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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LCV7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00126

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245326**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1053700856**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROSE OF SHARON MANOR**
(L4) **1000 LOVELL AVENUE**
(L5) **ROSEVILLE, MN** (L6) **55113**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **08/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **63** (L18)

13.Total Certified Beds **63** (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
	63			
(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 :
Mary Beth Lacina, HFE NE II 08/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(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) **00**

VOLUNTARY
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.
06301
(L31)

30. REMARKS
Posted 09/01/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/27/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245326
August 24, 2016

Mr. Dennis Decosta, Administrator
Rose of Sharon Manor
1000 Lovell Avenue
Roseville, MN 55113

Dear Mr. Decosta:

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 July 20, 2016 the above facility is certified for or recommended for:

63 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 63 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
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 24, 2016

Mr. Dennis Decosta, Administrator
Rose of Sharon Manor
1000 Lovell Avenue
Roseville, MN 55113

RE: Project Number S5326025

Dear Mr. Decosta:

On June 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 10, 2016 that included an investigation of complaint number H5326055, H5326057, H5326058, H5326060, H5326061, H5326063, H5326064, & H5326065. 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 August 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 10, 2016, effective July 20, 2016 and therefore remedies outlined in our letter to you dated June 30, 2016, 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
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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
245326 Y1	A. Building B. Wing Y2	8/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	1000 LOVELL AVENUE ROSEVILLE, MN 55113

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 F0165	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(f)(1)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	07/20/2016	LSC	07/20/2016	LSC	07/20/2016
ID Prefix F0242	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	07/20/2016	LSC	07/20/2016	LSC	07/20/2016
ID Prefix F0312	Correction	ID Prefix F0313	Correction	ID Prefix F0315	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(b)	Completed	Reg. # 483.25(d)	Completed
LSC	07/20/2016	LSC	07/20/2016	LSC	07/20/2016
ID Prefix F0412	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.55(b)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	07/20/2016	LSC	07/20/2016	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
	SR/KJ	08/24/2016	30921	08/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/10/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245326 Y1	A. Building 01 - MAIN BUILDING 0102 B. Wing Y2	7/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	1000 LOVELL AVENUE ROSEVILLE, MN 55113

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 K0018	07/20/2016	LSC K0020	06/30/2016	LSC K0025	06/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0034	06/30/2016	LSC K0046	06/30/2016	LSC K0050	06/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	06/30/2016	LSC K0056	07/18/2016	LSC K0062	07/06/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0064	06/30/2016	LSC K0076	06/30/2016	LSC K0144	06/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0147	06/30/2016	LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	08/24/2016	12424	07/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/7/2016

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 24, 2016

Mr. Dennis Decosta, Administrator
Rose of Sharon Manor
1000 Lovell Avenue
Roseville, MN 55113

Re: Reinspection Results - Project Number S5326025

Dear Mr. Decosta:

On August 10, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 10, 2016, that included an investigation of complaint number H5326055, H5326057, H5326058, H5326060, H5326061, H5326063, H5326064, & H5326065, with orders received by you on July 5, 2016. 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
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00126 Y1	A. Building B. Wing Y2	8/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	1000 LOVELL AVENUE ROSEVILLE, MN 55113

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	20840	Correction
Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed	Reg. #	MN Rule 4658.0520 Subp. 2 B	Completed
LSC		07/20/2016	LSC		07/20/2016	LSC		07/20/2016
ID Prefix	20910	Correction	ID Prefix	20920	Correction	ID Prefix	21390	Correction
Reg. #	MN Rule 4658.0525 Subp. 5 A.B	Completed	Reg. #	MN Rule 4658.0525 Subp. 6 B	Completed	Reg. #	MN Rule 4658.0800 Subp. 4 A-I	Completed
LSC		07/20/2016	LSC		07/20/2016	LSC		07/20/2016
ID Prefix	21426	Correction	ID Prefix	21830	Correction	ID Prefix	21880	Correction
Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	MN St. Statute 144.651 Subd. 10	Completed	Reg. #	MN St. Statute 144.651 Subd. 20	Completed
LSC		07/20/2016	LSC		07/20/2016	LSC		07/20/2016
ID Prefix	21980	Correction	ID Prefix	21995	Correction	ID Prefix		Correction
Reg. #	MN St. Statute 626.557 Subd. 3	Completed	Reg. #	MN St. Statute 626.557 Subd. 4a	Completed	Reg. #		Completed
LSC		07/20/2016	LSC		07/20/2016	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
	SR/KJ	08/24/2016	30921	08/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/10/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LCV7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00126

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245326**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1053700856**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROSE OF SHARON MANOR**
(L4) **1000 LOVELL AVENUE**
(L5) **ROSEVILLE, MN** (L6) **55113**

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) **07/01/2015**

6. DATE OF SURVEY **06/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **63** (L18)

13.Total Certified Beds **63** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(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 :
Mohammed Fatty, HFE NE II 07/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/26/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(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.
06301
(L31)

30. REMARKS
Posted 07/27/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 20, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 20, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 10, 2016 (three months

after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. 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
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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
	245326	A. BUILDING _____ B. WING _____	06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	1000 LOVELL AVENUE ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted June 6, 7, 8, 9, 10, 2016. The following complaint investigations were also completed at the time of the standard survey: H5326055 was found to be substantiated at F315 H5326057 was found to be substantiated at F309 H5326058 was found to be substantiated at F225, F226 H5326060 was found to be substantiated at F165, F225, F226 H5326061 was found not to be substantiated H5326063 was found to be substantiated at F165, F225, F226 H5326064 was found to be substantiated at F309, F225, F226 H5326065 was found to be substantiated at F225, F226	F 000 ser 7/15/16	Submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in this statement of deficiency This plan is being submitted because it is required by law.	
F 165 SS=D	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has	F 165		

RECEIVED
JUL 11 2016
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

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

Executive Director | 7/8/16

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

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F 165	Continued From page 1 been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that prompt efforts were made by the facility to ensure resident rights to voice grievances without reprisal affecting 2 of 3 residents (R3, R81) in the sample who filed a grievance. Findings include: R3 filed 3 concerns with the facility of improper treatment. R3 was assessed as cognitively intact according to the minimum data set (MDS) quarterly review 3/25/16. R3 was interviewed on 6/7/16, at 10:33 a.m. and reported grave concern about nursing assistant (NA-B) who was "abusive" to R3 several months ago. R3 expressed "fear and retaliation" from NA-B and that the facility did not take the concern seriously. R3 further stated, "My heart ached after [NA-B] did what [NA-B] did." R3 expressed not feeling confident to go to the social service department because does not trust there will be follow up. R3 confided seeing other residents in the facility mistreated and that the residents are not taken seriously. 6/7/16, at 10:45 a.m., interview with R3's roommate (R78) regarding help from the nursing assistants, R78 reported that "[NA-B] plays mind games with us." R78 verified having issues with	F 165	F165 R (3) OHFC report has been completed regarding resident concern 06/09/2016 Employee (NA-B) is no longer an employee at the facility. R (81) Resident Concern Report was documented on 06/09/2016 and investigation is in process. Resident rights will be reviewed during resident council meeting including facilities Zero tolerance policy on fear of reprisal. All residents will be encouraged to share feed back with facility management. Resident concerns regarding facility employees will be investigated and documented accordingly. Employee interventions, including any education or disciplinary actions up to and including terminations, will be documented in the HR personal files.	

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F 165	Continued From page 2 [NA-B] but that there is no one to listen to what they are saying from management in this facility. Document review of a 4/6/16, Resident Concern Report, from R3 read, "I have had 2 incidents of retaliation from care recently. 1. I told [NA-L] not to flirt while working. In response, the next day [NA-B] took me in the bathroom, left me naked on the toilet and said, '[NA-L] life is [NA-L] life and my life is my life. I have a life at home.' 2. [NA-B] did not take me to lunch after that so by the time someone else took me my lunch was cold. [NA-B] always retaliates if complaints are made." Although administration wrote on the investigation that the roommate and neighbors were interviewed, there was no documented information regarding the interviews. Administration changed the staff members assignment so that NA-B would not take care of R3, however, there was no documented education and/or learning report for the staff member, there was no documented statement obtained from the care givers NA-B or NA-L and there was no report filed with the State Agency pending investigation. On 6/9/16, at 3:00 p.m. administration reviewed the Resident Concern Report from 3/15/16, and at this time, filed a report to the State Agency. NA-B was suspended pending investigation. Document review of the 3/15/16, Resident Concern Report, written by R3 read, "On Sunday 3/13[16] I asked [NA-A] to put me in bed bc/ (because) my legs hurt. [NA-A] said "No" bc/ it was too close to lunchtime. I said I needed to lie down bc/ my legs were bothering me a lot. [NA-A] said [NA-A] would come back to get me for lunch	F 165	Staff has received education regarding the abuse neglect policy including zero tolerance of residents' fear of reprisal. Facility staff education completed on call light wait times and need for prompt response. IDT team to complete Random Call light audits on each shift/ hallway 3 times weekly for one month and one time weekly after one month. ED or designee will audit resident satisfaction, including call light response times through facility Caring Partner program weekly and concerns addressed according to resident concern policy. Results of the Caring Partner surveys will be reviewed monthly for tracking and trending during the QAPI process for identification of areas of opportunity. ED or designee will monitor for resident concern reports and HR files for trends regarding employee performance and address accordingly. Alleged date of compliance: July 20, 2016.	

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F 165	Continued From page 3 but never did. My tablemate [R5] asked [NA-F]to come get me for lunch but [NA-F] refused. Eventually I started to yell for help bc/ my bed was wet, I needed to be changed. I was hungry." R81 completed a Resident Concern Report to corroborate R3's concern and wrote, "I was coming in from the outside and [R3] was screaming with [R3] call light on help me, help me. As I was coming up the hallway to get [R3] help, [licensed practical nurse (LPN-A)] got on the phone and called for east aides. [NA-A] came from somewhere in the west wing and [NA-B] came up the back stairs. There were no aides on that wing. [R3] said this went on for 20 minutes." Although the Resident Concern Report under Disposition read, "Staff educated to communicate between peers when going on break or leaving the unit. Staff educated to coordinate breaks to allow coverage/Resident cares." there was no documentation of this education. The administrator wrote, "Writer will check on resident during daily rounds to interview regarding needs being met." There was no documentation to support this intervention by the administrator. R81 completed another Resident Concern Report on 3/15/15, which read, "During the day shifts especially, it takes far too long to answer the call lights. I am entirely depending for help w/ my bathroom needs, getting up, and dressed. I cannot operate my wheelchair by myself." The disposition written by administration read, "Writer will perform call light audits every shift. Writer will monitor resident council minutes regarding call light times. Writer will round multiple times for observations. Writer will remind staff regarding call light times." During an	F 165		

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F 165	Continued From page 4 interview with the administrator on 6/9/16, at 3:00 p.m. verified there was no documentation to support the interventions occurred as no documentation was implemented. On 5/9/16 R3 wrote a Resident Concern Report which read, " When [NA-B] is assigned as the aide on my hall [NA-B] refuses to help me. Why is [NA-B] working here if [NA-B] can refuse to help residents? I feel as if my past complaints about [NA-B] have not been taken seriously, for example, when [NA-B] left me naked on the toilet." The investigation report completed by the administrator read, "Administrator changed assignments on the hall. Resident requested and agreed with the change on 4/6/16. [NA-B] has not worked with that resident since 4/6/16. Previous allegations 4/6/16 followed up with. Employee resident per policy and protocol. Unsubstantiated and also resident agreed with change in caregiver assignments. Writer assigned BOM BH to monitor resident well being 4/17/16 thru 4/21/16-No concern reported." A review of the facility policy dated, July 2015, titled, Concern-Resident/Family, read, "The center provides residents and their family members with an uninhibited resident/family concern procedure. The procedure is such that each and every resident and/or family has the right to express their grievance or concerns directly to the center's administration either verbally or in writing. Assure the resident and/or family that they can voice their concern without fear of discrimination or reprisal." During an interview with the administrator on 6/9/16, at 3:00 p.m. verified there was no documentation to support the interventions	F 165		

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F 165	Continued From page 5 occurred as no documentation was implemented. R81 on 6/6/16 at 11:55 a.m., R81 approached a surveyor and reported having a concern that one evening in recent months he had chest pain, self-medicated with nitro tablets, and asked a facility nurse to call his after-hours clinic for medical care. R81 stated he was informed later that evening that his after-hours clinic was not called, but a facility nurse had called the facility's medical director and received an order for "Oxy," and R81 refused that medication because he did not want to take opiates. R81 stated that he told facility administration about his concerns for appropriate care related to this incident but has never been told of a resolution to his concerns. R81 did not remember the date of the incident or the names of the staff involved. When interviewed on 6/8/16, at 2:10 p.m. the director of nursing (DON) stated that this concern of R81 had been investigated. Document review of R81's record showed no documentation of investigation of this incident. During interview on 6/9/16, at 11:21 a.m. the DON was asked about the investigation of this incident and R81 was present. The DON was asked if there was documentation of the investigation of this incident and she stated that there was no documentation of the investigation of this incident because R81 had not been sure of the date of the incident or the staff involved. R81 then stated that there had been a meeting regarding this incident that included himself, the DON and the medical director, and R81 had been upset with the medical director at this meeting because the	F 165		

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F 165	Continued From page 6 medical director said at that meeting that he did not recall the incident being investigated. The DON was asked by the surveyor if there had been a meeting regarding this incident that included herself, R81, and the medical director and she confirmed that the meeting did take place--she did not recall the date, but believed that it took place in recent weeks. R81 then stated that it was true that he did not want to get the nurses involved in the incident into trouble by telling their names, but he had previously told the director of nursing that one of the nurses involved had an accent specific to a nurse at the facility. The DON confirmed that R81 had mentioned that one of the nurses involved in the incident had a particular type of accent and that a facility nurse has that type of accent.	F 165		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225	F225 R(3) R (54) R (81) and R (5) have had grievance reports reported, investigated and concluded accordingly. Abuse/Neglect and Resident concern training with ED and DON was completed on 06/16/2016. Resident concerns are to be written up on a resident concern form, including ED notification, and entered on the resident concern log by Social Service. The ED or designee will review the concern reports during the clinical meetings for follow up. Investigations will be completed within 5 business days and follow up will be completed with the reporting individual. The ED/ designee will review all completed resident concern reports for final review.	

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F 225	Continued From page 7 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment neglect and abuse were reported to the administrator immediately, reported immediately to the state agency and thoroughly investigated for 4 of 5 residents (R3, R54, R81, R5) reviewed for incidents. Findings include: R3 filed 3 concerns with the facility of improper treatment. R3 was assessed as cognitively intact according to the minimum data set (MDS) quarterly review 3/25/16.	F 225	Any concern regarding abuse, neglect, mistreatment, or injury of unknown origin will be reported immediately to ED and DON with follow up by writer to report to state agency if appropriate and to be investigated thoroughly Facility staff has completed education regarding Resident concern and Abuse/ Neglect policy and procedure. Social Services will review resident concern log monthly for tracking and trending during QAPI meetings monthly. ED/ designee will audit resident concerns 3 x week for 4 weeks, then weekly for 4 weeks, and then ongoing monthly through the QAPI process. Alleged date of compliance: July 20, 2016.	

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F 225	Continued From page 8 During the initial resident (R3) interview on 6/7/16, at 10:33 a.m. reported grave concern about nursing assistant (NA-B) who was abusive to R3 several months ago. R3 expressed "fear and retaliation" from NA-B and that the facility did not take the concern seriously. R3 further stated, "My heart ached after [NA-B] did what [NA-B] did." R3 doesn't feel confident to go to the social service department because does not trust there will be follow up. R3 confided seeing other residents in the facility mistreated and that the residents are not taken seriously. Interview with R3's roomate (R78) 6/7/16 at 10:45 a.m., R78 reported that "[NA-B] plays mind games with us." R78 verified having issues with [NA-B] but that there is no one to listen to what they are saying from management in this facility. Document review of a 4/6/16, Resident Concern Report, from R3 read, "I have had 2 incidents of retaliation from care recently. 1. I told [NA-L] not to flirt while working. In response, the next day [NA-B] took me in the bathroom, left me naked on the toilet and said, '[NA-L] life is [NA-L] life and my life is my life. I have a life at home.' 2. [NA-B] did not take me to lunch after that so by the time someone else took me my lunch was cold. [NA-B] always retaliates if complaints are made." There was no evidence the administrator was immediately notifed, the State agency notified or a thorough investigation completed. Although administration wrote on the investigation report that roomate and neighbors were interviewed, documentation lacked evidence of the interview findings. The report idenfied that staff members assignments were changed so that NA-B would not take care of R3, however, there was no	F 225		

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F 225	Continued From page 9 documented education and learning for the staff member, there was no documented statement obtained from the care givers NA-B or NA-L and there was no report filed with the state agency pending investigation. On 6/9/16, at 3:00 p.m. administration again reviewed the Resident Concern Report from 3/15/16, and at this time, filed a report to the state agency. NA-B was suspended pending investigation. R54 sustained an injury of unknown origin on 3/7/16, between 6:30 a.m. and 7:00 a.m., sustained a skin tear of unknown origin on 3/7/16, between 11:00 a.m. and 11:30 a.m. and on 2/24/16 a 10 cm bruise was discovered on R54's right inner thigh of unknown origin that lacked a report to the administrator, state agency and an investigation. According to a document titled, Admission Record, onset date, 10/1/15, R54 was diagnosed with unspecified dementia with behavioral disturbances, contracture unspecified hand, delusional disorders, and unspecified psychosis not due to a substance or known physiological condition. R54 was assessed as severe cognitive impairment according to the minimum data set (MDS) assessment completed 2/20/16. Document review of a form titled, Witness Investigation Statement, an incident that occurred on 3/7/16, between 6:30 a.m. and 7:00 a.m. revealed R54 had a left shoulder that looked very different from the right shoulder.	F 225		

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F 225	Continued From page 10 Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-B) read, "On the 7th of March, around 6:30 a.m. I went to [R54] room to get [R54} dressed for breakfast. After shaving [R54}, I realize that [R54] left shoulder looked different, so I called the nurse (registered nurse RN-G) to pls (please) come to [R54] room to check [R54] out." Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-A) read, "I didn't see it but I was told by my co-worker that [NA-B] went to dress the resident for [R54's] morning meal and notice that resident shoulder wasn't right so [NA-B] immediately informed the charge nurse to come and accessed the shoulder." Document review of a form titled, Witness Investigation Statement, from RN-G, dated 3/8/16, from an incident that occurred 3/7/16 read, "Nurse called to residents room in AM to see residents shoulder. Upon assessment left shoulder seem different, but I wasn't sure why." There was no documented evidence that the administrator was informed immediately and no documented evidence that the injury of unknown origin was reported to the state agency. Document review of the form titled, Progress notes, dated 3/7/16, at 7:30 a.m. read, "Nurse was called to dining area this am, Resident was observed to be bleeding from an open area on right hand. [family member F-B] was contacted and informed about skin tear via phone. NP on site updated, nurse manager updated." Documentaion lacked evidence that the administrator was informed immediately	F 225		

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F 225	Continued From page 11 regarding the injury of unknown origin and that the state agency was notified. When interviewed on 6/9/16, at 2:00 p.m. the administrator verified not being informed immediately of the injuries of unknown origin that occurred 3/7/16. Review of a Resident Concern Report indicated the administrator was notified 3/8/16 of R54's shoulder injury of unknown origin and the state agency was contacted 3/8/16, at 12:30 p.m., according to the form titled Confirmation of submitting an Incident report to MDH. Review of 54's progress notes also identified that on, "2/24/16, Observed a 10 cm (centimeter) faded yellow bruise upper inner Rt (right) thigh-unknown etiology- 0 (no) s/s (signs/symptoms) of discomfort. A or 2- {sic} turned on rounds. [signed by RN-G]. There was no evidence that the injury of unknown origin was immediately called to the administrator, reported to the state agency and investigated thoroughly. On 3/14/16, at 11:36 a.m. the adminisrator was interviewed and unable to provide an investigation and subsequent report for this bruise to the upper inner right thigh of unknown etiology. Document review of the facility July 2015, Abuse Policy addressed, Injuries of Unknown Source and read, "Classify as an "injury of unknown source" when both of the following conditions are met. The source of the injury was not observed by any person or the resident could not explain the source of the injury. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time, or the incidence of	F 225		

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F 225	Continued From page 12 injuries over time." R81, on 6/6/16 at 11:55 a.m., approached a surveyor and reported an allegation of neglect regarding a concern that one evening in recent months he had chest pain, self-medicated with nitro tablets, and asked a facility nurse to call his after-hours clinic for medical care. R81 stated he was informed later that evening that his after-hours clinic was not called, but a facility nurse had called the facility's medical director and received an order for "Oxy," and R81 refused that medication because he did not want to take opiates. R81 stated that he told facility administration about his concerns for appropriate care related to this incident but has never been told of a resolution to the concerns. R81 did not remember the date of the incident or the names of the staff involved. When interviewed on 6/8/16, at 2:10 p.m. the director of nursing (DON) stated that this concern of R81 had been investigated. Document review of R81's record showed no documentation of investigation of this incident. During interview on 6/9/16, at 11:21 a.m. the DON was asked about the investigation of this incident and R81 was present. The DON was asked if there was documentation of the investigation of this incident and she stated that there was no documentation of the investigation of this incident because R81 had not been sure of the date of the incident or the staff involved. R81 then stated that there had been a meeting regarding this incident that included himself, the DON and the medical director, and R81 had been upset with	F 225		

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the medical director at this meeting because the medical director said at that meeting that he did not recall the incident being investigated. The DON was asked by the surveyor if there had been a meeting regarding this incident that included herself, R81, and the medical director and she confirmed that the meeting did take place--she did not recall the date, but believed that it took place in recent weeks. R81 then stated that it was true that he did not want to get the nurses involved in the incident into trouble by telling their names, but he had previously told the director of nursing that one of the nurses involved had an accent specific to a nurse at the facility. The DON confirmed that R81 had mentioned that one of the nurses involved in the incident had a particular type of accent and that a facility nurse has that type of accent.

R5's quarterly Minimum Data Set (MDS) dated 12/31/15, revealed R5 was cognitively intact.

R5 had an allegation of verbal abuse and the facility failed to follow their policy regarding the allegation of abuse.

During the initial resident interview on 6/7/16, at 11:33 a.m. R5 expressed a verbal abuse concern with nursing assistant (NA)-B. R5 stated NA-B will "ball her out", tells R5 who to talk to and who R5 should stay away from. RN-B will also tell R5 she should eat. R5 indicated she feels NA-B acts like her boss and is very demanding.

On 6/8/16, at 9:18 a.m. R5 stated NA-B was working today in the east hallway and indicated NA-B had not bothered her today. R5 indicated she talks to the social service director (SSD), but doesn't feel SSD is much help and used to be

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F 225	Continued From page 14 more helpful. On 6/8/16, at 11:36 a.m. SSD stated R5 had mostly complained about other residents, was not aware of any complaints with nursing assistants. On 6/10/16, at 9:20 a.m. R5 stated when R38 came into her room offering pizza last night R5 told R38 she did not want any. Then NA-B came into room balling R5 out and told R5 not to talk to R38. On 6/10/16, at 9:22 a.m. R5 stated when incident occurred with NA-B approximately three months ago, R5 reported it to the Administrator and director of nursing (DON) and was informed they would take care of it right away, yet R5 felt nothing was done. On 6/10/16, at 9:44 a.m. nursing assistant (NA)-E stated she recalled NA-B would remind R5 to take her medications. NA-E indicated R5 feels like NA-B makes her take medications, but R5 will state knows she needs to take them. NA-E further indicated NA-B tells R5 to eat and will remind R5 so her blood sugar doesn't get too low. On 6/10/16, at 11:02 a.m. DON stated she was not aware of any issues between R5 and NA-B. On 6/10/16, at 11:08 a.m. when interviewed, the administrator stated he was informed about an incident between R5 and NA-B, but R5 wanted to retract statements because they were influenced by R81. The administrator stated R5 had not reported any other problems with NA-B. Review of facility's resident concern report dated 11/6/15, indicated R5 was uncomfortable with	F 225		

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F 225	Continued From page 15 NA-B around and talk was intimidating. Resolution and disposition indicated NA-B was "advised to always have another staff member present when interacting with R5." Review of facility's resident concern report dated 3/20/16, indicated NA-B was advised regarding approach and suggestion made to switch residents for a period of time and would monitor satisfaction on daily rounds and caring partners QA. NA-B's assignments were changed when possible in best interest of all parties and behaviors. Review of facility policy dated July 2015 and titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, revealed "Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability." "Mental/Emotional Abuse Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment, neglect and abuse were reported to the administrator immediately, reported to the state agency and thoroughly investigated for 4 of 5 residents (R3, R54, R81, R5) reviewed for incidents. Findings include: Document review of the facility policy dated, July 2015, and titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries of Unknown Source, and Misappropriation of Resident Property, read, "The center requires centers to report these alleged violations to the Executive Director and DON/designee immediately. "Immediately" means as soon as possible but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirements. Prevention 1. Ensure implementation of prevention techniques in the center including, but not limited to: Ongoing supervision of residents and staff. Observation of care delivery. Observation and recognition of signs of staff burnout. Observation and recognition of signs of resident to resident and/or resideent -to-staff frustration of stress. Document review of the policy dated July 2015, titled, Investigation Protocol, in Summary directed staff to meet with the complaining party. Interview and take notes, Plan the investigation. Review accused employee's file.Interview the accused	F 226	F226 R(3) R (54) R (81) and R (5) have had grievance reports reported, investigated and concluded accordingly. Abuse/Neglect and Resident concern training with ED and DON was completed on 06/16/2016. Resident concerns are to be written up on a resident concern form, including ED notification, and entered on the resident concern log by Social Service. The ED or designee will review the concern reports during the clinical meetings for follow up. Investigations will be completed within 5 business days and follow up will be completed with the reporting individual.	

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F 226	Continued From page 17 employee. Listen carefully and take notes on the Who, What, When, Where, Why and How needed to establish facts of the situation. Review all of the interviews and supporting information. Complete an investigation summary and make recommendations. Follow up with the complaining party and if necessary any reporting agencies. Document review of the facility July 2015, Abuse Policy addresses, Injuries of Unknown Source and read, "Classify as an "injury of unknown source" when both of the following conditions are met. The source of the injury was not observed by any person or the resident could not explain the source of the injury. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time, or the incidence of injuries over time." R3 filed 3 concerns with the facility of improper treament. R3 was assessed as cognitively intact according to the minimum data set (MDS) quarterly review 3/25/16. During the initial resident (R3) interview on 6/7/16, at 10:33 a.m. revealed grave concern about nursing assistant (NA-B) who was abusive to R3 several months ago. R3 expressed "fear and retaliation" from NA-B and that the facility did not take the concern seriously. R3 further stated, "My heart ached after [NA-B] did what [NA-B] did." R3 doesn't feel confident to go to the social service department because does not trust there will be follow up. R3 confided seeing other residents in the facility mistreated and that the	F 226	The ED/ designee will review all completed resident concern reports for final review. Any concern regarding abuse, neglect, mistreatment, or injury of unknown origin will be reported immediately to ED and DON with follow up by writer to report to state agency if appropriate and to be investigated thoroughly Facility staff has completed education regarding Resident concern and Abuse/ Neglect policy and procedure. Social Services will review resident concern log monthly for tracking and trending during QAPI meetings monthly. ED/ designee will audit resident concerns 3 x week for 4 weeks, then weekly for 4 weeks, and then ongoing monthly through the QAPI process. Alleged date of compliance: July 20, 2016.	

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residents are not taken seriously.

R3's roomate (R78) was interviewed 6/7/16 at 10:45 a.m., and reported that "[NA-B] plays mind games with us." R78 verified having issues with [NA-B] but that there is no one to listen to what they are saying from management in this facility.

Document review of a 4/6/16, Resident Concern Report, from R3 read, "I have had 2 incidents of retaliation from care recently. 1. I told [NA-L] not to flirt while working. In response, the next day [NA-B] took me in the bathroom, left me naked on the toilet and said, '[NA-L] life is [NA-L] life and my life is my life. I have a life at home.' 2. [NA-B] did not take me to lunch after that so by the time someone else took me my lunch was cold. [NA-B] always retaliates if complaints are made."

Although administration wrote on the investigation roomate and neighbors were interviewed, the information lacked evidence of the interview findings. Although administration changed the staff members assignment so that NA-B would not take care of R3, there was no documented education and learning for the staff member, there was no documented statement obtained from the care givers NA-B or NA-L . There was no evidence that the administrator was informed immediately, reported to the State agency and that a thorough investigation occurred.

On 6/9/16, at 3:00 p.m. administration again reviewed the Resident Concern Report from 3/15/16, and at this time, filed a report to the State Agency. NA-B was suspended pending investigation.

R54 sustained an injury of unknown origin on

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3/7/16, between 6:30 a.m. and 7:00 a.m., sustained a skin tear of unknown origin on 3/7/16, between 11:00 a.m. and 11:30 a.m. and on 2/24/16 a 10 cm bruise was discovered on R54's right inner thigh of unknown origin that lacked immediate notification to the administrator, a report to the state agency and a thorough investigation.

According to a document titled, Admission Record, onset date, 10/1/15, R54 was diagnosed with unspecified dementia with behavioral disturbances, contracture unspecified hand, delusional disorders, and unspecified psychosis not due to a substance or known physiological condition.

R54 was assessed as severe cognitive impairment according to the minimum data set (MDS) assessment completed 2/20/16.

Document review of form titled, Witness Investigation Statement, on 3/7/16, between 6:30 a.m. and 7:00 a.m. R54 had a left shoulder that looked very different from the right shoulder.

Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-B) read, "On the 7th of March, around 6:30 a.m. I went to [R54] room to get [R54} dressed for breakfast. After shaving [R54}, I realize that [R54] left shoulder looked different, so I called the nurse (registered nurse RN-G) to pls (please) come to [R54] room to check [R54] out."

Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-A) read, "I didn't see it but I was told by my coworker that [NA-B] went to dress the resident

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F 226	Continued From page 20 for [R54's] morning meal and notice that resident shoulder wasn't right so [NA-B] immediately informed the charge nurse to come and accessed the shoulder." Document review of a form titled, Witness Investigation Statement, from RN-G read, "Nurse called to residents room in AM to see residents shoulder. Upon assessment left shoulder seem different, but I wasn't sure why." There was no documented evidence that the administrator was informed immediately and no documented evidence that the injury of unknown origin was reported to the state agency. Document review of the form titled, Progress notes, dated 3/7/16, at 7:30 a.m. read, "Nurse was called to dining area this am, Resident was observed to be bleeding from an open area on right hand. [F-B] was contacted and informed about skin tear via phone. NP on site updated, nurse manager updated." Documentaion lacked evidence that the administrator was informed immediately regarding the injury of unknown origin and that the state agency was notified. When interviewed on 6/9/16, at 2:00 p.m. the administrator verified not being informed immediately of the injuries of unknown origin that occurred 3/7/16. Review of a Resident Concern Report indicated the administrator was notified 3/8/16 of R54's shoulder injury of unknown origin and the state agency was contacted 3/8/16, at 12:30 p.m., according to the form titled Confirmation of submitting a Incident report to MDH. Review of 54's progress notes also identified that on, "2/24/16, Observed a 10 cm (centimeter)	F 226		

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faded yellow bruise upper inner Rt (right) thigh-unknown etiology- 0 (no) s/s (signs/symptoms) of discomfort. A or 2- {sic} turned on rounds. [signed by RN-G]. There was no evidence that the injury of unknown origin was immediately called to the administrator, reported to the state agency and investigated thoroughly. On 3/14/16, at 11:36 a.m. the adminisrator was interviewed and unable to provide an investigation and subsequent report for this bruise to the upper inner right thigh of unknown etiology.

Document review of the facility July 2015, Abuse Policy addressed, Injuries of Unknown Source and read, "Classify as an "injury of unknown source" when both of the following conditions are met. The source of the injury was not observed by any person or the resident could not explain the source of the injury. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time, or the incidence of injuries over time."

R81, 6/6/16 at 11:55 a.m., approached a surveyor and reported an allegation of neglect, explaining that he had asked the nurse to call the clinic when he had chest pain. R81 reported having a concern that one evening in recent months he had chest pain, self-medicated with nitro tablets, and asked a facility nurse to call his after-hours clinic for medical care. R81 stated he was informed later that evening that his after-hours clinic was not called, but a facility nurse had called the facility's medical director and received an order for "Oxy," and R81 refused that medication because he did not want to take opiates. R81 stated that he told facility

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administration about his concerns for appropriate care related to this incident but has never been told of a resolution to his concerns.

When interviewed on 6/8/16, at 2:10 p.m. the director of nursing (DON) stated that this concern of R81 had been investigated.

Document review of R81's record showed no documentation of investigation of this incident.

During interview on 6/9/16, at 11:21 a.m. the DON was asked about the investigation of this incident and R81 was present. The DON was asked if there was documentation of the investigation of this incident and she stated that there was no documentation of the investigation of this incident because R81 had not been sure of the date of the incident or the staff involved. R81 then stated that there had been a meeting regarding this incident that included himself, the DON and the medical director, and R81 had been upset with the medical director at this meeting because the medical director said at that meeting that he did not recall the incident being investigated. The DON was asked by the surveyor if there had been a meeting regarding this incident that included herself, R81, and the medical director and she confirmed that the meeting did take place--she did not recall the date, but believed that it took place in recent weeks. R81 then stated that it was true that he did not want to get the nurses involved in the incident into trouble by telling their names, but he had previously told the director of nursing that one of the nurses involved had an accent specific to a nurse at the facility. The DON confirmed that R81 had mentioned that one of the nurses involved in the incident had a particular type of accent and that a facility nurse

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F 226	Continued From page 23 has that type of accent. Review of R5's quarterly Minimum Data Set (MDS) dated 12/31/15, revealed R5 was cognitively intact. R5 had an allegation of verbal abuse and the facility failed to follow their policy regarding an allegation of abuse. Review of facility policy dated July 2015 and titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, revealed "Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability." "Mental/Emotional Abuse Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation." During the initial resident interview on 6/7/16, at 11:33 a.m. R5 expressed a verbal abuse concern with nursing assistant (NA)-B. R5 stated NA-B will "ball her out", tells R5 who to talk to and who R5 should stay away from. RN-B will also tell R5 she should eat. R5 indicated she feels NA-B acts like her boss and is very demanding. On 6/8/16, at 9:18 a.m. R5 stated NA-B was working today in the east hallway and indicated NA-B had not bothered her today. R5 indicated she talks to the social service director (SSD), but doesn't feel SSD is much help and used to be	F 226		

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F 226	Continued From page 24	F 226		

more helpful.

On 6/8/16, at 11:36 a.m. SSD stated R5 had mostly complained about other residents, was not aware of any complaints with nursing assistants.

On 6/10/16, at 9:20 a.m. R5 stated when R38 came into her room offering pizza last night R5 told R38 she did not want any. Then NA-B came into room balling R5 out and told R5 not to talk to R38.

On 6/10/16, at 9:22 a.m. R5 stated when incident occurred with NA-B approximately three months ago, R5 reported it to the Administrator and director of nursing (DON) and was informed they would take care of it right away, yet R5 felt nothing was done.

On 6/10/16, at 9:44 a.m. nursing assistant (NA)-E stated she recalled NA-B would remind R5 to take her medications. NA-E indicated R5 feels like NA-B makes her take medications, but R5 will state knows she needs to take them. NA-E further indicated NA-B tells R5 to eat and will remind R5 so her blood sugar doesn't get too low.

On 6/10/16, at 11:02 a.m. DON stated she was not aware of any issues between R5 and NA-B.

On 6/10/16, at 11:08 a.m. when interviewed, the administrator stated he was informed about an incident between R5 and NA-B, but R5 wanted to retract statements because they were influenced by R81. The administrator stated R5 had not reported any other problems with NA-B.

Review of facility's resident concern report dated 11/6/15, indicated R5 was uncomfortable with

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F 226	Continued From page 25 NA-B around and talk was intimidating. Resolution and disposition indicated NA-B was "advised to always have another staff member present when interacting with R5." Review of facility's resident concern report dated 3/20/16, indicated NA-B was advised regarding approach and suggestion made to switch residents for a period of time and would monitor satisfaction on daily rounds and caring partners QA. NA-B's assignments were changed when possible in best interest of all parties and behaviors.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident preferences was accommodated for bathing/shower for 1 of 3 resident (R32) reviewed for choices in daily routine. Findings include: R32 was interviewed on 6/6/16, at 7:09 p.m. and responded "no choice" regarding how many times she bathed or showered during a week. R32	F 242	F242 R (32) preferences have been reviewed for bathing, and care plan and nursing assistant communication sheet has been updated. Residents will be reviewed for bathing preferences have been reviewed and life Enrichment care plan and nursing assistant communication sheet has been updated. Residents will be reviewed for preferences upon admission by Life Enrichment and quarterly or with significant changes in status during care conferences by social	

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F 242	Continued From page 26 added, "I did not have a shower for two weeks now and I am supposed to have shower twice a week. No one comes to ask me and I did not ask them either." On 6/9/16 at 8:57 a.m. R32 was lying in bed, when approached by surveyor, R32 explained her preference was to take two showers per week as staff told her and posted a noted on her bedside stand that reads, "Maxine's shower Thursdays A.M. Sunday P.M." which was confirmed by surveyor when R32 pointed to the note. Further indicated, staff gave her shower yesterday even though she does not normally take shower on Wednesday but she took it because, "I have not had a shower for two weeks". R32 further stated, "I will take another one today if they want to give me another one today. I will be glad if they ask me and give me shower at least two times a week." R32's diagnoses included multiple sclerosis, anxiety disorder, Diabetes mellitus II, major depression, and abnormalities of gait and mobility obtained from Admission Record dated 6/30/14. R32's Activities of Daily Living (ADL) CAA dated 10/1/15, indicated, "Has assist needs with bed mobility, transfers, dressing, toileting, hygiene and bathing secondary to weakness with dx (diagnosis) of MS (multiple sclerosis), seizures disorder, anemia ...". R32's 30 day Minimum Data Set (MDS) dated 3/27/16, indicated R32 had had intact cognition with Brief Interview for Mental Status (BIMS) score of 15. Nursing note dated 6/6/16, read, "Client	F 242	services. All residents will be offered baths/ showers per preferences. Staff has received education regarding offering cares according to resident rights, preferences, and choices. DON or designee will complete audit of completion of bathing 3 x weeks for 4 weeks and then weekly ongoing. Alleged date of compliance: July 20, 2016.	

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F 242	Continued From page 27 requesting okay for shower and hair wash one week... Lacerations. Sutured put in..." however nursing notes lacked evidence that R32 refuses shower/bath in the last three weeks (5/6/16-6/8/16). The treatment administration record (TAR) dated May 23, 2016 thru June 8, 2016, indicated, "Weekly skin assessment: Complete on bath day, (+) new area of skin impairment ... (-) no new area of skin". However it was left blank. Care tracker indicated that resident showered only once dated 5/31/16 between the dates of 5/26/16-6/7/16. On 6/9/16 at 11:26 a.m. the director of nursing (DON) explained that the expectation is staff need to document what they are doing regarding showers and if a resident refuses, the nurse should be notified and written on the 24 hour board. DON further explained, "The nurses need to chart about it and let me know and document the refusal."	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review the facility failed to provide services in accordance with the resident's written plan of	F 282	F282 NA-A was provided education regarding following the residents plan of care. R(105) is no longer a resident at this facility.	

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F 282	Continued From page 28 care for 1 of 3 residents (R105) in the sample who required assistance with toileting/incontinence care, shaving, oral care and hearing accommodations. Findings include: R105's plan of care dated 6/7/16, read, "Incontinent" "Goal: Will be free of skin impairment r/t (related to) incontinence (See Skin Integrity Assessment Prevention and Treatment Plan)." The undated form titled, Bladder Data Collection and Assessment, directed staff R105 had "Difficulty starting urine stream" "Post void dribbling" and "Voiding small amounts often." The plan of care document dated 6/7/16, titled, Skin Integrity Assessment, read, "bladder incontinence, keep linen dry and wrinkle free. Implement an individualized turning schedule of every 2 hours." The facility policy dated July 2015, titled Urinary Incontinence directed staff to provide whenever necessary care for residents who are incontinent of urine and to follow the skin integrity guideline of every two hours. During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, lying on the left side, wearing an incontinence brief and there was a brown/tan ring of staining on the incontinence pad in the bed. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room and R105 asked for a urinal. NA-A assisted R105 with holding the urinal in place. At 8:20 a.m. R105 asked to sit up because R105 could not urinate	F 282	Residents will be assessed for toileting, shaving, oral care, and hearing accommodation needs upon admission, quarterly/ annually, and with significant changes and communicated via the resident care plans and nursing assistant communication sheet. Residents' toileting, shaving, oral care, and hearing accommodation needs have been assessed and care plans have been reviewed and updated accordingly. Staff will communicate between shifts of repositioning and elimination cares completion for continuity of care. Nursing department has been educated regarding completion of cares according to the plan of care, including how to manage concerns with hearing aides functioning appropriately.	

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F 282	Continued From page 29 lying down. NA-A sat R105 on the side of the bed. R105 told NA-A "My bed is wet." When interviewed on 6/8/16 at 8:30 a.m. NA-A verified R105 did not have any morning cares prior to NA-A providing the cares at this time. NA-A verified the 18 inch brown/tan ring of staining on the incontinence pad looked like a dried ring of urine. LPN-A was informed of the urine stain and would find out when the night shift last offered cares. On 6/8/16, not sure of the time, the DON produced a document dated 6/8/16, no time specified, which read, "[R105] was dry at 4am {sic} I found [R105] with the bed cord out, bed deflated. I plugged the bed back in,m it rein {sic} flated, and rechecked [R105] 4-4:30am. I gave report to [nurse] and informed her that [R105] did not I had done cares with [R105] at 4 am rounds, and [R105] was dry." Clarification to allegation-"[R105] did not have stool at 4 am. I had removed [R105] brief to check [R105] and there was no bm there." During an interview with the DON on 6/8/16, at 3:00 p.m. verified R105 was incontinent of urine sometime between 4:00 a.m. and 8:20 a.m. when NA-A provided cares. Furthermore the DON verified a dark drying brown/tan ring of urine would indicate a long period of time without being checked and changed for R105. When interviewed on 6/10/16, at 11:00 a.m. the DON verified the facility expectation would be to check on R105 every two hours for incontinence. The initial plan of care dated, 6/4/16, titled, Care	F 282	DON or designee will complete random audits to ensure cares are provided according to resident care plan 3 x a week for 4 weeks, and weekly x 4 weeks. Results will be brought to monthly qapi meeting for identification of potential opportunities of improvement and determine further needs. IDT team will ensure all residents have been assessed and plan of care communicated according to the MDS schedule and with significant changes in resident status during CCPR. Alleged date of compliance: July 20, 2016.	

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Delivery Guide, directed staff R105 required assistance of one with grooming. Oral Care indicated an upper denture and assist of one for oral care. There was no further direction with shaving.

A family (F-C) interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern had not been shaved since coming to the facility and was not receiving oral care. F-C expressed R105 was always clean shaven and would not like having all the facial hair that was currently present.

During an observation on 6/7/16, at 3:00 p.m. another family member (F-D) was visiting and expressed concern to this surveyor that R105 had not been shaved of facial hair and partial plate was not in R105's mouth.

During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, laying on the left side. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room using a a transfer belt, ambulated R105 to the bathroom (BR). R105 asked for a tooth brush to brush teeth. NA-A assisted R105 to the sink. There were no oral care supplies in the room and NA-A had to retrieve a basin, toothbrush, toothpaste and mouthwash from the storage room. Another NA-C came into the room and searched for oral care supplies and not finding any left the room. NA-A returned to the room and prepared a toothbrush with toothpaste. R105 asked NA-A, "Did you find my partial?" to which NA-A responded "The hair is long on your face." R105 repeated, "Did you find my partial?" NA-A explained being off for a week and did not have

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F 282	Continued From page 31 an assignment sheet for R105 so did not know R105 had teeth. On 6/8/16, during morning cares which started at 7:15 a.m.,NA-A produced an electric shaver from R105's top bedside drawer and proceeded to shave R105. NA-A verified there was a very heavy growth of facial hair. R105 expressed gratitude for being shaved and stated, "That's better!" The plan of care dated 6/7/16, read, Sensory Communication Care Plan, Auditory Disturbance, Hearing Aide, Intervention Assist to place in ear as needed. There was no further direction regarding the hearing aide. During observations, R105 did not have the hearing aide in place from 6/8/16, at 8:30 a.m. through 6/9/16, at 10:30 a.m. During an interview with the DON on 6/10/16, at 11:00 a.m. verified the facility expectation was to shave facial hair everyday Provide oral care twice a day and if a resident refused care to inform the nurse and to reapproach at another time.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 R (54) is no longer a resident at the facility Residents have had their pain assessed, with physician notification if indicated, and care plans reviewed and updated accordingly. Residents will receive a pain assessment and care plan reviewed upon admission, quarterly and annually or with a significant change. Residents utilizing PRN medication will be reviewed for ongoing pain assessments and MD updated accordingly for appropriate management.	

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F 309	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to assure that a comprehensive pain assessment which included non verbal signs and symptoms was conducted for 1 of 1 resident (R54) reviewed for pain control following an acute shoulder dislocation. The findings include: R54's medical record was reviewed. A facility document titled Admission Record dated 10/1/15, indicated R54 was diagnosed with unspecified dementia with behavioral disturbances, contracture unspecified hand, delusional disorders, and unspecified psychosis not due to a substance or known physiological condition. R54 was assessed as having severe cognitive impairment according to the minimum data set (MDS) assessment completed 2/20/16. Review of a Progress Note dated 3/8/16, indicated registered nurse (RN)-G had written a late entry for 3/7/16, "called to resident's room as [nursing assistant (NA)-B] seen [R54] shoulders do not both seem alike. Observed [R54] left shoulder to be off from right shoulder. Informed [NA-B] resident was scheduled to be seen by NP (nurse practitioner) would inform NP when [NP] arrives. Nurse held left arm up, resident was fidgeting, was not clear if resident fidgeted due to shoulder as [R54] fidgeted most of the time." An additional document entitled, Witness Investigation Statement also dated 3/8/16, indicated registered nurse (RN)-G was documenting a late entry for 3/7/16, "called to resident's room in AM (morning) to see resident's	F 309	Staff has been educated regarding the policy and procedure for pain management. IDT team will complete chart audit quarterly to ensure care plans and assessments are completed timely. DNS or designee will audit pain management weekly utilizing the systems review audit x 4 weeks and then monthly thereafter. Results of the audit will be reviewed at monthly QAPI for tracking and trending to identify further opportunities for improvement. Alleged date of compliance: July 20, 2016.	

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shoulder. Upon assessment left shoulder seems different, but I wasn't sure why. Informed CNA (certified nursing assistant) that [R54] was scheduled to be seen by NP (nurse practitioner). Nurse will ensure NP is informed about resident's shoulder. Expected NP in AM (morning) but [NP] was not here in AM."

R54's family member (F)-A, was interviewed 6/15/16 at 4:30 p.m.. F-A reported having been at the facility on 3/7/16 at lunch time. F-A stated she and F-B had been scheduled to meet with social services but F-B was running late. F-A stated when F-B arrived at the facility around 2:00 p.m., R54's face appeared red and clammy looking. NA-B was standing by R54's bedroom door at the time and F-B had told NA-B that R54 looked to be in pain

Progress Notes dated 3/7/16, identified the NP had been notified at 1:15 p.m. on 3/7/16 that R54's left shoulder looked very different from the right shoulder. The notes indicated the NP had arrived at the facility around 2:15 p.m. and had ordered a left shoulder X ray. Further notes indicated the X- ray company had been contacted but was unable to perform the X-ray until 3/8/16. Documentation is unclear as to whether the physician or NP were informed there would be a delay in getting the X-ray in order to determine whether alternate interventions or modifications were required to assure pain control for R54.

Review of documentation from a report, Witness Investigation Statement, from 3/7/16, at 11:00-11:30 a.m. reported by NA-B included: "Res (resident) was moving uncomfortably according to NA/R (nursing assistant registered)." On 3/7/16, after lunch R54's family member

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expressed concern that R54 "looks uncomfortable" and suggested maybe R54 had a high temperature. NA-B took the temperature and it was noted to be 95.5 degrees Fahrenheit (F).

On 3/7/16, at 2:15 p.m. NP-C documented on a Physician Progress Note, "Today staff note a change in patient. [R54] is diaphoretic, without temperature noted. [R54] sustained a skin tear to right forearm today, cause unknown. They note a left shoulder deformity. [R54] is shaking, skin is dusky."

On 3/8/16 at 11:58 a.m., X-ray results were faxed to the facility. Licensed practical nurse (LPN-A) reported to nurse practitioner (NP) the results of the X-ray that were electronically signed on 3/8/16, at 8:04 a.m. Report identified, "Shoulder 1 view, left. Results: The humerus is anteriorly and inferiorly dislocated with respect to the glenoid. There is no fracture. Acromioclavicular and coracoclavicular joints are normal. Conclusion: Anterior shoulder dislocation. Please monitor for pain cues, If noticed, report to provider."

A Witness Investigation Statement from licensed practical nurse (LPN)-B included: "Resident was noted on Monday to be in pain. On Wednesday morning the pt (patient) was noted to be moaning in pain, at this time the Doctor was updated and gave an order to send pt to the hospital."

On 3/9/16, no time specified, RN-I documented in a progress note: "Only taking sips tonight, is usually a very good drinker. Resident was grimacing early in the shift-given 680 [sic] mg (milligrams) PRN (as needed) Tylenol, slept well the rest of the noc (night)." Review of the MAR (medication administration record) lacked

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F 309	Continued From page 35 documentation that the PRN medication had been given. On 3/9/16 at 10:15 a.m. documentation in the progress notes included: "resident up in chair crying out." On 3/9/16, at 10:30 a.m. R54 was transported by ambulance to the hospital after LPN-A observed R54 at 10:15 a.m. and documented, "v/s (vital signs) 97-70-18-180/68 resident up in chair crying out-R (right) shoulder. NP called, per order send to [hospital] ER (emergency room) for ortho L (left) shoulder dislocation, [guardian] called she will meet at [hospital]." According to the documented vital signs, the typical blood pressure for R54 was 100/60 to 130/70. NP-C was interviewed on 6/9/16, at 10:13 a.m. the NP-C stated, "I do not know enough about the anterior dislocation on [R54]. I have seen cases where there have been contractures due to muscle fatigue, but typically an anterior dislocation is due to trauma. [R54] did not return to the facility. Another way the shoulder could have dislocated is to have been stretched too far forward." When interviewed on 6/10/16, at 1:00 p.m. LPN-A verified witnessing R54 had been "crying out in a lot of pain" when transported to the hospital on 3/9/16, and no PRN pain medication had been given prior to transport. R54's current Physician Orders, indicated R54 had utilized Acetaminophen (Tylenol) 500 mg (milligrams) caplets 2 by mouth three times daily since 6/6/14 for pain, with directions not to exceed 4000 mg /24 hours.	F 309		

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F 309	Continued From page 36 R54's March 2016 Medication Administration Record (MAR) was reviewed. The MAR indicated R54 was to receive the acetaminophen at 6:30 a.m., 12:30 p.m. and 4:30 p.m.. The MAR documentation for 3/7/16, at 12:30 p.m. was not signed off to indicate the medication had been given. According to a document titled March 2016 Medication, documentation in a section for pain control included: "Is your pain program effective for you? If no, provide pain rating (For non-interviewable residents, utilize Wong-Baker pain scale." On 3/7/16 that section of documentation was blank indicating no pain assessment had occurred for the day shift. Another section of the March 2016 Medication record included: "Please monitor for pain cues. If noted call provider." The 3/7/16 documentation was not completed to indicate whether pain cues were monitored, and/or what pain cues may have been evident. The March 2016 physician orders verified R54 had Standing Orders for "Acetaminophen 325-650 mg (milligram) PO (orally) or Suppository grain X q (every) 4 hrs (hours) prn (whenever neccesarry fever >100 or discomfort." The March 2016 plan of care for Pain Management included: "Assess for verbal and not-verbal signs and symptoms of distress or pain unrelieved by ordered treatments/medications. Report to Provider signs and symptoms of distress or pain unrelieved by ordered treatments/medications. Identify precipitating factors of pain."	F 309		

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F 312	Continued From page 37	F 312	F312	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene care for 1 of 1 resident (R105) in the sample who required assist from staff for oral care and shaving. Findings include: R105, during an observation on 6/6/16, at 5:00 p.m., was in bed positioned to the left side, uncovered, fully clothed, with legs extending over the edge of the mattress. There was a heavy accumulation of facial hair/whiskers.When an interview was attempted, R105 stated, "let me sleep." A family (F)-C interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern about R105 who had been mentally intact and living at home two weeks ago. F-C expressed concern that R105 had not been shaved since coming to the facility, was not getting out of bed, was not eating, was not receiving oral care, and the family did not understand what services the facility was providing for R105. Furthermore, F-C expressed R105 was always clean shaven and would not like having all the facial hair that was currently	F 312	R (105) is no longer a resident at the facility. NA-A received education regarding providing cares according to the plan of care. Resident oral cares and shaving needs will be assessed upon admission, quarterly, annually and with changes to resident status and communicated via the nursing assistant communication sheet. Dependent residents' shaving and oral care needs have been assessed and care plans reviewed and updated accordingly. Staff has been educated to complete personal hygiene cares according to the plan of care. DON or designee to complete random audits of dependent resident ADL's to be completed weekly for 4 weeks. Results of audits to be tracked and trended and reviewed at QAPI monthly for identification of areas of opportunities and frequency of audits to be determined as indicated. Alleged date of compliance: July 20, 2016.	

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F 312	Continued From page 38 present. During an observation on 6/7/16, at 3:00 p.m. another family member (F-D) was visiting and expressed concern to this surveyor that R105 was in the bed fully dressed, trying to get out of the bed, had not been shaved of facial hair and partial plate was not in R105's mouth. During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, laying on the left side. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room using a a transfer belt, ambulated R105 to the bathroom (BR). R105 asked for a tooth brush to brush teeth. NA-A assisted R105 to the sink. There were no oral care supplies in the room and NA-A had to retrieve a basin, toothbrush, toothpaste and mouthwash from the storage room. Another NA-C came into the room and searched for oral care supplies and not finding any left the room. NA-A returned to the room and prepared a toothbrush with toothpaste. R105 asked NA-A, "Did you find my partial?" to which NA-A responded "The hair is long on your face." R105 repeated, "Did you find my partial?" NA-A explained being off for a week and did not have an assignment sheet for R105 so did not know R105 had teeth. NA-A retrieved the partial upper plate from the nightstand (in a cup without water). R105 complained of mouth/tongue being sore. When R105 stuck out tongue, it was observed to be red, cratered, with a couple areas that appeared white/red sores.	F 312		

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NA-A produced an electric shaver from R105's top bedside drawer and proceeded to shave R105. NA-A verified there was a very heavy growth of facial hair. R105 expressed gratitude for being shaved and stated, "That's better!"

On 6/8/16, at 10:00 a.m. the licensed practical nurse (LPN-A) was informed that R105 had complained of having trouble swallowing and having a sore mouth/tongue. LPN-A documented in the progress notes, "11:00 a.m. Tongue has red and white patches present. Mouth and lips dry."

On 6/8/16, at 12:00 p.m. the director of nursing (DON) was informed that no oral care supplies were available in the bedside.

On 6/9/16, at 10:07 a.m. the hospice aide (HA) was providing cares. When interviewed regarding oral care provided on 6/7/16, HA stated, "I brought my own toothette's and provided the oral care with the toothette's because there was no toothbrush or toothpaste supplies in the room."

During an interview on 6/8/16, at 10:00 a.m. regarding the facility expectation for oral care, LPN-A verified oral cares were to be provided twice a day and the hospice services were to be above and beyond the services of the facility.

During an interview on 6/10/16 at 10:00 a.m. with RN-D explained that a mouth exam had not been completed on R105 because R105 was due 6/10/16, according to the minimum data set (MDS) schedule, and R105 was transferred to another facility, per family wishes, on 6/10/16 so the assessments were not completed.

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F 312	Continued From page 40 A facility policy regarding oral care and shaving of residents was requested but not received. During an interview with the DON on 6/10/16, at 11:00 a.m. verified the facility expectation was to shave facial hair everyday, provide oral care twice a day and if a resident refused care to inform the nurse and to reapproach at another time.	F 312		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R105) in the sample who was identified as requiring a hearing aide, received the communication device. Findings include: R105 was observed on 6/6/16, at 5:00 p.m. in bed positioned to the left side and had a hearing aid in place. When an interview was attempted, R105 replied, "let me sleep." On 6/8/16, at 8:30 a.m. R105's hearing aid was	F 313	F313 R(105) hearing aide was located and remained functional at the time of survey. No other concerns have been noted regarding audiology services. Residents audiology needs will be assessed upon admission, quarterly/ annually and with significant changes in resident status. Changes in resident status will be communicated to the nurse for further assessment and referral services obtained if indicated. Residents have been reviewed to ensure all audiology needs have been addressed and care plans reviewed and updated as indicated. Staff has been provided education regarding ensuring residents have the ancillary services and communication devices provided to allow the residents to function to the highest level of abilities.	

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F 313	Continued From page 41 noted to be in place, however, R105 appeared to be having difficulty hearing. Although extra batteries were observed to be located in the top dresser drawer, NA-C brought the hearing aide to LPN-A to assess and return to R105. During an observation on 6/9/16, at 10:31 a.m. R105 did not have the hearing aide and was having difficulty understanding the conversation. LPN-D assigned to R105 did not know anything about the hearing aide not being available and was unable to find the hearing aide in the medication cart. The health unit coordinator said there was a hearing aide at the nurses station but no one knew who it belonged to. LPN-A was interviewed on 6/9/16 at 10:40 a.m. to inquire about the hearing aide that NA-C had given her to check on 6/8/16. LPN-A recalled someone giving her a hearing aide yesterday but then found it on the floor and didn't know who it belonged to. NA-C, who was standing near by, overheard the conversation and reported specifically handing LPN-A the hearing aide and informing LPN-A the hearing aide belonged to R105. The plan of care dated 6/7/16, read, Sensory Communication Care Plan, Auditory Disturbance, Hearing Aide, Intervention Assist to place in ear as needed. There was no further direction regarding the hearing aide. A facility policy regarding working with hearing aides and what to do when a hearing aide was broken was requested, but not received.	F 313	DON or designee to complete random audits weekly for 4 weeks, and then monthly for 3 months. Results of audits to be tracked and trended and reviewed at QAPI monthly for identification of areas of opportunities and frequency of audits to be determined as indicated. Alleged date of compliance: July 20, 2016.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 42 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R105) in the sample, who was identified as incontinent of urine received the necessary care and services to manage incontinence. Findings include: R105 was admitted from the hospital to the facility on 6/4/16, at 4:30 p.m. with an order for hospice care. According to the physician progress notes dated 6/8/16, read, "Neurology: Pt with previous h/o (history of) left basal ganglia stroke and with decreased oral intake and increase in symptoms of dysphagia. Due to declining function agreed to pursue hospice which [R105] is now signed up for with diagnosis of CVA (cerebral vascular accident). Urology: Pt with h/o chronic urinary retention, Pt was noted to have UTI (urinary tract infection) and was placed on antibiotics. [R105] has been straight cathing twice a day at home." During an observation on 6/6/16, at 5:00 p.m. R105 was in bed positioned to the left side,	F 315	F315 NA-A was educated regarding providing cares according to the resident plan of care. Resident's bladder assessments have been reviewed and care plans and nursing assistant communication sheets have been updated accordingly. Nursing department has been provided education ensure residents who are identified as incontinent of urine receive the necessary care and services to manage incontinence. DON or designee to complete random audits weekly to ensure dependent residents toileting needs are completed according to the plan of care for 4 weeks, then monthly for 3 months. Results of audits to be tracked and trended and reviewed at QAPI monthly for identification of areas of opportunities and frequency of audits to be determined as indicated. Alleged date of compliance: July 20, 2016.	

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uncovered, fully clothed, with legs extending over the edge of the mattress.

A family (F-C) interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern about R105 who had been mentally intact and living at home two weeks ago. F-C expressed concern that R105 was not getting out of bed and the family did not understand what services the facility was providing for R105.

During an observation on 6/7/16, at 3:00 p.m. another family member (F-D) was visiting and expressed concern that R105 was in the bed fully dressed, trying to get out of the bed and turned on the call light for assistance.

During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, lying on the left side, wearing an incontinence brief and there was a brown/tan ring of staining on the incontinence pad in the bed. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room and R105 asked for a urinal. NA-A assisted R105 with holding the urinal in place. At 8:20 a.m. R105 asked to sit up because R105 could not urinate lying down. NA-A sat R105 on the side of the bed. R105 told NA-A "My bed is wet." NA-A used a transfer belt and ambulated R105 to the bathroom (BR) and assisted R105 to sit on the toilet. There was a 18 inch ring of dark brown/tan moisture on the incontinence pad in the bed. R105 voided what sounded like a small amount in the toilet.

When interviewed on 6/8/16 at 8:30 a.m. NA-A verified R105 did not have any morning cares

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prior to NA-A providing the cares at this time. NA-A verified the 18 inch brown/tan ring of staining on the incontinence pad looked like a dried ring of urine. LPN-A was informed of the urine stain and would find out when the night shift last offered cares.

On 6/8/16, DON produced a document dated 6/8/16, no time specified, which read, "[R105] was dry at 4am {sic} I found [R105] with the bed cord out, bed deflated. I plugged the bed back in,m it rein {sic} flated, and rechecked [R105] 4-4:30am. I gave report to [nurse] and informed her that [R105] did not I had done cares with [R105] at 4 am rounds, and [R105] was dry." Clarification to allegation-"[R105] did not have stool at 4 am. I had removed [R105] brief to check [R105] and there was no bm there."

During an interview with the DON on 6/8/16, at 3:00 p.m. verified R105 was incontinent of urine sometime between 4:00 a.m. and 8:20 a.m. when NA-A provided cares. Furthermore the DON verified a dark drying brown/tan ring of urine would indicate a long period of time without being checked and changed for R105.

The undated form titled, Bladder Data Collection and Assessment, indicated R105 had "Difficulty starting urine stream" "Post void dribbling" and "Voiding small amounts often."
The plan of care document dated 6/7/16, titled, Skin Integrity Assessment,bladder incontinence, keep linen dry and wrinkle free. Implement an individualized turning schedule of every 2 hours.

The facility policy dated July 2015, titled Urinary Incontinence directed staff to provide whenever necessary care for residents who are incontinent

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F 315	Continued From page 45 of urine and to follow the skin integrity guideline of every two hours. When interviewed on 6/10/16, at 11:00 a.m. the DON verified the facility expectation would be to check on R105 every two hours for incontinence.	F 315		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 Medicaid residents (R29) reviewed for dental issues were provided dental services. Findings include: On 6/7/16, at 10:40 a.m. during conversation, R29 was observed with several teeth missing in the lower jaw and R29 stated, she had cancer of the jaw and most of her teeth were removed. Review of the physician order sheet dated 6/2/16, R29 was admitted to the facility on 9/27/2005 with diagnoses including oral cavity squamous cell	F 412	F412 R (29) has a dentist appointment scheduled for 06/21/2016 per resident request. Residents offered dental services upon admission, quarterly, and with change in status. Consents will be obtained and ancillary services are offered to residents upon admit and reviewed quarterly and	

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F 412	Continued From page 46 carcinoma, feeding tube placement, dysphagia and depression. In review of R29's annual Minimum Data Set (MDS) dated 3/5/16, the dental sections were left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. The integrated care by Medica dated 4/5/16, read, "MALIGNANT NEOPLASM OF RETROMOLAR AREA w (with) dysphagia and PEG- Mandibular resection revision in 2014 Declines further ENT assessment. Stoma paste reducing proximal peg tube irritation. She remains NPO (nothing by mouth) and uses atropine gtt (drop) 1 qd (everyday) and q4 hr prn (every four hour as needed)." Apple Tree Coon Rapids sheet dated 8/12/15, revealed, "... reviewed ..., toothbrush with peridex, floss, prophy, cavitron, exam, placed a fluoride varnish. Radiographs not indicated at this time. Treatment recommendations; filling treatment plan will be sent to rparty for approval. Exam every 6 months, prophy every 6 months." However R29 had not been seen by dentist since 8/12/15 as recommended. Quarterly assessment dated 6/6/16, point out, "Difficulty swallowing yes" Care plan with goal date of 9/16 read, "Dysphagia with TF (tube feeding) Hx (history) oral cancer" "Oral cancer with revision slurred speech."	F 412	with change in status. Residents have been assessed for dental service requests and services scheduled accordingly. Staff have been provided education regarding communication and scheduling of ancillary services. IDT Team will complete audits to ensure completion and follow up of ancillary services upon admission, quarterly and with change in resident status during CCPR. Results of audits to be tracked and trended and reviewed at QAPI monthly for identification of areas of opportunities and frequency of audits to be determined as indicated. Alleged date of compliance: July 20, 2016.	

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	245326	A. BUILDING _____ B. WING _____	06/10/2016

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F 412	Continued From page 47 On 6/8/16 at 7:26 a.m. registered nurse (RN)-A stated R29 had diagnosis of retro molar area cancer, dysphagia and tube feeding. In addition, RN-A confirmed R29 was last seen by a dentist on 8/12/15 and indicated she had just scheduled the dental appointment on 6/14/16, after the concern had been brought to the facility staff attention and provided the number to the clinic. On 6/8/16 at 9:03 a.m., R29 mentioned, she could not remember when last seen by dentist and added "I would like to be seen by a dentist please, I do not take anything by mouth and have problems with swallowing." On 6/8/16 at 9:57 a.m. during a telephone interview with Apple Tree Coon Rapids dental community care coordinator (CCC), the CCC specified, R29 was last seen in the facility on 8/12/15 and a treatment plan was sent to R29's husband on 8/14/15, 9/25/15 and 12/9/15 with no responses and later learned that the husband was deceased. Furthermore CCC mentioned, a fax was sent to the facility 3/16/16 addressed to health unit coordinator (HUC). Surveyor requested the information refax to the facility and it read, "Wednesday... The treatment plan for [R29] was sent to R29's [husband], the person we have listed as the representative, three times for consent. At this time we have not received a response. If someone other than [husband] is representative now or if their address is not Rose of Sharon Manor, 1000 Lovell Ave, Roseville, MN 55113, please let me know. This proposed dental work will not be done at this time and [R29] will be updated to recall status and seen when due 08/12/2016.	F 412		

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F 412	Continued From page 48 Interview on 6/8/16 at 10:03 a.m.,the HUC indicated she had not received a fax from the Apple Tree Coon Rapids dental on 3/16/16. On surveyor request, Apple Tree Coon Rapids refaxed the information to the facility, which showed the original fax was sent on 3/16/16. On 6/8/16 at 11:14 a.m. with director of nursing verified R29's medical records lacked evidence of dental visit or appointment in last 6 months and stated, "My expectation is when we get referral from Apple Tree Coon Rapids dental, staff should be writing on the referral that someone noted it when is received and scheduled. We should be keeping track of that." On 6/8/16 at 3:11 p.m. social services director stated R29 is currently receiving Medicaid funding, that includes assistant with appointments and transportation arrangements. Policy and procedure title DENTAL SERVICES - REFERRAL TO, dated July 2015, direct staff, "... The social services such as, but not limited to, the assist and/or coordinate services such as, but not limited to, the following: Routine dental services. Emergency dental services. Appointments. Transportation to and from the office. Prompt referrals." The policy also indicated, "1. Determine/scheduled the dates for the contracted dental services to be available at the center. 2. Identify those residents who need routine services that include, but are not limited to: Inspection of oral cavity (new admission or annual) Dental radiographs. Dental cleaning. Fillings (new and repairs)..."	F 412		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 49 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 NA-A, NA-C, and NA-D received education regarding infection control techniques, usage of standard precautions, including proper handwashing and gloving techniques. Staff has received education regarding policy and procedures for infection control techniques, including standard precautions, hand washing, and gloving techniques. DON or Designee to complete random audits regarding infection control weekly for 4 weeks, and then monthly for 3 months. Results of audits to be tracked and trended and reviewed at QAPI monthly for identification of areas of opportunities and frequency of audits to be determined as indicated. Alleged date of compliance: July 20, 2016.	

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F 441	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement procedures to prevent the spread of infection during handwashing for 1 of 1 residents (R105) observed for handwashing during cares. Findings include: During observation of morning cares on 6/8/16, at 8:05 a.m., nursing assistant (NA)-A came to the room and without washing hands or using sanitizing gel, donned a pair of gloves from the nightstand, removed R105's incontinence brief, then went into the bathroom (BR) to obtain a urinal to assist R105 with using the urinal. R105 was incontinent of urine in the brief and on the incontinence pad in the bed. NA-A removed the gloves and without washing/sanitizing hands left the room. NA-A returned to the room at 8:20 a.m., did not wash hands or use sanitizing gel, donned a pair of gloves and proceeded to go through closets looking for morning clothing. NA-A put on R105's gripper stockings, raised the head of the bed, assisted R105 to sit up on the side of the bed. NA-A placed the transfer belt around R105 and walked R105 into the BR without difficulty and was positioned on the toilet. Wearing the same gloves, NA-A wet the wash cloth under the water faucet and proceeded to wash R105's back, underarms and groin areas. NA-A removed gloves, disposed of in the trash receptacle, obtained soap and washed hands for ten seconds, and turned off the water faucet without using a paper towel. NA-A donned a pair of gloves from the bedside stand. NA-C came to the room to assist. NA-C did not wash/sanitize hands and donned a pair of gloves. NA-C obtained a	F 441		

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F 441	Continued From page 51	F 441		

brief from the drawer and assisted to dress R105 while sitting on the toilet. R105 asked for a drink of water. There was none in the room so NA-A removed gloves, washed hands for six seconds, did not use a paper towel to turn the water on or off, and left the room to get a cup and straw. The incontinence brief was too big so NA-A left the room to get the right size brief. At 8:27 a.m. NA-A returned with the brief and donned gloves. NA-C proceeded to provide perineal cleansing for R105. NA-C adjusted the brief and pulled up the pants for R105. Then taking the transfer belt and putting around R105 for transfer while wearing the same gloves used to perform perineal cleansing. NA-C removed gloves and washed hands for thirteen seconds. NA-A removed gloves and washed hands for eleven seconds and turned the faucet off without using paper towels.

Initially R105 started to shave self but became tired and NA-A took over. After finishing shaving, NA-A removed the gloves, washed hands for ten seconds and retrieved the partial denture from the bedside. NA-A donned gloves, brushed the partial with toothpaste and put into R105's mouth. NA-A removed the gloves and did not wash hands, put away the supplies and transported R105 out to the dining room.

On 6/8/16, at 9:29 a.m. NA-D came to assist NA-A putting R105 back to bed. Both NA's donned gloves without washing/sanitizing hands to assist R105 into bed. After transferring R105, both nursing assistants removed gloves and left the room without washing/sanitizing hands.

When interviewed on 6/8/16 at 1:30 p.m. NA-A, NA-C and NA-D were not sure how many seconds hand washing was to take place. All

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F 441	Continued From page 52 three acknowledged the faucet was to be turned off using a clean paper towel after handwashing. The NA's verified they did not use sanitizing gel when assisting with R105's cares earlier. Document review the facility policy dated, July 2015, titled, Hand Hygiene-Plain Soap and Water Handwashing, directed to thoroughly distribute the soap over the entire area of the wrists, work suds between fingers, rub fingertips in palm of opposite hand and to rub hands together vigorously for 15-20 seconds generating friction on all surfaces of the hands and fingers. Rinse hands thoroughly, dry hands with paper towel and turn faucets off with the paper towel.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Rose of Sharon Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH	K 000	EPOC	

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

Electronically Signed — 07/18/2016

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

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K 000	Continued From page 1 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. Rose of Sharon Manor is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the North side that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 63 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door	K 018		7/20/16

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K 018	Continued From page 2 and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 45 of 63 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0830 and 1330 on 5/07/2016 observations revealed that the following room doors did not positively latch: Room S8, E1, and E7. Closet doors at ends of the halls in the shower areas do not meet code of corridor doors. The deficient practice was observed by the Maintenance Supervisor (TB).	K 018	K018 Rooms S8, E1 and E7 have been adjusted for positive latch. Director of Maintenance has reviewed all other doors on units for positive latch. Director of Maintenance will audit document all unit doors quarterly for positive latch and report to the safety committee. Closet doors at the end of the corridor have been replaced to comply with code requirements.	
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation	K 020		6/30/16

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K 020	Continued From page 3 shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 This STANDARD is not met as evidenced by: Observations revealed that pipes penetrating the ceiling floor assembly were not sealed in accordance with NFPA 101 "The Life Safety Code" 2000 edition section 19.3.1.1. This deficient practice could allow the products of combustion to travel vertically throughout the building, which will negatively impact all the residents, visitors and staff of the facility. Findings Include: During the facility tour on 06/07/2016, between 0830 and 1330 it was observed that a pipe penetration through the ceiling/floor assembly are located in the elevator equipment room were sealed with spray foam. . This was verified by Maintenance Supervisor (TB) during the facility tour and at the exit conference.	K 020	K020 The penetration in the elevator room has been properly sealed to meet requirements. Director of Maintenance will review all contrator work to ensure any and all penetrations created are properly sealed upon completion of any work.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 45 of the 63	K 025	K025 Penetrations above the smoke bariiers ceilings in South and West hall has been properly sealed on both sides of the smoke barrier. The penetration above ceiling leading to therapy wing has been	6/30/16

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K 025	Continued From page 4 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0830 and 1330 on 6/07/2016 observations revealed that smoke barriers had penetrations at the following locations: Above ceiling at the smoke doors in South Hall Above ceiling at the smoke doors in West Hall Above the ceiling in the wall leading to Therapy wing The penetrations will all need to be sealed on both sides of the smoke barrier. The deficient practice was observed by the Director of Environmental Services (EA).	K 025	properly sealed. Director of Maintenance will review all contrator work to ensure any and all penetrations created are properly sealed upon completion of any work.	
K 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain a clear and unobstructed exit stairway in accordance with NFPA 101 Life Safety Code (2000) section 7.2.2. This deficient practice could negatively affect the use of the exit stairway used by staff that would delay needed staff assistance to residents and visitors in the event of an emergency. Findings include: On facility tour between 0830 and 1330 on	K 034	K034 All equipment stored in both levels of the exit stairwell has been removed. Director of Maintenance and Environmental Services Director during weekly rounds will ensure no equipment is stored in either level of the stairwell.	6/30/16

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K 034	Continued From page 5 06/07/2016, It was observed, that there were several carts, floor scrubbing machines, batteries and battery chargers, and other equipment being stored in both levels of the exit stairwell. This deficient practice is restricting the exit capacity and the capability for this stairwell as a required egress. This deficient practice was verified by the Maintenance Supervisor (TB).	K 034		
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could effect all residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 0830 to 1330 on 06/07/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor (TB) revealed that the facility could not provide any documentation verifying that the battery backup emergency lights had been tested monthly or annually. This deficient practices were confirmed by the Maintenance Supervisor (TB) at the time of discovery.	K 046	K046 Emergency backup exit lighting has been tested and documented. Director of Maintenance shall test and document all battery backup emergency lights monthly and report monthly to safety Committee.	6/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**06/07/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	**1000 LOVELL AVENUE** **ROSEVILLE, MN 55113**

(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 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 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. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 0830 and 1330 on 06/07/2016, based on review of available documentation it was revealed that fire drills were not varied throughout the shift during the Morning shift. All drills on the first shift for the 1st quarter of 2016 and 2nd and 3rd quarters of 2016 were conducted between 1300 and 1315. This deficient practice was confirmed by the facility Maintenance Supervisor (TB) at the time of discovery.	K 050	K050 Fire drills shall be varied during all shifts. Director of Maintenance will ensure compliance and report to the Safety Committee monthly.	6/30/16
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily	K 052		6/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**06/07/2016**

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ROSE OF SHARON MANOR	**1000 LOVELL AVENUE ROSEVILLE, MN 55113**

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K 052	Continued From page 7 available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. This deficient practice could adversely affect 105 of 105 residents. FINDINGS INCLUDE: On 06/07/2016 between 0830 and 1330, while performing the record review of available documentation it was observed that the DACT was not being tested Monthly. This finding was confirmed with the Maintenance Supervisor (TB).	K 052	K052 The DACT is tested and documented monthly. The Director of Maintenance will test and document and report monthly to The Safety Committee.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Where required by section 19.1.6 of the 2000 Life Safety code Health care faclities shall be protected throughout by an approved, supervised	K 056	k056 The Director of Maintenance has been able to confirm the elevator shaft pits is properly sprinkled. Director of	7/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**06/07/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	**1000 LOVELL AVENUE ROSEVILLE, MN 55113**

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K 056	Continued From page 8 automatic sprinkler system in accordance with section 9.7 On the facility tour between 0830 and 1330 on 06/07/2016 the facility was unable to verify that the elevator shaft/pit was properly sprinklered. The dumpster is being stored in an outdoor area with a ceiling that is not sprinklered. The deficient practice was observed by the Maintenance Supervisor (TB) .	K 056	Maintenance shall maintain documentation to verify compliance. The dumpster storage area has been properly sprinkled.	
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all patients. Findings include: On facility tour between 0830 and 1330 on 06/07/2016, observation revealed that the sprinkler head escutcheon plates on sprinkler heads were missing in the following areas: Outside the kitchen door leading to the service area next to the cupboard space. East hall next to the smoke barrier doors. Also, the spare sprinkler heads box is missing 2 sidewall type pendants. This deficient practice was verified by the	K 062	K062 The escutcheon plates on the sprinkler heads outside the kitchen door leading to the service area next to the cupboard space has been installed. Two sidewall type pendants have been installed in the spare sprinkler head box. Director of Maintenance will review and report monthly to the Safety Committee.	7/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**06/07/2016**

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K 062	Continued From page 9 Maintenance Supervisor (TB).	K 062		
K 064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain portable fire extinguisher in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect 30 out of 63 residents. Findings include: On facility tour between 0830 and 1330 on 06/07/2016, observation revealed that the fire extinguisher located at the nurses station was being blocked by a cart. This deficient practice was confirmed by the Maintenance Supervisor (TB).	K 064	k064 The fire extinguisher located at the nurses station is no longer blocked. Director of Maintenance will audit and document during daily rounds. Findings will be reported monthly to the Safety Committee.	6/30/16
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	K 076		6/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**06/07/2016**

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ROSE OF SHARON MANOR	**1000 LOVELL AVENUE ROSEVILLE, MN 55113**

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K 076	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Sections 4-3.5.2.2 (2) and 8-3.1.11.2. This deficient practice could effect 40 out of 63 residents. FINDINGS INCLUDE: On facility tour between 0830 and 1330 on 06/07/2016, observation revealed that the 2nd floor oxygen storage room found numerous empty and full "E" cylinders intermingled. This deficient practice was confirmed by the Maintenance Supervisor (TB) at the time of this discovery.	K 076	K076 The second floor oxygen room no longer houses intermingled empty and full oxygen containers. Director of Maintenance will audit compliance once a week and document. Findings will be reported monthly to the Safety Committee.	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 0830 and 1330 on 06/07/2016, based on review of available documentation it was revealed that there was no documentation for:	K 144	K144 Documentation for the minimum 5 minute cool down period for the generator is being maintained. The Directof Maintenance will maintain documentation and report monthly to the Safety Committee.	6/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**06/07/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	**1000 LOVELL AVENUE ROSEVILLE, MN 55113**

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K 144	Continued From page 11 a. The minimum 5 minute cool down period when testing the generator. This deficient practice was verified by the Maintenance Supervisor (TB).	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain electrical devices in accordance with NFPA 70 (99), National Electrical Code this deficient practice could negatively affect the safety of staff and visitors. Findings include: On the facility tour between 0830 and 1330 on 06/07/2016 observations revealed that there was a grounding plug broken off in an outlet in the Executive Director's office. The deficient practice was observed by the Maintenance Supervisor (TB).	K 147	K147 The outlet in the Executive Direcor's office has been repaired. Broken electrical outlets will be repaired immediately upon identification by the Director of Maintenance.	6/30/16

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245326	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 0102** B. WING	DATE SURVEY COMPLETE: **6/7/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	**1000 LOVELL AVENUE ROSEVILLE, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 038	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect 4 of the 63 residents. Findings include: On facility tour between 0830 and 1330 on 06/07/2016, it was observed that: There was a barrel lock on a bathroom door of room W6. This deficiency was fixed during the remainder of the inspection. These deficiencies were observed by the Maintenance Supervisor (TB).

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

The above isolated deficiencies pose no actual harm to the residents

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6160
June 30, 2016

Mr. Dennis Decosta, Administrator
Rose of Sharon Manor
1000 Lovell Avenue
Roseville, Minnesota 55113

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5326025 & Complaints Numbered H5326055, H5326057, H5326058, H5326060, H5326061, H5326063, H5326064, & H5326065

Dear Mr. Decosta:

The above facility was surveyed on June 6, 2016 through June 10, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaints numbered H5326055, H5326057, H5326058, H5326060, H5326061, H5326063, H5326064, & H5326065. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St Paul MN, 55164-0900. 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 Susanne Reuss, Unit Supervisor at (651) 201-3793 .

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
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00126	A. BUILDING: _____ B. WING _____	06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON MANOR	1000 LOVELL AVENUE ROSEVILLE, MN 55113

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 6, 7, 8, 9, 10, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and mail or email to: Susanne Reuss, Unit Supervisor	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	7/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 6, 7, 8, 9, 10, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and mail or email to: Susanne Reuss, Unit Supervisor	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0900 At the time of the survey, investigations of the following complaints were completed: H5326055 was found to be substantiated at MN Rule 4658.0525 Subp. A. B H5326057 was found to be substantiated at MN Rule 4658.0520 Subp. 1 H5326058 was found to be substantiated at MN St. Statute 626.557 subd. 3 and MN St. Statute 626.557 subd. 4a H5326060 was found to be substantiated at MN St. Statute 144.651 subd. 20; MN St. Statute 626.557 subd. 3 and MN St. Statute 626.557 subd. 4a H5326061 was found not to be substantiated H5326063 was found to be substantiated at MN St. Statute 144.651 subd. 20; MN St. Statute 626.557 subd. 3 and MN St. Statute 626.557 subd. 4a H5326064 was found to be substantiated at MN Rule 4658.0520 Subp. 1; MN St. Statute 626.557 subd. 3 and MN St. Statute 626.557 subd. 4a H5326065 was found to be substantiated at MN St. Statute 626.557 subd. 3 and MN St. Statute 626.557 subd. 4a	2 000	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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00126	A. BUILDING: _____ B. WING _____	06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 565	Continued From page 2	2 565		

This MN Requirement is not met as evidenced by:
Based on interview, observation and document review the facility failed to provide services in accordance with the resident's written plan of care for 1 of 3 residents (R105) in the sample who required assistance with toileting/incontinence care, shaving, oral care and hearing accommodations.

Findings include:

R105's plan of care dated 6/7/16, read, "Incontinent" "Goal: Will be free of skin impairment r/t (related to) incontinence (See Skin Integrity Assessment Prevention and Treatment Plan)."
The undated form titled, Bladder Data Collection and Assessment, directed staff R105 had "Difficulty starting urine stream" "Post void dribbling" and "Voiding small amounts often."
The plan of care document dated 6/7/16, titled, Skin Integrity Assessment, read, "bladder incontinence, keep linen dry and wrinkle free. Implement an individualized turning schedule of every 2 hours."

The facility policy dated July 2015, titled Urinary Incontinence directed staff to provide whenever necessary care for residents who are incontinent of urine and to follow the skin integrity guideline of every two hours.

During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, lying on the left side, wearing an incontinence brief and there was a brown/tan ring of staining

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2 565	Continued From page 3 on the incontinence pad in the bed. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room and R105 asked for a urinal. NA-A assisted R105 with holding the urinal in place. At 8:20 a.m. R105 asked to sit up because R105 could not urinate lying down. NA-A sat R105 on the side of the bed. R105 told NA-A "My bed is wet." When interviewed on 6/8/16 at 8:30 a.m. NA-A verified R105 did not have any morning cares prior to NA-A providing the cares at this time. NA-A verified the 18 inch brown/tan ring of staining on the incontinence pad looked like a dried ring of urine. LPN-A was informed of the urine stain and would find out when the night shift last offered cares. On 6/8/16, not sure of the time, the DON produced a document dated 6/8/16, no time specified, which read, "[R105] was dry at 4am {sic} I found [R105] with the bed cord out, bed deflated. I plugged the bed back in,m it rein {sic} flated, and rechecked [R105] 4-4:30am. I gave report to [nurse] and informed her that [R105] did not I had done cares with [R105] at 4 am rounds, and [R105] was dry." Clarification to allegation-"[R105] did not have stool at 4 am. I had removed [R105] brief to check [R105] and there was no bm there." During an interview with the DON on 6/8/16, at 3:00 p.m. verified R105 was incontinent of urine sometime between 4:00 a.m. and 8:20 a.m. when NA-A provided cares. Furthermore the DON verified a dark drying brown/tan ring of urine would indicate a long period of time without being checked and changed for R105.	2 565		

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2 565	Continued From page 4 When interviewed on 6/10/16, at 11:00 a.m. the DON verified the facility expectation would be to check on R105 every two hours for incontinence. The initial plan of care dated, 6/4/16, titled, Care Delivery Guide, directed staff R105 required assistance of one with grooming. Oral Care indicated an upper denture and assist of one for oral care. There was no further direction with shaving. A family (F-C) interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern had not been shaved since coming to the facility and was not receiving oral care. F-C expressed R105 was always clean shaven and would not like having all the facial hair that was currently present. During an observation on 6/7/16, at 3:00 p.m. another family member (F-D) was visiting and expressed concern to this surveyor that R105 had not been shaved of facial hair and partial plate was not in R105's mouth. During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, laying on the left side. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room using a a transfer belt, ambulated R105 to the bathroom (BR). R105 asked for a tooth brush to brush teeth. NA-A assisted R105 to the sink. There were no oral care supplies in the room and NA-A had to retrieve a basin, toothbrush, toothpaste and mouthwash from the storage room. Another NA-C came into the room and searched for oral care supplies and not finding any left the room. NA-A returned to the room and prepared a	2 565		

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2 565	Continued From page 5 toothbrush with toothpaste. R105 asked NA-A, "Did you find my partial?" to which NA-A responded "The hair is long on your face." R105 repeated, "Did you find my partial?" NA-A explained being off for a week and did not have an assignment sheet for R105 so did not know R105 had teeth. On 6/8/16, during morning cares which started at 7:15 a.m.,NA-A produced an electric shaver from R105's top bedside drawer and proceeded to shave R105. NA-A verified there was a very heavy growth of facial hair. R105 expressed gratitude for being shaved and stated, "That's better!" The plan of care dated 6/7/16, read, Sensory Communication Care Plan, Auditory Disturbance, Hearing Aide, Intervention Assist to place in ear as needed. There was no further direction regarding the hearing aide. During observations, R105 did not have the hearing aide in place from 6/8/16, at 8:30 a.m. through 6/9/16, at 10:30 a.m. During an interview with the DON on 6/10/16, at 11:00 a.m. verified the facility expectation was to shave facial hair everyday Provide oral care twice a day and if a resident refused care to inform the nurse and to reapproach at another time. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff	2 565		

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2 565	Continued From page 6 and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (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 document review and interview, the facility failed to assure that pain was managed for 1 of 1 resident (R54) reviewed for pain control following an acute shoulder dislocation. Harm occured to R54 when the resident suffered pain following a dislocated left shoulder 3/7/16 and displayed signs/symptoms of pain until transferred to the hospital 3/9/16. The findings include: According to R54's Admission Record onset date,	2 830		

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2 830	Continued From page 7 10/1/15, R54 was diagnosed with unspecified dementia with behavioral disturbances, contracture unspecified hand, delusional disorders, and unspecified psychosis not due to a substance or known physiological condition. A quarterly minimum data set (MDS) assessment dated 2/20/16 indicated R54 had been assessed as having severe cognitive impairment. Document review of Progress Notes dated 3/8/16, Registered Nurse (RN)-G wrote a late entry for 3/7/16, "called to residents room as [NA-B] seen [R54] shoulders do not both seem alike. Observed [R54] left shoulder to be off from right shoulder. Informed [NA-B] resident was scheduled to be seen by NP would inform NP when [NP] arrives. Nurse held left arm up, resident was fidgeting, was not clear if resident fidgeted due to shoulder as [R54] fidgeted most of the time." A facility form Witness Investigation Statement, dated 3/8/16, identified RN-G wrote a late entry for 3/7/16, "called to resident's room in AM (morning) to see resident's shoulder. Upon assessment left shoulder seems different, but I wasn't sure why. Informed CNA (certified nursing assistant) that [R54] was scheduled to be seen by NP (nurse practitioner). Nurse will ensure NP is informed about resident's shoulder. Expected NP in AM (morning) but [NP] was not here in AM." Family member (F)-A, interviewed 6/15/16, at 4:30 p.m., reported being at the facility on 3/7/16, at lunch time. F-A explained that F-A and F-B had been scheduled to meet with social services but F-B was running late. F-A reported that when F-B returned to the facility around 2:00 p.m., R54's face appeared red and clammy looking. NA-B was standing by R54's bedroom door at the	2 830		

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2 830	Continued From page 8 time and F-B told NA-B that R54 looked to be in pain. Progress Notes, dated 3/7/16, identified the nurse practitioner (NP) was notified at 1:15 p.m. regarding R54's left shoulder that looked very different from the right shoulder. NP arrived around 2:15 p.m. to the facility and ordered a left shoulder X ray. The X ray company was notifed, however, unable to perform the X-ray until 3/8/16. The physician and/or NP were not informed of the X-ray delay to determine if alternative interventions or modifications were required to assure pain control for R54. Review of documentation from a report, Witness Investigation Statement, from 3/7/16, at 11:00-11:30 a.m. reported by nursing assistant (NA)-B included: "Res (resident) was moving uncomfortably according to NA/R (nursing assistant registered)." On 3/7/16, after lunch R54's family member expressed concern that R54 "looks uncomfortable" and suggested maybe R54 had a high temperature. NA-B took the temperature and it was noted to be 95.5 degrees Fahrenheit (F). On 3/7/16, at 2:15 p.m. the nurse practitioner (NP)-C documented on a Physician Progress Note, "Today staff note a change in patient. [R54] is diaphoretic, without temperature noted. [R54] sustained a skin tear to right forearm today, cause unknown. They note a left shoulder deformity. [R54] is shaking, skin is dusky." On 3/8/16 at 11:58 a.m., X-ray results were faxed to the facility. Licensed practical nurse (LPN-A) reported to nurse practitioner (NP) the results of the X-ray that were electronically signed on 3/8/16, at 8:04 a.m. Report identified, "Shoulder 1	2 830		

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2 830	Continued From page 9 view, left. Results: The humerus is anteriorly and inferiorly dislocated with respect to the glenoid. There is no fracture. Acromioclavicular and coracoclavicular joints are normal. Conclusion: Anterior shoulder dislocation. Please monitor for pain cues, If noticed, report to provider." A Witness Investigation Statement for 3/7/16, from licensed practical nurse (LPN)-B included: "Resident was noted on Monday to be in pain. On Wednesday morning the pt (patient) was noted to be moaning in pain, at this time the Doctor was updated and gave an order to send pt to the hospital." On 3/9/16, no time specified, RN-I documented in a progress note: "Only taking sips tonight, is usually a very good drinker. Resident was grimacing early in the shift-given 680 mg {sic} PRN Tylenol. slept well the rest of the noc (night)." Review of the MAR lacked documentation that the PRN medication had been given. On 3/9/16 at 10:15 a.m. documentation in the progress notes included: "resident up in chair crying out." On 3/9/16, at 10:30 a.m. R54 was transported by ambulance to the hospital after LPN-A observed R54 at 10:15 a.m. and documented, "v/s (vital signs) 97-70-18-180/68 resident up in chair crying out-R. shoulder. NP called per order send to [hospital] ER (emergency room) for ortho L shoulder dislocation, [guardian] called she will meet at [hospital]." According to the documented vital signs, the typical blood pressure for R54 was 100/60 to 130/70. NP-C was interviewed on 6/9/16, at 10:13 a.m.	2 830		

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2 830	Continued From page 10	2 830		

the NP-C stated, "I do not know enough about the anterior dislocation on [R54]. I have seen cases where there have been contractures due to muscle fatigue, but typically an anterior dislocation is due to trauma. [R54] did not return to the facility. Another way the shoulder could have dislocated is to have been stretched too far forward."

When interviewed on 6/10/16, at 1:00 p.m. LPN-A verified witnessing R54 had been "crying out in a lot of pain." when transported to the hospital on 3/9/16, and that no PRN pain medication had been given prior to transport.

R54's current Physician Orders, indicated R54 had utilized Acetaminophen (Tylenol) 500 mg (milligrams) caplets 2 by mouth three times daily since 6/6/14 for pain, with directions not to exceed 4000 mg /24 hours.

R54's March 2016 Medication Administration Record (MAR) was reviewed. The MAR indicated R54 was to receive the acetaminophen at 6:30 a.m., 12:30 p.m. and 4:30 p.m.. The MAR documentation for 3/7/16, at 12:30 p.m. was not signed off to indicate the medication had been given.

According to a document titled March 2016 Medication, documentation in a section for pain control included: "Is your pain program effective for you? If no, provide pain rating (For non-interviewable residents, utilize Wong-Baker pain scale." On 3/7/16 that section of documentation was blank indicating no pain assessment had occurred for the day shift. Another section of the March 2016 Medication record included: "Please monitor for pain cues. If noted call provider." The 3/7/16 documentation

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2 830	Continued From page 11 was not completed to indicate whether pain cues were monitored, and/or what pain cues may have been evident. The March 2016 physician orders verified R54 had Standing Orders for "Acetaminophen 325-650 mg (milligram) PO (orally) or Suppository grain X q (every) 4 hrs (hours) prn (whenever neccesarry fever >100 or discomfort." The March 2016 plan of care for Pain Management included: "Assess for verbal and not-verbal signs and symptoms of distress or pain unrelieved by ordered treatments/medications. Report to Provider signs and symptoms of distress or pain unrelieved by ordered treatments/medications. Identify precipitating factors of pain." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff on the assessment process for residents who experience pain. An audit could be developed to ensure the proper assessment and interventions have been implemented after each resident pain. The results of the audit could be reported to the quality assurance committee during the quarterly meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and	2 840		

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2 840	Continued From page 12 proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene care for 1 of 1 resident (R105) in the sample who required assist from staff for oral care and shaving. Findings include: R105, during an observation on 6/6/16, at 5:00 p.m., was in bed positioned to the left side, uncovered, fully clothed, with legs extending over the edge of the mattress. There was a heavy accumulation of facial hair/whiskers.When an interview was attempted, R105 stated, "let me sleep." A family (F)-C interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern about R105 who had been mentally intact and living at home two weeks ago. F-C expressed concern that R105 had not been shaved since coming to the facility, was not getting out of bed, was not eating, was not receiving oral care, and the family did not understand what services the facility was providing for R105. Furthermore, F-C expressed R105 was always clean shaven and would not like having all the facial hair that was currently present. During an observation on 6/7/16, at 3:00 p.m. another family member (F-D) was visiting and expressed concern to this surveyor that R105 was in the bed fully dressed, trying to get out of the bed, had not been shaved of facial hair and partial plate was not in R105's mouth.	2 840		

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2 840	Continued From page 14 During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, laying on the left side. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room using a a transfer belt, ambulated R105 to the bathroom (BR). R105 asked for a tooth brush to brush teeth. NA-A assisted R105 to the sink. There were no oral care supplies in the room and NA-A had to retrieve a basin, toothbrush, toothpaste and mouthwash from the storage room. Another NA-C came into the room and searched for oral care supplies and not finding any left the room. NA-A returned to the room and prepared a toothbrush with toothpaste. R105 asked NA-A, "Did you find my partial?" to which NA-A responded "The hair is long on your face." R105 repeated, "Did you find my partial?" NA-A explained being off for a week and did not have an assignment sheet for R105 so did not know R105 had teeth. NA-A retrieved the partial upper plate from the nightstand (in a cup without water). R105 complained of mouth/tongue being sore. When R105 stuck out tongue, it was observed to be red, cratered, with a couple areas that appeared white/red sores. NA-A produced an electric shaver from R105's top bedside drawer and proceeded to shave R105. NA-A verified there was a very heavy growth of facial hair. R105 expressed gratitude for being shaved and stated, "That's better!" On 6/8/16, at 10:00 a.m. the licensed practical nurse (LPN-A) was informed that R105 had complained of having trouble swallowing and	2 840		

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2 840	Continued From page 15 having a sore mouth/tongue. LPN-A documented in the progress notes, "11:00 a.m. Tongue has red and white patches present. Mouth and lips dry." On 6/8/16, at 12:00 p.m. the director of nursing (DON) was informed that no oral care supplies were available in the bedside. On 6/9/16, at 10:07 a.m. the hospice aide (HA) was providing cares. When interviewed regarding oral care provided on 6/7/16, HA stated, "I brought my own toothette's and provided the oral care with the toothette's because there was no toothbrush or toothpaste supplies in the room." During an interview on 6/8/16, at 10:00 a.m. regarding the facility expectation for oral care, LPN-A verified oral cares were to be provided twice a day and the hospice services were to be above and beyond the services of the facility. During an interview on 6/10/16 at 10:00 a.m. with RN-D explained that a mouth exam had not been completed on R105 because R105 was due 6/10/16, according to the minimum data set (MDS) schedule, and R105 was transferred to another facility, per family wishes, on 6/10/16 so the assessments were not completed. A facility policy regarding oral care and shaving of residents was requested but not received. During an interview with the DON on 6/10/16, at 11:00 a.m. verified the facility expectation was to shave facial hair everyday, provide oral care twice a day and if a resident refused care to inform the nurse and to reapproach at another time.	2 840		

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2 840	Continued From page 16 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to the provision of assistance with activities of daily living (ADLs) such as oral care. Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of ADL services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate provision of ADL services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 840		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence 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.	2 910		

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2 910	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R105) in the sample, who was identified as incontinent of urine received the necessary care and services to manage incontinence. Findings include: R105 was admitted from the hospital to the facility on 6/4/16, at 4:30 p.m. with an order for hospice care. According to the physician progress notes dated 6/8/16, read, "Neurology: Pt with previous h/o (history of) left basal ganglia stroke and with decreased oral intake and increase in symptoms of dysphagia. Due to declining function agreed to pursue hospice which [R105] is now signed up for with diagnosis of CVA (cerebral vascular accident). Urology: Pt with h/o chronic urinary retention, Pt was noted to have UTI (urinary tract infection) and was placed on antibiotics. [R105] has been straight cathing twice a day at home." During an observation on 6/6/16, at 5:00 p.m. R105 was in bed positioned to the left side, uncovered, fully clothed, with legs extending over the edge of the mattress. A family (F-C) interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern about R105 who had been mentally intact and living at home two weeks ago. F-C expressed concern that R105 was not getting out of bed and the family did not understand what services the facility was providing for R105. During an observation on 6/7/16, at 3:00 p.m.	2 910		

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2 910	Continued From page 18	2 910		

another family member (F-D) was visiting and expressed concern that R105 was in the bed fully dressed, trying to get out of the bed and turned on the call light for assistance.

During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, lying on the left side, wearing an incontinence brief and there was a brown/tan ring of staining on the incontinence pad in the bed. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room and R105 asked for a urinal. NA-A assisted R105 with holding the urinal in place. At 8:20 a.m. R105 asked to sit up because R105 could not urinate lying down. NA-A sat R105 on the side of the bed. R105 told NA-A "My bed is wet." NA-A used a transfer belt and ambulated R105 to the bathroom (BR) and assisted R105 to sit on the toilet. There was a 18 inch ring of dark brown/tan moisture on the incontinence pad in the bed. R105 voided what sounded like a small amount in the toilet.

When interviewed on 6/8/16 at 8:30 a.m. NA-A verified R105 did not have any morning cares prior to NA-A providing the cares at this time. NA-A verified the 18 inch brown/tan ring of staining on the incontinence pad looked like a dried ring of urine. LPN-A was informed of the urine stain and would find out when the night shift last offered cares.

On 6/8/16, DON produced a document dated 6/8/16, no time specified, which read, "[R105] was dry at 4am {sic} I found [R105] with the bed cord out, bed deflated. I plugged the bed back in,m it rein {sic} flated, and rechecked [R105] 4-4:30am. I gave report to [nurse] and informed

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2 910	Continued From page 19 her that [R105] did not I had done cares with [R105] at 4 am rounds, and [R105] was dry." Clarification to allegation-"[R105] did not have stool at 4 am. I had removed [R105] brief to check [R105] and there was no bm there." During an interview with the DON on 6/8/16, at 3:00 p.m. verified R105 was incontinent of urine sometime between 4:00 a.m. and 8:20 a.m. when NA-A provided cares. Furthermore the DON verified a dark drying brown/tan ring of urine would indicate a long period of time without being checked and changed for R105. The undated form titled, Bladder Data Collection and Assessment, indicated R105 had "Difficulty starting urine stream" "Post void dribbling" and "Voiding small amounts often." The plan of care document dated 6/7/16, titled, Skin Integrity Assessment,bladder incontinence, keep linen dry and wrinkle free. Implement an individualized turning schedule of every 2 hours. The facility policy dated July 2015, titled Urinary Incontinence directed staff to provide whenever necessary care for residents who are incontinent of urine and to follow the skin integrity guideline of every two hours. When interviewed on 6/10/16, at 11:00 a.m. the DON verified the facility expectation would be to check on R105 every two hours for incontinence. SUGGESTED METHOD OF CORRECTION: The facility could review the state requirements, review their policies/procedures and revise them to include individualized toileting/urinary incontinence schedules/plan/program, the facility	2 910		

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2 910	Continued From page 20 could then develop assessments and tools and educate staff on how to assess, implement, and maintain an individualized toileting/urinary incontinence plan for all residents. The facility could then develop and implement an auditing system as part of the quality assure process to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene care for 1 of 1 resident (R105) in the sample who required assist from staff for oral care and shaving. Findings include: R105, during an observation on 6/6/16, at 5:00 p.m., was in bed positioned to the left side, uncovered, fully clothed, with legs extending over the edge of the mattress. There was a heavy accumulation of facial hair/whiskers.When an interview was attempted, R105 stated, "let me sleep."	2 920		

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2 920	Continued From page 21 A family (F)-C interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern about R105 who had been mentally intact and living at home two weeks ago. F-C expressed concern that R105 had not been shaved since coming to the facility, was not getting out of bed, was not eating, was not receiving oral care, and the family did not understand what services the facility was providing for R105. Furthermore, F-C expressed R105 was always clean shaven and would not like having all the facial hair that was currently present. During an observation on 6/7/16, at 3:00 p.m. another family member (F-D) was visiting and expressed concern to this surveyor that R105 was in the bed fully dressed, trying to get out of the bed, had not been shaved of facial hair and partial plate was not in R105's mouth. During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, laying on the left side. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room using a a transfer belt, ambulated R105 to the bathroom (BR). R105 asked for a tooth brush to brush teeth. NA-A assisted R105 to the sink. There were no oral care supplies in the room and NA-A had to retrieve a basin, toothbrush, toothpaste and mouthwash from the storage room. Another NA-C came into the room and searched for oral care supplies and not finding any left the room. NA-A returned to the room and prepared a toothbrush with toothpaste. R105 asked NA-A, "Did you find my partial?" to which NA-A responded "The hair is long on your face." R105 repeated, "Did you find my partial?" NA-A	2 920		

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2 920	Continued From page 22 explained being off for a week and did not have an assignment sheet for R105 so did not know R105 had teeth. NA-A retrieved the partial upper plate from the nightstand (in a cup without water). R105 complained of mouth/tongue being sore. When R105 stuck out tongue, it was observed to be red, cratered, with a couple areas that appeared white/red sores. NA-A produced an electric shaver from R105's top bedside drawer and proceeded to shave R105. NA-A verified there was a very heavy growth of facial hair. R105 expressed gratitude for being shaved and stated, "That's better!" On 6/8/16, at 10:00 a.m. the licensed practical nurse (LPN-A) was informed that R105 had complained of having trouble swallowing and having a sore mouth/tongue. LPN-A documented in the progress notes, "11:00 a.m. Tongue has red and white patches present. Mouth and lips dry." On 6/8/16, at 12:00 p.m. the director of nursing (DON) was informed that no oral care supplies were available in the bedside. On 6/9/16, at 10:07 a.m. the hospice aide (HA) was providing cares. When interviewed regarding oral care provided on 6/7/16, HA stated, "I brought my own toothette's and provided the oral care with the toothette's because there was no toothbrush or toothpaste supplies in the room." During an interview on 6/8/16, at 10:00 a.m. regarding the facility expectation for oral care, LPN-A verified oral cares were to be provided twice a day and the hospice services were to be	2 920		

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2 920	Continued From page 23 above and beyond the services of the facility. During an interview on 6/10/16 at 10:00 a.m. with RN-D explained that a mouth exam had not been completed on R105 because R105 was due 6/10/16, according to the minimum data set (MDS) schedule, and R105 was transferred to another facility, per family wishes, on 6/10/16 so the assessments were not completed. A facility policy regarding oral care and shaving of residents was requested but not received. During an interview with the DON on 6/10/16, at 11:00 a.m. verified the facility expectation was to shave facial hair everyday, provide oral care twice a day and if a resident refused care to inform the nurse and to reapproach at another time. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would review and revise the policy and procedures related to dental services cares and treatment plan and provide education to staff members. A monitoring system could be developed to ensure staff are providing cares as directed and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in	21390		

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21390	Continued From page 24 residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement procedures to prevent the spread of infection during handwashing for 1 of 1 residents (R105) observed for handwashing during cares. Findings include: During observation of morning cares on 6/8/16, at 8:05 a.m., nursing assistant (NA)-A came to the room and without washing hands or using sanitizing gel, donned a pair of gloves from the nightstand, removed R105's incontinence brief,	21390		

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21390	Continued From page 25	21390		

then went into the bathroom (BR) to obtain a urinal to assist R105 with using the urinal. R105 was incontinent of urine in the brief and on the incontinence pad in the bed. NA-A removed the gloves and without washing/sanitizing hands left the room. NA-A returned to the room at 8:20 a.m., did not wash hands or use sanitizing gel, donned a pair of gloves and proceeded to go through closets looking for morning clothing. NA-A put on R105's gripper stockings, raised the head of the bed, assisted R105 to sit up on the side of the bed. NA-A placed the transfer belt around R105 and walked R105 into the BR without difficulty and was positioned on the toilet. Wearing the same gloves, NA-A wet the wash cloth under the water faucet and proceeded to wash R105's back, underarms and groin areas. NA-A removed gloves, disposed of in the trash receptacle, obtained soap and washed hands for ten seconds, and turned off the water faucet without using a paper towel. NA-A donned a pair of gloves from the bedside stand. NA-C came to the room to assist. NA-C did not wash/sanitize hands and donned a pair of gloves. NA-C obtained a brief from the drawer and assisted to dress R105 while sitting on the toilet. R105 asked for a drink of water. There was none in the room so NA-A removed gloves, washed hands for six seconds, did not use a paper towel to turn the water on or off, and left the room to get a cup and straw. The incontinence brief was too big so NA-A left the room to get the right size brief. At 8:27 a.m. NA-A returned with the brief and donned gloves. NA-C proceeded to provide perineal cleansing for R105. NA-C adjusted the brief and pulled up the pants for R105. Then taking the transfer belt and putting around R105 for transfer while wearing the same gloves used to perform perineal cleansing. NA-C removed gloves and washed hands for thirteen seconds. NA-A removed gloves

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21390	Continued From page 26 and washed hands for eleven seconds and turned the faucet off without using paper towels. Initially R105 started to shave self but became tired and NA-A took over. After finishing shaving, NA-A removed the gloves, washed hands for ten seconds and retrieved the partial denture from the bedside. NA-A donned gloves, brushed the partial with toothpaste and put into R105's mouth. NA-A removed the gloves and did not wash hands, put away the supplies and transported R105 out to the dining room. On 6/8/16, at 9:29 a.m. NA-D came to assist NA-A putting R105 back to bed. Both NA's donned gloves without washing/sanitizing hands to assist R105 into bed. After transferring R105, both nursing assistants removed gloves and left the room without washing/sanitizing hands. When interviewed on 6/8/16 at 1:30 p.m. NA-A, NA-C and NA-D were not sure how many seconds hand washing was to take place. All three acknowledged the faucet was to be turned off using a clean paper towel after handwashing. The NA's verified they did not use sanitizing gel when assisting with R105's cares earlier. Document review the facility policy dated, July 2015, titled, Hand Hygiene-Plain Soap and Water Handwashing, directed to thoroughly distribute the soap over the entire area of the wrists, work suds between fingers, rub fingertips in palm of opposite hand and to rub hands together vigorously for 15-20 seconds generating friction on all surfaces of the hands and fingers. Rinse hands thoroughly, dry hands with paper towel and turn faucets off with the paper towel. SUGGESTED METHOD OF CORRECTION:	21390		

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21390	Continued From page 27 The Director of Nursing or designee could assure policy and procedures are up to date, clear directions for staff to follow regarding infection control practices, specific to hand washing when providing cares to residents to minimize the spread of infection. The Director of nursing or designee could assure staff are trained, randomly monitored, supervised and systems evaluated to assure good infection control practice. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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21426	Continued From page 28 This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to update the tuberculosis (TB) risk assessment plan, failed to complete accurate baseline TB screenings for 1 of 5 employees registered nurse (RN-A) and for 2 of 5 residents (R105 and R000) reviewed according to the recommendations from the Centers for Disease Control (CDC). 1 of 1 employee (E1) had a chest X Ray without complete Medical evaluation interpreted for TB. 1 of 1 R105 did not receive the TB Mantoux until 3 days after admission. This practice had the potential to affect all 53 residents who resided in the facility. Findings Include: Document review of the facility policy titled, Facility Tuberculosis (TB) Risk Assessment Plan dated 2015, with data used in 2014, indicated the facility was identified at medium risk for TB exposure and the health care settings were to complete the risk assessment annually. During an interview with the director of nursing (DON) on 6/10/16, at 11:00 a.m. verified the facility risk assessment was completed sometime in 2015 by the former DON and the exact date is not known. Furthermore, the DON verified completing the risk assessment now for June 2016 and verified the facility is to complete a risk assessment yearly. Document review of the facility symptom screening policy dated July 2013, and titled, Regulations for Tuberculosis Control in Minnesota Health Care Settings, indicated all employees and residents were to have a symptom screening	21426		

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21426	Continued From page 29 completed upon admission and upon hire. RN-A was hired 4/26/16, and did not have a Symptom Screening in the employee file. When interviewed on 6/10/16 at 9:30 a.m. RN-A verified a Symptom screening was not completed upon hire. Document review of R000 admission documents since admission of 5/31/16, and R105, admission documents since admission of 6/4/16, a Symptom Screening could not be located. When interviewed on 6/10/16, at with the health unit coordinator (HUC) verified a symptom screening could not be located for R000 or R105. Health care worker E1 was hired 5/17/16, and identified as a newly-identified positive TST requiring a chest X Ray completed 1/26/16. The form was completed by a DC (Doctor of Chiropractics) and the Impression read, "Negative chest study. No evidence of acute pulmonary disease or skeletal abnormality." According to the policy dated July 2013, Medical evaluation is to rule out a diagnosis of infectious TB disease in other organs of the body. E1 did not receive a medical evaluation to rule out a diagnosis of infectious TB disease R105 was admitted to the facility on 6/4/16, and was not offered the first step Mantoux until 6/8/16, at which time the resident refused but there was no documentation of any training due to the refusal. Furthermore there was not a reapproach attempt to administer the Mantoux. During an interview with the director of nursing (DON) on 6/10/16, at 10:00 a.m. regarding the tuberculosis policies and procedures, the DON	21426		

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21426	Continued From page 30 verified the follow up needed to be enhanced. SUGGESTED METHOD OF CORRECTION: The DON or designee could conduct resident screening audits, interventions and monitoring to ensure residents are free from communicable disease. The DON or designee could ensure the staff were educated on the importance of chest X Ray without complete Medical evaluation interpreted, induration and interpretation of tuberculin skin testing. The DON or designee could randomly audit resident's documents to ensure adequate documentation for induration. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify	21830		

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either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the

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patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure resident preferences was accommodated for bathing/shower for 1 of 3 resident (R32) reviewed for choices in daily routine.

Findings include:

R32 was interviewed on 6/6/16, at 7:09 p.m. and

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responded "no choice" regarding how many times she bathed or showered during a week. R32 added, "I did not have a shower for two weeks now and I am supposed to have shower twice a week. No one comes to ask me and I did not ask them either."

On 6/9/16 at 8:57 a.m. R32 was lying in bed, when approached by surveyor, R32 explained her preference was to take two showers per week as staff told her and posted a noted on her bedside stand that reads, "Maxine's shower Thursdays A.M. Sunday P.M." which was confirmed by surveyor when R32 pointed to the note. Further indicated, staff gave her shower yesterday even though she does not normally take shower on Wednesday but she took it because, "I have not had a shower for two weeks". R32 further stated, "I will take another one today if they want to give me another one today. I will be glad if they ask me and give me shower at least two times a week."

R32's diagnoses included multiple sclerosis, anxiety disorder, Diabetes mellitus II, major depression, and abnormalities of gait and mobility obtained from Admission Record dated 6/30/14.

R32's Activities of Daily Living (ADL) CAA dated 10/1/15, indicated, "Has assist needs with bed mobility, transfers, dressing, toileting, hygiene and bathing secondary to weakness with dx (diagnosis) of MS (multiple sclerosis), seizures disorder, anemia ...".

R32's 30 day Minimum Data Set (MDS) dated 3/27/16, indicated R32 had had intact cognition with Brief Interview for Mental Status (BIMS) score of 15.

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21830	Continued From page 34 Nursing note dated 6/6/16, read, "Client requesting okay for shower and hair wash one week... Lacerations. Sutured put in..." however nursing notes lacked evidence that R32 refuses shower/bath in the last three weeks (5/6/16-6/8/16). The treatment administration record (TAR) dated May 23, 2016 thru June 8, 2016, indicated, "Weekly skin assessment: Complete on bath day, (+) new area of skin impairment ... (-) no new area of skin". However it was left blank. Care tracker indicated that resident showered only once dated 5/31/16 between the dates of 5/26/16-6/7/16. On 6/9/16 at 11:26 a.m. the director of nursing (DON) explained that the expectation is staff need to document what they are doing regarding showers and if a resident refuses, the nurse should be notified and written on the 24 hour board. DON further explained, "The nurses need to chart about it and let me know and document the refusal." SUGGESTED METHOD OF CORRECTION: The director of nursing and social worker could review and revise policies and procedures to ensure residents were offered choices for bathing. The social worker or administrator could in-service all employees to offer residents choices. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		

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21880	Continued From page 35	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		

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21880	Continued From page 36 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that prompt efforts were made by the facility to ensure resident rights to voice grievances without reprisal affecting 2 of 3 residents (R3, R81) in the sample who filed a grievance. Findings include: R3 filed 3 concerns with the facility of improper treatment. R3 was assessed as cognitively intact according to the minimum data set (MDS) quarterly review 3/25/16. R3 was interviewed on 6/7/16, at 10:33 a.m. and reported grave concern about nursing assistant (NA-B) who was "abusive" to R3 several months ago. R3 expressed "fear and retaliation" from NA-B and that the facility did not take the concern seriously. R3 further stated, "My heart ached after [NA-B] did what [NA-B] did." R3 expressed not feeling confident to go to the social service department because does not trust there will be follow up. R3 confided seeing other residents in the facility mistreated and that the residents are not taken seriously. 6/7/16, at 10:45 a.m., interview with R3's roommate (R78) regarding help from the nursing	21880		

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assistants, R78 reported that "[NA-B] plays mind games with us." R78 verified having issues with [NA-B] but that there is no one to listen to what they are saying from management in this facility.

Document review of a 4/6/16, Resident Concern Report, from R3 read, "I have had 2 incidents of retaliation from care recently. 1. I told [NA-L] not to flirt while working. In response, the next day [NA-B] took me in the bathroom, left me naked on the toilet and said, '[NA-L] life is [NA-L] life and my life is my life. I have a life at home.' 2. [NA-B] did not take me to lunch after that so by the time someone else took me my lunch was cold. [NA-B] always retaliates if complaints are made."

Although administration wrote on the investigation that the roommate and neighbors were interviewed, there was no documented information regarding the interviews. Administration changed the staff members assignment so that NA-B would not take care of R3, however, there was no documented education and/or learning report for the staff member, there was no documented statement obtained from the care givers NA-B or NA-L and there was no report filed with the State Agency pending investigation.

On 6/9/16, at 3:00 p.m. administration reviewed the Resident Concern Report from 3/15/16, and at this time, filed a report to the State Agency. NA-B was suspended pending investigation.

Document review of the 3/15/16, Resident Concern Report, written by R3 read, "On Sunday 3/13[16] I asked [NA-A] to put me in bed bc/ (because) my legs hurt. [NA-A] said "No" bc/ it was too close to lunchtime. I said I needed to lie down bc/ my legs were bothering me a lot. [NA-A]

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21880	Continued From page 38 said [NA-A] would come back to get me for lunch but never did. My tablemate [R5] asked [NA-F]to come get me for lunch but [NA-F] refused. Eventually I started to yell for help bc/ my bed was wet, I needed to be changed. I was hungry." R81 completed a Resident Concern Report to corroborate R3's concern and wrote, "I was coming in from the outside and [R3] was screaming with [R3] call light on help me, help me. As I was coming up the hallway to get [R3] help, [licensed practical nurse (LPN-A)] got on the phone and called for east aides. [NA-A] came from somewhere in the west wing and [NA-B] came up the back stairs. There were no aides on that wing. [R3] said this went on for 20 minutes." Although the Resident Concern Report under Disposition read, "Staff educated to communicate between peers when going on break or leaving the unit. Staff educated to coordinate breaks to allow coverage/Resident cares." there was no documentation of this education. The administrator wrote, "Writer will check on resident during daily rounds to interview regarding needs being met." There was no documentation to support this intervention by the administrator. R81 completed another Resident Concern Report on 3/15/15, which read, "During the day shifts especially, it takes far too long to answer the call lights. I am entirely depending for help w/ my bathroom needs, getting up, and dressed. I cannot operate my wheelchair by myself." The disposition written by administration read, "Writer will perform call light audits every shift. Writer will monitor resident council minutes regarding call light times. Writer will round multiple times for observations. Writer will remind staff regarding call light times." During an	21880		

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21880	Continued From page 39 interview with the administrator on 6/9/16, at 3:00 p.m. verified there was no documentation to support the interventions occurred as no documentation was implemented. On 5/9/16 R3 wrote a Resident Concern Report which read, " When [NA-B] is assigned as the aide on my hall [NA-B] refuses to help me. Why is [NA-B] working here if [NA-B] can refuse to help residents? I feel as if my past complaints about [NA-B] have not been taken seriously, for example, when [NA-B] left me naked on the toilet." The investigation report completed by the administrator read, "Administrator changed assignments on the hall. Resident requested and agreed with the change on 4/6/16. [NA-B] has not worked with that resident since 4/6/16. Previous allegations 4/6/16 followed up with. Employee resident per policy and protocol. Unsubstantiated and also resident agreed with change in caregiver assignments. Writer assigned BOM BH to monitor resident well being 4/17/16 thru 4/21/16-No concern reported." A review of the facility policy dated, July 2015, titled, Concern-Resident/Family, read, "The center provides residents and their family members with an uninhibited resident/family concern procedure. The procedure is such that each and every resident and/or family has the right to express their grievance or concerns directly to the center's administration either verbally or in writing. Assure the resident and/or family that they can voice their concern without fear of discrimination or reprisal." During an interview with the administrator on 6/9/16, at 3:00 p.m. verified there was no documentation to support the interventions occurred as no documentation was implemented.	21880		

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During stage one, on 6/6/16 at 11:55 a.m., R81 approached a surveyor and asked to speak with her. R81 stated that he had a concern that one evening in recent months he had chest pain, self-medicated with nitro tablets, and asked a facility nurse to call his after-hours clinic for medical care. R81 stated he was informed later that evening that his after-hours clinic was not called, but a facility nurse had called the facility's medical director and received an order for "Oxy," and R81 refused that medication because he did not want to take opiates. R81 stated that he told facility administration about his concerns for appropriate care related to this incident but has never been told of a resolution to his concerns. R81 did not remember the date of the incident or the names of the staff involved.

When interviewed on 6/8/16, at 2:10 p.m. the director of nursing (DON) stated that this concern of R81 had been investigated.

Document review of R81's record showed no documentation of investigation of this incident.

During interview on 6/9/16, at 11:21 a.m. the DON was asked about the investigation of this incident and R81 was present. The DON was asked if there was documentation of the investigation of this incident and she stated that there was no documentation of the investigation of this incident because R81 had not been sure of the date of the incident or the staff involved. R81 then stated that there had been a meeting regarding this incident that included himself, the DON and the medical director, and R81 had been upset with the medical director at this meeting because the

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21880	Continued From page 41 medical director said at that meeting that he did not recall the incident being investigated. The DON was asked by the surveyor if there had been a meeting regarding this incident that included herself, R81, and the medical director and she confirmed that the meeting did take place--she did not recall the date, but believed that it took place in recent weeks. R81 then stated that it was true that he did not want to get the nurses involved in the incident into trouble by telling their names, but he had previously told the director of nursing that one of the nurses involved had an accent specific to a nurse at the facility. The DON confirmed that R81 had mentioned that one of the nurses involved in the incident had a particular type of accent and that a facility nurse has that type of accent. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff on the requirement to address resident concerns and make a good faith attempt to resolve the grievances. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not	21980		

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	00126	A. BUILDING: _____ B. WING _____	06/10/2016

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21980	Continued From page 42	21980		

reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause

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21980	Continued From page 43 (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment neglect and abuse were reported to the administrator immediately, reported immediately to the state agency and thoroughly investigated for 4 of 5 residents (R3, R54, R81, R5) reviewed for incidents. Findings include: R3 filed 3 concerns with the facility of improper treatment. R3 was assessed as cognitively intact according to the minimum data set (MDS) quarterly review 3/25/16. During the initial resident (R3) interview on 6/7/16, at 10:33 a.m. reported grave concern about nursing assistant (NA-B) who was abusive to R3 several months ago. R3 expressed "fear and retaliation" from NA-B and that the facility did not take the concern seriously. R3 further stated, "My heart ached after [NA-B] did what [NA-B] did." R3 doesn't feel confident to go to the social service department because does not trust there will be follow up. R3 confided seeing other residents in the facility mistreated and that the residents are not taken seriously. Interview with R3's roomate (R78) 6/7/16 at 10:45 a.m., R78 reported that "[NA-B] plays mind	21980		

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21980	Continued From page 44 games with us." R78 verified having issues with [NA-B] but that there is no one to listen to what they are saying from management in this facility. Document review of a 4/6/16, Resident Concern Report, from R3 read, "I have had 2 incidents of retaliation from care recently. 1. I told [NA-L] not to flirt while working. In response, the next day [NA-B] took me in the bathroom, left me naked on the toilet and said, '[NA-L] life is [NA-L] life and my life is my life. I have a life at home.' 2. [NA-B] did not take me to lunch after that so by the time someone else took me my lunch was cold. [NA-B] always retaliates if complaints are made." There was no evidence the administrator was immediately notifed, the State agency notified or a thorough investigation completed. Although administration wrote on the investigation report that roomate and neighbors were interviewed, documentation lacked evidence of the interview findings. The report idenfied that staff members assignments were changed so that NA-B would not take care of R3, however, there was no documented education and learning for the staff member, there was no documented statement obtained from the care givers NA-B or NA-L and there was no report filed with the state agency pending investigation. On 6/9/16, at 3:00 p.m. administration again reviewed the Resident Concern Report from 3/15/16, and at this time, filed a report to the state agency. NA-B was suspended pending investigation. R54 sustained an injury of unknown origin on 3/7/16, between 6:30 a.m. and 7:00 a.m., sustained a skin tear of unknown origin on 3/7/16,	21980		

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21980	Continued From page 45 between 11:00 a.m. and 11:30 a.m. and on 2/24/16 a 10 cm bruise was discovered on R54's right inner thigh of unknown origin that lacked a report to the administrator, state agency and an investigation. According to a document titled, Admission Record, onset date, 10/1/15, R54 was diagnosed with unspecified dementia with behavioral disturbances, contracture unspecified hand, delusional disorders, and unspecified psychosis not due to a substance or known physiological condition. R54 was assessed as severe cognitive impairment according to the minimum data set (MDS) assessment completed 2/20/16. Document review of a form titled, Witness Investigation Statement, an incident that occurred on 3/7/16, between 6:30 a.m. and 7:00 a.m. revealed R54 had a left shoulder that looked very different from the right shoulder. Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-B) read, "On the 7th of March, around 6:30 a.m. I went to [R54] room to get [R54} dressed for breakfast. After shaving [R54}, I realize that [R54] left shoulder looked different, so I called the nurse (registered nurse RN-G) to pls (please) come to [R54] room to check [R54] out." Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-A) read, "I didn't see it but I was told by my co-worker that [NA-B] went to dress the resident for [R54's] morning meal and notice that resident shoulder wasn't right so [NA-B] immediately informed the charge nurse to come and accessed	21980		

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21980	Continued From page 46 the shoulder." Document review of a form titled, Witness Investigation Statement, from RN-G, dated 3/8/16, from an incident that occurred 3/7/16 read, "Nurse called to residents room in AM to see residents shoulder. Upon assessment left shoulder seem different, but I wasn't sure why." There was no documented evidence that the administrator was informed immediately and no documented evidence that the injury of unknown origin was reported to the state agency. Document review of the form titled, Progress notes, dated 3/7/16, at 7:30 a.m. read, "Nurse was called to dining area this am, Resident was observed to be bleeding from an open area on right hand. [family member F-B] was contacted and informed about skin tear via phone. NP on site updated, nurse manager updated." Documentaion lacked evidence that the administrator was informed immediately regarding the injury of unknown origin and that the state agency was notified. When interviewed on 6/9/16, at 2:00 p.m. the administrator verified not being informed immediately of the injuries of unknown origin that occurred 3/7/16. Review of a Resident Concern Report indicated the administrator was notified 3/8/16 of R54's shoulder injury of unknown origin and the state agency was contacted 3/8/16, at 12:30 p.m., according to the form titled Confirmation of submitting an Incident report to MDH. Review of 54's progress notes also identified that on, "2/24/16, Observed a 10 cm (centimeter) faded yellow bruise upper inner Rt (right) thigh-unknown etiology- 0 (no) s/s	21980		

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21980	Continued From page 47 (signs/symptoms) of discomfort. A or 2- {sic} turned on rounds. [signed by RN-G]. There was no evidence that the injury of unknown origin was immediately called to the administrator, reported to the state agency and investigated thoroughly. On 3/14/16, at 11:36 a.m. the adminisrator was interviewed and unable to provide an investigation and subsequent report for this bruise to the upper inner right thigh of unknown etiology. Document review of the facility July 2015, Abuse Policy addressed, Injuries of Unknown Source and read, "Classify as an "injury of unknown source" when both of the following conditions are met. The source of the injury was not observed by any person or the resident could not explain the source of the injury. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time, or the incidence of injuries over time." R81, on 6/6/16 at 11:55 a.m., approached a surveyor and reported an allegation of neglect regarding a concern that one evening in recent months he had chest pain, self-medicated with nitro tablets, and asked a facility nurse to call his after-hours clinic for medical care. R81 stated he was informed later that evening that his after-hours clinic was not called, but a facility nurse had called the facility's medical director and received an order for "Oxy," and R81 refused that medication because he did not want to take opiates. R81 stated that he told facility administration about his concerns for appropriate care related to this incident but has never been told of a resolution to the concerns. R81 did not	21980		

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21980	Continued From page 48 remember the date of the incident or the names of the staff involved. When interviewed on 6/8/16, at 2:10 p.m. the director of nursing (DON) stated that this concern of R81 had been investigated. Document review of R81's record showed no documentation of investigation of this incident. During interview on 6/9/16, at 11:21 a.m. the DON was asked about the investigation of this incident and R81 was present. The DON was asked if there was documentation of the investigation of this incident and she stated that there was no documentation of the investigation of this incident because R81 had not been sure of the date of the incident or the staff involved. R81 then stated that there had been a meeting regarding this incident that included himself, the DON and the medical director, and R81 had been upset with the medical director at this meeting because the medical director said at that meeting that he did not recall the incident being investigated. The DON was asked by the surveyor if there had been a meeting regarding this incident that included herself, R81, and the medical director and she confirmed that the meeting did take place--she did not recall the date, but believed that it took place in recent weeks. R81 then stated that it was true that he did not want to get the nurses involved in the incident into trouble by telling their names, but he had previously told the director of nursing that one of the nurses involved had an accent specific to a nurse at the facility. The DON confirmed that R81 had mentioned that one of the nurses involved in the incident had a particular type of accent and that a facility nurse has that type of accent.	21980		

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21980	Continued From page 49 R5's quarterly Minimum Data Set (MDS) dated 12/31/15, revealed R5 was cognitively intact. R5 had an allegation of verbal abuse and the facility failed to follow their policy regarding the allegation of abuse. During the initial resident interview on 6/7/16, at 11:33 a.m. R5 expressed a verbal abuse concern with nursing assistant (NA)-B. R5 stated NA-B will "ball her out", tells R5 who to talk to and who R5 should stay away from. RN-B will also tell R5 she should eat. R5 indicated she feels NA-B acts like her boss and is very demanding. On 6/8/16, at 9:18 a.m. R5 stated NA-B was working today in the east hallway and indicated NA-B had not bothered her today. R5 indicated she talks to the social service director (SSD), but doesn't feel SSD is much help and used to be more helpful. On 6/8/16, at 11:36 a.m. SSD stated R5 had mostly complained about other residents, was not aware of any complaints with nursing assistants. On 6/10/16, at 9:20 a.m. R5 stated when R38 came into her room offering pizza last night R5 told R38 she did not want any. Then NA-B came into room balling R5 out and told R5 not to talk to R38. On 6/10/16, at 9:22 a.m. R5 stated when incident occurred with NA-B approximately three months ago, R5 reported it to the Administrator and director of nursing (DON) and was informed they would take care of it right away, yet R5 felt nothing was done.	21980		

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21980	Continued From page 50 On 6/10/16, at 9:44 a.m. nursing assistant (NA)-E stated she recalled NA-B would remind R5 to take her medications. NA-E indicated R5 feels like NA-B makes her take medications, but R5 will state knows she needs to take them. NA-E further indicated NA-B tells R5 to eat and will remind R5 so her blood sugar doesn't get too low. On 6/10/16, at 11:02 a.m. DON stated she was not aware of any issues between R5 and NA-B. On 6/10/16, at 11:08 a.m. when interviewed, the administrator stated he was informed about an incident between R5 and NA-B, but R5 wanted to retract statements because they were influenced by R81. The administrator stated R5 had not reported any other problems with NA-B. Review of facility's resident concern report dated 11/6/15, indicated R5 was uncomfortable with NA-B around and talk was intimidating. Resolution and disposition indicated NA-B was "advised to always have another staff member present when interacting with R5." Review of facility's resident concern report dated 3/20/16, indicated NA-B was advised regarding approach and suggestion made to switch residents for a period of time and would monitor satisfaction on daily rounds and caring partners QA. NA-B's assignments were changed when possible in best interest of all parties and behaviors. Review of facility policy dated July 2015 and titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, revealed "Verbal abuse is oral, written, or gestured language that includes	21980		

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21980	Continued From page 51 disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability." "Mental/Emotional Abuse Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to abuse prohibition. Responsible personnel could be re-educated on these policies and procedures. Reports of abuse/ neglect/ injuries of unknown origin could be reviewed for compliance with these policies, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting	21995		

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21995	Continued From page 52 internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment, neglect and abuse were reported to the administrator immediately, reported to the state agency and thoroughly investigated for 4 of 5 residents (R3, R54, R81, R5) reviewed for incidents. Findings include: Document review of the facility policy dated, July 2015, and titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries of Unknown Source, and Misappropriation of Resident Property, read, "The center requires centers to report these alleged violations to the Executive Director and DON/designee immediately. "Immediately" means as soon as possible but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirements. Prevention 1. Ensure implementation of prevention techniques in the center including, but not limited to: Ongoing supervision of residents and staff. Observation of care delivery. Observation and recognition of signs of staff burnout. Observation and recognition of signs of resident to resident and/or resideent -to-staff frustration of stress. Document review of the policy dated July 2015, titled, Investigation Protocol, in Summary directed staff to meet with the complaining party. Interview	21995		

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21995	Continued From page 53	21995		

and take notes, Plan the investigation. Review accused employee's file.Interview the accused employee. Listen carefully and take notes on the Who, What, When, Where, Why and How needed to establish facts of the situation. Review all of the interviews and supporting information. Complete an investigation summary and make recommendations. Follow up with the complaining party and if necessary any reporting agencies.

Document review of the facility July 2015, Abuse Policy addresses, Injuries of Unknown Source and read, "Classify as an "injury of unknown source" when both of the following conditions are met. The source of the injury was not observed by any person or the resident could not explain the source of the injury. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time, or the incidence of injuries over time."

R3 filed 3 concerns with the facility of improper treament.

R3 was assessed as cognitively intact according to the minimum data set (MDS) quarterly review 3/25/16.

During the initial resident (R3) interview on 6/7/16, at 10:33 a.m. revealed grave concern about nursing assistant (NA-B) who was abusive to R3 several months ago. R3 expressed "fear and retaliation" from NA-B and that the facility did not take the concern seriously. R3 further stated, "My heart ached after [NA-B] did what [NA-B] did." R3 doesn't feel confident to go to the social service department because does not trust there will be follow up. R3 confided seeing other

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21995	Continued From page 54	21995		

residents in the facility mistreated and that the residents are not taken seriously.

R3's roomate (R78) was interviewed 6/7/16 at 10:45 a.m., and reported that "[NA-B] plays mind games with us." R78 verified having issues with [NA-B] but that there is no one to listen to what they are saying from management in this facility.

Document review of a 4/6/16, Resident Concern Report, from R3 read, "I have had 2 incidents of retaliation from care recently. 1. I told [NA-L] not to flirt while working. In response, the next day [NA-B] took me in the bathroom, left me naked on the toilet and said, '[NA-L] life is [NA-L] life and my life is my life. I have a life at home.' 2. [NA-B] did not take me to lunch after that so by the time someone else took me my lunch was cold. [NA-B] always retaliates if complaints are made."

Although administration wrote on the investigation roomate and neighbors were interviewed, the information lacked evidence of the interview findings. Although administration changed the staff members assignment so that NA-B would not take care of R3, there was no documented education and learning for the staff member, there was no documented statement obtained from the care givers NA-B or NA-L . There was no evidence that the administrator was informed immediately, reported to the State agency and that a thorough investigation occurred.

On 6/9/16, at 3:00 p.m. administration again reviewed the Resident Concern Report from 3/15/16, and at this time, filed a report to the State Agency. NA-B was suspended pending investigation.

R54 sustained an injury of unknown origin on

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21995	Continued From page 55 3/7/16, between 6:30 a.m. and 7:00 a.m., sustained a skin tear of unknown origin on 3/7/16, between 11:00 a.m. and 11:30 a.m. and on 2/24/16 a 10 cm bruise was discovered on R54's right inner thigh of unknown origin that lacked immediate notification to the administrator, a report to the state agency and a thorough investigation. According to a document titled, Admission Record, onset date, 10/1/15, R54 was diagnosed with unspecified dementia with behavioral disturbances, contracture unspecified hand, delusional disorders, and unspecified psychosis not due to a substance or known physiological condition. R54 was assessed as severe cognitive impairment according to the minimum data set (MDS) assessment completed 2/20/16. Document review of form titled, Witness Investigation Statement, on 3/7/16, between 6:30 a.m. and 7:00 a.m. R54 had a left shoulder that looked very different from the right shoulder. Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-B) read, "On the 7th of March, around 6:30 a.m. I went to [R54] room to get [R54} dressed for breakfast. After shaving [R54}, I realize that [R54] left shoulder looked different, so I called the nurse (registered nurse RN-G) to pls (please) come to [R54] room to check [R54] out." Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-A) read, "I didn't see it but I was told by my coworker that [NA-B] went to dress the resident for [R54's] morning meal and notice that resident	21995		

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21995	Continued From page 56 shoulder wasn't right so [NA-B] immediately informed the charge nurse to come and accessed the shoulder." Document review of a form titled, Witness Investigation Statement, from RN-G read, "Nurse called to residents room in AM to see residents shoulder. Upon assessment left shoulder seem different, but I wasn't sure why." There was no documented evidence that the administrator was informed immediately and no documented evidence that the injury of unknown origin was reported to the state agency. Document review of the form titled, Progress notes, dated 3/7/16, at 7:30 a.m. read, "Nurse was called to dining area this am, Resident was observed to be bleeding from an open area on right hand. [F-B] was contacted and informed about skin tear via phone. NP on site updated, nurse manager updated." Documentaion lacked evidence that the administrator was informed immediately regarding the injury of unknown origin and that the state agency was notified. When interviewed on 6/9/16, at 2:00 p.m. the administrator verified not being informed immediately of the injuries of unknown origin that occurred 3/7/16. Review of a Resident Concern Report indicated the administrator was notified 3/8/16 of R54's shoulder injury of unknown origin and the state agency was contacted 3/8/16, at 12:30 p.m., according to the form titled Confirmation of submitting a Incident report to MDH. Review of 54's progress notes also identified that on, "2/24/16, Observed a 10 cm (centimeter) faded yellow bruise upper inner Rt (right) thigh-unknown etiology- 0 (no) s/s	21995		

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21995	Continued From page 57 (signs/symptoms) of discomfort. A or 2- {sic} turned on rounds. [signed by RN-G]. There was no evidence that the injury of unknown origin was immediately called to the administrator, reported to the state agency and investigated thoroughly. On 3/14/16, at 11:36 a.m. the adminisrator was interviewed and unable to provide an investigation and subsequent report for this bruise to the upper inner right thigh of unknown etiology. Document review of the facility July 2015, Abuse Policy addressed, Injuries of Unknown Source and read, "Classify as an "injury of unknown source" when both of the following conditions are met. The source of the injury was not observed by any person or the resident could not explain the source of the injury. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time, or the incidence of injuries over time." R81, 6/6/16 at 11:55 a.m., approached a surveyor and reported an allegation of neglect, explaining that he had asked the nurse to call the clinic when he had chest pain. R81 reported having a concern that one evening in recent months he had chest pain, self-medicated with nitro tablets, and asked a facility nurse to call his after-hours clinic for medical care. R81 stated he was informed later that evening that his after-hours clinic was not called, but a facility nurse had called the facility's medical director and received an order for "Oxy," and R81 refused that medication because he did not want to take opiates. R81 stated that he told facility administration about his concerns for appropriate care related to this incident but has never been	21995		

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21995	Continued From page 58 told of a resolution to his concerns. When interviewed on 6/8/16, at 2:10 p.m. the director of nursing (DON) stated that this concern of R81 had been investigated. Document review of R81's record showed no documentation of investigation of this incident. During interview on 6/9/16, at 11:21 a.m. the DON was asked about the investigation of this incident and R81 was present. The DON was asked if there was documentation of the investigation of this incident and she stated that there was no documentation of the investigation of this incident because R81 had not been sure of the date of the incident or the staff involved. R81 then stated that there had been a meeting regarding this incident that included himself, the DON and the medical director, and R81 had been upset with the medical director at this meeting because the medical director said at that meeting that he did not recall the incident being investigated. The DON was asked by the surveyor if there had been a meeting regarding this incident that included herself, R81, and the medical director and she confirmed that the meeting did take place--she did not recall the date, but believed that it took place in recent weeks. R81 then stated that it was true that he did not want to get the nurses involved in the incident into trouble by telling their names, but he had previously told the director of nursing that one of the nurses involved had an accent specific to a nurse at the facility. The DON confirmed that R81 had mentioned that one of the nurses involved in the incident had a particular type of accent and that a facility nurse has that type of accent.	21995		

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21995	Continued From page 59 Review of R5's quarterly Minimum Data Set (MDS) dated 12/31/15, revealed R5 was cognitively intact. R5 had an allegation of verbal abuse and the facility failed to follow their policy regarding an allegation of abuse. Review of facility policy dated July 2015 and titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, revealed "Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability." "Mental/Emotional Abuse Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation." During the initial resident interview on 6/7/16, at 11:33 a.m. R5 expressed a verbal abuse concern with nursing assistant (NA)-B. R5 stated NA-B will "ball her out", tells R5 who to talk to and who R5 should stay away from. RN-B will also tell R5 she should eat. R5 indicated she feels NA-B acts like her boss and is very demanding. On 6/8/16, at 9:18 a.m. R5 stated NA-B was working today in the east hallway and indicated NA-B had not bothered her today. R5 indicated she talks to the social service director (SSD), but doesn't feel SSD is much help and used to be more helpful. On 6/8/16, at 11:36 a.m. SSD stated R5 had	21995		

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21995	Continued From page 60 mostly complained about other residents, was not aware of any complaints with nursing assistants. On 6/10/16, at 9:20 a.m. R5 stated when R38 came into her room offering pizza last night R5 told R38 she did not want any. Then NA-B came into room balling R5 out and told R5 not to talk to R38. On 6/10/16, at 9:22 a.m. R5 stated when incident occurred with NA-B approximately three months ago, R5 reported it to the Administrator and director of nursing (DON) and was informed they would take care of it right away, yet R5 felt nothing was done. On 6/10/16, at 9:44 a.m. nursing assistant (NA)-E stated she recalled NA-B would remind R5 to take her medications. NA-E indicated R5 feels like NA-B makes her take medications, but R5 will state knows she needs to take them. NA-E further indicated NA-B tells R5 to eat and will remind R5 so her blood sugar doesn't get too low. On 6/10/16, at 11:02 a.m. DON stated she was not aware of any issues between R5 and NA-B. On 6/10/16, at 11:08 a.m. when interviewed, the administrator stated he was informed about an incident between R5 and NA-B, but R5 wanted to retract statements because they were influenced by R81. The administrator stated R5 had not reported any other problems with NA-B. Review of facility's resident concern report dated 11/6/15, indicated R5 was uncomfortable with NA-B around and talk was intimidating. Resolution and disposition indicated NA-B was "advised to always have another staff member present when interacting with R5."	21995		

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21995	Continued From page 61 Review of facility's resident concern report dated 3/20/16, indicated NA-B was advised regarding approach and suggestion made to switch residents for a period of time and would monitor satisfaction on daily rounds and caring partners QA. NA-B's assignments were changed when possible in best interest of all parties and behaviors. SUGGESTED METHOD OF CORRECTION: The facility could assure that all allegations of potential abuse are thoroughly investigated and immediately reported to the state agency and that residents are protected from potential retaliation while an investigation is pending. The Administrator, director of nursing and/or designee could assure policies are reviewed, up to date, implemented and that staff training has been completed. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		