly ROM data collection tools from March to May 2017 entitled: Attachment C identified the following frequency: May 1-3, 2017 - received 2 treatments April 1-30, 2017 - received only 4 treatments with the 5th documented as "AG" (agitated) March 1-31, 2017 - received only 7 treatments with one treatment documented as "AG" and another "O" (MD appointment, visitor, etc) During interview on 5/3/17, at 11:52 a.m., Rehab-A stated there were two nursing rehabilitation staff work alternating days, and are not scheduled as direct care nursing assistants. However, at times the two have been pulled to cover direct care positions along with rehab and to lead the facility's exercise group daily. Rehab-A identified because of the heavy work load ROM does not get always get completed. Rehab-A reviewed the ROM data collection tool from March to May 2017 and the ROM frequency was not met for R38 as identified by the care plan. During an interview on 5/3/17 at 1:59 p.m., Wing B care manager registered nurse (RN)-B stated the Rehab RN reviews with the rehab staff once a week (on Fridays), to see if there are changes or concerns with the residents. RN-B stated she was unaware that R38 had not received ROM 3-5 times a week for the months of March and April 2017, as identified by the care plan. R18's facesheet (undated) had the diagnoses of	F 282	rehab staff and audits were completed on all residents in the restorative nursing program on 5/19/17 and 5/26/17 to monitor that care plan interventions are carried out by staff. 3) Measures put into place or systemic changes made to ensure practice will not recur: The structure of the restorative nursing program was revised to include the addition of an activity exercise program for those unable to meet the criteria of participation for the Fit 4 life class. Additional nursing hours have been dedicated to the restorative nursing program to assure compliance with care planned goals. The restorative nursing program and policies and procedures have been revised and staffed trained on the changes. Weekly rehab meetings to review individual resident goals and compliance with the program will continue. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system. An RN will audit the implementation of the care planned interventions weekly for four weeks then monthly for three months after the correction date. The results will be discussed monthly at the Quality of Life committee and the committee will determine when compliance is indicated.	

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F 282	Continued From page 3 dementia with Lewy Bodies, transient ischemic attack (TIA) and sleep disorder. R18's quarterly MDS, dated 3/15/17, indicated they were severely cognitively impaired and totally dependant with all ADLs and had no functional limitations in ROM. The restorative nursing section identified restorative nursing had not occurred. R18's care plan, updated 4/24/17, indicated, "[R18] participates in a nursing rehab program to maintain current ability and to prevent decline in ability to do ADLs." Rehab nursing to perform "bilateral LE ROM program in supine (on R18's back) X [times] 20 reps [repetitions] each direction 3-5 times wk [weekly], and "UE [upper extremity] ROM program" 3-5 times a week. Review of the monthly ROM data collection tools, entitled: Attachment C (last revised 3/08), indicated that R18 received ROM for the following frequency: May 1-3, 2017 - received 1 treatment April 1-30, 2017 - received only 4 treatments with the 5th documented as "O" (MD appointment, visitor, etc) March 1-31, 2017 - received only 6 treatments with one treatment documented as "I" (illness) and two others documented as "O" (MD appointment, visitor, etc) During interview on 5/4/2017 at 11:20 a.m., the assistant director of nursing (ADON) reviewed the ROM data collection tool, and stated R18 was missing ROM treatments. R18's care plan for ROM was not being implemented. R67's Resident Face Sheet, undated, identified	F 282	5) The date each deficiency will be corrected: Correction date: June 9, 2017	

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F 282	Continued From page 4	F 282		

resident had arthritis in multiple sites. R67's quarterly MDS of 3/14/17 identified the resident was cognitively intact, required staff assistance of one to two to complete activities of daily living including. The MDS identified R67 had functional limitations in range of motion bilateral upper extremities of shoulder, elbow, wrist and hand. There was no indication R67 received any restorative nursing.

During interview on 5/3/17, at 11:07 a.m. R67 reported increased pain and discomfort in her right shoulder, hip, and thigh but dislikes taking pain medications for this. R67 stated exercises are completed with by an "Aide who has been trained by therapy", however these are not completed with any frequency. The exercises are completed on an average of one time per week. She stated her, "Shoulders are definitively worse" since coming to the facility. Per observation R67 had some limitations with opening and closing her right hand and held her right shoulder close to her body.

R67's care plan, updated 3/15/17, identified resident was to participate in the Fit 4 Life program which consisted of stretches, balance-transfer exercises and strength training for Tuesday and Thursday programs. The care plan also identified R67 had shoulder exercise/stretch program 3 to 5 times per week with Nursing Rehab program.

Review of the monthly ROM data collection tools, titled: Attachment C (last revised 3/08), indicated R67 received ROM bilateral shoulder exercise program at the following frequency:

May 1-3, 2017 - received 0 treatments

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F 282	Continued From page 5 April 1-30, 2017 - received only 1 treatments at the frequency of "30", five entries were denoted "O" representing Other (MD appointment, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and another entry indicated "R" refused. March 1-31, 2017 - received only 3 treatments with the frequency of 20-30-20, with an additional 9 entries identified as "O", with no additional information, and 1 entry identified as "A" for participation in another activity. February 1-28, 2017-2 entries are identified as "O" with no additional information, 1 entry was identified as "A", and one noted resident was on LOA (leave of absence). January 1-31, 2017-1 entry identified resident received 15 minutes of 1:1 interaction, 1 entry was identified as "A", 2 entries indicated "I" (illness), and 3 entries indicated "O". December 1-31, 2017-2 entries identified R67 received 15 minutes of 1:1 therapy, 6 entries identified "O", with no additional explanation, 1 entry identified resident was "A", and 1 entry indicated "A/R". During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R67 comes to exercise class, Fit 4 Life, on Tuesday and Thursdays. Rehab-A stated R67 had consistently declined participation in class and was to receive shoulder exercise/stretch program three to five times a week, Rehab-A stated if R67 was not ready for her exercises when they arrived, they were unable to return at a later time to complete exercises as directed by the care plan. R36's undated Resident Face Sheet identified R36 had arthritis with difficulty with multiple joints	F 282		

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F 282	Continued From page 6	F 282		

impacted. R36's quarterly MDS of 1/31/17 identified resident had moderate cognitive impairment and received assistance of one to two staff to complete ADL's. The MDS did not identify any functional limitation in ROM.

R36's care plan, edited on 12/7/16, identified R36 was to be evaluated by physical therapy and occupational therapy for strength training and toning. The care plan directed staff to follow recommendations outlined by therapy. Rehab Nursing was instructed by OT to assist R36 with "right upper extremity repetitions with prolonged stretch at the end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." R36 was also to attend the Fit 4 Life class.

Review of the facility document Attachment C monthly logs for R36's participation in rehab nursing of PROM to the right upper extremity from January to May 2017 logs identified the following:

May 1-3, 2017 - received 1 treatment.
April 1-30, 2017 - received only 7 treatments at the frequency of "10" 1:1 (one to one) minutes, 5 entries were denoted "O" representing Other (MD appointment, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and 1 entry indicated "R."
March 1-31, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, with an additional 2 entries where resident had refused therapy.
February 1-28, 2017-received 2 episodes of treatment with the frequency of "15" 1:1 minutes,

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and two dates "I" (illness) was indicated.
January 1-31, 2017-received 5 episodes of treatment with a frequency of "15" 1:1 minutes, and one noted incident where resident refused.

During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R36 has been an active participant in the Fit 4 Life program and has been willing to complete the program. R36 was to receive a hamstring stretch with standing frame, and PROM (passive range of motion) to right upper extremity. Rehab-A stated R36 was an active participant in exercise group so the PROM exercises were not completed due to prioritizing other Rehab Nursing tasks to be completed.

R15's undated Resident Face Sheet identified a diagnosis of arthritis. R15's quarterly MDS of 3/18/17 indicated a severe cognitive deficit and the need for extensive assistance of one to two staff to complete ADL's. The MDS identified no functional impairment of range of motion.

R15's care plan, reviewed 3/20/17, identified R15 was to receive bilateral ROM to lower extremities with nursing rehab program 3 to 5 times per week to maintain current ability.

In review of the monthly rehabilitation logs from December 2016 thru February 2017 identified R15 received ROM bilateral shoulder exercise program as follows:

December 1-31, 2016 - received 8 treatments of 15 1:1 (one to one) minutes
January 1-31, 2017 - received only 7 treatments of 15 1:1 minutes
February 1-28, 2017 - received only 5 treatments

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F 282	Continued From page 8 with the frequency of 15 1:1 minutes, and one notation of "O". During interview on 5/3/17, at 12:06 p.m. Rehab-A stated they were unable to complete exercises because of limited time. During interview on 5/4/17, at 12:20 p.m. the director of nursing (DON) stated she was aware Rehab Nursing was not being completed at the frequency recommended by therapy. The facility was currently re-evaluating the process. A policy, titled Care Planning Process , dated 12/02, identified that the care plan was to direct the deliverance of care provided and documentation was reflective of following the plan of care.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309		5/12/17

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F 309	Continued From page 9 practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate care with an outside psychiatry service and act on their recommendations for 1 of 1 residents (R51) reviewed who received outside psychiatry services. Findings include: R51's quarterly Minimum Data Set (MDS) dated 2/25/17, identified R51 had intact cognition and required extensive assistance with her activities of daily living (ADLs). Further, the MDS identified R51 displayed symptoms of depression including, "Feeling tired or having little energy," nearly everyday and had pain, "Almost constantly." During observation on 5/1/17, at 6:03 p.m. R51 was seated in an electric wheelchair in the hallway. R51 had visible contractures on her	F 309	F309 Provide care/ services for the highest well being 1) How corrective action will be accomplished for those residents found to be affected: Annandale Care Center coordinates the care and recommendations of outside providers. R51's primary care provider reviewed and addressed the psychology recommendations on 5/4/17. 2) How to identify other residents having the potential to be affected by the same practice: A facility wide audit for those with psychology services was completed and found in compliance with the coordination	

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F 309	Continued From page 10 lower extremities with nearly constant tremors of her arms and neck. R51 stated her contractures hurt, "Awful bad," at times. R51's care plan dated 2/28/17, identified R51 had depression and was taking antidepressant medication. The care plan identified R51, "Worries and ruminates over changes in body/medical problems," and directed staff to attempt gradual dose reductions of medications when indicated and monitor R51's status and update the physician as needed. The care plan lacked any interventions or dictation which identified R51 was being seen by psychology services. R51's Associated Clinic of Psychology Progress Note dated 3/31/17, identified R51 had adjustment and personality disorder(s) and had been working with the psychologist to help cope from some family relationship stressors. R51 was identified to, "...reports her own mood is about the same with continued episodes of crying and sweating," and, "[R51] does report pain." Further, the note identified a section labeled, Recommendations, and listed R51, "Continues to report sadness and depressive symptoms ... may benefit from Cymbalta [medication used to treat pain and depression] if not contraindicated, given her reports of sadness and pain. This will be deferred to her PCP [primary care provider]." R51's following physician progress note dated 4/4/17, identified R51 had chronic pain and depression with anxiety. The note listed an, "Assessment [and] Plan," section and identified each diagnosis R51 displayed including, "Moderate episode of recurrent major depressive disorder," and, "Chronic pain of both extremities."	F 309	of care. 3) Measures put into place or systemic changes made to ensure practice will not recur: A new process was implemented on 5/4/17 to have psychology notes distributed to the care planning team for review and follow-up. The Psychology Services policy and procedure was updated and communicated to the team. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system. Social services will audit all of the psychology progress notes for 4 weeks and randomly thereafter. The audit results will be discussed at the Quality Assurance meeting who will determine when compliance is indicated.	

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F 309	Continued From page 11	F 309		

The physician increased R51's ordered Fentanyl patch (narcotic duragesic patch) and identified R51 was, "Stable," on her current medication regimen for depression. There was no identified reference or dictation addressing the psychologist' recommendation to consider adding Cymbalta to R51's medication regimen as identified in the 3/31/17 note.

R51's medical record was reviewed and lacked any evidence R51's physician had addressed or considered the psychologist's recommendation. Further, R51's signed physician orders dated 4/4/17, lacked any orders or trial dosing of Cymbalta.

When interviewed on 5/4/17, at 8:36 a.m. nursing assistant (NA)-A stated R51's mood, "hasn't really changed," in the past months. NA-A stated R51 still does have episodes of crying, "Every once in awhile," about being unable to care for herself or return to her home.

During interview on 5/4/17, at 12:04 p.m. registered nurse (RN)-A stated R51 had a history of pain and recently had her narcotic medication dosing increased as a result. RN-A stated R51 also had, a lot of personal "stuff," going on in her life; however, felt R51's mood was good. At 12:41 p.m. RN-A stated she had reviewed R51's medical record and spoke to R51's nurse practitioner. The psychologist's recommendation to consider adding Cymbalta had not been addressed because someone missed it. Further, RN-A stated the recommendations should have been looked at and addressed.

A facility Psychology Services policy dated 6/2016, identified a procedure which included,

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F 309	Continued From page 12 "Dictated notes are sent to the facility for resident charts. Notes with recommendations are reviewed by the primary physician at the next scheduled resident visit."	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the	F 315		6/5/17

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F 315	Continued From page 13 facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess a change in continence status for 1 of 1 residents (R39) reviewed for urinary incontinence. Findings include: R39's admission Minimum Data Set (MDS) dated 12/28/16, indicated she was moderately cognitively impaired. The MDS further indicated she needed total assist of two with toileting and had occasional incontinence (seven or less episodes of incontinence). R39's care area assessment (CAA) dated 12/28/16, identified she had urinary urgency and had problems with occasional dribbling, and had cognitive and mobility impairment. R39's Bowel And Bladder Assessment dated 12/28/16, indicated she was continent of bowel and bladder and she would call for toileting during the day and toilet with bedpan at night every four hours. R39's Point Of Care History (lists episodes of incontinent and continence of urine) dated 12/22/16 to 1/17/17, identified she was incontinent of urine once. R39's quarterly MDS dated 3/30/17, indicated she needed extensive assist of two with toileting and was frequently incontinent of urine (seven or more episodes). R39's Bowel and Bladder Assessment dated 3/29/17, indicated she was incontinent of urine and wore absorbent pads. The assessment further indicated she will call for toileting and toilet every four hours at night. A	F 315	F315 No catheter, prevent UTI, restore bladder 1) How corrective action will be accomplished for those residents found to be affected: A comprehensive assessment was completed for R39 and accurately reflects the continence status and toileting plan of the resident. The care plan was updated to reflect the resident's current needs and this was communicated to staff caring for R39. 2) How to identify other residents having the potential to be affected by the same practice: All residents who have bowel and bladder incontinence were reassessed for accuracy. Residents will continue to have a comprehensive Bowel & Bladder assessment completed per the revised policy and procedure on admission, quarterly, annually and with a significant change in status. The information will be reflected on each residents care plan to indicate individualized continence and toileting needs.	

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F 315	Continued From page 14 Point Of Care History dated 3/23/17 to 3/30/17, indicated she was incontinent of urine 11 times with various times over the day. R39's care plan dated 1/12/17, indicated she was on a will call toileting plan related to occasional dribbling of urine, and wore an incontinence products. During interview 5/2/17, at 3:06 p.m. registered nurse (RN)-B stated she thought the reason R39 had an increase in incontinence was related to a urinary tract infection and was started on a antibiotic on 3/26/17. RN-B stated she was not sure if R39 still had problems with incontinence. During interview 5/2/17, at 3:30 p.m. NA-C stated she works the day shift and about 2-3 times a week R39 was incontinent of urine. She got R39 up this morning and she was incontinence of a medium amount of urine. During interview 5/2/17, at 3:24 p.m. nursing assistant (NA)- B stated he works evenings and nights and R39 will usually let him know when she has to use the bathroom on the evening shift. When he works nights she was always incontinent and was usually wet around 2:00-2:30 a.m. During interview 5/2/17, at 3:26 p.m. licensed practical nurse (LPN)-A stated works on the day shift and R39 was usually incontinent of urine when she gets up in the morning. During interview 5/3/17, at 7:08 a.m. NA-E stated she works the day shift and R39 was very sleepy at night and this may be a reason why she was incontinent at night. NA-E stated (R39) was	F 315	3) Measures put into place or systemic changes made to ensure practice will not recur: RN case managers were educated on the revised Bowel and Bladder Policy and Procedure. Nursing staff were educated on Bowel and Bladder documentation and policy. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system. The DON or designee will perform monthly audits on Bowel and Bladder assessments for 10% of the residents scheduled for an MDS for three months after compliance date and randomly thereafter or as deemed necessary by the Quality of Life subcommittee. The results will be discussed monthly at the Quality of Life committee and the committee will determine when compliance is indicated. 5) The date each deficiency will be corrected: Correction date: June 5, 2017	

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F 315	Continued From page 15 usually wet when she wakes up, but during the day she will tell us when she needs to use the bathroom. During observation 5/3/17, at 7:20 a.m. R39 was in the bathroom voiding in the toilet with NA-D assisting her. During interview 5/3/17, at 10:56 a.m. RN-B stated she did not realize (R39) had an increase with urinary incontinence, and they needed to reassess R39's bladder function, and develop a new plan that was more specific to her needs. The facilities Bladder and Bowel Policy and Procedure revised 2/15, indicated "It is the policy that the facility will ensure that each resident that is incontinent of bladder and/or bowel is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible through use of appropriate treatment and services. It is the policy to also identify risk factors and assess resident who are continent of bladder and bowel for the purpose of maintaining current function." The policy further indicated the RN determines the appropriate toileting or bladder/bowel retraining program as assessed. This is care planned and staff are informed of the plan.	F 315		
F 318 SS=E	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		6/9/17

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F 318	Continued From page 16 (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative nursing programs for range of motion (ROM) as directed for 5 of 5 residents (R38, R18, R67, R36 and R15) reviewed for ROM services. Findings include: R38's facesheet (undated) had the diagnoses of Alzheimer's dementia with behaviors, major depression and contractures of muscle on multiple sites. R38's Significant Change in Status Minimum Data Set (MDS), dated 4/14/2017, indicated the resident was severely cognitively impaired, was totally dependant with all activities of daily living (ADLs). The MDS identified R38 had functional limitations in ROM on one side of upper extremities which included shoulder, elbow, wrist and hand. The restorative nursing section identified no restorative programs occurred. During observations on 05/03/2017 at 9:10 a.m., nursing assistant rehabilitation (Rehab)-A entered R38's to provide ROM. Rehab-A positioned R38 on his back and wrapped a warm moist wash cloth around his left hand. Rehab-A completed ROM of R38's shoulder, elbow, and hand. She continued to provide ROM to R38's left leg, knee and foot, repeating the same on the right side, and finished with R38's right shoulder, arm and hand.	F 318	F318 Increase/ Prevent decrease in range of motion 1) How corrective action will be accomplished for those residents found to be affected: Resident R38 had restorative nursing needs reassessed and the individual care plan updated to reflect current status. Resident R18 is currently working with physical therapy and care plan interventions will be updated when completed to reflect current needs. Resident R67 is currently working with occupational therapy and care plan interventions will be updated when completed to reflect current needs. Resident R36 is currently working with occupational therapy and care plan interventions will be updated when completed to reflect current needs. Resident 15 had restorative nursing needs reassessed and the individual care plan updated to reflect current status. 2) How to identify other residents having the potential to be affected by the same practice: Multiple meetings were held with therapy	

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F 318	Continued From page 17 After completion of the ROM on 05/03/17 at 9:45 a.m., Rehab-A, stated R38 could be resistive to ROM, pull away and strike out. When this occurred, you stop and explain what was occurring or move to a different extremity, which usually calms him. In review of R38's Rehab Visions Occupational Therapy Discharge Information, dated 2/24/17, indicated: "Please complete washing and drying [left] hand and ROM (range of motion) on [both] arms and hands 3-5x/week (time per week)." In R38's Rehab Visions Physical Therapy Discharge Information, , dated 6/8/16, the orders indicated: "please completed [both] [lower extremities] ROM (range of motion program in a supine (on back) 3-5x/wk." R38's care plan (last reviewed 4/21/17), indicated that "R38 participates in a nursing rehab program to prevent contractures." The facility indicated in the care plan that R38 was to receive, "Nsg [nursing] rehab program: up to 3-5 x/wk has with ROM, LE [lower extremities] PROM [passive range of motion] 3/-5x/wk [3 to 5 times a week]. Complete bilateral upper extremity ROM. Wash left hand." Review of R38's monthly ROM data collection tools from March to May 2017 entitled: Attachment C identified the following: May 1-3, 2017 - received 2 treatments April 1-30, 2017 - received only 4 treatments with the 5th documented as "AG" (agitated) March 1-31, 2017 - received only 7 treatments with one treatment documented as "AG" and another "O" (MD appointment, visitor,	F 318	and RN to evaluate current programs and care plan interventions for each resident in restorative nursing. A meeting with the team was held on May 24th where each residents program was evaluated and the overall structure of the restorative nursing program was revised. 3) Measures put into place or systemic changes made to ensure practice will not recur The restorative nursing program and policies and procedures have been revised and staffed trained on the changes. Weekly rehab meetings will continue and any changes will be updated on the individual care plan. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system. An RN will audit the implementation of the care planned interventions weekly for four weeks then monthly for three months after the correction date. The results will be discussed monthly at the Quality of Life committee and the committee will determine when compliance is indicated.	

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F 318	Continued From page 18 etc) During interview on 5/3/17, at 11:52 a.m., Rehab-A stated there were two nursing rehabilitation staff work alternating days, and are not scheduled as direct care nursing assistants. However, at times the two have been pulled to cover direct care positions along with rehab and to lead the facility's exercise group daily. Rehab-A stated if resident's are out to appointments, have visitors, or refuses, it is difficult to reproach and or reschedule their rehab because of heavy case load. Rehab-A stated residents who receive nursing rehab are scheduled by the therapy department and seen 3-5 times each week for ROM. Rehab-A reviewed the ROM data collection tool from March to May 2017 and identified the frequency of ROM was not being completed for R38. During an interview on 5/3/17 at 1:59 p.m., the B Wing care manager, registered nurse (RN)-B stated the Rehab RN reviews resident progression with the rehabilitation staff once a week (on Fridays), for changes and concerns with any of the residents. RN-B stated she was unaware that R38 did not receive ROM 3-5 times a week for the months of March and April 2017. In an interview on 5/4/17 at 9:01 a.m., the occupational therapist (OTR)-A, stated during the last quarterly screen on 2/24/17, there was no noticeable change in R38's ROM. OTR-A stated the resident fluctuated day to day because of behavior and cognition. They expect the nursing rehab to complete ROM exercises 3-5 times a week as they have directed for R38.	F 318		

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F 318	Continued From page 19 R18 facesheet had the diagnoses of dementia with Lewy Bodies, transient ischemic attack (TIA) and sleep disorder. R18's quarterly MDS, dated 3/15/17, identified severe cognitive impaired, totally dependent with all ADLs and had no functional limitations in ROM. The restorative nursing section of the MDS identified restorative nursing had not occurred. In review of R18's Rehab Visions Occupational Therapy Discharge Information, dated 11/19/16, indicated: "Please complete [upper extremity] ROM (range of motion) program", on 4/13/17: "Please complete [upper extremity] ROM program. Refer to ROM FMP (functional maintenance program) for further information." During an interview on 5/4/17 at 9:01 a.m., the occupational therapist (OTR)-A stated her expectations was for treatments completed 3-5 times each week for R18. In R18's Rehab Visions Physical Therapy Discharge Information, dated 6/08/16, the orders indicated: "Please completed [both] [lower extremities] ROM (range of motion program in a supine (on back) 3-5x/wk." R18's care plan, updated 4/24/17, indicated, "[R18] participates in a nursing rehab program to maintain current ability and to prevent decline in ability to do ADLs." Rehab nursing to perform "bilateral LE ROM program in supine (on R18's back) X [times] 20 reps [repetitions] each direction 3-5 times wk [weekly], and "UE [upper extremity] ROM program" 3-5 times a week. In review of the monthly ROM data collection tools, entitled: Attachment C, indicated R18	F 318		

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F 318	Continued From page 20 received ROM for the following frequency: May 1-3, 2017 - received 1 treatment April 1-30, 2017 - received only 4 treatments with the 5th documented as "O" (MD appointment, visitor, etc) March 1-31, 2017 - received only 6 treatments with one treatment documented as "I" (illness) and two others documented as "O" (MD appointment, visitor, etc) During interview on 5/4/2017 at 11:20 a.m., the assistant director of nursing (ADON) reviewed the ROM data collection tool, and stated R18 was missing ROM treatments. An interview on 5/4/17 at 9:01 a.m., OTR-A, stated the last quarterly OT screen on 4/13/17, identified no noticeable decline in R18's ROM. R18 fluctuated from day to day because of behavior and cognition. They expect nursing rehab to complete ROM exercises 3-5 times a week as they have directed for R18. R67's Resident Face Sheet, undated, identified resident had arthritis in multiple sites. R67's quarterly MDS of 3/14/17 identified resident was cognitively intact and required assistance of one to two staff to complete ADL's. The MDS identified R67 had functional limitations in range of motion of bilateral upper extremities of shoulder, elbow, wrist and hand. There was no indication R67 received any restorative nursing. R67's care plan, updated 3/15/17, identified resident was to participate in the Fit 4 Life program which consisted of stretches, balance-transfer exercises and strength training for Tuesday and Thursday programs. The care	F 318		

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plan also identified R67 had shoulder exercise/stretch program 3 to 5 times per week with Nursing Rehab program.

The OT Evaluation Information form, dated 9/21/16, identified resident required limited assist with upper body dressing and extensive assist of two to complete lower body. A Rehab Nursing program was developed to assist resident with shoulder exercise/stretch program 3 to 5 times per week.

During interview on 5/3/17, at 11:07 a.m. R67 reported increased pain and discomfort in her right shoulder, hip, and thigh but dislikes taking pain medications for this. R67 stated exercises are completed with by an "Aide who has been trained by therapy", however these are not completed with any frequency. The exercises are completed on an average of one time per week. She stated her, "Shoulders are definitively worse" since coming to the facility. Per observation R67 had some limitations with opening and closing her right hand and held her right shoulder close to her body.

Review of the facility monthly ROM data collection tools, entitled: Attachment C, indicated R67 received ROM bilateral shoulder exercise program as follows:

May 1-3, 2017 - received 0 treatments
April 1-30, 2017 - received only 1 treatments at the frequency of "30", five entries were denoted "O" representing Other (MD appointment, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and another entry indicated "R."
March 1-31, 2017 - received only 3 treatments

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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with the frequency of 20-30-20, with an additional 9 entries identified as "O", with no additional information, and 1 entry identified as "A" for participation in another activity.
February 1-28, 2017-2 entries are identified as "O" with no additional information, 1 entry was identified as "A", and one noted resident was on LOA (leave of absence).
January 1-31, 2017-1 entry identified resident received 15 minutes of 1:1 interaction, 1 entry was identified as "A", 2 entries indicated "I" (illness), and 3 entries indicated "O".
December 1-31, 2017-2 entries identified R67 received 15 minutes of 1:1 therapy, 6 entries identified "O", with no additional explanation, 1 entry identified resident was "A", and 1 entry indicated "A/R".

During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R67 comes to exercise class, Fit 4 Life, on Tuesday and Thursdays. Rehab-A stated R67 had consistently declined participation in class and was to receive shoulder exercise/stretch program three to five times a week, Rehab-A stated if R67 was not ready for her exercises when they arrived, they were unable to return at a later time to complete exercises. Rehab-A stated R67 does complain of more pain when completing exercises and she had seen a notice a difference in R67's shoulder.

During interview on 5/3/17, at 1:19 p.m. NA-A stated R67 had vocalized increased pain in the right shoulder and more requests for pain medication. NA-A stated R67 had exercises to perform in bed as taught by therapy and exercises are to be completed with rehab nursing.

During interview on 5/3/17, at 1:35 p.m. with

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	245364	A. BUILDING _____ B. WING _____	C 05/04/2017

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doctorate physical therapist (DPT)-A stated R67 does have limitations related to arthritis and mobility is uncomfortable. Occupational therapy has placed her on a ROM program and has worked with R67 regarding her shoulder limitations and comfort.

During interview on 5/4/17, at 9:01 a.m. with OTR-A stated R67 was admitted with decrease ROM, both active and passive (exercises complete independently-active, and with assistance-passive). They developed a program for rehab nursing to complete active assisted ROM with table top exercises. DPT-A who was present during this interview, stated R67 has demonstrated no functional changes in her recent functional range of motion screen.

R36's undated Resident Face Sheet identified R36 had arthritis with difficulty with multiple joints impacted. R36's quarterly MDS of 1/31/17 identified resident had moderate cognitive impairment and received assistance of one to two staff to complete ADL's. The MDS did not identify any functional limitation in ROM.

R36's Rehab Vision occupational therapy discharge instructions, dated 11/25/16, identified rehab nursing was to assist resident with right upper extremity ROM with prolonged stretch at the end of movement. This routine was to be completed 3 to 5 times week and attend the Fit 4 Life class.

R36's care plan, last updated 2/6/17, identified the resident participates in nursing rehab program to maintain current ability and prevent further decline. The care plan directed Rehab

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Nursing to "complete 5 reps [repetitions] with prolonged stretch at end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." R36 was also to attend the Fit 4 Life class.

An Updated physical therapy information sheet, dated 4/2/17, identified rehab nursing was to assist R36 perform hamstring stretching bilaterally 3 to 5 times a week 5 times with a 30 second hold.

In review of the monthly ROM data collection tools, R36 received rehab nursing as follows:

May 1-3, 2017 - received 1 treatments
April 1-30, 2017 - received only 7 treatments at the frequency of "10" 1:1 (one to one) minutes, 5 entries were denoted "O" representing Other (MD appointment, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and 1 entry indicated "R."
March 1-31, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, with an additional 2 entries where resident had refused therapy.
February 1-28, 2017-received 2 episodes of treatment with the frequency of "15" 1:1 minutes, and two dates "I" (illness) was indicated.
January 1-31, 2017-received 5 episodes of treatment with a frequency of "15" 1:1 minutes, and one noted incident where resident refused.
December 1-31, 2016-received 12 episodes of treatment with a frequency of "15" 1:1 minutes identified.

During interview on 5/3/17, at 12:06 p.m.

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Rehab-A stated R36 has been an active participant in the Fit 4 Life program and has been willing to complete the program. R36 was to receive a hamstring stretch with standing frame, and PROM (passive range of motion) to right upper extremity. Rehab-A stated R36 was an active participant in exercise group so the PROM exercises were not completed at times due to prioritizing other Rehab Nursing tasks to be completed.

During interview on 5/4/17 at 9:01 a.m. OTR-A stated R36 had been evaluated and recommended to receive "right upper extremity repetitions with prolonged stretch at the end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." OTR-A stated rehab nursing should be completing the program 3-5 x week as directed.

R15's undated Resident Face Sheet identified a diagnosis of arthritis. R15's quarterly MDS of 3/18/17 indicated a severe cognitive deficit and the need for extensive assistance of one to two staff to complete ADL's. The MDS identified no functional impairment of range of motion or any restorative nursing.

The physical therapy evaluation information, dated 9/8/16, identified R15 received assistance of 2 and use of the Medi-Lift with transfers. The note directed rehab aides to complete bilateral lower extremity ROM 3 to 5 times a week.

R15's care plan, reviewed on 3/20/17, identified participation in the rehab nursing program to maintain current ability. The care plan outlined the

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F 318	Continued From page 26 nursing rehab program to assist with bilateral lower extremity ROM 3 to 5 times per week. In review of the monthly rehabilitation logs from December 2016 thru February 2017 identified R15 received ROM bilateral shoulder exercise program as follows: December 1-31, 2016 - received 8 treatments of 15 1:1 (one to one) minutes January 1-31, 2017 - received only 7 treatments of 15 1:1 minutes February 1-28, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, and one notation of "O". During interview on 5/3/17, at 12:06 p.m. Rehab-A stated they were unable to complete exercises as directed because of limited time. During interview on 5/4/17, at 9:01 a.m. DPT-A stated R15 was set up to complete bilateral lower extremity ROM with 20 repetitions 3-5 times per week to maintain function, and had had no changes in his functional ability. During interview on 5/4/17, at 9:31 a.m. ADON, who is responsible for the nursing rehab program, stated they had reviewed the tracking log from April of 2017 and noted completion of exercises had declined and were currently in the process of evaluating this program but had made no changes. During interview on 5/4/17, at 12:20 p.m. the director of nursing identified the ROM Rehab program was in the process of being re-evaluated and the intent was to look at alternative to meet the needs of the residents.	F 318		

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F 318	Continued From page 27 A policy, titled Rehabilitation and Restorative Program Nursing, reviewed 5/12. identified under the Policy statement, first bullet: "Nursing care is directed toward the conservation of abilities of residents, restoration of optimal levels of function, and independence, adaptation to an altered life style, prevention of deterioration, and complications of disability whenever possible."	F 318		

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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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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 YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Annandale Care Center Building 1 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/07/2017

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

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By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Annandale Care Center is a 1-story building with no basement. The building was constructed at 5 different times. The original building was constructed in 1982 and was determined to be of Type II(000) construction. In 1986 , an addition was constructed to the north and was determined to be of Type II(000) construction. In 1990 an addition was constructed at the front entrance and was determined to be of Type II(000) construction. In 2004 and addition was constructed to the ends of A and B wings and was determined to be of Type II(000) construction. In 2008 an addition was added to the northwest corner of the facility and was determined to be of type II(000) construction. The facility was surveyed as one building.

The building is automatic sprinkler protected. 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

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K 000	Continued From page 2 department notification. The facility has a capacity of 60 beds and had a census of 51 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 341 SS=C	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which would affect all residents and an undetermined amount of staff and visitors. Findings include:	K 341	K341 The smoke detector in B23 was observed to be too close to the HVAC diffuser. On 5/2/2017 we moved the 1 smoke detector in B23 one space over from the HVAC diffuser. In the future we will be looking for the 36" separation anytime ceiling work is done. The Director of Maintenance is responsible for the correction and for preventing reoccurrence.	5/2/17

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K 341	Continued From page 3 On the facility tour between 1:15 PM to 4:30 PM on 05/01/2017, observations and staff interview revealed 3 smoke detectors with 36 inches of an HVAC diffuser by room B23. This deficient condition was confirmed by the Facility Maintenance Director.	K 341		
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect all residents, visitors and staff. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345	K345 The fire alarm panel was showing that 1 detector by the nurses station was dirty. On 5/1/2017, the detector was removed and cleaned with compressed air, reinstalled and the fire alarm trouble code cleared. The Director of Maintenance is responsible for the correction and for preventing reoccurrence.	5/1/17

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K 345	Continued From page 4 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 72. Findings include: On the facility tour between 1:15 PM to 4:30 PM on 05/01/2017, observations revealed the Fire Alarm in "Trouble Status." When interviewed the facility maintenance director it was stated it because of a dirty smoke detector. Documentation reviewed revealed that the DACT System was not tested during these times: 1) First quarter 2017 2) Second quarter First and Third shift 3) Third quarter third shift 4) Second and Third Shift Fourth quarter This deficient condition was confirmed by the Facility Maintenance Director.	K 345		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		6/6/17

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K 353	Continued From page 5 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 60 residents and an undetermined amount of staff and visitors. Findings include: During the facilty documentation review on 05/01/2017, documentation reviewed and staff interview revealed there was no record of a quarterly flow test in the last 12 months. This deficient condition was confirmed by the Facility Maintenance Director.	K 353	K353 Documentation on the sprinkler risers showed they had been inspected twice in the last 12 months; 5/2/2016, and 11/05/2016 on each of the 2 risers. Simplex Grinnell, the facility's contracted sprinkler company, performed the inspection and testing on June 6th, 2017. Simplex Grinnell also completed the 5 year maintenance on both risers in order to place them both onto the same quarterly inspection schedule. The Director of Maintenance is responsible for the correction and for preventing reoccurrence.	
K 374 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window	K 374		5/2/17

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K 374	Continued From page 6 assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 2 of the three smoke barrier doors in accordance with the Life Safety Code (NFPA 101) 2012 edition section 101.8.5.4.1 and NFPA 80 the Standard for Fire Doors and Other Opening Protective's, 2010 edition, section 6.3.1.7. This deficient practice could allow the transfer of smoke from one smoke compartment to another making the corridors untenable. This condition could affect 29 of the 60 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 1:15 PM to 4:30 PM on 05/01/2017, observations and staff interview revealed the door gap in the cross corridor doors in the smoke barriers of the A and B Wings exceeded 1/8 inch. This deficient condition was confirmed by the Facility Maintenance Director.	K 374	K374 On 5/2/2017, the door closers on the smoke barrier doors of A Wing and B Wing were adjusted by resetting the closers to ensure the gap between the barriers did not exceed 1/8 inch. Smoke barrier doors will be inspected quarterly and coinciding with the fire drills to ensure that no more than 1/8 inch gap is present. The Director of Maintenance is responsible for the correction and for preventing reoccurrence.	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly	K 712		5/1/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 7 on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors. Findings include: During the facility documentation review on 05/01/2017, documentation reviewed revealed that Fire drills were not performed or incomplete during these times: 1) First quarter 2017 2) Second quarter First shift 3) Second quarter Third shift improper documentation 4) Second shift third quarter improper documentation 5) Third Shift third quarter 6) Fourth quarter second and third shift This deficient condition was confirmed by the	K 712	K712 All staff were trained on the facility's fire procedure on 5-1-17. Additional fire drills were conducted on each shift during the month of May. Future fire Drills were added to the facility's scheduled maintenance software program and will be monitored monthly by the Safety Director and Safety Committee. The Director of Maintenance is responsible for the correction and for preventing reoccurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/01/2017**

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K 712	Continued From page 8 Facility Maintenance Director.	K 712		
K 920 SS=F	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect an undetermined amount of staff and visitors.	K 920	K920 1) On 5/1/2017, the power strips were removed from the two refrigerators and the coffee pot was removed from the premises so that only one outlet was needed at each location. 2) On 5/8/2017, an extension cord to the nurse call display was replaced by an outlet above the ceiling. The Director of Maintenance is	5/8/17

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K 920	Continued From page 9 Findings include: On the facility tour between 1:15 PM to 4:30 PM on 05/01/2017, observations and staff interview revealed: 1) 2 refrigerators, 1 microwave and a coffee pot in the maintenance shop plugged into a power strip and not directly into a wall outlet. 2) 1 Extension cord plugged in the copy room and going into the ceiling to plug in the nurse call display. This deficient condition was confirmed by the Facility Maintenance Director.	K 920	responsible for the correction and for preventing reoccurrence.	
K 923 SS=C	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		5/30/17

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K 923	Continued From page 10 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.6.2.3 item 11. This deficient practice could create an oxygen filled atmosphere and accelerate the spread of fire. This condition could affect all of the 60 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 1:15 PM to 4:30 PM on 05/01/2017, observations and staff interview revealed full and empty oxygen tanks combined in the same area. This deficient condition was confirmed by the Facility Maintenance Director.	K 923	K923 On 05/30/2017, the extra O2 bottles in the Oxygen storage room were removed from the storage area. Signage was installed to show FULL BOTTLE AREA and EMPTY BOTTLE AREA. Segregation will be maintained by use of bottle storage racks. The Director of Maintenance is responsible for the correction and for preventing reoccurrence.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 18, 2017

Ms. Debra Reitmeier, Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5364029

Dear Ms. Reitmeier:

The above facility was surveyed on May 1, 2017 through May 4, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338 or brenda.fischer@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 05/04/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 1st to May 4th, 2017 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 implement care plan interventions as directed for 5 of 5 residents (R38, R18, R67, R15, and R36) who received range of motion (ROM) from restorative nursing. This had the potential to effect 28 residents identified as receiving a restorative nursing program. Findings include: R38's facesheet (undated) had diagnoses of Alzheimer's dementia with behaviors, major depression and Contractures of muscle, multiple sites. R38's Significant Change in Status Minimum Data Set (MDS), dated 4/14/2017, indicated the resident was severely cognitively impaired, was totally dependant with all activities of daily living (ADLs). The MDS identified R38 had functional limitations in ROM on one side of upper extremities which included shoulder, elbow, wrist and hand. The restorative nursing section identified no restorative programs were	2 565	Corrected	6/9/17

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2 565	Continued From page 3 implemented. Review of R38's care plan (last reviewed 4/21/17), indicated that "R38 participates in a nursing rehab program to prevent contractures." The facility indicated in the care plan that R38 was to receive, "Nsg [nursing] rehab program: up to 3-5 x/wk has with ROM, LE [lower extremities] PROM [passive range of motion] 3/-5x/wk [3 to 5 times a week]. Complete bilateral upper extremity ROM. Wash left hand." During observations on 05/03/2017 at 9:10 a.m., nursing assistant rehabilitation (Rehab)-A entered R38's to provide ROM. Rehab-A positioned R38 on his back and wrapped a warm moist wash cloth around his left hand. Rehab-A completed ROM of R38's shoulder, elbow, and hand. She continued to provide ROM to R38's left leg, knee and foot, repeating the same on the right side, and finished with R38's right shoulder, arm and hand. Review of R38's monthly ROM data collection tools from March to May 2017 entitled: Attachment C identified the following frequency: May 1-3, 2017 - received 2 treatments April 1-30, 2017 - received only 4 treatments with the 5th documented as "AG" (agitated) March 1-31, 2017 - received only 7 treatments with one treatment documented as "AG" and another "O" (MD appointment, visitor, etc) During interview on 5/3/17, at 11:52 a.m., Rehab-A stated there were two nursing rehabilitation staff work alternating days, and are not scheduled as direct care nursing assistants. However, at times the two have been pulled to cover direct care positions along with rehab and	2 565		

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2 565	Continued From page 4 to lead the facility's exercise group daily. Rehab-A identified because of the heavy work load ROM does not get always get completed. Rehab-A reviewed the ROM data collection tool from March to May 2017 and the ROM frequency was not met for R38 as identified by the care plan. During an interview on 5/3/17 at 1:59 p.m., Wing B care manager registered nurse (RN)-B stated the Rehab RN reviews with the rehab staff once a week (on Fridays), to see if there are changes or concerns with the residents. RN-B stated she was unaware that R38 had not received ROM 3-5 times a week for the months of March and April 2017, as identified by the care plan. R18's facesheet (undated) had the diagnoses of dementia with Lewy Bodies, transient ischemic attack (TIA) and sleep disorder. R18's quarterly MDS, dated 3/15/17, indicated they were severely cognitively impaired and totally dependant with all ADLs and had no functional limitations in ROM. The restorative nursing section identified restorative nursing had not occurred. R18's care plan, updated 4/24/17, indicated, "[R18] participates in a nursing rehab program to maintain current ability and to prevent decline in ability to do ADLs." Rehab nursing to perform "bilateral LE ROM program in supine (on R18's back) X [times] 20 reps [repetitions] each direction 3-5 times wk [weekly], and "UE [upper extremity] ROM program" 3-5 times a week. Review of the monthly ROM data collection tools, entitled: Attachment C (last revised 3/08), indicated that R18 received ROM for the following frequency:	2 565		

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2 565	Continued From page 5 May 1-3, 2017 - received 1 treatment April 1-30, 2017 - received only 4 treatments with the 5th documented as "O" (MD appointment, visitor, etc) March 1-31, 2017 - received only 6 treatments with one treatment documented as "I" (illness) and two others documented as "O" (MD appointment, visitor, etc) During interview on 5/4/2017 at 11:20 a.m., the assistant director of nursing (ADON) reviewed the ROM data collection tool, and stated R18 was missing ROM treatments. R18's care plan for ROM was not being implemented. R67's Resident Face Sheet, undated, identified resident had arthritis in multiple sites. R67's quarterly MDS of 3/14/17 identified the resident was cognitively intact, required staff assistance of one to two to complete activities of daily living including. The MDS identified R67 had functional limitations in range of motion bilateral upper extremities of shoulder, elbow, wrist and hand. There was no indication R67 received any restorative nursing. During interview on 5/3/17, at 11:07 a.m. R67 reported increased pain and discomfort in her right shoulder, hip, and thigh but dislikes taking pain medications for this. R67 stated exercises are completed with by an "Aide who has been trained by therapy", however these are not completed with any frequency. The exercises are completed on an average of one time per week. She stated her, "Shoulders are definitively worse" since coming to the facility. Per observation R67 had some limitations with opening and closing her right hand and held her right shoulder close to her body.	2 565		

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2 565	Continued From page 6 R67's care plan, updated 3/15/17, identified resident was to participate in the Fit 4 Life program which consisted of stretches, balance-transfer exercises and strength training for Tuesday and Thursday programs. The care plan also identified R67 had shoulder exercise/stretch program 3 to 5 times per week with Nursing Rehab program. Review of the monthly ROM data collection tools, titled: Attachment C (last revised 3/08), indicated R67 received ROM bilateral shoulder exercise program at the following frequency: May 1-3, 2017 - received 0 treatments April 1-30, 2017 - received only 1 treatments at the frequency of "30", five entries were denoted "O" representing Other (MD appointment, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and another entry indicated "R" refused. March 1-31, 2017 - received only 3 treatments with the frequency of 20-30-20, with an additional 9 entries identified as "O", with no additional information, and 1 entry identified as "A" for participation in another activity. February 1-28, 2017-2 entries are identified as "O" with no additional information, 1 entry was identified as "A", and one noted resident was on LOA (leave of absence). January 1-31, 2017-1 entry identified resident received 15 minutes of 1:1 interaction, 1 entry was identified as "A", 2 entries indicated "I" (illness), and 3 entries indicated "O". December 1-31, 2017-2 entries identified R67 received 15 minutes of 1:1 therapy, 6 entries identified "O", with no additional explanation, 1 entry identified resident was "A", and 1 entry indicated "A/R".	2 565		

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2 565	Continued From page 7 During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R67 comes to exercise class, Fit 4 Life, on Tuesday and Thursdays. Rehab-A stated R67 had consistently declined participation in class and was to receive shoulder exercise/stretch program three to five times a week, Rehab-A stated if R67 was not ready for her exercises when they arrived, they were unable to return at a later time to complete exercises as directed by the care plan. R36's undated Resident Face Sheet identified R36 had arthritis with difficulty with multiple joints impacted. R36's quarterly MDS of 1/31/17 identified resident had moderate cognitive impairment and received assistance of one to two staff to complete ADL's. The MDS did not identify any functional limitation in ROM. R36's care plan, edited on 12/7/16, identified R36 was to be evaluated by physical therapy and occupational therapy for strength training and toning. The care plan directed staff to follow recommendations outlined by therapy. Rehab Nursing was instructed by OT to assist R36 with "right upper extremity repetitions with prolonged stretch at the end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." R36 was also to attend the Fit 4 Life class. Review of the facility document Attachment C monthly logs for R36's participation in rehab nursing of PROM to the right upper extremity from January to May 2017 logs identified the following:	2 565		

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2 565	Continued From page 8 May 1-3, 2017 - received 1 treatment. April 1-30, 2017 - received only 7 treatments at the frequency of "10" 1:1 (one to one) minutes, 5 entries were denoted "O" representing Other (MD appointment, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and 1 entry indicated "R." March 1-31, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, with an additional 2 entries where resident had refused therapy. February 1-28, 2017-received 2 episodes of treatment with the frequency of "15" 1:1 minutes, and two dates "I" (illness) was indicated. January 1-31, 2017-received 5 episodes of treatment with a frequency of "15" 1:1 minutes, and one noted incident where resident refused. During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R36 has been an active participant in the Fit 4 Life program and has been willing to complete the program. R36 was to receive a hamstring stretch with standing frame, and PROM (passive range of motion) to right upper extremity. Rehab-A stated R36 was an active participant in exercise group so the PROM exercises were not completed at times due to prioritizing other Rehab Nursing tasks to be completed. R15's undated Resident Face Sheet identified a diagnosis of arthritis. R15's quarterly MDS of 3/18/17 indicated a severe cognitive deficit and the need for extensive assistance of one to two staff to complete ADL's. The MDS identified no functional impairment of range of motion. R15's care plan, reviewed 3/20/17, identified R15 was to receive bilateral ROM to lower extremities	2 565		

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2 565	Continued From page 9 with nursing rehab program 3 to 5 times per week to maintain current ability. In review of the monthly rehabilitation logs from December 2016 thru February 2017 identified R15 received ROM bilateral shoulder exercise program as follows: December 1-31, 2016 - received 8 treatments of 15 1:1 (one to one) minutes January 1-31, 2017 - received only 7 treatments of 15 1:1 minutes February 1-28, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, and one notation of "O". During interview on 5/3/17, at 12:06 p.m. Rehab-A stated they were unable to complete exercises as identified in the care plan because of limited time. During interview on 5/4/17, at 12:20 p.m. the director of nursing (DON) stated she was aware Rehab Nursing was not being completed on the frequency as recommended and the facility was currently re-evaluating the process. A policy, titled Care Planning Process , dated 12/02, identified that the care plan was to direct the deliverance of care provided and documentation was reflective of following the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff on following the individualized plan of care, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 565		

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2 565	Continued From page 10 (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate care with an outside psychiatry service and act on their recommendations for 1 of 1 residents (R51) reviewed who received outside psychiatry services. Findings include: R51's quarterly Minimum Data Set (MDS) dated 2/25/17, identified R51 had intact cognition and required extensive assistance with her activities of daily living (ADLs). Further, the MDS identified R51 displayed symptoms of depression including, "Feeling tired or having little energy," nearly everyday and had pain, "Almost constantly."	2 830	Corrected	5/18/17

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2 830	Continued From page 11 During observation on 5/1/17, at 6:03 p.m. R51 was seated in an electric wheelchair in the hallway. R51 had visible contractures on her lower extremities with nearly constant tremors of her arms and neck. R51 stated her contractures hurt, "Awful bad," at times. R51's care plan dated 2/28/17, identified R51 had depression and was taking antidepressant medication. The care plan identified R51, "Worries and ruminates over changes in body/medical problems," and directed staff to attempt gradual dose reductions of medications when indicated and monitor R51's status and update the physician as needed. The care plan lacked any interventions or dictation which identified R51 was being seen by psychology services. R51's Associated Clinic of Psychology Progress Note dated 3/31/17, identified R51 had adjustment and personality disorder(s) and had been working with the psychologist to help cope from some family relationship stressors. R51 was identified to, "...reports her own mood is about the same with continued episodes of crying and sweating," and, "[R51] does report pain." Further, the note identified a section labeled, Recommendations, and listed R51, "Continues to report sadness and depressive symptoms ... may benefit from Cymbalta [medication used to treat pain and depression] if not contraindicated, given her reports of sadness and pain. This will be deferred to her PCP [primary care provider]." R51's following physician progress note dated 4/4/17, identified R51 had chronic pain and depression with anxiety. The note listed an, "Assessment [and] Plan," section and identified each diagnosis R51 displayed including,	2 830		

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2 830	Continued From page 12 "Moderate episode of recurrent major depressive disorder," and, "Chronic pain of both extremities." The physician increased R51's ordered Fentanyl patch (narcotic duragesic patch) and identified R51 was, "Stable," on her current medication regimen for depression. There was no identified reference or dictation addressing the psychologist' recommendation to consider adding Cymbalta to R51's medication regimen as identified in the 3/31/17 note. R51's medical record was reviewed and lacked any evidence R51's physician had addressed or considered the psychologist's recommendation. Further, R51's signed physician orders dated 4/4/17, lacked any orders or trial dosing of Cymbalta. When interviewed on 5/4/17, at 8:36 a.m. nursing assistant (NA)-A stated R51's mood, "hasn't really changed," in the past months. NA-A stated R51 still does have episodes of crying, "Every once in awhile," about being unable to care for herself or return to her home. During interview on 5/4/17, at 12:04 p.m. registered nurse (RN)-A stated R51 had a history of pain and recently had her narcotic medication dosing increased as a result. RN-A stated R51 also had, a lot of personal "stuff," going on in her life; however, felt R51's mood was good. At 12:41 p.m. RN-A stated she had reviewed R51's medical record and spoke to R51's nurse practitioner. The psychologist's recommendation to consider adding Cymbalta had not been addressed because someone missed it. Further, RN-A stated the recommendations should have been looked at and addressed. A facility Psychology Services policy dated	2 830		

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2 830	Continued From page 13 6/2016, identified a procedure which included, "Dictated notes are sent to the facility for resident charts. Notes with recommendations are reviewed by the primary physician at the next scheduled resident visit." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding making sure psychiatry recommendations are acted upon timely; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative nursing programs for range of motion (ROM) as	2 895	Corrected	6/9/17

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2 895	Continued From page 14 directed for 5 of 5 residents (R38, R18, R67, R36 and R15) reviewed for ROM services. Findings include: R38's facesheet (undated) had the diagnoses of Alzheimer's dementia with behaviors, major depression and contractures of muscle on multiple sites. R38's Significant Change in Status Minimum Data Set (MDS), dated 4/14/2017, indicated the resident was severely cognitively impaired, was totally dependant with all activities of daily living (ADLs). The MDS identified R38 had functional limitations in ROM on one side of upper extremities which included shoulder, elbow, wrist and hand. The restorative nursing section identified no restorative programs occurred. During observations on 05/03/2017 at 9:10 a.m., nursing assistant rehabilitation (Rehab)-A entered R38's to provide ROM. Rehab-A positioned R38 on his back and wrapped a warm moist wash cloth around his left hand. Rehab-A completed ROM of R38's shoulder, elbow, and hand. She continued to provide ROM to R38's left leg, knee and foot, repeating the same on the right side, and finished with R38's right shoulder, arm and hand. After completion of the ROM on 05/03/17 at 9:45 a.m., Rehab-A, stated R38 could be resistive to ROM, pull away and strike out. When this occurred, you stop and explain what was occurring or move to a different extremity, which usually calms him. In review of R38's Rehab Visions Occupational Therapy Discharge Information, dated 2/24/17, indicated: "Please complete washing and drying [left] hand and ROM (range of motion) on [both]	2 895		

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2 895	Continued From page 15	2 895		

arms and hands 3-5x/week (time per week)." In R38's Rehab Visions Physical Therapy Discharge Information, , dated 6/8/16, the orders indicated: "please completed [both] [lower extremities] ROM (range of motion program in a supine (on back) 3-5x/wk."

R38's care plan (last reviewed 4/21/17), indicated that "R38 participates in a nursing rehab program to prevent contractures." The facility indicated in the care plan that R38 was to receive, "Nsg [nursing] rehab program: up to 3-5 x/wk has with ROM, LE [lower extremities] PROM [passive range of motion] 3/-5x/wk [3 to 5 times a week]. Complete bilateral upper extremity ROM. Wash left hand."

Review of R38's monthly ROM data collection tools from March to May 2017 entitled: Attachment C identified the following:

May 1-3, 2017 - received 2 treatments
April 1-30, 2017 - received only 4 treatments with the 5th documented as "AG" (agitated)
March 1-31, 2017 - received only 7 treatments with one treatment documented as "AG" and another "O" (MD appointment, visitor, etc)

During interview on 5/3/17, at 11:52 a.m., Rehab-A stated there were two nursing rehabilitation staff work alternating days, and are not scheduled as direct care nursing assistants. However, at times the two have been pulled to cover direct care positions along with rehab and to lead the facility's exercise group daily. Rehab-A stated if resident's are out to appointments, have visitors, or refuses, it is difficult to reproach and or reschedule their rehab because of heavy case load. Rehab-A stated residents who receive nursing rehab are scheduled by the therapy

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2 895	Continued From page 16 department and seen 3-5 times each week for ROM. Rehab-A reviewed the ROM data collection tool from March to May 2017 and identified the frequency of ROM was not being completed for R38. During an interview on 5/3/17 at 1:59 p.m., the B Wing care manager, registered nurse (RN)-B stated the Rehab RN reviews resident progression with the rehabilitation staff once a week (on Fridays), for changes and concerns with any of the residents. RN-B stated she was unaware that R38 did not receive ROM 3-5 times a week for the months of March and April 2017. In an interview on 5/4/17 at 9:01 a.m., the occupational therapist (OTR)-A, stated during the last quarterly screen on 2/24/17, there was no noticeable change in R38's ROM. OTR-A stated the resident fluctuated day to day because of behavior and cognition. They expect the nursing rehab to complete ROM exercises 3-5 times a week as they have directed for R38. R18 facesheet had the diagnoses of dementia with Lewy Bodies, transient ischemic attack (TIA) and sleep disorder. R18's quarterly MDS, dated 3/15/17, identified severe cognitive impaired, totally dependent with all ADLs and had no functional limitations in ROM. The restorative nursing section of the MDS identified restorative nursing had not occurred. In review of R18's Rehab Visions Occupational Therapy Discharge Information, dated 11/19/16, indicated: "Please complete [upper extremity] ROM (range of motion) program", on 4/13/17: "Please complete [upper extremity] ROM	2 895		

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2 895	Continued From page 17 program. Refer to ROM FMP (functional maintenance program) for further information." During an interview on 5/4/17 at 9:01 a.m., the occupational therapist (OTR)-A stated her expectations was for treatments completed 3-5 times each week for R18. In R18's Rehab Visions Physical Therapy Discharge Information, dated 6/08/16, the orders indicated: "Please completed [both] [lower extremities] ROM (range of motion program in a supine (on back) 3-5x/wk." R18's care plan, updated 4/24/17, indicated, "[R18] participates in a nursing rehab program to maintain current ability and to prevent decline in ability to do ADLs." Rehab nursing to perform "bilateral LE ROM program in supine (on R18's back) X [times] 20 reps [repetitions] each direction 3-5 times wk [weekly], and "UE [upper extremity] ROM program" 3-5 times a week. In review of the monthly ROM data collection tools, entitled: Attachment C, indicated R18 received ROM for the following frequency: May 1-3, 2017 - received 1 treatment April 1-30, 2017 - received only 4 treatments with the 5th documented as "O" (MD appointment, visitor, etc) March 1-31, 2017 - received only 6 treatments with one treatment documented as "I" (illness) and two others documented as "O" (MD appointment, visitor, etc) During interview on 5/4/2017 at 11:20 a.m., the assistant director of nursing (ADON) reviewed the ROM data collection tool, and stated R18 was missing ROM treatments.	2 895		

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2 895	Continued From page 18 An interview on 5/4/17 at 9:01 a.m., OTR-A, stated the last quarterly OT screen on 4/13/17, identified no noticeable decline in R18's ROM. R18 fluctuated from day to day because of behavior and cognition. They expect nursing rehab to complete ROM exercises 3-5 times a week as they have directed for R18. R67's Resident Face Sheet, undated, identified resident had arthritis in multiple sites. R67's quarterly MDS of 3/14/17 identified resident was cognitively intact and required assistance of one to two staff to complete ADL's. The MDS identified R67 had functional limitations in range of motion of bilateral upper extremities of shoulder, elbow, wrist and hand. There was no indication R67 received any restorative nursing. R67's care plan, updated 3/15/17, identified resident was to participate in the Fit 4 Life program which consisted of stretches, balance-transfer exercises and strength training for Tuesday and Thursday programs. The care plan also identified R67 had shoulder exercise/stretch program 3 to 5 times per week with Nursing Rehab program. The OT Evaluation Information form, dated 9/21/16, identified resident required limited assist with upper body dressing and extensive assist of two to complete lower body. A Rehab Nursing program was developed to assist resident with shoulder exercise/stretch program 3 to 5 times per week. During interview on 5/3/17, at 11:07 a.m. R67 reported increased pain and discomfort in her right shoulder, hip, and thigh but dislikes taking pain medications for this. R67 stated exercises	2 895		

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2 895	Continued From page 19	2 895		

are completed with by an "Aide who has been trained by therapy", however these are not completed with any frequency. The exercises are completed on an average of one time per week. She stated her, "Shoulders are definitively worse" since coming to the facility. Per observation R67 had some limitations with opening and closing her right hand and held her right shoulder close to her body.

Review of the facility monthly ROM data collection tools, entitled: Attachment C, indicated R67 received ROM bilateral shoulder exercise program as follows:

May 1-3, 2017 - received 0 treatments
April 1-30, 2017 - received only 1 treatments at the frequency of "30", five entries were denoted "O" representing Other (MD appt, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and another entry indicated "R."
March 1-31, 2017 - received only 3 treatments with the frequency of 20-30-20, with an additional 9 entries identified as "O", with no additional information, and 1 entry identified as "A" for participation in another activity.
February 1-28, 2017-2 entries are identified as "O" with no additional information, 1 entry was identified as "A", and one noted resident was on LOA (leave of absence).
January 1-31, 2017-1 entry identified resident received 15 minutes of 1:1 interaction, 1 entry was identified as "A", 2 entries indicated "I" (illness), and 3 entries indicated "O".
December 1-31, 2017-2 entries identified R67 received 15 minutes of 1:1 therapy, 6 entries identified "O", with no additional explanation, 1 entry identified resident was "A", and 1 entry indicated "A/R".

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2 895	Continued From page 20 During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R67 comes to exercise class, Fit 4 Life, on Tuesday and Thursdays. Rehab-A stated R67 had consistently declined participation in class and was to receive shoulder exercise/stretch program three to five times a week, Rehab-A stated if R67 was not ready for her exercises when they arrived, they were unable to return at a later time to complete exercises. Rehab-A stated R67 does complain of more pain when completing exercises and she had seen a notice a difference in R67's shoulder. During interview on 5/3/17, at 1:19 p.m. NA-A stated R67 had vocalized increased pain in the right shoulder and more requests for pain medication. NA-A stated R67 had exercises to perform in bed as taught by therapy and exercises are to be completed with rehab nursing. During interview on 5/3/17, at 1:35 p.m. with doctorate physical therapist (DPT)-A stated R67 does have limitations related to arthritis and mobility is uncomfortable. Occupational therapy has placed her on a ROM program and has worked with R67 regarding her shoulder limitations and comfort. During interview on 5/4/17, at 9:01 a.m. with OTR-A stated R67 was admitted with decrease ROM, both active and passive (exercises complete independently-active, and with assistance-passive). They developed a program for rehab nursing to complete active assisted ROM with table top exercises. DPT-A who was present during this interview, stated R67 has demonstrated no functional changes in her recent functional range of motion screen.	2 895		

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2 895	Continued From page 21 R36's undated Resident Face Sheet identified R36 had arthritis with difficulty with multiple joints impacted. R36's quarterly MDS of 1/31/17 identified resident had moderate cognitive impairment and received assistance of one to two staff to complete ADL's. The MDS did not identify any functional limitation in ROM. R36's Rehab Vision occupational therapy discharge instructions, dated 11/25/16, identified rehab nursing was to assist resident with right upper extremity ROM with prolonged stretch at the end of movement. This routine was to be completed 3 to 5 times week and attend the Fit 4 Life class. R36's care plan, last updated 2/6/17, identified the resident participates in nursing rehab program to maintain current ability and prevent further decline. The care plan directed Rehab Nursing to "complete 5 reps [repetitions] with prolonged stretch at end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." R36 was also to attend the Fit 4 Life class. An Updated physical therapy information sheet, dated 4/2/17, identified rehab nursing was to assist R36 perform hamstring stretching bilaterally 3 to 5 times a week 5 times with a 30 second hold. In review of the monthly ROM data collection tools, R36 received rehab nursing as follows: May 1-3, 2017 - received 1 treatments April 1-30, 2017 - received only 7 treatments at the frequency of "10" 1:1 (one to one) minutes, 5	2 895		

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2 895	Continued From page 22 entries were denoted "O" representing Other (MD appt, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and 1 entry indicated "R." March 1-31, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, with an additional 2 entries where resident had refused therapy. February 1-28, 2017-received 2 episodes of treatment with the frequency of "15" 1:1 minutes, and two dates "I" (illness) was indicated. January 1-31, 2017-received 5 episodes of treatment with a frequency of "15" 1:1 minutes, and one noted incident where resident refused. December 1-31, 2016-received 12 episodes of treatment with a frequency of "15" 1:1 minutes identified. During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R36 has been an active participant in the Fit 4 Life program and has been willing to complete the program. R36 was to receive a hamstring stretch with standing frame, and PROM (passive range of motion) to right upper extremity. Rehab-A stated R36 was an active participant in exercise group so the PROM exercises were not completed at times due to prioritizing other Rehab Nursing tasks to be completed. During interview on 5/4/17 at 9:01 a.m. OTR-A stated R36 had been evaluated and recommended to receive "right upper extremity repetitions with prolonged stretch at the end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." OTR-A stated rehab nursing should be completing the program 3-5 x week as directed.	2 895		

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2 895	Continued From page 23 R15's undated Resident Face Sheet identified a diagnosis of arthritis. R15's quarterly MDS of 3/18/17 indicated a severe cognitive deficit and the need for extensive assistance of one to two staff to complete ADL's. The MDS identified no functional impairment of range of motion or any restorative nursing. The physical therapy evaluation information, dated 9/8/16, identified R15 received assistance of 2 and use of the Medi-Lift with transfers. The note directed rehab aides to complete bilateral lower extremity ROM 3 to 5 times a week. R15's care plan, reviewed on 3/20/17, identified participation in the rehab nursing program to maintain current ability. The care plan outlined the nursing rehab program to assist with bilateral lower extremity ROM 3 to 5 times per week. In review of the monthly rehabilitation logs from December 2016 thru February 2017 identified R15 received ROM bilateral shoulder exercise program as follows: December 1-31, 2016 - received 8 treatments of 15 1:1 (one to one) minutes January 1-31, 2017 - received only 7 treatments of 15 1:1 minutes February 1-28, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, and one notation of "O". During interview on 5/3/17, at 12:06 p.m. Rehab-A stated they were unable to complete exercises as directed because of limited time. During interview on 5/4/17, at 9:01 a.m. DPT-A	2 895		

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2 895	Continued From page 24 stated R15 was set up to complete bilateral lower extremity ROM with 20 repetitions 3-5 times per week to maintain function, and had had no changes in his functional ability. During interview on 5/4/17, at 9:31 a.m. ADON, who is responsible for the nursing rehab program, stated they had reviewed the tracking log from April of 2017 and noted completion of exercises had declined and were currently in the process of evaluating this program but had made no changes. During interview on 5/4/17, at 12:20 p.m. the director of nursing identified the ROM Rehab program was in the process of being re-evaluated and the intent was to look at alternative to meet the needs of the residents. A policy, titled Rehabilitation and Restorative Program Nursing, reviewed 5/12. identified under the Policy statement, first bullet: "Nursing care is directed toward the conservation of abilities of residents, restoration of optimal levels of function, and independence, adaptation to an altered life style, prevention of deterioration, and complications of disability whenever possible." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding range of motion and audit to ensure it is completed as directed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		6/5/17

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2 910	Continued From page 25 Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess a change in continence status for 1 of 1 residents (R39) reviewed for urinary incontinence. Findings include: R39's admission Minimum Data Set (MDS) dated 12/28/16, indicated she was moderately cognitively impaired. The MDS further indicated she needed total assist of two with toileting and had occasional incontinence (seven or less episodes of incontinence). R39's care area assessment (CAA) dated 12/28/16, identified she had urinary urgency and had problems with occasional dribbling, and had cognitive and mobility impairment. R39's Bowel And Bladder Assessment dated 12/28/16, indicated she was continent of bowel and bladder and she would call	2 910	Corrected	

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2 910	Continued From page 26	2 910		

for toileting during the day and toilet with bedpan at night every four hours. R39's Point Of Care History (lists episodes of incontinent and continence of urine) dated 12/22/16 to 1/17/17, identified she was incontinent of urine once.

R39's quarterly MDS dated 3/30/17, indicated she needed extensive assist of two with toileting and was frequently incontinent of urine (seven or more episodes). R39's Bowel and Bladder Assessment dated 3/29/17, indicated she was incontinent of urine and wore absorbent pads. The assessment further indicated she will call for toileting and toilet every four hours at night. A Point Of Care History dated 3/23/17 to 3/30/17, indicated she was incontinent of urine 11 times with various times over the day.

R39's care plan dated 1/12/17, indicated she was on a will call toileting plan related to occasional dribbling of urine, and wore an incontinence products.

During interview 5/2/17, at 3:06 p.m. registered nurse (RN)-B stated she thought the reason R39 had an increase in incontinence was related to a urinary tract infection and was started on a antibiotic on 3/26/17. RN-B stated she was not sure if R39 still had problems with incontinence.

During interview 5/2/17, at 3:24 p.m. nursing assistant (NA)- B stated he works evenings and nights and R39 will usually let him know when she has to use the bathroom on the evening shift. When he works nights she was always incontinent and was usually wet around 2:00-2:30 a.m.

During interview 5/2/17, at 3:26 p.m. licensed practical nurse (LPN)-A stated works on the day

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2 910	Continued From page 27 shift and R39 was usually incontinent of urine when she gets up in the morning. During interview 5/2/17, at 3:30 p.m. NA-C stated she works the day shift and about 2-3 times a week R39 was incontinent of urine. She got R39 up this morning and she was incontinence of a medium amount of urine. During interview 5/3/17, at 7:08 a.m. NA-E stated she works the day shift and R39 was very sleepy at night and this may be a reason why she was incontinent at night. NA-E stated (R39) was usually wet when she wakes up, but during the day she will tell us when she needs to use the bathroom. During observation 5/3/17, at 7:20 a.m. R39 was in the bathroom voiding in the toilet with NA-D assisting her. During interview 5/3/17, at 10:56 a.m. RN-B stated she did not realize (R39) had an increase with urinary incontinence, and they needed to reassess R39's bladder function, and develop a new plan that was more specific to her needs. The facilities Bladder and Bowel Policy and Procedure revised 2/15, indicated "It is the policy that the facility will ensure that each resident that is incontinent of bladder and/or bowel is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible through use of appropriate treatment and services. It is the policy to also identify risk factors and assess resident who are continent of bladder and bowel for the purpose of maintaining current function." The policy further indicated the RN determines the appropriate toileting or bladder/bowel	2 910		

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2 910	Continued From page 28 retraining program as assessed. This is care planned and staff are informed of the plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who needed assistance with toileting, to assure they are receiving the necessary treatment/services to prevent potential decline in toileting. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 1st to May 4th, 2017 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 implement care plan interventions as directed for 5 of 5 residents (R38, R18, R67, R15, and R36) who received range of motion (ROM) from restorative nursing. This had the potential to effect 28 residents identified as receiving a restorative nursing program. Findings include: R38's facesheet (undated) had diagnoses of Alzheimer's dementia with behaviors, major depression and Contractures of muscle, multiple sites. R38's Significant Change in Status Minimum Data Set (MDS), dated 4/14/2017, indicated the resident was severely cognitively impaired, was totally dependant with all activities of daily living (ADLs). The MDS identified R38 had functional limitations in ROM on one side of upper extremities which included shoulder, elbow, wrist and hand. The restorative nursing section identified no restorative programs were	2 565		

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2 565	Continued From page 3	2 565		

implemented.

Review of R38's care plan (last reviewed 4/21/17), indicated that "R38 participates in a nursing rehab program to prevent contractures." The facility indicated in the care plan that R38 was to receive, "Nsg [nursing] rehab program: up to 3-5 x/wk has with ROM, LE [lower extremities] PROM [passive range of motion] 3/-5x/wk [3 to 5 times a week]. Complete bilateral upper extremity ROM. Wash left hand."

During observations on 05/03/2017 at 9:10 a.m., nursing assistant rehabilitation (Rehab)-A entered R38's to provide ROM. Rehab-A positioned R38 on his back and wrapped a warm moist wash cloth around his left hand. Rehab-A completed ROM of R38's shoulder, elbow, and hand. She continued to provide ROM to R38's left leg, knee and foot, repeating the same on the right side, and finished with R38's right shoulder, arm and hand.

Review of R38's monthly ROM data collection tools from March to May 2017 entitled: Attachment C identified the following frequency:

May 1-3, 2017 - received 2 treatments
April 1-30, 2017 - received only 4 treatments with the 5th documented as "AG" (agitated)
March 1-31, 2017 - received only 7 treatments with one treatment documented as "AG" and another "O" (MD appointment, visitor, etc)

During interview on 5/3/17, at 11:52 a.m., Rehab-A stated there were two nursing rehabilitation staff work alternating days, and are not scheduled as direct care nursing assistants. However, at times the two have been pulled to cover direct care positions along with rehab and

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2 565	Continued From page 4	2 565		

to lead the facility's exercise group daily. Rehab-A identified because of the heavy work load ROM does not get always get completed. Rehab-A reviewed the ROM data collection tool from March to May 2017 and the ROM frequency was not met for R38 as identified by the care plan.

During an interview on 5/3/17 at 1:59 p.m., Wing B care manager registered nurse (RN)-B stated the Rehab RN reviews with the rehab staff once a week (on Fridays), to see if there are changes or concerns with the residents. RN-B stated she was unaware that R38 had not received ROM 3-5 times a week for the months of March and April 2017, as identified by the care plan.

R18's facesheet (undated) had the diagnoses of dementia with Lewy Bodies, transient ischemic attack (TIA) and sleep disorder. R18's quarterly MDS, dated 3/15/17, indicated they were severely cognitively impaired and totally dependant with all ADLs and had no functional limitations in ROM. The restorative nursing section identified restorative nursing had not occurred.

R18's care plan, updated 4/24/17, indicated, "[R18] participates in a nursing rehab program to maintain current ability and to prevent decline in ability to do ADLs." Rehab nursing to perform "bilateral LE ROM program in supine (on R18's back) X [times] 20 reps [repetitions] each direction 3-5 times wk [weekly], and "UE [upper extremity] ROM program" 3-5 times a week.

Review of the monthly ROM data collection tools, entitled: Attachment C (last revised 3/08), indicated that R18 received ROM for the following frequency:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	500 PARK STREET EAST ANNANDALE, MN 55302

(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
2 565	Continued From page 5 May 1-3, 2017 - received 1 treatment April 1-30, 2017 - received only 4 treatments with the 5th documented as "O" (MD appointment, visitor, etc) March 1-31, 2017 - received only 6 treatments with one treatment documented as "I" (illness) and two others documented as "O" (MD appointment, visitor, etc) During interview on 5/4/2017 at 11:20 a.m., the assistant director of nursing (ADON) reviewed the ROM data collection tool, and stated R18 was missing ROM treatments. R18's care plan for ROM was not being implemented. R67's Resident Face Sheet, undated, identified resident had arthritis in multiple sites. R67's quarterly MDS of 3/14/17 identified the resident was cognitively intact, required staff assistance of one to two to complete activities of daily living including. The MDS identified R67 had functional limitations in range of motion bilateral upper extremities of shoulder, elbow, wrist and hand. There was no indication R67 received any restorative nursing. During interview on 5/3/17, at 11:07 a.m. R67 reported increased pain and discomfort in her right shoulder, hip, and thigh but dislikes taking pain medications for this. R67 stated exercises are completed with by an "Aide who has been trained by therapy", however these are not completed with any frequency. The exercises are completed on an average of one time per week. She stated her, "Shoulders are definitively worse" since coming to the facility. Per observation R67 had some limitations with opening and closing her right hand and held her right shoulder close to her body.	2 565		

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2 565	Continued From page 6 R67's care plan, updated 3/15/17, identified resident was to participate in the Fit 4 Life program which consisted of stretches, balance-transfer exercises and strength training for Tuesday and Thursday programs. The care plan also identified R67 had shoulder exercise/stretch program 3 to 5 times per week with Nursing Rehab program. Review of the monthly ROM data collection tools, titled: Attachment C (last revised 3/08), indicated R67 received ROM bilateral shoulder exercise program at the following frequency: May 1-3, 2017 - received 0 treatments April 1-30, 2017 - received only 1 treatments at the frequency of "30", five entries were denoted "O" representing Other (MD appointment, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and another entry indicated "R" refused. March 1-31, 2017 - received only 3 treatments with the frequency of 20-30-20, with an additional 9 entries identified as "O", with no additional information, and 1 entry identified as "A" for participation in another activity. February 1-28, 2017-2 entries are identified as "O" with no additional information, 1 entry was identified as "A", and one noted resident was on LOA (leave of absence). January 1-31, 2017-1 entry identified resident received 15 minutes of 1:1 interaction, 1 entry was identified as "A", 2 entries indicated "I" (illness), and 3 entries indicated "O". December 1-31, 2017-2 entries identified R67 received 15 minutes of 1:1 therapy, 6 entries identified "O", with no additional explanation, 1 entry identified resident was "A", and 1 entry indicated "A/R".	2 565		

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2 565	Continued From page 7 During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R67 comes to exercise class, Fit 4 Life, on Tuesday and Thursdays. Rehab-A stated R67 had consistently declined participation in class and was to receive shoulder exercise/stretch program three to five times a week, Rehab-A stated if R67 was not ready for her exercises when they arrived, they were unable to return at a later time to complete exercises as directed by the care plan. R36's undated Resident Face Sheet identified R36 had arthritis with difficulty with multiple joints impacted. R36's quarterly MDS of 1/31/17 identified resident had moderate cognitive impairment and received assistance of one to two staff to complete ADL's. The MDS did not identify any functional limitation in ROM. R36's care plan, edited on 12/7/16, identified R36 was to be evaluated by physical therapy and occupational therapy for strength training and toning. The care plan directed staff to follow recommendations outlined by therapy. Rehab Nursing was instructed by OT to assist R36 with "right upper extremity repetitions with prolonged stretch at the end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." R36 was also to attend the Fit 4 Life class. Review of the facility document Attachment C monthly logs for R36's participation in rehab nursing of PROM to the right upper extremity from January to May 2017 logs identified the following:	2 565		

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2 565	Continued From page 8 May 1-3, 2017 - received 1 treatment. April 1-30, 2017 - received only 7 treatments at the frequency of "10" 1:1 (one to one) minutes, 5 entries were denoted "O" representing Other (MD appointment, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and 1 entry indicated "R." March 1-31, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, with an additional 2 entries where resident had refused therapy. February 1-28, 2017-received 2 episodes of treatment with the frequency of "15" 1:1 minutes, and two dates "I" (illness) was indicated. January 1-31, 2017-received 5 episodes of treatment with a frequency of "15" 1:1 minutes, and one noted incident where resident refused. During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R36 has been an active participant in the Fit 4 Life program and has been willing to complete the program. R36 was to receive a hamstring stretch with standing frame, and PROM (passive range of motion) to right upper extremity. Rehab-A stated R36 was an active participant in exercise group so the PROM exercises were not completed at times due to prioritizing other Rehab Nursing tasks to be completed. R15's undated Resident Face Sheet identified a diagnosis of arthritis. R15's quarterly MDS of 3/18/17 indicated a severe cognitive deficit and the need for extensive assistance of one to two staff to complete ADL's. The MDS identified no functional impairment of range of motion. R15's care plan, reviewed 3/20/17, identified R15 was to receive bilateral ROM to lower extremities	2 565		

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2 565	Continued From page 9	2 565		

with nursing rehab program 3 to 5 times per week to maintain current ability.

In review of the monthly rehabilitation logs from December 2016 thru February 2017 identified R15 received ROM bilateral shoulder exercise program as follows:

December 1-31, 2016 - received 8 treatments of 15 1:1 (one to one) minutes
January 1-31, 2017 - received only 7 treatments of 15 1:1 minutes
February 1-28, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, and one notation of "O".

During interview on 5/3/17, at 12:06 p.m. Rehab-A stated they were unable to complete exercises as identified in the care plan because of limited time.

During interview on 5/4/17, at 12:20 p.m. the director of nursing (DON) stated she was aware Rehab Nursing was not being completed on the frequency as recommended and the facility was currently re-evaluating the process.

A policy, titled Care Planning Process , dated 12/02, identified that the care plan was to direct the deliverance of care provided and documentation was reflective of following the plan of care.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could inservice staff on following the individualized plan of care, then audit to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 565	Continued From page 10 (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate care with an outside psychiatry service and act on their recommendations for 1 of 1 residents (R51) reviewed who received outside psychiatry services. Findings include: R51's quarterly Minimum Data Set (MDS) dated 2/25/17, identified R51 had intact cognition and required extensive assistance with her activities of daily living (ADLs). Further, the MDS identified R51 displayed symptoms of depression including, "Feeling tired or having little energy," nearly everyday and had pain, "Almost constantly."	2 830		

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2 830	Continued From page 11 During observation on 5/1/17, at 6:03 p.m. R51 was seated in an electric wheelchair in the hallway. R51 had visible contractures on her lower extremities with nearly constant tremors of her arms and neck. R51 stated her contractures hurt, "Awful bad," at times. R51's care plan dated 2/28/17, identified R51 had depression and was taking antidepressant medication. The care plan identified R51, "Worries and ruminates over changes in body/medical problems," and directed staff to attempt gradual dose reductions of medications when indicated and monitor R51's status and update the physician as needed. The care plan lacked any interventions or dictation which identified R51 was being seen by psychology services. R51's Associated Clinic of Psychology Progress Note dated 3/31/17, identified R51 had adjustment and personality disorder(s) and had been working with the psychologist to help cope from some family relationship stressors. R51 was identified to, "...reports her own mood is about the same with continued episodes of crying and sweating," and, "[R51] does report pain." Further, the note identified a section labeled, Recommendations, and listed R51, "Continues to report sadness and depressive symptoms ... may benefit from Cymbalta [medication used to treat pain and depression] if not contraindicated, given her reports of sadness and pain. This will be deferred to her PCP [primary care provider]." R51's following physician progress note dated 4/4/17, identified R51 had chronic pain and depression with anxiety. The note listed an, "Assessment [and] Plan," section and identified each diagnosis R51 displayed including,	2 830		

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2 830	Continued From page 12 "Moderate episode of recurrent major depressive disorder," and, "Chronic pain of both extremities." The physician increased R51's ordered Fentanyl patch (narcotic duragesic patch) and identified R51 was, "Stable," on her current medication regimen for depression. There was no identified reference or dictation addressing the psychologist' recommendation to consider adding Cymbalta to R51's medication regimen as identified in the 3/31/17 note. R51's medical record was reviewed and lacked any evidence R51's physician had addressed or considered the psychologist's recommendation. Further, R51's signed physician orders dated 4/4/17, lacked any orders or trial dosing of Cymbalta. When interviewed on 5/4/17, at 8:36 a.m. nursing assistant (NA)-A stated R51's mood, "hasn't really changed," in the past months. NA-A stated R51 still does have episodes of crying, "Every once in awhile," about being unable to care for herself or return to her home. During interview on 5/4/17, at 12:04 p.m. registered nurse (RN)-A stated R51 had a history of pain and recently had her narcotic medication dosing increased as a result. RN-A stated R51 also had, a lot of personal "stuff," going on in her life; however, felt R51's mood was good. At 12:41 p.m. RN-A stated she had reviewed R51's medical record and spoke to R51's nurse practitioner. The psychologist's recommendation to consider adding Cymbalta had not been addressed because someone missed it. Further, RN-A stated the recommendations should have been looked at and addressed. A facility Psychology Services policy dated	2 830		

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2 830	Continued From page 13 6/2016, identified a procedure which included, "Dictated notes are sent to the facility for resident charts. Notes with recommendations are reviewed by the primary physician at the next scheduled resident visit." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding making sure psychiatry recommendations are acted upon timely; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative nursing programs for range of motion (ROM) as	2 895		

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2 895	Continued From page 14 directed for 5 of 5 residents (R38, R18, R67, R36 and R15) reviewed for ROM services. Findings include: R38's facesheet (undated) had the diagnoses of Alzheimer's dementia with behaviors, major depression and contractures of muscle on multiple sites. R38's Significant Change in Status Minimum Data Set (MDS), dated 4/14/2017, indicated the resident was severely cognitively impaired, was totally dependant with all activities of daily living (ADLs). The MDS identified R38 had functional limitations in ROM on one side of upper extremities which included shoulder, elbow, wrist and hand. The restorative nursing section identified no restorative programs occurred. During observations on 05/03/2017 at 9:10 a.m., nursing assistant rehabilitation (Rehab)-A entered R38's to provide ROM. Rehab-A positioned R38 on his back and wrapped a warm moist wash cloth around his left hand. Rehab-A completed ROM of R38's shoulder, elbow, and hand. She continued to provide ROM to R38's left leg, knee and foot, repeating the same on the right side, and finished with R38's right shoulder, arm and hand. After completion of the ROM on 05/03/17 at 9:45 a.m., Rehab-A, stated R38 could be resistive to ROM, pull away and strike out. When this occurred, you stop and explain what was occurring or move to a different extremity, which usually calms him. In review of R38's Rehab Visions Occupational Therapy Discharge Information, dated 2/24/17, indicated: "Please complete washing and drying [left] hand and ROM (range of motion) on [both]	2 895		

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2 895	Continued From page 15	2 895		

arms and hands 3-5x/week (time per week)." In R38's Rehab Visions Physical Therapy Discharge Information, , dated 6/8/16, the orders indicated: "please completed [both] [lower extremities] ROM (range of motion program in a supine (on back) 3-5x/wk."

R38's care plan (last reviewed 4/21/17), indicated that "R38 participates in a nursing rehab program to prevent contractures." The facility indicated in the care plan that R38 was to receive, "Nsg [nursing] rehab program: up to 3-5 x/wk has with ROM, LE [lower extremities] PROM [passive range of motion] 3/-5x/wk [3 to 5 times a week]. Complete bilateral upper extremity ROM. Wash left hand."

Review of R38's monthly ROM data collection tools from March to May 2017 entitled: Attachment C identified the following:

May 1-3, 2017 - received 2 treatments
April 1-30, 2017 - received only 4 treatments with the 5th documented as "AG" (agitated)
March 1-31, 2017 - received only 7 treatments with one treatment documented as "AG" and another "O" (MD appointment, visitor, etc)

During interview on 5/3/17, at 11:52 a.m., Rehab-A stated there were two nursing rehabilitation staff work alternating days, and are not scheduled as direct care nursing assistants. However, at times the two have been pulled to cover direct care positions along with rehab and to lead the facility's exercise group daily. Rehab-A stated if resident's are out to appointments, have visitors, or refuses, it is difficult to reproach and or reschedule their rehab because of heavy case load. Rehab-A stated residents who receive nursing rehab are scheduled by the therapy

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2 895	Continued From page 16 department and seen 3-5 times each week for ROM. Rehab-A reviewed the ROM data collection tool from March to May 2017 and identified the frequency of ROM was not being completed for R38. During an interview on 5/3/17 at 1:59 p.m., the B Wing care manager, registered nurse (RN)-B stated the Rehab RN reviews resident progression with the rehabilitation staff once a week (on Fridays), for changes and concerns with any of the residents. RN-B stated she was unaware that R38 did not receive ROM 3-5 times a week for the months of March and April 2017. In an interview on 5/4/17 at 9:01 a.m., the occupational therapist (OTR)-A, stated during the last quarterly screen on 2/24/17, there was no noticeable change in R38's ROM. OTR-A stated the resident fluctuated day to day because of behavior and cognition. They expect the nursing rehab to complete ROM exercises 3-5 times a week as they have directed for R38. R18 facesheet had the diagnoses of dementia with Lewy Bodies, transient ischemic attack (TIA) and sleep disorder. R18's quarterly MDS, dated 3/15/17, identified severe cognitive impaired, totally dependent with all ADLs and had no functional limitations in ROM. The restorative nursing section of the MDS identified restorative nursing had not occurred. In review of R18's Rehab Visions Occupational Therapy Discharge Information, dated 11/19/16, indicated: "Please complete [upper extremity] ROM (range of motion) program", on 4/13/17: "Please complete [upper extremity] ROM	2 895		

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2 895	Continued From page 17 program. Refer to ROM FMP (functional maintenance program) for further information." During an interview on 5/4/17 at 9:01 a.m., the occupational therapist (OTR)-A stated her expectations was for treatments completed 3-5 times each week for R18. In R18's Rehab Visions Physical Therapy Discharge Information, dated 6/08/16, the orders indicated: "Please completed [both] [lower extremities] ROM (range of motion program in a supine (on back) 3-5x/wk." R18's care plan, updated 4/24/17, indicated, "[R18] participates in a nursing rehab program to maintain current ability and to prevent decline in ability to do ADLs." Rehab nursing to perform "bilateral LE ROM program in supine (on R18's back) X [times] 20 reps [repetitions] each direction 3-5 times wk [weekly], and "UE [upper extremity] ROM program" 3-5 times a week. In review of the monthly ROM data collection tools, entitled: Attachment C, indicated R18 received ROM for the following frequency: May 1-3, 2017 - received 1 treatment April 1-30, 2017 - received only 4 treatments with the 5th documented as "O" (MD appointment, visitor, etc) March 1-31, 2017 - received only 6 treatments with one treatment documented as "I" (illness) and two others documented as "O" (MD appointment, visitor, etc) During interview on 5/4/2017 at 11:20 a.m., the assistant director of nursing (ADON) reviewed the ROM data collection tool, and stated R18 was missing ROM treatments.	2 895		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 18 An interview on 5/4/17 at 9:01 a.m., OTR-A, stated the last quarterly OT screen on 4/13/17, identified no noticeable decline in R18's ROM. R18 fluctuated from day to day because of behavior and cognition. They expect nursing rehab to complete ROM exercises 3-5 times a week as they have directed for R18. R67's Resident Face Sheet, undated, identified resident had arthritis in multiple sites. R67's quarterly MDS of 3/14/17 identified resident was cognitively intact and required assistance of one to two staff to complete ADL's. The MDS identified R67 had functional limitations in range of motion of bilateral upper extremities of shoulder, elbow, wrist and hand. There was no indication R67 received any restorative nursing. R67's care plan, updated 3/15/17, identified resident was to participate in the Fit 4 Life program which consisted of stretches, balance-transfer exercises and strength training for Tuesday and Thursday programs. The care plan also identified R67 had shoulder exercise/stretch program 3 to 5 times per week with Nursing Rehab program. The OT Evaluation Information form, dated 9/21/16, identified resident required limited assist with upper body dressing and extensive assist of two to complete lower body. A Rehab Nursing program was developed to assist resident with shoulder exercise/stretch program 3 to 5 times per week. During interview on 5/3/17, at 11:07 a.m. R67 reported increased pain and discomfort in her right shoulder, hip, and thigh but dislikes taking pain medications for this. R67 stated exercises	2 895		

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2 895	Continued From page 19 are completed with by an "Aide who has been trained by therapy", however these are not completed with any frequency. The exercises are completed on an average of one time per week. She stated her, "Shoulders are definitively worse" since coming to the facility. Per observation R67 had some limitations with opening and closing her right hand and held her right shoulder close to her body. Review of the facility monthly ROM data collection tools, entitled: Attachment C, indicated R67 received ROM bilateral shoulder exercise program as follows: May 1-3, 2017 - received 0 treatments April 1-30, 2017 - received only 1 treatments at the frequency of "30", five entries were denoted "O" representing Other (MD appt, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and another entry indicated "R." March 1-31, 2017 - received only 3 treatments with the frequency of 20-30-20, with an additional 9 entries identified as "O", with no additional information, and 1 entry identified as "A" for participation in another activity. February 1-28, 2017-2 entries are identified as "O" with no additional information, 1 entry was identified as "A", and one noted resident was on LOA (leave of absence). January 1-31, 2017-1 entry identified resident received 15 minutes of 1:1 interaction, 1 entry was identified as "A", 2 entries indicated "I" (illness), and 3 entries indicated "O". December 1-31, 2017-2 entries identified R67 received 15 minutes of 1:1 therapy, 6 entries identified "O", with no additional explanation, 1 entry identified resident was "A", and 1 entry indicated "A/R".	2 895		

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2 895	Continued From page 20 During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R67 comes to exercise class, Fit 4 Life, on Tuesday and Thursdays. Rehab-A stated R67 had consistently declined participation in class and was to receive shoulder exercise/stretch program three to five times a week, Rehab-A stated if R67 was not ready for her exercises when they arrived, they were unable to return at a later time to complete exercises. Rehab-A stated R67 does complain of more pain when completing exercises and she had seen a notice a difference in R67's shoulder. During interview on 5/3/17, at 1:19 p.m. NA-A stated R67 had vocalized increased pain in the right shoulder and more requests for pain medication. NA-A stated R67 had exercises to perform in bed as taught by therapy and exercises are to be completed with rehab nursing. During interview on 5/3/17, at 1:35 p.m. with doctorate physical therapist (DPT)-A stated R67 does have limitations related to arthritis and mobility is uncomfortable. Occupational therapy has placed her on a ROM program and has worked with R67 regarding her shoulder limitations and comfort. During interview on 5/4/17, at 9:01 a.m. with OTR-A stated R67 was admitted with decrease ROM, both active and passive (exercises complete independently-active, and with assistance-passive). They developed a program for rehab nursing to complete active assisted ROM with table top exercises. DPT-A who was present during this interview, stated R67 has demonstrated no functional changes in her recent functional range of motion screen.	2 895		

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2 895	Continued From page 21 R36's undated Resident Face Sheet identified R36 had arthritis with difficulty with multiple joints impacted. R36's quarterly MDS of 1/31/17 identified resident had moderate cognitive impairment and received assistance of one to two staff to complete ADL's. The MDS did not identify any functional limitation in ROM. R36's Rehab Vision occupational therapy discharge instructions, dated 11/25/16, identified rehab nursing was to assist resident with right upper extremity ROM with prolonged stretch at the end of movement. This routine was to be completed 3 to 5 times week and attend the Fit 4 Life class. R36's care plan, last updated 2/6/17, identified the resident participates in nursing rehab program to maintain current ability and prevent further decline. The care plan directed Rehab Nursing to "complete 5 reps [repetitions] with prolonged stretch at end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." R36 was also to attend the Fit 4 Life class. An Updated physical therapy information sheet, dated 4/2/17, identified rehab nursing was to assist R36 perform hamstring stretching bilaterally 3 to 5 times a week 5 times with a 30 second hold. In review of the monthly ROM data collection tools, R36 received rehab nursing as follows: May 1-3, 2017 - received 1 treatments April 1-30, 2017 - received only 7 treatments at the frequency of "10" 1:1 (one to one) minutes, 5	2 895		

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2 895	Continued From page 22 entries were denoted "O" representing Other (MD appt, visitor, etc) with no additional information, 1 entry indicated "A" (in another activity), and 1 entry indicated "R." March 1-31, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, with an additional 2 entries where resident had refused therapy. February 1-28, 2017-received 2 episodes of treatment with the frequency of "15" 1:1 minutes, and two dates "I" (illness) was indicated. January 1-31, 2017-received 5 episodes of treatment with a frequency of "15" 1:1 minutes, and one noted incident where resident refused. December 1-31, 2016-received 12 episodes of treatment with a frequency of "15" 1:1 minutes identified. During interview on 5/3/17, at 12:06 p.m. Rehab-A stated R36 has been an active participant in the Fit 4 Life program and has been willing to complete the program. R36 was to receive a hamstring stretch with standing frame, and PROM (passive range of motion) to right upper extremity. Rehab-A stated R36 was an active participant in exercise group so the PROM exercises were not completed at times due to prioritizing other Rehab Nursing tasks to be completed. During interview on 5/4/17 at 9:01 a.m. OTR-A stated R36 had been evaluated and recommended to receive "right upper extremity repetitions with prolonged stretch at the end of movement for shoulder flexion and abduction, elbow flexion/extension, forearm suspiration/pronation, wrist flexion/extension, and full fist (all fingers)flexion/extension 3-5 x week." OTR-A stated rehab nursing should be completing the program 3-5 x week as directed.	2 895		

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2 895	Continued From page 23 R15's undated Resident Face Sheet identified a diagnosis of arthritis. R15's quarterly MDS of 3/18/17 indicated a severe cognitive deficit and the need for extensive assistance of one to two staff to complete ADL's. The MDS identified no functional impairment of range of motion or any restorative nursing. The physical therapy evaluation information, dated 9/8/16, identified R15 received assistance of 2 and use of the Medi-Lift with transfers. The note directed rehab aides to complete bilateral lower extremity ROM 3 to 5 times a week. R15's care plan, reviewed on 3/20/17, identified participation in the rehab nursing program to maintain current ability. The care plan outlined the nursing rehab program to assist with bilateral lower extremity ROM 3 to 5 times per week. In review of the monthly rehabilitation logs from December 2016 thru February 2017 identified R15 received ROM bilateral shoulder exercise program as follows: December 1-31, 2016 - received 8 treatments of 15 1:1 (one to one) minutes January 1-31, 2017 - received only 7 treatments of 15 1:1 minutes February 1-28, 2017 - received only 5 treatments with the frequency of 15 1:1 minutes, and one notation of "O". During interview on 5/3/17, at 12:06 p.m. Rehab-A stated they were unable to complete exercises as directed because of limited time. During interview on 5/4/17, at 9:01 a.m. DPT-A	2 895		

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2 895	Continued From page 24 stated R15 was set up to complete bilateral lower extremity ROM with 20 repetitions 3-5 times per week to maintain function, and had had no changes in his functional ability. During interview on 5/4/17, at 9:31 a.m. ADON, who is responsible for the nursing rehab program, stated they had reviewed the tracking log from April of 2017 and noted completion of exercises had declined and were currently in the process of evaluating this program but had made no changes. During interview on 5/4/17, at 12:20 p.m. the director of nursing identified the ROM Rehab program was in the process of being re-evaluated and the intent was to look at alternative to meet the needs of the residents. A policy, titled Rehabilitation and Restorative Program Nursing, reviewed 5/12. identified under the Policy statement, first bullet: "Nursing care is directed toward the conservation of abilities of residents, restoration of optimal levels of function, and independence, adaptation to an altered life style, prevention of deterioration, and complications of disability whenever possible." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding range of motion and audit to ensure it is completed as directed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		

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2 910	Continued From page 25 Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess a change in continence status for 1 of 1 residents (R39) reviewed for urinary incontinence. Findings include: R39's admission Minimum Data Set (MDS) dated 12/28/16, indicated she was moderately cognitively impaired. The MDS further indicated she needed total assist of two with toileting and had occasional incontinence (seven or less episodes of incontinence). R39's care area assessment (CAA) dated 12/28/16, identified she had urinary urgency and had problems with occasional dribbling, and had cognitive and mobility impairment. R39's Bowel And Bladder Assessment dated 12/28/16, indicated she was continent of bowel and bladder and she would call	2 910		

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2 910	Continued From page 26 for toileting during the day and toilet with bedpan at night every four hours. R39's Point Of Care History (lists episodes of incontinent and continence of urine) dated 12/22/16 to 1/17/17, identified she was incontinent of urine once. R39's quarterly MDS dated 3/30/17, indicated she needed extensive assist of two with toileting and was frequently incontinent of urine (seven or more episodes). R39's Bowel and Bladder Assessment dated 3/29/17, indicated she was incontinent of urine and wore absorbent pads. The assessment further indicated she will call for toileting and toilet every four hours at night. A Point Of Care History dated 3/23/17 to 3/30/17, indicated she was incontinent of urine 11 times with various times over the day. R39's care plan dated 1/12/17, indicated she was on a will call toileting plan related to occasional dribbling of urine, and wore an incontinence products. During interview 5/2/17, at 3:06 p.m. registered nurse (RN)-B stated she thought the reason R39 had an increase in incontinence was related to a urinary tract infection and was started on a antibiotic on 3/26/17. RN-B stated she was not sure if R39 still had problems with incontinence. During interview 5/2/17, at 3:24 p.m. nursing assistant (NA)- B stated he works evenings and nights and R39 will usually let him know when she has to use the bathroom on the evening shift. When he works nights she was always incontinent and was usually wet around 2:00-2:30 a.m. During interview 5/2/17, at 3:26 p.m. licensed practical nurse (LPN)-A stated works on the day	2 910		

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2 910	Continued From page 27 shift and R39 was usually incontinent of urine when she gets up in the morning. During interview 5/2/17, at 3:30 p.m. NA-C stated she works the day shift and about 2-3 times a week R39 was incontinent of urine. She got R39 up this morning and she was incontinence of a medium amount of urine. During interview 5/3/17, at 7:08 a.m. NA-E stated she works the day shift and R39 was very sleepy at night and this may be a reason why she was incontinent at night. NA-E stated (R39) was usually wet when she wakes up, but during the day she will tell us when she needs to use the bathroom. During observation 5/3/17, at 7:20 a.m. R39 was in the bathroom voiding in the toilet with NA-D assisting her. During interview 5/3/17, at 10:56 a.m. RN-B stated she did not realize (R39) had an increase with urinary incontinence, and they needed to reassess R39's bladder function, and develop a new plan that was more specific to her needs. The facilities Bladder and Bowel Policy and Procedure revised 2/15, indicated "It is the policy that the facility will ensure that each resident that is incontinent of bladder and/or bowel is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible through use of appropriate treatment and services. It is the policy to also identify risk factors and assess resident who are continent of bladder and bowel for the purpose of maintaining current function." The policy further indicated the RN determines the appropriate toileting or bladder/bowel	2 910		

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2 910	Continued From page 28 retraining program as assessed. This is care planned and staff are informed of the plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who needed assistance with toileting, to assure they are receiving the necessary treatment/services to prevent potential decline in toileting. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		