Minnesota Department of Health

Protecting, Maintaining and Improving the Health of Minnesotans

CERTIFIED MAIL 7010 1670 0000 8044 3755

January 26, 2016

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

Re: Stewartville Care Center Independent Informal Dispute Resolution
Provider # 245349
Project # S5349025

Dear Mr. Gustason:

In a request dated July 15, 2015, Stewartville Care Center requested removal of deficiencies cited at F223, F225, F226, F490 and F493 as a result of a certification survey completed on June 17, 2015 by the Licensing and Certification program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated December 18, 2015. The revised CMS 2567 is enclosed.

Also, corresponding State licensing orders cited at have been reviewed and revised. The revised Minnesota Department of Health order form is enclosed.

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

Sincerely,

Holly Kranz

CC: Office of Ombudsman for Long-Term Care
Mary Absolon, Program Manager
Maria King, Assistant Program Manager
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Minnesota Department of Health on June 8, 9, 10, 11, 12, 13, 15, 16 & 17, 2015. The survey resulted in an Immediate Jeopardy (IJ) at F223 and F225 related to the facility's failure to comprehensively assess, investigate, report allegations of abuse immediately to the administrator and state agency and then implement interventions to ensure residents were free from abuse which resulted in the high potential for harm or death. Facility staff were notified of the IJ on June 12, 2015 at 3:00 p.m. The IJ was removed on June 16, 2015 at 2:40 p.m., however non-compliance remained at a scope and severity of isolated with actual harm that is not immediate jeopardy. An extended survey was conducted by the Minnesota Department of Health on June 12, 13, 15, 16 & 17, 2015. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		7/16/15

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

Electronically Signed | 07/17/2015

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F 166	Continued From page 1 A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident grievances were resolved promptly for 4 of 4 residents (R53, R46, R7 & R66) who expressed a grievance to the facility staff. Findings include: During an interview with R53 on 6/8/15, at 6:05 p.m. R53 reported her roommate hollers all night long. R53 stated, "She sleeps all day, hollers all night. I've told all the nurses. Nothing gets done. I've asked if they can give her a private room, but nothing happens. They try different stuff, it doesn't work. She keeps me up all night. They don't do anything for me." Documentation in R53's medical record dated 5/3/15, at 1:39 a.m. indicated R53 had reported, "can't sleep with her hollering." Another note from 5/3/15 at 1:46 a.m. indicated, "message left on ss [social services] telephone in regards to that incident." On 5/3/15 at 5:13 a.m. a nurse's note entry included, "asked her [R53] what she was doing over by [R30's] bed during the night and she states she was giving her a stuffed animal to hold so she wouldn't holler" R53's quarterly Minimum Data Set (MDS) dated 3/18/15, identified intact cognition with no behavioral or communication issues.	F 166	Stewartville Care Center staff respects the residents¿ right to autonomy and choice and protects and promotes the residents¿ legal rights as well as their right to privacy and a dignified existence. The staff encourage the residents to voice concerns about care and/or services and respect their right to have prompt staff attention to help resolve grievances including concerns about the behavior of other residents. The policies and procedures for responding to residents¿ grievances were reviewed and found appropriate. After receiving a complaint/grievance, the facility seeks a resolution in a timely manner and keeps the resident appropriately apprised of the progress toward resolution. The residents/families are asked about care concerns during the quarterly interdisciplinary care conferences. The grievance reporting procedure is explained to the resident at the time of admission and grievance forms are provided in the admission packets. Grievance forms are also available at the nursing desks and first floor reception area. Concerns expressed orally or using	

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F 166	Continued From page 2 During an interview with R46 on 6/9/15, at 09:23 a.m. R46 state, "at different times someone hollers. It keeps me up at night." An entry in R46's medical record dated 5/16/15, at 4:43 a.m. included, "States she can't sleep during the night because her roommate keeps her awake which usually sets off the alarm and that makes her nervous... Message left for SS." R46's annual Minimum Data Set (MDS) dated 4/29/15, indicated the resident had intact cognition with no behavioral or communication issues. During an interview with R7 on 6/8/15, at 6:36 p.m. R7 stated, "we have a person (R30) next door that yells before she goes to bed." During an interview with R7 on 6/11/15, at 3:40 p.m. R7 said she had complained to the director of nursing (DON) about the noise R30 made at night, so the DON had moved R30 to another room, "but she is now in the room next to me." R7's annual MDS dated 3/31/15, identified R7 had intact cognition with no behavioral or communication issues. During an interview with R66 on 6/8/15, at 06:44 p.m. R66 said, "It is noisy because another lady is yelling for help a lot at night." R66's quarterly MDS dated 4/22/15, identified the resident was cognitively intact with no behavioral or communication issues. During an interview with nursing assistant (NA)-D	F 166	the comment form is reviewed by the social worker and addressed in a timely manner. Residents¿ grievances and concerns are routinely reviewed during the shift-to-shift reports, quarterly care conferences, and the Quality Assessment and Assurance Committee meetings. During the mandatory meetings July 14, 15 and 16, 2015, the staffs were reminded of the residents¿ right to report grievances and care concerns and their responsibility to respond appropriately and in a timely manner. Discussion will include the residents¿ right to have 1) customary routines respected and accommodated to fullest extent possible and 2) a quiet environment that promotes restful sleep. The staff were reminded of the procedures to alert the social worker and other appropriate staff of their concerns/observations and the concerns expressed by the residents/families. Residents¿ rights are reviewed with the staff annually and are included as part of new employee orientation. Satisfaction with cares and services will continue to be discussed during each resident¿s care conference and more often as necessary. Residents will be asked about their satisfaction with noise levels during the night during the next three resident council meetings. The record of resident number 30 was reviewed; there was no recent documentation of incidences of night time	

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F 166	Continued From page 3 on 6/11/15 at 2:32 p.m., NA-D said, "I have heard [R30] yells a lot at night from the night staff." During an interview on 6/11/15, at 2:41 p.m. licensed practical nurse (LPN)-J said, "(R30) has a problem yelling and cries at night. The staff will try to medicate her and sit with her. This happens at least a couple times a week. Her roommate has said she (R30) has kept her up all night. Everybody is aware of it, social services (SS), the director of nursing (DON). I don't know why we can't fix it." During an interview with LPN-K on 6/12/15 at 9:55 a.m., LPN-K stated, "(R30) slept last night but it has been a problem with her yelling in the night. She cries out at night or at least makes noise, about 1-2 times a week. SS and the DON know about it but it is a difficult issue to resolve." During an interview with SS-A on 6/11/15 at 2:56 p.m., SS-A stated, "I don't have any written grievances for the past six months. I have heard about (R30) crying out but I have not gotten a grievance form about it. Everyone is given a grievance form on admission. We do not remind residents to use the grievance form. The staff try to get to her (R30) as fast as they can but she still hollers and cries out." During an interview on 6/11/15 at 5:24 p.m., the DON said he was not aware [R30] was keeping people awake at night but acknowledged, "I was aware of the daytime noises." The DON stated he knew the grievance process needed to be "repaired." An undated facility policy entitled, Filing Grievances/Complaints indicated: "Grievances	F 166	yelling. The Assistant Director of Nursing will meet with the nurses on the night staff to discuss the past behavior of resident number 30 disturbing the sleep of near by residents. The resident will be reassessed for symptoms of pain and her sleep habits will be monitored and documented for nightly for 14 nights. If there are continued incidences of yelling, the interdisciplinary team will meet to assess the resident¿s behavior and discuss further interventions to promote a restful environment; the resident¿s attending physician/nurse practitioner will be notified of behavior symptoms adversely impacting other residents. Resident number 53 - The staff have been informed of the resident¿s concern regarding the sleep disturbing behavior of resident number 30. The staff will monitor the night time behavior patterns of resident number 30 and implement interventions to minimize the disturbance of near by residents. The social worker will interview the resident at least weekly for three weeks to determine whether there are ongoing concerns regarding the night time noise levels. If concerns are voiced, additional monitoring will be done and alternative interventions attempted/implemented. Resident number 46 - The staff have been informed of the resident¿s concern regarding the sleep disturbing behavior of resident number 30 and the safety alarms used by her roommate. The staff will monitor the night time behavior patterns of	

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F 166	Continued From page 4 and/or complaints may be submitted orally or in writing...the administrator has delegated the responsibility of grievance and/or complaint investigation to Social Services. Upon receipt of a grievance and/or complaint, Social Services will investigate the allegation and submit a written report of such finding to the administrator within (5) working days of receiving the grievance and/or complaint.	F 166	resident number 30 and the use her roommate¿s safety alarms. The social worker will interview the resident at least weekly for three weeks to determine whether there are ongoing concerns regarding the night time noise levels. Interventions to minimize the noise levels will be discussed/implemented and the resident¿s ongoing satisfaction with the staff responses to concerns will be addressed as necessary. The resident was visited by the social worker July 14, 2015 and she expressed interest in moving to a different room. She is ¿content and agreeable¿ with the plan to be offered the first window beds that become available. Resident number 7 - The staff have been informed of the resident¿s concern regarding the sleep disturbing behavior of resident number 30. When questioned during her care conference July 14, 2015, the resident stated that the behaviors of resident number 30 were not disturbing her sleep. The social worker will interview the resident at least weekly for three weeks to determine whether there are ongoing concerns regarding the night time noise levels. If concerns are voiced, additional monitoring will be done and alternative interventions attempted/implemented. Resident number 66 - The staff have been informed of the resident¿s concern regarding the sleep disturbing behavior of resident number 30. The staff will monitor the night time behavior patterns of	

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F 166	Continued From page 5	F 166	resident number 30 and implement interventions to minimize the disturbance of near by residents. The resident resides across and down the hall from resident number 30 and has a very severe hearing deficit when not wearing her hearing aides which she removes at night. The social worker will interview the resident at least weekly for three weeks to determined whether there are ongoing concerns regarding the night time noise levels. If concerns are voiced, additional monitoring will be done and alternative interventions attempted/implemented. The night nurses will document the behaviors of resident number 30 nightly for 14 nights; the data will be assessed to determine whether additional interventions are necessary to address night time behaviors. The Social Worker will monitor resident satisfaction with a restful sleep environment during one-to-one visits, care conferences, and resident council meetings for the next 90 days and randomly thereafter.	
F 223 SS=K	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223		6/17/15

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F 223	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R75 and R65) reviewed for abuse, were free from verbal and physical abuse by staff. Although facility staff were aware of the abuse, the staff did not immediately report/intervene to prevent further abuse from occurring. The facility's failure to implement interventions to prevent continued abuse resulted in an immediate jeopardy (IJ) for R75, R65 and other residents residing on the main and lower floor levels where the alleged perpetrator worked.. The IJ began on 4/24/15, when facility staff had observed the abuse but failed to implement preventative interventions, failed to provide initial and ongoing education to staff for use of therapeutic interventions when dealing with residents with cognitive deficits, and failed to immediately report the abuse as efforts to prevent abuse from reoccurring. The director of nursing (DON) and administrator were notified of the immediate jeopardy at 3:00 p.m. on 6/12/15. The immediate jeopardy was removed on 6/16/15, but noncompliance remained at a lower scope and severity level of G, isolated scope and severity level, actual harm (bruising and swelling of R65's hand) that is not immediate jeopardy. Findings include: Although R75 was observed by staff to be yelled at by licensed practical nurse (LPN)-E on 4/24/15 following the supper meal, and LPN-E was subsequently observed to be verbally and physically abusive to R65 that same evening, the incidents were not immediately reported to the	F 223	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply with all applicable state and feral regulatory requirements and constitutes the facility¿s allegation of compliance. Stewartville Care Center policy requires that each resident be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The resident will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, or other individuals. The facility¿s policies and procedures for investigating/reporting of incidents were reviewed and found appropriate. The facility¿s Vulnerable Adult Abuse policies were distributed to all staff on June 16 and June 17, 2015. The staff were required to sign to verify that they received the information. On June 16, 2015, all Stewartville Care Center staff including management staff	

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F 223	Continued From page 7 administrator or the State agency, nor were interventions initiated to prevent further abuse. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C dated 4/25/15. The concern read, "EMPLOYEE NAME: [LPN-E's first name]..." "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." R75's quarterly minimum data set (MDS) dated 5/12/15 indicated R75 had a brief interview for mental status (BIMS) score of 4 which indicated R75 was severely cognitively impaired. The MDS also indicated R4 could hear with minimal difficulty. During an interview and observations on 6/9/15 at 9:51 a.m., R75 was observed during an interview with family (F)-A. R75 conversed with F-A and the surveyor without hearing difficulty. R75's care plan directed staff to provide, "Clear, careful, explanations to facilitate her comprehension...repeat/rephrase words as needed to facilitate hearing and comprehension." Information provided by the DON related to the investigation of these incidents, included a typed interview conducted 4/25/15 at 10:00 a.m., by the DON with NA-L. The interview documentation	F 223	were instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirements of immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies and 5) forms and procedures for appropriate and timely reporting. The staff is educated on vulnerable adult issues at least every twelve months; vulnerable adult investigation and reporting are addressed during new employee orientation. The employee (LPN-E) involved in the April 24, 2015 incidents with residents number 65 and 75 was initially suspended for three days pending an investigation of the alleged abuse. After returning to work, he was assigned to another care unit. After the June 2015 state review of the issue, the LPN-e was requested to complete a Health Professional Services Program evaluation as a condition of continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has had no further practice/performance issues. Resident number 65 ¿ The resident continues to wander throughout the first floor of the facility. She has had no recent	

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F 223	Continued From page 8 included, "Spoke to [NA-L] concerning incident Friday 4-24-15 p.m. shift. She stated he [LPN-E] was talking to [R75]. [R75] was repeating questions and as [LPN-E] was answering questions he was becoming more upset and yelling, and was probably yelling more than he should. [R65] was standing nearby with her walker but did not say anything. Stated she (NA-L) heard a little later from another CNA (certified nursing assistant) that [R65] was hitting at staff, kicking and attempting to hit them with her walker." Another typed account of these incidents had been documented by LPN-J on 4/25/15. LPN-J's account included, "On Friday 4/24/15 I was here for staff potluck, overheard loud voice of a staff member [LPN-E] addressing a resident. I did not see who it was but another staff stated it was [R75]. Went out for a smoke break after eating, when a staff member came out and said [LPN-E] had stated 'could just kill them all'. When I came back in I asked [LPN-E] if he was ok, he stated 'we had a call in for night shift', (he also said his grandson was back in the hospital.) I offered to call to see if I could get someone to come in for night shift, he said that would be great. Received page from another staff [registered nurse (RN)-H], had me come down to the breakroom and talk with [assistant director of nursing (ADON) RN-A]. Discussed issue regarding [LPN-E] and it was decided [LPN-E] would be asked to go home." According to interviews and written witness statements, following the verbal altercation with R75, LPN-E was instructed to go home. However, LPN-E continued to remain in the facility without continuous supervision or	F 223	altercations with staff; her usual resistiveness to bathing continues. The resident has severe cognitive impairments and believes that she works at the facility and is a care taker for her grandparents. She does not recall the incident from April 2015. The social worker frequently interacts with the resident as she walks by the social service office several times a day. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The care plan was reviewed and found appropriate. Resident number 75 ¿ The resident has cognitive deficits and self-propels her wheelchair around the facility. She has occasional negative interactions with other residents which require staff intervention. She does not recall the incident from April 2015. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The resident frequently visits the Social Worker¿s office work to obtain a piece of candy from the candy bowl. The care plan was reviewed and found appropriate. The Social Worker will monitor compliance by auditing incident reports for timely and appropriate notification of the administrator and government offices for the next three months. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee	

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F 223	Continued From page 9 immediate removal from resident access. LPN-E verbally and physically abused R65 after the altercation with R76. During that altercation R65 sustained an injury to her left hand. The facility's time clock records indicated LPN-E had punched out from his shift at 7:37 p.m., approximately one hour after the incident of verbal abuse with R75 had occurred. RN- H had documented a late entry progress note in R75's medical record on 4/27/15 at 19:38 (7:38 p.m.) which included, "Late entry from 4/24/15. Several staff members were in the south conference room when a staff nurse was heard raising his [LPN-E] voice towards resident. This writer came out in attempts to ascertain what the resident [R75] needed. Asked if she wanted to go to her room." The notes indicated LPN-E had stated, "she can drive herself wherever she wants to go," and had then made some comments about arguing with her. RN-H further documented, "Able to redirect the resident and diffuse the situation. DON, ADON and social services all notified of incident." LPN-E was observed on 6/9/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility. LPN-E's personnel record was reviewed. LPN-E had an active Minnesota Nursing License and had been employed at the facility since January 2015. Review of LPN-E's in-service training record indicated that LPN-E had received initial Abuse Protocol training during orientation, but had not received training on dealing with cognitively impaired residents since hire until after the incidents of alleged abuse on 4/24/15. LPN-E had completed online education related to Abuse	F 223	quarterly meeting and ongoing.	

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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Prohibition/Resident rights/Caring for the Alzheimer's client on 4/28/15.

During an interview with NA-C on 6/11/15 at 5:41 p.m., NA-C recalled the incident form 4/24/15 and stated, "I was sitting in the back nursing area, we heard [LPN-E] yelling and screaming at [R75]." NA-C then explained she had walked up the hallway near the nurse's station and was able to re-direct R75, "We started walking away with her but then she [R75] asked him [LPN-E] another question and he started yelling and screaming at her again. We were finally able to remove her from the situation." NA-C stated she could not remember what LPN-E was yelling and screaming about.

During an interview on 6/11/15 at 6:00 p.m., NA-E indicated she could not recall all of the events that had taken place the evening of 4/24/15. However, she stated she could remember she'd heard LPN-E yelling at R75. NA-E could not remember what had been said during the confrontation but stated the yelling had lasted at least 10 minutes. NA-E also stated she had never been interviewed about the incident and was not aware she could report abuse to the State agency.

During an interview on 6/12/15, at 9:30 a.m., the DON was asked to provide all information regarding the immediate reporting of the allegations of abuse between LPN-E and the residents to the administrator or State agency, and any interventions taken to protect R75 or other residents, or any investigation of the abuse incident. The DON confirmed he had not reported the allegation involving R75 to the State agency because he had been more focused on the

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F 223	Continued From page 11 physical abuse allegation between LPN-E and R65. During a follow-up interview with NA-C on 6/12/15 at 2:34 p.m., NA-C stated the yelling had started after dinner which was around 6:30 p.m. NA-C stated, "[LPN-E] was really loud, we could hear him down the hallway. We went to see what the yelling was all about, when we went up there, he was in her face yelling at her, she was sitting in the wheelchair, and I think [R75] was more confused than usual." NA-C further explained that after the incident R75 had kept repeating, "That man was yelling at me, why was he yelling at me?" until she went to bed. NA-C stated that besides the repeated question, R75 had been anxious and quiet the rest of the night until she went to bed. NA-C stated she could not recall who she'd told about the incident. The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up." A typed witness account of the physical abuse that occurred on 4/24/15, as part of the investigation for R65, had been documented on 4/25/15 by LPN-J and included: "Discussed issue regarding [LPN-E] and it was decided [LPN-E] would be asked to go home. He was finishing up a medication admin at cart when [R65] came up,	F 223		

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grabbed the water pitcher, and tried to hit him with it. He grabbed it out of her hands and set it back on cart. She then raised up her walker, as if to hit him with it, not sure if he knocked it down or she dropped it but it fell on the floor. [LPN-E] picked it up and [R65] went as if to hit him with a closed fist at which time I got between them and asked [R65] to leave the area which she did. [LPN-E] left shortly after that."

Another witness statement regarding the alleged physical abuse of R65 had been documented by RN-H on 4/25/15 and included: "I did not witness the interaction between [LPN-E] and [R65] on 4/24/15 as I was on phone [symbol for with] [RN-A]. I was informed by [LPN-J] that [R65] had gotten in [LPN-E's] face but was unaware of the fact that [LPN-E] had put his arm and hand around [R65] until 11 p.m. on 4/24/15. CNA [NA-C] is filling out an incident report stating it was reported to myself and [LPN-H]. I was made aware of this situation 4 hours [symbol for after] it had occurred by [LPN-B]. I reported incident as soon as able."

R65's quarterly MDS dated 4/28/15, indicated R65 had a BIMS score of 4 indicating severe cognitive impairment.

R65's care plan verified the resident demonstrated behavioral problems and interventions included: "She is much more receptive when she has familiar staff working with her using calm, direct approach."

Review of R65's medical record indicated a certified nurse practitioner (CNP)-D had been requested to conduct an assessment of R65 on 4/28/15. The CNP's assessment was

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F 223	Continued From page 13 documented as an "Evaluation of patient after physical assault." The documented assessment included: "Charge nurse has informed me that patient was physically assaulted by a staff nurse on April 24, 2015. According to the charge nurse, the patient had been placed in a chokehold per another eyewitness. No bruising was noted after the event. Patient had no difficulty breathing, no laryngeal edema, stridor, or tracheal deviation. Director of nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from assault. Patient has no evidence of any trauma to her neck. There is no bruising, abrasions, evidence of finger prints on her neck or shoulder area. She has some resolving bruising noted on her left hand and nurse reported that she has some mild soft tissue swelling of her left thumb after the incident which has now resolved ..." An additional entry written by CNP-D on 4/28/15 at 6:18 p.m. included, "... Charge nurse has informed me that patient [R65] had an altercation with a staff nurse on April 24, 2015. The patient was agitated and attempted to throw her water pitcher at the nurse. The nurse reached and grabbed the patient's wrist with one hand and the water pitcher with the other hand. There was some mild swelling noted on the patient's left thumb web space with a bruise occurring after the incident. Today she has some resolving bruising noted on her left hand and no further swelling of her left thumb after the incident which has now resolved. Director of Nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from the altercation. She [R65] denies all complaints of	F 223		

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pain today. Patient has no evidence of any trauma to her body with no bruising or abrasions, or change in her functional status..."

During an interview on 6/11/15, at 9:34 a.m. in regards to when he was notified of the abuse incident with R65 which occurred on 4/24/15 after evening meal, DON stated staff had placed a phone message on his home phone following the incident but he did not listen to it until the next morning (Saturday 4/25/15) at which time he had come to the facility to follow-up on the incident. The DON stated it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit any internal investigative reports to the State designated agency.

The facility provided the incident report, a submission report to the State agency (Office of Health Facility Complaints-OHFC), and all investigative notes regarding these allegations. According to the report submitted to OHFC, the allegations were not immediately reported. The allegation of physical abuse against R65 had been reported the day after it had occurred, 4/25/15. There had been no report of the allegation of verbal abuse against R75. The documentation indicated an investigative report had been submitted to the OHFC on 4/29/15. The report included LPN-E's account of the physical abuse of R65 however, it lacked other eye witness accounts of the physical abuse testimony and accounts from all of the witnesses. Despite the CNP's assessment, the investigative report indicated R65 had suffered no harm or injury. However, nurses reported swelling in the hand area that was grabbed by LPN-E during abuse altercation and CNP-D's physical and functional

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assessment completed on 4/28/15 verified there had been swelling and bruising of R65's left wrist. The investigative report also documented a personal improvement plan for LPN-E that included education re., vulnerable adult and dementia training, follow up with social worker, report to the board of nursing, and reassignment to another unit.

During an interview with the DON on 6/12/15 at 9:45 a.m., the DON stated LPN-E receiving counseling, education on dealing with difficult behaviors especially residents with dementia who might become agitated and combative. However, the DON stated the social worker who had followed-up with LPN-E after the alleged abuse incidents for R75 and R65 was no longer employed by the facility and there was no documentation as to what improvements LPN-E was working on in regards to his performance improvement, competence of handling agitated dementia related behaviors, or dealing with personal stress in a healthy manner to prevent abuse situations from redeveloping.

RN-A was interviewed on 6/12/15, at 11:57 a.m. she verified that LPN-E had received initial Abuse Protocol training during orientation, but had not received training on dealing with cognitively impaired residents since hire until after the incidents of alleged abuse on 4/24/15.
RN-A verified that following the incidents, LPN-E had been required to complete online education related to Abuse Prohibition/Resident rights/Caring for the Alzheimer's client on 4/28/15.

Following the surveyor's inquiry about the reporting of these alleged incidents of verbal/physical abuse, the DON made a report to

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F 223	Continued From page 16 the State agency (OHFC) regarding the verbal abuse R75 had sustained on 4/24/15. The report was made on 6/12/15, as part of the immediate plan of correction following the facility having been informed that an immediate jeopardy situation existed. The incident description sent to the State agency included: "During routine MDH [Minnesota Department of Health], it was brought to this writer's attention that on 4/24/15, staff LPN [LPN-E] was yelling at resident [R75]. An incident was initially reported on 4/25/15 regarding another demented resident [however, R65 was the main focus of that OHFC report and information in regards to R75 was to support the investigation of R65. During this incident [R75] was also agitated and following the nurse and not responding to re-direction. Nurse [LPN-E] did yell at resident due to his frustration with resident [R75] and her continued agitation. This writer initially combined both of these actions by the nurse [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident ..." On 6/16/15 all staff received a copy of the facility's abuse protocol packet (forms undated) from the assistant director of nursing as they reported for work. The staff were requested to read the packet of information in regards to abuse protocol. The packet included specific policies entitled: Background Screening Investigations, In-Service Training, Preventing Resident Abuse, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting/Investigating Resident Accidents/Incidents. Abuse and/or Neglect Investigation, Protection of Residents During Abuse Investigation, Report Abuse to State Agencies and Other Entities/Individuals,	F 223		

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Reporting Suspected Cases and/or Incidents of Rape, Vulnerable Adult Reporting of Alleged Misappropriation of Residents Personal Property, Investigating Unexplained Injuries, Resident-to-Resident Abuse, and reporting forms. In addition the packet of information included undated facility policies for Visitation, Quality of Life-Dignity, Employee In-Service Program, Six Keys to Resident Loyalty, Indicators of Abuse, and Indicators of Neglect.
Interviews were conducted by survey staff with direct care staff, activities staff, pool nursing staff, and supervisory nursing from day and evening shifts on 6/16/15 between 2:20 p.m. and 2:40 p.m. to verify receipt of education prior to starting their shifts. Each staff person interviewed verified they had received a packet of information and were in the process of reading it as detailed in the facility's IJ removal plan.

RN-A was interviewed on 6/16/17 at 2:45 p.m.. RN-A stated all staff were provided training as described as they reported to work.

Facility policies related to Abuse Prohibition were reviewed. An undated policy entitled Reporting/Investigating Resident Accidents/Incidents included: "All accidents/incidents involving residents must be reported to the director of nursing services and immediately to the administrator...All accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing."

An undated policy entitled Abuse and/or Neglect Investigation included: "All reports of resident abuse or neglect shall be promptly and thoroughly

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F 223	Continued From page 18 investigated." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies." The immediate jeopardy that began on 4/24/15, was removed on 6/16/15 when it could be determined the facility had operationalized their plan for removal in regards to educating all staff as they reported to work regarding the facility's policies related to abuse, neglect, maltreatment and reporting prior to allowing staff to work with residents. In addition, montioring systems had been developed and initiated to ensure continued complaince with facility protocols. However, non-compliance remained.	F 223		
F 225 SS=K	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,	F 225		6/17/15

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F 225	Continued From page 19 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and 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 observation, interview and document review, the facility failed to immediately report allegations of verbal and physical abuse to the administrator and State agency, failed to thoroughly investigate allegations of staff abuse, neglect, and/or mistreatment for 2 of 5 residents (R75, R65) reviewed for abuse, and failed to ensure residents were protected from further abuse. The facility's failure to operationalize their abuse/neglect/maltreatment policy/procedures following identification of abuse to R75 and R65, resulted in an immediate jeopardy (IJ) situation for R75 and R65 as well as for other residents who resided on the main and lower floor living units where the alleged perpetrator worked,	F 225	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply with all applicable state and feral regulatory requirements and constitutes the facility¿s allegation of compliance. Stewartville Care Center policy requires	

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F 225	Continued From page 20 presenting a risk of additional staff abuse, neglect, and/or mistreatment. In addition the facility failed to operationalize their abuse/neglect policy that clearly identified reporting, investigation, and protection of residents if allegation/s of staff abuse, neglect, and mistreatment for 3 of 6 other allegations reviewed (R64, R99, and R98). The immediate jeopardy began on 4/24/15 when facility staff witnessed licensed practical nurse (LPN)-E verbally abuse R75 and then physically abuse R65. The director of nursing (DON) and administrator were notified of the immediate jeopardy at 3:00 p.m. on 6/12/15. The immediate jeopardy was removed on 6/16/15 but noncompliance remained at the lower scope and severity level of an E, a pattern scope, with severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Although R75 was observed by staff to be yelled at by licensed practical nurse (LPN)-E on 4/24/15 following the supper meal, and LPN-E was subsequently observed to be verbally and physically abusive to R65 that same evening, however, the incidents were not immediately reported to the administrator or the State agency, nor were interventions initiated to prevent further abuse. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C dated 4/25/15. The concern included: "EMPLOYEE	F 225	that all alleged violations involving resident mistreatment, neglect, abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator and appropriate state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process. Stewartville Care Center does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service in a resident care position is investigated and reported to the State nurse aid registry or licensing authorities. The facility¿s policies and procedures for investigation/reporting of incidents were reviewed and found appropriate. The facility¿s Vulnerable Adult Abuse policies were distributed to all staff on June 16 and June 17, 2015. The staff were required to sign to verify that they received the information. On June 16, 2015, all Stewartville Care Center staff including management staff were instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation	

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F 225	Continued From page 21 NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." R75's quarterly minimum data set (MDS) dated 5/12/15 indicated R75 had a brief interview for mental status (BIMS) score of 4 which indicated R75 was severely cognitively impaired. The MDS also indicated R4 could hear with minimal difficulty. During an interview and observations on 6/9/15 at 9:51 a.m., R75 was observed during an interview with family (F)-A. R75 conversed with F-A and the surveyor without hearing difficulty and surveyor did not have to speak loudly for resident to hear. R75's care plan directed staff to provide, "Clear, careful, explanations to facilitate her comprehension...repeat/rephrase words as needed to facilitate hearing and comprehension." Information provided by the DON related to the investigation of these incidents, included a typed interview conducted 4/25/15 at 10:00 a.m., by the DON with NA-L. The interview documentation included, "Spoke to [NA-L] concerning incident Friday 4-24-15 p.m. shift. She stated he [LPN-E] was talking to [R75]. [R75] was repeating questions and as [LPN-E] was answering questions he was becoming more upset and	F 225	of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirements of immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies and 5) forms and procedures for appropriate and timely reporting. The staff is educated on vulnerable adult issues at least every twelve months; vulnerable adult investigation and reporting are addressed during new employee orientation. The employee (LPN-E) involved in the April 24, 2015 incidents with residents number 65 and 75 was initially suspended for three days pending an investigation of the alleged abuse. After returning to work, he was assigned to another care unit. After the June 2015 state review of the issue, the LPN-e was requested to complete a Health Professional Services Program evaluation as a condition of continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has had no further practice/performance issues. Resident number 75 ¿ The resident has cognitive deficits and self-propels her wheelchair around the facility. She has occasional negative interactions with other residents which require staff intervention. She does not recall the incident from April 2015. The social worker will meet with the resident weekly for four weeks and then	

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F 225	Continued From page 22 yelling, and was probably yelling more than he should. [R65] was standing nearby with her walker but did not say anything. Stated she (NA-L) heard a little later from another CNA (certified nursing assistant) that [R65] was hitting at staff, kicking and attempting to hit them with her walker." Another typed account of these incidents had been documented by LPN-J on 4/25/15. LPN-J's account included, "On Friday 4/24/15 I was here for staff potluck, overheard loud voice of a staff member [LPN-E] addressing a resident. I did not see who it was but another staff stated it was [R75]. Went out for a smoke break after eating, when a staff member came out and said [LPN-E] had stated 'could just kill them all'. When I came back in I asked [LPN-E] if he was ok, he stated 'we had a call in for night shift', (he also said his grandson was back in the hospital.) I offered to call to see if I could get someone to come in for night shift, he said that would be great. Received page from another staff [registered nurse (RN)-H], had me come down to the breakroom and talk with [assistant director of nursing (ADON) RN-A]. Discussed issue regarding [LPN-E] and it was decided [LPN-E] would be asked to go home." According to interviews and written witness statements, following the verbal altercation with R75, LPN-E was instructed to go home. However, LPN-E continued to remain in the facility without continuous supervision or immediate removal from resident access. LPN-E verbally and physically abused R65 after the altercation with R76. During that altercation R65 sustained an injury to her left hand. The facility's time clock records indicated LPN-E had	F 225	monthly for six months to assess mood and behavior. The resident frequently visits the Social Worker¿s office to obtain a piece of candy from the candy bowl. The care plan was reviewed and found appropriate. Resident number 65 ¿ The resident continues to wander throughout the first floor of the facility. She has had no recent altercations with staff; her usual resistiveness to bathing continues. The resident has severe cognitive impairments and believes that she works at the facility and is a care taker for her grandparents. She does not recall the incident from April 2015. The social worker frequently interacts with the resident as she walks by the social service office several times a day. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The care plan was reviewed and found appropriate. Residents number 64 ¿ The alleged abuse by the resident¿s spouse was observed 4/15/15 at 4:40 pm and was not reported to the State agency until the next day. The related facility policy and the regulatory requirements for immediate reporting were reviewed by the administrative and social service staff for quality improvement purposes. Resident number 99 ¿ The resident died at the facility September 15, 2014. The circumstances of the Alleged Resident Abuse Investigation Report Form for an	

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F 225	Continued From page 23 punched out from his shift at 7:37 p.m., approximately one hour after the incident of verbal abuse with R75 had occurred. RN- H had documented a late entry progress note in R75's medical record on 4/27/15 at 19:38 (7:38 p.m.) which included, "Late entry from 4/24/15. Several staff members were in the south conference room when a staff nurse was heard raising his [LPN-E] voice towards resident. This writer came out in attempts to ascertain what the resident [R75] needed. Asked if she wanted to go to her room." The notes indicated LPN-E had stated, "she can drive herself wherever she wants to go," and had then made some comments about arguing with her. RN-H further documented, "Able to redirect the resident and diffuse the situation. DON, ADON and social services all notified of incident." LPN-E was observed on 6/9/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility. LPN-E's personnel record was reviewed. LPN-E had an active Minnesota Nursing License and had been employed at the facility since January 2015. Review of LPN-E's in-service training record indicated that LPN-E had received initial Abuse Protocol training during orientation, but had not received training on dealing with cognitively impaired residents since hire until after the incidents of alleged abuse on 4/24/15. LPN-E had completed online education related to Abuse Prohibition/Resident rights/Caring for the Alzheimer's client on 4/28/15. During an interview with NA-C on 6/11/15 at 5:41 p.m., NA-C recalled the incident form 4/24/15 and	F 225	incident during the morning of August 20, 2014 not being submitted until the afternoon was reviewed by the management staff for continuing quality improvement purposes. Resident number 98 ¿ The resident died at the facility December 29, 2014. The circumstances regarding the 48-hour delay in reporting a bruise to the administrator and State agency were reviewed by the management staff for continuing quality improvement purposes. The Social Worker will monitor compliance by auditing incident reports for timely and appropriate notification of the administrator and State agencies for the next three months. If noncompliance is noted, additional auditing and training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting and ongoing.	

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stated, "I was sitting in the back nursing area, we heard [LPN-E] yelling and screaming at [R75]." NA-C then explained she had walked up the hallway near the nurse's station and was able to re-direct R75, "We started walking away with her but then she [R75] asked him [LPN-E] another question and he started yelling and screaming at her again. We were finally able to remove her from the situation." NA-C stated she could not remember what LPN-E was yelling and screaming about.

During an interview on 6/11/15 at 6:00 p.m., NA-E indicated she could not recall all of the events that had taken place the evening of 4/24/15. However, she stated she could remember she'd heard LPN-E yelling at R75. NA-E could not remember what had been said during the confrontation but stated the yelling had lasted at least 10 minutes. NA-E also stated she had never been interviewed about the incident and was not aware she could report abuse to the State agency.

During an interview on 6/12/15, at 9:30 a.m., the DON was asked to provide all information regarding the immediate reporting of the allegations of abuse between LPN-E and the residents to the administrator or State agency, and any interventions taken to protect R75 or other residents, or any investigation of the abuse incident. The DON confirmed he had not reported the allegation involving R75 to the State agency because he had been more focused on the physical abuse allegation between LPN-E and R65.

During a follow-up interview with NA-C on 6/12/15 at 2:34 p.m., NA-C stated the yelling had started

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after dinner which was around 6:30 p.m. NA-C stated, "[LPN-E] was really loud, we could hear him down the hallway. We went to see what the yelling was all about, when we went up there, he was in her face yelling at her, she was sitting in the wheelchair, and I think [R75] was more confused than usual." NA-C further explained that after the incident R75 had kept repeating, "That man was yelling at me, why was he yelling at me?" until she went to bed. NA-C stated that besides the repeated question, R75 had been anxious and quiet the rest of the night until she went to bed. NA-C stated she could not recall who she'd told about the incident.

The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up."

A typed witness account of the physical abuse that occurred on 4/24/15, as part of the investigation for R65, had been documented on 4/25/15 by LPN-J and included: "Discussed issue regarding [LPN-E] and it was decided [LPN-E] would be asked to go home. He was finishing up a medication admin at cart when [R65] came up, grabbed the water pitcher, and tried to hit him with it. He grabbed it out of her hands and set it back on cart. She then raised up her walker, as if to hit him with it, not sure if he knocked it down or she dropped it but it fell on the floor. [LPN-E]

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picked it up and [R65] went as if to hit him with a closed fist at which time I got between them and asked [R65] to leave the area which she did. [LPN-E] left shortly after that."

Another witness statement regarding the alleged physical abuse of R65 had been documented by RN-H on 4/25/15 and included: "I did not witness the interaction between [LPN-E] and [R65] on 4/24/15 as I was on phone [symbol for with] [RN-A]. I was informed by [LPN-J] that [R65] had gotten in [LPN-E's] face but was unaware of the fact that [LPN-E] had put his arm and hand around [R65] until 11 p.m. on 4/24/15. CNA [NA-C] is filling out an incident report stating it was reported to myself and [LPN-H]. I was made aware of this situation 4 hours [symbol for after] it had occurred by [LPN-B]. I reported incident as soon as able."

R65's quarterly MDS dated 4/28/15, indicated R65 had a BIMS score of 4 indicating severe cognitive impairment.

R65's care plan verified the resident demonstrated behavioral problems and interventions included: "She is much more receptive when she has familiar staff working with her using calm, direct approach."

Review of R65's medical record indicated a certified nurse practitioner (CNP)-D had been requested to conduct an assessment of R65 on 4/28/15. The CNP's assessment was documented as an "Evaluation of patient after physical assault." The documented assessment included: "Charge nurse has informed me that patient was physically assaulted by a staff nurse on April 24, 2015. According to the charge nurse,

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the patient had been placed in a chokehold per another eyewitness. No bruising was noted after the event. Patient had no difficulty breathing, no laryngeal edema, stridor, or tracheal deviation. Director of nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from assault. Patient has no evidence of any trauma to her neck. There is no bruising, abrasions, evidence of finger prints on her neck or shoulder area. She has some resolving bruising noted on her left hand and nurse reported that she has some mild soft tissue swelling of her left thumb after the incident which has now resolved ..."

An additional entry written by CNP-D on 4/28/15 at 6:18 p.m. included, "... Charge nurse has informed me that patient [R65] had an altercation with a staff nurse on April 24, 2015. The patient was agitated and attempted to throw her water pitcher at the nurse. The nurse reached and grabbed the patient's wrist with one hand and the water pitcher with the other hand. There was some mild swelling noted on the patient's left thumb web space with a bruise occurring after the incident. Today she has some resolving bruising noted on her left hand and no further swelling of her left thumb after the incident which has now resolved. Director of Nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from the altercation. She [R65] denies all complaints of pain today. Patient has no evidence of any trauma to her body with no bruising or abrasions, or change in her functional status..."

During an interview on 6/11/15, at 9:34 a.m. in

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regards to when he was notified of the abuse incident with R65 which occurred on 4/24/15 after evening meal, DON stated staff had placed a phone message on his home phone following the incident but he did not listen to it until the next morning (Saturday 4/25/15) at which time he had come to the facility to follow-up on the incident. The DON stated it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit any internal investigative reports to the State designated agency.

The facility provided the incident report, a submission report to the State agency (Office of Health Facility Complaints-OHFC), and all investigative notes regarding these allegations. According to the report submitted to OHFC, the allegations were not immediately reported. The allegation of physical abuse against R65 had been reported the day after it had occurred, 4/25/15. There had been no report of the allegation of verbal abuse against R75. The documentation indicated an investigative report had been submitted to the OHFC on 4/29/15. The report included LPN-E's account of the physical abuse of R65 however, it lacked other eye witness accounts of the physical abuse testimony and accounts from all of the witnesses. Despite the CNP's assessment, the investigative report indicated R65 had suffered no harm or injury. However, nurses reported swelling in the hand area that was grabbed by LPN-E during abuse altercation and CNP-D's physical and functional assessment completed on 4/28/15 verified there had been swelling and bruising of R65's left wrist. The investigative report also documented a personal improvement plan for LPN-E that included education re., vulnerable adult and

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dementia training, follow up with social worker, report to the board of nursing, and reassignment to another unit.

During an interview with the DON on 6/12/15 at 9:45 a.m., the DON stated LPN-E receiving counseling, education on dealing with difficult behaviors especially residents with dementia who might become agitated and combative. However, the DON stated the social worker who had followed-up with LPN-E after the alleged abuse incidents for R75 and R65 was no longer employed by the facility and there was no documentation as to what improvements LPN-E was working on in regards to his performance improvement, competence of handling agitated dementia related behaviors, or dealing with personal stress in a healthy manner to prevent abuse situations from redeveloping.

RN-A was interviewed on 6/12/15, at 11:57 a.m. she verified that LPN-E had received initial Abuse Protocol training during orientation, but had not received training on dealing with cognitively impaired residents since hire until after the incidents of alleged abuse on 4/24/15.
RN-A versified that following the incidents, LPN-E had been required to complete online education related to Abuse Prohibition/Resident rights/Caring for the Alzheimer's client on 4/28/15.

Following the surveyor's inquiry about the reporting of these alleged incidents of verbal/physical abuse, the DON made a report to the State agency (OHFC) regarding the verbal abuse R75 had sustained on 4/24/15. The report was made on 6/12/15, as part of the immediate plan of correction following the facility having been informed that an immediate jeopardy

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situation existed. The incident description sent to the State agency included: "During routine MDH [Minnesota Department of Health], it was brought to this writer's attention that on 4/24/15, staff LPN [LPN-E] was yelling at resident [R75]. An incident was initially reported on 4/25/15 regarding another demented resident [however, R65 was the main focus of that OHFC report and information in regards to R75 was to support the investigation of R65. During this incident [R75] was also agitated and following the nurse and not responding to re-direction. Nurse [LPN-E] did yell at resident due to his frustration with resident [R75] and her continued agitation. This writer initially combined both of these actions by the nurse [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident ..."

On 6/16/15 all staff received a copy of the facility's abuse protocol packet (forms undated) from the assistant director of nursing as they reported for work. The staff were requested to read the packet of information in regards to abuse protocol. The packet included specific policies entitled: Background Screening Investigations, In-Service Training, Preventing Resident Abuse, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting/Investigating Resident Accidents/Incidents. Abuse and/or Neglect Investigation, Protection of Residents During Abuse Investigation, Report Abuse to State Agencies and Other Entities/Individuals, Reporting Suspected Cases and/or Incidents of Rape, Vulnerable Adult Reporting of Alleged Misappropriation of Residents Personal Property, Investigating Unexplained Injuries, Resident-to-Resident Abuse, and reporting forms.

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In addition the packet of information included undated facility policies for Visitation, Quality of Life-Dignity, Employee In-Service Program, Six Keys to Resident Loyalty, Indicators of Abuse, and Indicators of Neglect.
Interviews were conducted by survey staff with direct care staff, activities staff, pool nursing staff, and supervisory nursing from day and evening shifts on 6/16/15 between 2:20 p.m. and 2:40 p.m. to verify receipt of education prior to starting their shifts. Each staff person interviewed verified they had received a packet of information and were in the process of reading it as detailed in the facility's IJ removal plan.

RN-A was interviewed on 6/16/17 at 2:45 p.m.. RN-A stated all staff were provided training as described as they reported to work.

Facility policies related to Abuse Prohibition were reviewed. An undated policy entitled Reporting/Investigating Resident Accidents/Incidents included: "All accidents/incidents involving residents must be reported to the director of nursing services and immediately to the administrator...All accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing."

An undated policy entitled Abuse and/or Neglect Investigation included: "All reports of resident abuse or neglect shall be promptly and thoroughly investigated."

The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all

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substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies."

The immediate jeopardy that began on 4/24/15, was removed on 6/16/15 when it could be determined the facility had operationalized their plan for removal in regards to educating all staff as they reported to work regarding the facility's policies related to abuse, neglect, maltreatment and reporting prior to allowing staff to work with residents. In addition, montioring systems had been developed and initiated to ensure continued complaince with facility protocols. However, non-compliance remained.

Additional incidents of failure to follow facility policies for reporting/investigating:

The facility had submitted a report to the state agency on 4/16/15, indicating a nurse had witnessed R64 being hit on the forearm by family (F)-B on 4/15/15, around 4:40 p.m. The report indicated, "[R64] was sitting in a reclining chair next to [F-B]...As he was attempting to get up and out of the chair, [F-B] struck him on the forearm..."

R64's diagnosis, according to the resident admission record dated 1/21/15, included debility with functional decline and dementia. The quarterly Minimum Data Set (MDS) dated 3/25/15, identified R64 had severe cognitive impairment and required extensive assistance from one person for all activities of daily living (ADL)'s.

A review of the nursing progress notes dated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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4/15/15, included a note from 4:30 p.m., "Nurse observed resident attempting to get out of a recliner chair. [F-B] attempted to tell resident to sit back down. Nurse noted agitation in the [F-B ' s] voice. Nurse then observed resident's [F-B] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well."

Although the facility was aware of the family member striking R64 on 4/15/15, the incident was not reported to the State agency until the next day, 4/16/15.

Although R99 sustained an injury of unknown origin on 8/19/14, the facility failed to ensure the administrator and state agency were notified immediately.

An incident report for R99 had been submitted to the State agency on 8/20/14 for an incident that had occurred the previous day, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident..was lying on the floor...[R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..."

R99's record was reviewed. The resident admission record dated 2/26/10, identified diagnoses including: senile dementia and osteoporosis. The quarterly MDS dated 8/12/14, identified R99 as having severe cognitive impairment and requiring limited assistance from one person for transferring and walking.

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A review of the nursing progress notes dated 8/19/14 at 10:30 a.m. included, "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]."

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident had been reported to the administrator on "8/20/14, AM," and had been reported to the State licensing agency on "8/20/14, PM."

Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and state agency were notified immediately.

The facility had submitted a report to the State agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's disease."

R98's record was reviewed and the resident admission record dated 12/5/08 indicated the resident had diagnoses including: dementia and Alzheimer's disease. A quarterly MDS dated 11/18/14, identified R98 had severe cognitive impairment and was totally dependent on staff for all activities of daily living.

A review of the nursing progress notes dated

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8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. The progress notes also indicated R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved.

A Skin Integrity Events Report dated 8/10/14, indicated the purplish-black bruise on R98's left medial forearm extending to the side of the thumb and index finger, was mildly painful and was swollen.

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed as reviewed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on resident's L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." The investigative report also indicated the administrator had not been notified of the 8/10/14 incident until 8/12/14.

During interview on 6/11/15 at 9:34 a.m., the DON stated administrative staff were to submit reports to the State agency, "Other staff can, but I want them to call me." The DON stated he carried a cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. The DON verified the reports that were submitted for R64, R99, and R98, had not all been submitted immediately to the

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F 225	Continued From page 36 administrator or State agency as required. The DON confirmed he was aware the reports needed to be submitted immediately and stated, "We have a system problem." Review of the facility's undated policy Reporting Abuse to State Agencies and Other Entities/Individuals included: "Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be suspected, it must be immediately reported to the administrator and to proper State agencies."	F 225		
F 226 SS=F	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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policies and procedures related to immediate reporting of alleged abuse/neglect to the administrator and State agency, protecting resident/s from ongoing abuse, and completing a thorough investigation following an allegation of abuse/neglect for 5 of 26 residents (R75, R65, R64, R99, R98) who were reviewed for abuse prohibition. This had the potential to affect all 68 residents currently residing in the facility. Findings include:	F 226	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply with all applicable state and feral regulatory requirements and constitutes the facility¿s allegation of compliance.	6/17/15

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F 226	Continued From page 37 On 6/11/15 the facility provided a package of undated Policy and Procedure Standards related to Abuse Prohibition: The undated policy entitled Recognizing Signs and Symptoms of Abuse/Neglect read, "...all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services and immediately to the Administrator." The procedure directed signs and symptoms of abuse should be reported promptly. The procedure lists signs of actual physical abuse, signs of actual physical neglect, and signs/symptoms of psychological abuse/neglect. The undated policy entitled Reporting/Investigating Resident Accidents/Incidents read, "All accidents/incidents involving residents must be report to the director of nursing services and immediately to the administrator." The procedure directed staff that "all accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing." The undated policy entitled Abuse and/or Neglect Investigation read, "All reports of resident abuse or neglect shall be promptly and thoroughly investigated." The procedure directed the administrator would appoint a designee to investigate the incident and that person would report daily to the administrator the progress of the investigation. The procedure also directed that employees that had been accused of resident abuse would be reassigned to nonresident care duties or put on leave until the	F 226	Stewartville Care Center has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures address the seven following components: screening, training, prevention, identification, investigation, protection, and reporting/response. Stewartville Care Center staff recognizes and respects each resident¿s right to be free from maltreatment, neglect, and misappropriation of property and does all that is within its control to prevent such occurrences. The facility staff 1) identifies residents who are at risk for abuse, neglect, and/or misappropriation of property 2) develops intervention strategies to prevent occurrences and 3) routinely reassesses the effectiveness of the interventions. During the mandatory staff training July 14, 15 and 16, 2015, the facility policies related to abuse prevention/ reporting were reviewed and the staff were instructed on 1) the types of incidents/accidents that need to be immediately reported to the administrative/supervisory staff 2) procedures for notifying the administrative staff and the appropriate government agencies of the incident/accident and 3) necessary documentation related to incidents/accidents.	

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F 226	Continued From page 38 results of the investigation had been reviewed by the administrator. The undated policy entitled Protection of Residents During Abuse Investigation read, "Our facility will protect residents from harm during investigations of abuse allegations." The procedure directed that during abuse investigations, employees accused of resident abuse would be reassigned to nonresident care duties or put on leave; and that if employees were reassigned to non-resident care duties, such assignments would not be in any part of the building which the resident frequents. The procedure read, "Should the results indicate that abuse occurred, appropriate authorities will be notified." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals read, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate state agencies. The procedure directed "A. Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of unknown source, or abuse to be suspected. It must be immediately reported to the administrator and to proper state agencies 1. Olmsted County Social Services 2. Minnesota Department of Health/OHFC. B. Verbal/written notices to the above agencies will be made immediately following the incident if possible...C. The administrator, or his/her designee, will submit internal investigation report to OHFC website 5 working days of the occurrence of the incident." R75 was observed to have been verbally abused	F 226	Resident number 75 ¿ The resident has cognitive deficits and self-propels her wheelchair around the facility. She has occasional negative interactions with other residents which require staff intervention. She does not recall the incident from April 2015. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The resident frequently visits the Social Worker¿s office to obtain a piece of candy from the candy bowl. The care plan was reviewed and found appropriate. Resident number 65 ¿ The resident continues to wander throughout the first floor of the facility. She has had no recent altercations with staff; her usual resistiveness to bathing continues. The resident has severe cognitive impairments and believes that she works at the facility and is a care taker for her grandparents. She does not recall the incident from April 2015. The social worker frequently interacts with the resident as she walks by the social service office several times a day. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The care plan was reviewed and found appropriate. Residents number 64 ¿ The alleged abuse by the resident¿s spouse was observed 4/15/15 at 4:40 p.m. and was not reported to the State agency until the next day. The related facility policy and the regulatory requirements for immediate	

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F 226	Continued From page 39 by licensed practical nurse (LPN)-E on 4/24/15. The incident was not immediately reported to the administrator or designated State agency, nor was R75 protected following this incident, or a thorough investigation completed. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C 4/25/15. The concern included: "EMPLOYEE NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." During an interview on 6/12/15, at 9:30 a.m., the DON was asked for all information regarding the immediate reporting of the verbal abuse to the administrator, OHFC, and interventions taken to protect R75 from further abuse as well as other residents and a thorough investigation of the abuse incident. None was provided and the DON stated he did not report this incident with R75 separately but was with the report sent to OHFC in regards to the physical abuse to R65. Then the DON stated he was more focused on the physical abuse incident with R65 at the time. Again the physical abuse of R65 occurred shortly after the verbal abuse of R75 by LPN-E on 4/24/25 after the evening meal as LPN-E was passing medications. Progress note was not entered into the medical	F 226	reporting were reviewed by the administrative and social service staff for continued quality improvement purposes. Resident number 99 ¿ The resident died at the facility September 15, 2014. The circumstances of the Alleged Resident Abuse Investigation Report Form for an incident during the morning of August 20, 2014 not being submitted until the afternoon was reviewed by the management staff for continuing quality improvement purposes. Resident number 98 ¿ The resident died at the facility December 29, 2014. The circumstances regarding a bruise observed 8/10/14 and the 48-hour delay in reporting the bruise to the administrator and State agency were reviewed by the management staff for continuing quality improvement purposes. The Social Worker will monitor compliance by auditing incident reports for timely and appropriate notification of the administrator and State agencies for the next three months. If noncompliance is noted, additional auditing and training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee meeting and ongoing.	

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record until two days later on 4/27/15 and read, "Several staff members were in the south conference room when a staff nurse heard raising voice towards resident." The progress note also indicated notification of DON, ADON, and Social services, however did not indicate when the notifications were given.

The DON reported the verbal abuse of R75 to the OHFC and to the Common Entry Point (CEP) on 6/12/15 after the survey team had informed the facility an immediate jeopardy (IJ) related to abuse existed.

R65 had been verbally and physically abused by LPN-E on 4/24/15 however, this was not immediately reported to the administrator or OHFC.

The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up."

A typed witness account of the physical abuse that occurred on 4/24/15 as part of the investigation for R65 completed on 4/25/15 by LPN-J read, "On Friday 4/24/15 I was here for staff potluck, ...He [LPN-E] was finishing up a medication admin at cart when [R65] came up grabbed the water pitcher and tried to hit him with it. He grabbed it out of her hands and set it back

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on cart. She then raised up her walker, as if to hit him with it, not sure if he knocked it down or she dropped it but it fell on the floor. [LPN-E] picked it up and [R65] went as if to hit him with a closed fist at which time I got between them and asked [R65] to leave the area which she did. [LPN-E] left shortly after that."

The facility provided the incident report, submission report to the State agency (the Office of Health Facility Complaints-OHFC), and all investigative notes. According to the OHFC complaint, the allegation of verbal/physical abuse to R65 had not been not immediately reported but had been reported the following day 4/25/15.
R64 had an allegation of physical abuse by a family (F) member which occurred on 4/15/15 however, it was not reported to the State agency until the next day.
The facility submitted a report to the State agency on 4/16/15 indicating a nurse witnessed R64 being hit on the forearm by [F-A] on 4/15/15, around 4:40 p.m. "[R64] was sitting in a reclining chair next to [F-A]... As he was attempting to get up and out of the chair, [F-A] struck him on the forearm..."

A review of the nursing progress notes, dated 4/15/15, at 4:30 p.m., included, "Nurse observed resident attempting to get out of a recliner chair. [F-A] attempted to tell resident to sit back down. Nurse noted agitation in the [F-A]'s voice. Nurse then observed resident's [F-A] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well."

R99 had received an injury of unknown origin

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F 226	Continued From page 42 causing a fracture the facility did not immediately report the incident to the state agency. An incident report for R99, submitted to the State agency on 8/20/14 indicated, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident ...was lying on the floor... [R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..." A review of the nursing progress notes dated 8/19/14 at 10:30 a.m., included: "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]." A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident from 8/19/14 had first been reported to the administrator on "8/20/14, AM," and had subsequently been reported to the State Licensing Agency on "8/20/14, PM." R98 was found to have a large bruise on her left forearm which was found to be a fracture however, this was not immediately reported to the State agency or the administrator as directed by the facility abuse policy and procedure. The facility submitted a report to the state agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm	F 226		

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extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's Disease."

A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. Also included, R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved.

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on residents L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM [range of motion]. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." Also included, the administrator was not notified until 8/12/14.

Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and State agency were notified immediately.

During interview on 6/11/15, at 9:34 a.m. the director of nursing (DON) indicated the administrative staff were to submit reports to the State agency and stated, "Other staff can, but I want them to call me." DON stated he carried a

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F 226	Continued From page 44 cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem."	F 226		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide prior notice of a new roommate for 2 of 2 residents (R11, R40) reviewed for admission, transfer, and discharge. Findings Include: R11 was interviewed and asked about any roommate changes on 6/09/2015 at 10:41 a.m. R11 stated she has had several temporary roommates after her family member (F)-Q died. R11 stated she knew she would have to get one, but was not told in advance of them coming. R11 also stated she was not told when her current roommate moved into their shared room. R11's quarterly Minimum Data Set (MDS) dated 3/24/15 indicated R11 had intact cognition based	F 247	The staff at Stewartville Care Center respect the residents¿ right to receive notice before the resident¿s room or roommate is changed. The staff is sensitive to the trauma that a move or change of roommate causes some residents and attempt to be as accommodating as possible. The resident is asked about his/her preferences which are than taken into account when discussing changes of rooms or roommates and the timing of such changes. When a resident is moved at the facility¿s request, an explanation of the reason for the move is provided. The resident is given the opportunity to see the new location, ask questions about the	7/27/15

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 247	Continued From page 45 on a score of fifteen on the brief interview for mental status (BIMS). R11's diagnoses included anemia, depression and diabetes mellitus. SS progress note dated 3/26/15 read, "Resident survey done recently and I followed up on concerns. R11 said that she was not informed of getting a new roommate after her [F-Q] died, which was some time ago. I apologized for that..." On 6/09/2015 2:54 p.m. social services (SS)-A shared R11 had new roommates move into her shared room on 4/29/14, 7/24/14 and her current roommate moved in on 8/18/14. The SS-A verified she was unable to find documentation of new roommate notifications in the medical record for the above dates she received a new roommate. R40 was asked about roommate changes recently on 6/08/2015 at 6:58:56 p.m. R40 stated he had a new roommate move in two weeks ago and was not told in advance he would be getting a new roommate. R40's quarterly Minimum Data Set (MDS) dated 4/21/15 indicated R40 had intact cognition based on a score of fifteen on the BIMS. R40's diagnoses included Parkinson's disease and anemia. On 6/09/2015 2:54 p.m. SS-A verified R40 did have a recent roommate move into his shared room on 5/20/14. The SS-A verified she was unable to find documentation of notification of a new roommate in R40's medical record. SS-A stated when a resident in the facility will be having a new roommate move in, the social service department documented a progress note in the	F 247	move, and meet the new roommate when possible. When a resident receives a new roommate, the resident is given as much notice and information about the new person as possible, while maintaining confidentiality regarding medical information. The facility provides support to a resident whose roommate has died, and whenever possible provides time for adjustment before moving another person into the room. On June 24, 2015, the facility¿s medical record consultant met with the social worker who started employment June 22, 2015 to discuss the required resident notifications including the resident¿s right to be informed prior to changes in rooms and roommates. A copy of the related regulations was provided for reference. The updated policy addressing new roommate notification was reviewed with the social service staff. The situation regarding lack of documentation verifying that residents number 11 and 40 were notified of new roommates was also reviewed as part of the ongoing continuing education and quality improvement procedures/process. The administrator will monitor compliance weekly for four weeks through staff interview and record review verifying that residents received notice prior to receiving a new roommate. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the September Quality	

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F 247	Continued From page 46 resident's medical record the resident had received notification they would be having a new roommate move in to their shared room. A facility policy was requested on resident notification of having a new roommate move in to a shared room, but was not received from the facility.	F 247	Assessment and Assurance Committee quarterly meeting.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. Findings include: R26 was admitted to the facility on 4/29/14 according to the facility admission record. R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with activities of daily living. During an interview on 6/9/15, at 8:26 a.m. in an answer to the question "Have there been any	F 250	The Stewartville Care Center interdisciplinary team is committed to provide residents with comprehensive services to attain or maintain their highest practicable physical, mental and psychosocial well-being. The interdisciplinary team address residents¿ concerns with the goal to provide social supports, physical care, and an enriched environment that meet the residents¿ individual needs and preferences. All residents are routinely assessed by qualified staff, including a social worker, to assure they are effectively coping with changes in health status, admission to the facility, current family relationships, etc. Medically-related social service needs are	7/27/15

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F 250	Continued From page 47 concerns or problems with a roommate or any other resident," R26 stated, "Yes.!" R26 went on to say that she had problems with R1 (R1's quarterly MDS dated 4/8/15 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that her roommate (R68 who had moderate cognitive impairment according to the quarterly MDS dated 5/6/15). R26 stated R1 had yelled and cursed at her on multiple occasions over the past months and kept R26's bathroom door locked so she had to go into the other residents room to unlock it to use on several occasions. R26 then said her roommate (R68) daily told her when to go to bed, when she could watch television, where to put her walker, and when and how to get dressed. R26 stated R68 seemed to want more space in the shared room for her things. In response to the question, "How does that make you feel to have someone telling you what to do?" R26 stated, "She is kinda bossy, I feel like I'm walking on eggshells around her, she's always telling me what to do. I've reported it to the social worker about the concerns, I'm not sure if the same social worker is still here...I'm not aware if she followed up with my concerns. They come and go fast. I more or less just got used to it, so I don't even say anything more." R26 further stated R68 snored very loud at night and kept her awake often. R26 stated she did not want to be treated the way she had been treated (in reference to both R1 and R68) and was not expecting anything to change because nothing had changed despite asking for help from the facility. R26 stated it would be nice not to deal with it, however had learned to deal with it. During a follow up interview on 6/10/15, at. 1:30 p.m. R26 indicated she had not been able to cope	F 250	identified through completion of resident assessment tools, quality indicator report results, review of the medical history, information from family/direct care staff, and social service interviews/evaluations. The staff follow up on situations/behaviors that impact the resident¿s psychosocial well-being; referrals are made to the attending physician or other clinical practitioners as indicated. The interdisciplinary team will review significant resident incidents, behaviors, changes in condition, etc. on a weekly basis and during the quarterly care conferences. A nursing communication tool will be developed to alert the social worker to resident incidents/moods/behaviors and facilitate appropriate follow up. During the mandatory meetings July 14, 15 and 16, 2015, the nursing staff will be 1) oriented to use of the new communication tool and 2) reminded to be alert for and report any resident behaviors/conditions/statements and/or family concerns that indicate need for interventions to meet the resident¿s medically-related social service needs. Resident number 26 - The social worker met with the resident on June 10, 2015 to discuss her concerns regarding her roommate. The social worker noted, ¿(resident) states she gets along fine with roommate . . . neither roommate wants to move or have the other roommate move out.¿ The resident did not mention any problems with the shared	

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F 250	Continued From page 48 well with problems with neighbor (R1) and roommate (R68) and said, "I try not to let it bother me now... It still hurts my feelings, and I'm frustrated, I'm not a child you know." In response to the question, "How do you deal with it?" R26 stated, "When [R68] starts in, I just say "I don't know what I did, but I'm sorry." R26 stated she dealt with the neighbor bathroom issue by having a bedside commode at night to avoid confrontation with. R26 stated she would preferred to use the bathroom vs. the bed side commode. R26 stated, "I can't even move a little bit without one of them questioning me on what I am doing." R26 stated she had asked for a room change several months ago, stated the social worker had not ever come in to talk with her. R26 stated, " I am tired of reporting the concerns and nothing changes, so what's the point? I've just learned to deal with it." R26's care plan provided by the facility on 6/11/15 read, "Has occasional difficulties in dealing with her roommate and others that she share a common bathroom with but seeks out staff support with is as needed. Care plan also included intervention of "provide on-going support to resident and encourage resident to share her concerns and feeling." The care plan lacked explanation of difficulties and interventions to resolve the concerns. Social service progress note dated 12/5/14 read, "[R26] came to social work office late in the day on 12/5/14 seeking support due to conflicts with other residents. She describes one resident being particularly cruel on an ongoing basis and said that hurt was compounded when her roommate, whom she has previously shared a good relationship with, aligned with the other party and has been also making hurtful remarks over the past month....she has tried to speak back more	F 250	bathroom. The social worker met with the resident on July 10, 2015. The social work note states, ¿Visited with resident regarding her roommate. She reports that things have been `straightened out¿, and that they are getting along together in the room. Resident reports that she feels as though she has enough room for all of her belongings. She also reports that she independently uses the commode instead of the adjoining bathroom in her room at night, and she is satisfied with this arrangement. Resident reports that she is satisfied with her current room and would not like to switch at this time.¿ The resident¿s care plan was reviewed and updated. The care plans of residents number 1 and number 65 have been reviewed and updated to address issues regarding shared space. The resident was visited by the social worker July 14, 2015 and reported that ¿things are going well.¿ She declined an offer for a room change and stated she is happy with her current room. To monitor compliance, the RN medical record consultant will randomly audit records twice monthly for two months and randomly thereafter for appropriate documentation and follow up to medically-related psychosocial issues. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting and ongoing.	

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often but that appears to be making things worse for her. She is adjusting her bathroom routines to avoid confrontation... The comments also take place in the hallways and dining room. I spoke with the supervisors about the situation and the pros and cons of a room change and was advised to speak with roommate to ascertain her thoughts on the interactions reported to be taken place." The progress note further indicated social services would continue to offer emotional support and indicated if problem persisted the social worker would attempt mediation.

R1's progress notes were reviewed, no evidence of follow-up performed related to the concerns of R26 shared with social worker on 12/5/14. R1's care plan read, "Does present with an argumentative disposition at times with other residents. She has verbal behaviors toward other..." The care plan also indicated she is confrontational with residents and has had multiple room changes. The care plan did not reflect the issue with the shared bathroom with R1.

R68's progress notes were reviewed, no evidence of follow-up performed related to the concerns of R26. R68's care plan did not reflect or identify any concerns, interventions, or problems with roommate.

R26's progress notes did not reflect follow-up or monitoring had been performed as a result of voiced concerns at the 12/5/15 meeting and no further mention of the issues until 4/29/15 when the resident brought the same concerns forward again in her care conference.

Care conference progress note dated 4/29/15 read, "We provided [R26] the opportunity to vent about her interactions with her roommate and next door neighbor, mainly bathroom sharing issues. She reports that these issues remain the

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same but she had grown to better deal with them. She tends to accommodate others but also has spoken up."
No follow-up was evident in R26's, R1's, or R68's medical record as a result of the again mentioned concerns and issues at the 4/29/15 care conference.
During an interview on 6/9/15, at 3:30 p.m. licensed social worker (LSW) explained nursing staff reported to her with any concerns pertaining to the residents and "every morning I see what is going on" however, LSW stated she was not aware of the concerns despite the concerns documented in the medical record. LSW stated the facility had turned over three social workers in the last year. LSW stated the social worker who had been assigned to that wing, left in May 2015. LSW stated a grievance had not been filed.
During an interview on 6/9/15, at 4:00 p.m. director of nursing (DON) stated a grievance had not been filed. DON stated a grievance should have been filled out in regards to R26's concern with roommate (R68) and neighbor (R1). Stated he had not been aware of the problem with the roommate despite the concerns documented in the medical record. DON stated the concerns should have been followed up on. DON indicated his expectation would have been re-evaluation of a situation for a possible room change and social worker involvement.
During an interview on 6/10/15, at 2:08 p.m., family member (F)-A indicated awareness of roommate and neighbor problems. Stated the roommate had always been complaining and telling [R26] what to do, "[R68] tells her to turn the TV off, when to go to bed, and where to put things... I hear it. [R68] is always saying smart thing, sarcastic things to [R26]. [R26] says she doesn't want to listen to her. She [R26] seems

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really frustrated, everyday there is something. Every time I call she expresses frustration with her roommate. I haven't noticed a big change is [R26's] mood but I do know she is frustrated." F-A stated had not been notified by the facility of the ongoing issues concerning the roommate or the neighbor. F-A explained had offered assistance to R26, but had been told by R26 she had been handling the problems. To the question, "Do you think [R26] is happy?" F-A stated, "No, I don't think she is happy. I would think if those people were not around she would have a better quality of life. [R26] was never a person who let people know if she was upset about something. She will deal with it and deal with it until it explodes, takes a while before she reports anything. She doesn't want to create waves, she wants to just do her thing and mind her own business."

During an interview on 6/11/15, at 2:32 p.m., nursing assistant (NA)-K stated R1 tends to be judgmental of people and had been aware of R26's bathroom concerns related to R1 locking the door so R26 cannot enter from her room. NA-K further stated knowledge of the issues with the roommate, "[R68] is always arguing about the line [which divides room in half] of where things go...and they have some issues with the curtains. [R26] was shutting the curtains too far." NA-K explained R26 was not the type of person to voice concerns, "she would wait and wait until it's really bad." NA-K explained when there had been resident concerns, they would be reported to social worker.

During an interview on 6/11/15, at 2:46 p.m., licensed practical nurse (LPN)-J stated she had not been aware of the concerns with the roommate despite the concerns documented in the medical record. LPN-J stated, "Everybody knew about the whole bathroom thing, [R1] made

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sure everybody knew about it." LPN-J stated a commode had been placed in R26's as a compromise to the bathroom problem with R1.
During an interview on 6/11/15, at 3:13 p.m., NA-E stated "[R1] tends to be more aggressive...she tends to pick on people that are a little more vulnerable ....she really goes after [R26] about the bathroom ...and is very vocal about letting people know." NA-E stated, "[R68] wants things a certain way even if it's on [R26's] side...R26 will just shrug it off and ignore it. I have seen her get upset and frustrated. She's the type of person that holds things in. She is the type that tries to get along with everyone, she is quiet and keeps to herself." NA-E explained an example, where R68 had attempted to take R26's calendar down and had to be redirected.
During an interview on 6/11/15, at 3:35 p.m., NA-A stated had witnessed arguments between R26 and R1 in the past. Stated everybody knew of the problems with R1 not wanting to share the bathroom with R26.
An undated policy entitled filing grievances/complaints indicated "Grievances and/or complaints may be submitted orally or in writing." "The administrator has delegated the responsibility of grievance and/or complaint investigation to Social Services." Upon receipt of a grievance and/or complaint, Social Services will investigate the allegation and submit a written report of such finding to the administrator within (5) working days of receiving the grievance and/or complaint.
An undated facility policy entitled Content Of The Clinical Record read, "Records of Social Service. Records of each resident's pertinent social data about personal and family problems medically related to the resident's illness and care and of action taken to meet these needs, will be entered

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F 250	Continued From page 53 in the clinical record."	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive care plan for mood, behavior and psychotropic drug use for 1 of 5 residents (R45) who received psychotropic medications. Findings include: R45 was admitted to the facility 6/12/14 according to the facility admission record with diagnoses that included but was not limited to bipolar disorder.	F 279	Stewartville Care Center uses the results of the comprehensive assessment to develop, review and revise the resident¿s comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident¿s needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the	7/17/15

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F 279	Continued From page 54 R45's significant change Minimum Data Set (MDS) dated 3/12/15 indicated moderate depression with a PHQ-9 (resident mood interview) score of 9, identified diagnosis of bipolar disorder, and indicated behavior status, care rejection, and wondering had worsened when compared to previous assessment. In addition, the MDS indicated R45 received antipsychotic and antidepressant medications. Care Area Assessment (CAA's) were triggered based off of the MDS assessment information that required a plan of care. The CAA's triggered as a result of the MDS assessment included: mood state, behavioral symptoms, and psychotropic drug use. R45's physician orders provided by the facility on 6/10/15 included Lexapro (antidepressant medication) 20 milligrams (mg) once per day, Wellbutrin XL (antidepressant medication) 300 mg per day, Depakene (anti-seizure medication used as a mood stabilizer) 250 mg two times per day, and Zyprexa (antipsychotic medication) 5 mg at bedtime. R45's care plan did not include a plan of care that included individualized goals and interventions for the triggered care areas for behavioral symptoms and psychotropic drug use. Although depression was identified; the care plan lacked interventions in regards to care and services associated with depression and associated mood state concerns. During an interview on 6/10/15 at 1:00 p.m., the MDS coordinator licensed practical nurse (LPN)-G verified the care plan did not reflect the CAA's triggered by the MDS. LPN-G stated mood state, behavioral symptoms, and psychotropic drug use should have been included in the care plan. The facility policy Minimum Data Set/Resident Assessment Protocol/Care Planning that was not	F 279	resident¿s highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents¿ right to refuse cares/services. The care plan and MDS (minimum data set) related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and revised. Within seven days of completion of the comprehensive assessment, an interdisciplinary care plan is developed. During the mandatory meetings on June 14, 15, and 16, 2015, the licensed nursing staff were 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents¿ care plans must be current at all times and 3) instructed that care plans must address the MDS triggered care areas that are assessed as needing to be included in the plan of care. The care plan for resident number 45 was reviewed and revised to more comprehensively address the triggered care areas of ¿behavioral symptoms¿ and ¿psychotropic drug use.¿ The care area ¿mood state¿ was not triggered on the significant change MDS with an assessment reference date of June 10, 2015; the resident reported only two symptoms indicative of depressed mood. As part of the quarterly care conference process, the interdisciplinary team reviews	

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F 279	Continued From page 55 dated does not reflect current standards.	F 279	the care plans for completeness, accuracy, and relevancy. For the next quarter, the MDS Coordinator will conduct focused audits on the care plans for residents who trigger the care areas of behavior symptoms, mood state and psychotropic drug use. If noncompliance is noted, additional monitoring will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		7/17/15

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F 280	Continued From page 56 Based on observation, interview and document review, the facility failed to revised the plan of care to include the dietician's recommendations for 1 of 1 resident (R65) reviewed. Findings include: R65 received house supplement however, the supplement was given to the resident but the amount consumed was not documented and the amount consumed of meals was not documented to determine if there was an effective intervention in stabilizing weight loss. The registered dietician (RD)-B's progress note dated 5/7/15, indicated staff to monitor intake; although, The need for monitoring food and supplement intake was not indicated on the care plan. R65's care plan dated 2/2/15, indicated R65 "Is able to feed self after setup is provided and needs observing if she is eating and assist as needed." The listed approach is "One staff to provide setup for reach meal-open containers, apply condiments, cut foods and butter breads." An interview on 06/10/2015 at 12:32 a.m. with certified dietary manager (CDM) who said R65 wanders up and down the hallway. She lost weight this month, currently she weighs 114 lbs. The nurses gave her a house supplement three times a day. No one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. registered dietician (RD)-B said R65 consumes her meals well and takes a supplement three times a day. R65 expels a lot of energy by walking so much. In May 2015, she had a weight	F 280	Stewartville Care Center staff routinely develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents¿ functional abilities and quality of life. The residents and their family/legal representative are encouraged to participate in the care planning process and care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary. During mandatory meetings July 14, 15, and 16, 2015, the care staff will be 1) reinstructed on the facility¿s policies for care plan reviews and updates 2) informed of the regulatory requirement that the residents¿ care plans be current at all times and 3) reminded of the importance of facilitating accurate care plans by communicating resident care/condition changes to the departmental supervisors, including the dietary department, in a timely manner. The Nutritional Care Plan Policy was reviewed and revised. The Nutritional Supplement Policy was updated to address tracking the amount of supplement consumed other than at meal time. The procedure for tracking	

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F 280	Continued From page 57 loss of 9.2% for the past six months. As of today her weight loss is 11.6% for the past six months. "She is on the risk list and being monitored for months now." RD-B continued to say I haven't looked at what the nurses are signing out for her supplement. An interview on 06/11/2015, at 9:09 a.m. with registered nurse (RN)-G who said R65 takes her house supplement three times a day but said no one records how much is consumed. A policy dated 4/2000, entitled supplements read, "...Nursing service record intake of supplement" and "Need for an intake of supplement will be monitored by nursing personnel."	F 280	supplement intake at meal time was reviewed and found appropriate. The care plan of resident number 65 reflects the May 12, 2015 physician¿s order for an increase in the nutritional supplement from four ounces once per day to three times per day due her recent weight loss related to increased calorie expenditure from physical activity (continually walks throughout the first floor of the facility). The nutrition care plan was updated to include offering the resident snacks and finger foods as the resident walks about the facility. The resident¿s weight will be monitored on a monthly basis and her supplement intake will be monitored on a daily basis. The resident currently weighs 114.8 pounds showing a slight weight gain in the past month. She weighed 105 pounds when admitted to the facility April 30, 2013. After an initial weight gain of ten pounds in 2013, she gained an addition fifteen pounds last year after an extended period of reduced physical activity related to non weight bearing status while recovering from a fracture. After a successful recovery and resumption of her usual physical activity, she is now back to her September 1, 2013 baseline weight of 114.0 pounds. The resident¿s care plan will continue to be reviewed at least quarterly and revised as needed. The physician/nurse practitioner and consultant dietitian will be informed of any further weight loss.	

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F 280	Continued From page 58	F 280	To monitor compliance, the dietary manager will audit the care plans of residents receiving nutritional supplements to assure that supplements are appropriately addressed. The dietary manager will monitor intake tracking of liquid supplements ordered for increased calories/protein weekly for four weeks and monthly thereafter. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to reassess pain after a change in condition for 2 of 2 residents (R11 & R2) with chronic pain. Findings include: R11 was interviewed on 06/09/2015 at 10:26 a.m. and stated she had lots of pain in her back and shoulders. R11 stated she took a lot of pain medication for it and stated that she currently had	F 309	Stewartville Care Center provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident¿s condition indicates. The	7/16/15

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F 309	Continued From page 59 pain in the area that she would rate almost a 10 (scale 0 no pain and 10 severe pain). Stated that she used Ultram (pain medication), but felt that she had "out-grown it." R11 stated that she needed to have both rotator cuffs (shoulders) repaired, but did not want surgery again. On 6/11/15 at 6:15 p.m. R11 was observed sitting in her chair and eating her meal. R11 stated her shoulder pain was at a 10 out of 10 and that nothing was being done for her. R11 was admitted to the facility in 2006 and had diagnoses listed on the physician orders that included: chronic pain and osteoarthrosis. Physician orders of 6/11/15 included: scheduled Ultram twice a day and as needed (PRN), scheduled Tylenol extra strength twice a day, scheduled Narco (narcotic medication) three times a day. On 3/18/15 the physician note read, "Patient otherwise continues to have symptoms in regards to her arthritis in her shoulders. Patient also has failed all conservative therapies for that." Assessment read,"degenerative joint disease - shoulder - quite symptomatic." The quarterly Minimum Data Set (MDS) indicated R11 had a BIMS (brief interview of mental status) of 15 or no cognitive impairment and indicated R11 had rated her pain at 6 out of 10 but that an assessment for pain was not necessary. The care area assessment (CAA) completed 7/9/14 indicated the resident would rate her pain at 10 in the shoulders and arms, that she received scheduled and as needed (PRN) pain medications, had limited bilateral functional range of motion. The CAA read, "She may be at	F 309	resident¿s condition and needs including effective pain management are evaluated. When a resident experiences pain, a plan of care is developed, implemented, routinely reevaluated, and revised as necessary based on the physician¿s analgesic orders and continuing assessments. In April 2015, the facility reviewed and revised the pain assessment policies and procedures to include 1) a Pain Flow Sheet tool to track the location, intensity, precipitating factors for pain as well as pharmacological and nonpharmacological interventions and their effectiveness and 2) the Comprehensive Pain Assessment Form to evaluate the resident¿s history of pain, type of pain, causes of pain, and interventions to alleviate pain. The residents who flagged the pain quality indicator on the MDS 3.0 Resident Level Quality Measure Report were first to have the Pain Flow Sheet and the Comprehensive Assessment Form completed. Based on findings from the pain assessment, the pain management plan will be reassessed. The physician/nurse practitioner will be notified regarding ongoing pain symptoms. The care plan will be revised as necessary to reflect current pharmacological and nonpharmacological interventions to alleviate pain. During the mandatory meetings, July 14, 15, and 16, 2015, the nursing staff will be reminded 1) to be alert to pain symptoms and 2) of the need to complete the pain	

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F 309	Continued From page 60 risk for increased sx [symptoms] of pain limiting her quality of life, for falls and injury." The Pain Interview section for MDS 3.0 section J. dated 3/23/15 noted the resident had occasional pain, that made it hard to sleep, and would rate the pain at a 8 out of 10. No further assessment/s was found. During an interview on 6/11/15 at 6:24 p.m. licensed practical nurse (LPN)-J stated R11 usually had pain and that the physician only wanted her to have pain medications for control. The facility would also provide warm packs. LPN-J stated she thought the pain was related to the "gas" (air in bowels) in the abdomen and that the facility could use a rectal tube and anti-gas pills. During an interview on 6/11/15 at 11:30 a.m. in regards to a pain assessment for R11, RN-F stated that she was just starting to do pain assessments and any pain assessment would be in the hard copy chart. However, none was located nor provided when requested. R2 was interviewed on 6/8/15 at 6:29 p.m. and stated that her legs ached. R2 also stated that her bottom was sore because of cancer and use of the Hoyer mechanical lift. R2 stated her pain level was up to 7 out of 10 scale, but currently did not have any. The care conference on 4/7/15 documentation indicated R2 stated she was having more pain than usual. Physician documentation of 4/20/15 noted right ankle pain and swelling for R2. The nursing	F 309	tracking forms. The MDS Coordinator will continue to initiate the pain flow sheets and complete pain assessments for residents flagging the pain indicator on the Resident Level Quality Measure Report and for residents who report a significant increase in pain or have uncontrolled pain. The physician/nurse practitioner will be notified and reassessments will be done as indicated. Resident number 2 ¿ A 5-day pain tracking tool has been initiated to help identify pain frequency, location, intensity and effectiveness of interventions. A reassessment of the pain management plan will be done after a review of the collected data, resident/staff interviews, and review of the nurses and physician/nurse practitioner progress notes. (The physician was called July 7, 2015 regarding uncontrolled pain and a visit is scheduled for June 14, 2015). During the June 23, 2015 MDS pain interview, the resident indicated her pain was a ¿ten¿ on a ten-point intensity scale, but stated her pain did not impact her sleep or day-to-day activities. Evaluation of the resident¿s pain and the effectiveness of the interventions will be ongoing. The care plan will continue to be updated to reflect the resident¿s pain symptoms and interventions. Resident number 11 ¿ A 5-day pain tracking tool has been initiated to help identify pain frequency, location, intensity and effectiveness of interventions. A	

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F 309	Continued From page 61 documentation of 5/20/15 through 6/11/15 did not document the resident having pain. The annual MDS dated 12/23/14 indicated a BIMS of 14 or no cognitive impairment, the pain section was left undone. The quarterly MDS dated 3/24/15 indicated a pain intensity of 7 on a scale of 10. R2's care plan dated 4/6/15 indicate the resident had pain due to gout and generalized pain usually in back and shoulders. On 06/11/2015 at 11:30 a.m. RN-F, the MDS coordinator, stated that she was just starting to do pain assessments and had not done any for R2 yet. The facility's undated policy entitled Resident Pain Evaluation Protocol directed the resident's pain was to be reassessed quarterly and when condition indicates the need. On 06/11/2015 at 12:03 p.m. the director of nursing stated he would expect pain assessments be completed and that he knew the assessments had not been done for R2.	F 309	reassessment of the pain management plan will be done after a review of the collected data, resident/staff interviews, and a review of the nurses¿ and physician/nurse practitioner progress notes (a physician visit is scheduled for June 14, 2015). The June 9, 2015 social service note states, ¿reports that her mood is improving and she is starting to feel better.¿ The July 10, 2015 nurse¿s note states, ¿No complaint of pain on evening shift.¿ The pain management plan of care will be reviewed and updated as necessary. Evaluation of the resident¿s pain and the effectiveness of the interventions will be ongoing. Compliance will be monitored by the Assistant Director of Nurses/Designee by auditing for pain assessments for residents flagging the indicator measuring pain on the Monthly Resident Level Quality Measure Report for three months. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		7/17/15

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F 323	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess a resident's fall risk following multiple falls for 1 of 3 residents (R73) reviewed for accidents and the facility failed to ensure a safe environment free from fall hazards in the facility for 3 of 3 residents (R68, R46, R26) reviewed for falls history. Findings include: R73 was observed on 6/8/15 at 5:22 p.m. sitting in his wheelchair at the dining room table with his shoulders rounded and leaning forward to the table. At 5:27 p.m. R73 was observed to independently wheel the chair away from the table using his feet on the floor. The wheelchair foot rests were in the down position with R73 using his feet in between the foot rests. The quarterly Minimum Data Set (MDS) dated 3/3/15 was reviewed. R73 had a BIMS (brief interview of mental status) of 12 or mild cognitive loss, no history of recent falls, required extensive assist with bed mobility and transfer, required limit assistance with mobility, and had a diagnosis of traumatic brain injury (TBI). The incident report dated 5/22/15 read On 5/19/15 at 6:10 p.m. the nursing assistant found R73 on his knees attempting a self transfer from the chair. No injuries were noted. The progress notes of 5/20/15 indicated R22 understood the needs of waiting for help to transfer. He wanted to go to the attached assisted living to visit his wife.	F 323	Stewartville Care Center has policies and procedures to ensure that the residents¿ environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues with interventions to enhance mobility and promote safety. The policies and procedures related to assessing the resident¿s risk of falls were reviewed and found appropriate. An assessment of fall risk will continue to be done at the time of admission. A reassessment will be done as part the quarterly interdisciplinary assessment process and whenever there is a change in the resident¿s behavior, physical condition, and/or mental function. The resident¿s care plan is modified as necessary to ensure maximum safety and minimal risk of injury. During the mandatory meetings July 14, 15, and 16, 2015, the licensed nurses and direct care staff were reinstructed on 1) the importance of providing a safe environment for residents 2) the procedures for completing the fall risk assessments and 3) the need to assess the resident¿s need for safety	

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F 323	Continued From page 63 The incident report of 5/22/15 read On 5/20/15 at 6:;26 p.m. R73 was found self transferring from his wheelchair into bed after supper. As resident is independent in the facility and able to visit his wife at assisted living on his own, pin alarm is not effective. He is alert and oriented x 3 and has the ability to take the pin alarm off. Floor alarm placed next to resident's bed to prevent further attempts of resident self transferring in and out of his wheelchair. The facility had completed a fall report dated 4/10/15 at 9:06 a.m. The report noted the nursing assistant had heard a noise while in the next room, and found the resident on the floor next to the bed. The resident attempted put himself to bed. R73 reported hitting his buttock, but no injury found. No further incidents after 8/14/14 were found. The resident's care plan dated 3/17/15 noted R73 was a fall risk and that R73 was a greater than normal risk for falls secondary to recent fall resulting in hip fracture, history of falls, mildly impaired cognition. Interventions include: strips on floor for safety and one staff to assist with all transfers. Fall Risk Evaluation/Physical Devices Assessment were dated 8/14/15, 11/11/14, 2/11/15 were found in the chart. All assessments scored a 17 or moderate risk for falls. Physical therapist (PT)-A was interviewed on 6/11/15 at 3:15 p.m. to discuss the fall risk. He had told her that no one came in when he put the call light on and that he required assist with all transfer. PT-A stated R73 was last seen by	F 323	interventions/devices and routinely evaluate their effectiveness. All the floor nonskid safety strips have been inspected and either removed or replaced. The Environmental Director will include monitoring of the condition of floor nonskid safety strips as part of the routine safety inspection process. Resident number 73 - The resident¿s risk and history of falls were reassessed. Due to the resident¿s recent increase in falls and impulsiveness (related to a history of traumatic brain injury and fracture hip with ataxic gait) a physical therapy referral was made. After therapy goals are met, a nursing restorative program will be implemented to maintain strength and ambulation abilities and reduce the risk of falls. The care plan was reviewed and updated accordingly. Resident number 68 ¿ The use of floor nonskid safety strips was reassessed; safety strips will continue to be used in front of the resident¿s bed. New strips have been installed. Resident number 46 ¿ The use of floor nonskid safety strips was reassessed. The strips were removed. Resident number 26, The use of floor nonskid safety strips was reassessed. The strips were removed. The Director of Nurses/designee will monitor compliance with post-fall	

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F 323	Continued From page 64 therapy in May 2014. PT-A stated she had not been notified of further falls. PT-A added that R73 was at a high fall risk related to his impulsiveness, history of hip fracture and medical history of TBI that affects his balance. PT-A felt that R73 could work with physical therapy for balance safety and sequency. PT-A stated R73 needed contact guard and lacked impulse control. The director of nursing (DON) was interviewed on 6/11/15 at 5:28 p.m. and stated R73 should probably be reassessed following the falls to determine the cause. DON added R73 could use physical therapy but needed to first be assessed for need. LACK OF SECURED SAFETY STRIPS TO PREVENT SLIPPING: During an environmental facility tour on 06/11/15, at 10:14 a.m. with maintenance manager (MM)-A the following was observed: R68's room had anti slip strips which were originally stuck to the floor to prevent slipping were loose and frayed. The strips were located in the middle of the residents room about 2 feet in front of the resident's bed. MM-A agreed that its a trip hazard and agreed the strips need to be removed and said, "those are a trip hazard" as he preceded to remove one of loose strips from the floor. R68's care plan dated 5/19/15, indicated "... greater than normal risk for falls secondary to her diagnosis of dizziness and stroke and has a history of falls." The approach listed on the care plan read, "Review the environment to make sure	F 323	assessments through record review weekly for four weeks. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	

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F 323	Continued From page 65	F 323		

it is free from hazards such as poor lighting, obstacles, items on the floor..."

R46's room had non slip strips adhered to her floor which were curling up around the edges located in front of her recliner. MM-A again agreed they were a trip hazard.

R46's care plan dated 5/12/15, read, "...comprehensive assessment reveals a greater than normal risk for falls ... is on an antipsychotic increasing her fall risk." The approach listed on the care plan read, "Review the environment to make sure it is free from hazards such as poor lighting, obstacles, items on the floor..."

R26's room had three non skid strips which were attached to the floor in the middle of the room about two feet in front of the bed. The middle and the ends of these strips were loose and curling up. MM-A again agreed they were a trip hazard.

R26's care plan dated 4/28/15, read, "...comprehensive assessment reveals a greater than normal risk for falls secondary to: heart failure and use of demodex and pain..." The approach listed on the care plan read, "Review the environment to make sure it is free from hazards such as poor lighting, obstacles, items on the floor..."

On 06/11/15, at 10:44 a.m. MM-A said two weeks ago he did a safety inspection but he did not document his findings from the inspection. MM-A also said he does not document any concerns during these inspections.

An interview on 06/11/15, at 10:54 a.m. the

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F 323	Continued From page 66 director of nursing (DON) said he was not aware there is any documentation of safety inspections but did agree the peeling non slip strips need to be removed. A safety policy was requested but not received.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess nutritional status for 1 of 3 residents (R65) reviewed for nutritional status. Findings include: R65 had a significant weight loss over the past 180 days however, interventions put in place were not monitored/assessed if appropriate to maintain or gain weight. R65 received house supplement however, the supplement was given to the resident but the	F 325	Based on a resident¿s comprehensive assessment, Stewartville Care Center ensures that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident¿s clinical condition demonstrates that this is not possible. Therapeutic diets are provided as ordered by the physician. The Nutritional Care Plan Policy was reviewed and revised. The Nutritional Supplement Policy was updated to address tracking the amount of	7/17/15

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F 325	Continued From page 67 actual amount consumed was not documented and the amount consumed of meals was not documented to determine if there was an effective intervention in stabilizing weight loss. R65's most recent weight from dietary resident progress note dated 6/10/2015, was 114 pounds reflected weight loss of four pounds (3.4 percent) past 30 days, six pounds (5 percent) past 90 days and 16 pounds (12.3 percent) past 180 days. Weight loss is significant past 180 days. Dietary progress notes authored by the registered dietician (RD)-B dated 5/7/15, indicated resident's current weight is 118 pounds and weight six months ago, 130 pounds. This reflects weight loss of 9.2 percent in 6 months. Recommended house supplement be increased to four ounces three times a day to prevent further weight loss was initiated and staff to monitor intake. R65 was admitted with diagnoses that included dementia and CVA (cerebral vascular accident). A quarterly Minimum Data Set (MDS) dated 4/28/15, identified R65 required supervision for eating. the MDS also indicated R65 had no problems with coughing/choking during meals or complaints of difficult chewing or swallowing. The significant change MDS dated 1/28/15, R65 required supervision, oversight, encouragement or cueing during meal time. R65's weight was 128 pounds at that time. Nursing progress notes reviewed from 3/17/15, to 6/9/15, with the only time when the amount of meals consumed was mentioned was on 5/12/15, which indicated an "increase in house supplement to 4 oz with each meal for weight loss." On 5/22/15, the progress note read, "Up	F 325	supplement consumed other than at meal time. A designated space was added to the medication administration record (MAR) to document the amount of supplement consumed. The procedure for tracking supplement intake at meal time was reviewed and found appropriate. The staff will continue to assess the residents¿ condition, including nutritional needs/risks upon admission, when a significant change occurs, and no less than once every three months. Based on the (re)assessments, a comprehensive plan of care is developed that addresses the resident¿s nutritional needs and preferences; the plan is reviewed at least quarterly and revised as necessary. The policies and procedures for recording and monitoring weights have been reviewed and found appropriate. Residents are weighed monthly and more often as ordered by the physician or as requested by the dietitian or licensed nurse. If the resident has had nontherapeutic weight changes or is at risk of weight loss, the resident¿s nutritional status is reassessed and the attending physician and consultant dietitian are notified. During mandatory meetings July 14, 15, and 16, 2015, the licensed nurses will be instructed on the changes in procedures related to recording the amount of supplement consumed on the MAR. The nursing assistants will be reminded of the importance of recording the amount of	

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F 325	Continued From page 68 around 6 hours wandering up and down halls. ...offered food, fluids and activity as appropriate." No other mention of food consumed was available nor was any provided when requested. Medication flow sheets reviewed from 3/1/15, until 6/10/15, indicate R65 given four ounces of house supplement but no monitoring of amount consumed. The medication flow sheet for 3/1/15, until 5/31/15, indicate once a day house supplement with three times a day started on 6/1/15. Monthly weights also listed on medication sheet during this period. A dietary nutritional assessment dated 1/28/15, indicated no concerns at that time and no further nutritional assessments were provided since that time. Computer generated weight variance report received from certified dietary manager (CDM), weight on 1/5/15, 127.8 pounds (lbs); 2/2/15, 124 lbs; 3/1/15, 120.4 lbs; 4/1/15, 120 lbs; 5/1/15, 118.4 lbs; 6/1/15, 114 lbs. Observations on 6/10/15, at 12:06 p.m. R65 ate 75% of her meal. On 6/11/15, at 12:03 p.m. R65 ate 50% of meal. An interview on 06/10/2015 at 12:32 a.m. with CDM who said R65 wanders up and down the hallway. She lost weight this month, currently she weighs 114 lbs. The nurses give her a house supplement three times a day. However, no one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. RD-B said R65 consumes her meals well and takes a	F 325	supplements consumed at meal times on the Food Acceptance Record flow sheet. The care plan of resident number 65 reflects the May 12, 2015 physician¿s order for an increase in the nutritional supplement from four ounces once per day to three times per day due her recent weight loss related to increased calorie expenditure from physical activity (continually walks throughout the first floor of the facility). The nutrition care plan was updated to include offering the resident snacks and finger foods as the resident walks about the facility. The resident¿s weight will be monitored on a monthly basis and her supplement intake will be monitored on a daily basis. The resident currently weighs 114.8 pounds showing a slight weight gain in the past month. She weighed 105 pounds when admitted to the facility April 30, 2013. After an initial weight gain of ten pounds in 2013, she gained an addition fifteen pounds last year after an extended period of reduced physical activity related to non weight bearing status while recovering from a fracture. After a successful recovery and resumption of her usual physical activity, she is now back to her September 1, 2013 baseline weight of 114.0 pounds. The resident¿s care plan will continue to be reviewed at least quarterly and revised as needed. The physician/nurse practitioner and consultant dietitian will be informed of any further weight loss.	

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F 325	Continued From page 69 supplement three times a day. She expels a lot of energy by walking so much. In May 2015, she had a weight loss of 9.2% for the past six months. As of today her weight loss is 11.6% for the past six months. "She is on the risk list and being monitored for months now" and I haven't looked at what the nurses are signing out for her nutritional supplement. An interview on 06/11/2015, at 9:09 a.m. with registered nurse (RN)-G who said R65 takes her house supplement three times a day but said does not measures how much is given nor does anyone record how much is consumed by R65. An interview with RD and CDM on 06/11/2015, at 9:14 a.m. both said they have not assessed how much supplement the resident consumes. They validated they can not assess effectiveness of the treatment when it is not monitored. An interview on 06/11/2015, at 9:55 a.m. with director of nurses (DON) who stated my expectation is the dietary staff monitor how much of the meal R65 eats and nursing needs to monitor how much supplement R65 consumes of her supplement when they give it to her. R65's care plan dated 2/2/15, read, "Is able to feed self after setup is provided and needs observing if she is eating and assist as needed." The listed approach is "One staff to provide setup for reach meal-open containers, apply condiments, cut foods and butter breads." A undated policy entitled monitoring and preventing ongoing weight loss read, "All residents in the facility will be weighed monthly. If they exhibit an unexpected continual weight loss	F 325	To monitor compliance, the dietary manager will audit the care plans of residents receiving nutritional supplements to assure that supplements are appropriately addressed. The dietary manager will also monitor intake tracking of liquid supplements ordered for increased calories/protein weekly for four weeks and monthly thereafter. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	

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F 325	Continued From page 70 for two month, they will be addressed as a risk and risk interventions will begin." A policy dated 4/2000, entitled residents at nutritional risk read, "Residents with any of the following conditions should be considered at Nutritional risk: Low body weight and increased caloric and/or nutrient needs related to medical condition." A policy dated 4/2000, entitled supplements read, "...Nursing service record intake of supplement" and "Need for an intake of supplement will be monitored by nursing personnel."	F 325		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		7/17/15

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F 431	Continued From page 71 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure safe and secure disposal of used Fentanyl (topical narcotic analgesic medication) patches according to currently accepted principles to prevent potential diversion for 2 of 2 residents (R7 & R55)reviewed with prescribed Fentanyl patches. Also medications that were outdated were not removed to prevent accidental use and medications opened lacked open date to determine when it would be outdated this had the potential to affect several residents including (R29, R4, R65, R42, R46, R10, & R71) who utilized stock medications and prescription medications. Findings include: R7's admission record dated 4/9/10, indicated diagnosis including lumbago and abnormal sensation with pain in the left leg. R7's physician orders dated 5/14/15, included an order for Fentanyl patch 25 micrograms (mcg) to be applied transdermally (to the skin) every 72	F 431	Stewartville Care Center provides pharmaceutical services to meet the needs of each resident. The facility contracts with a licensed consultant pharmacist who collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of related procedures to ensure the accurate acquiring, receiving, dispensing, storing and administering of all drugs and biologicals. The pharmacist has established a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals are labeled in accordance with currently accepted professional principles, and include the appropriate instructions and expiration dates when applicable. In accordance with	

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F 431	Continued From page 72 hours, with special instructions, "Apply 1 patch and change patch q [every] 72 h [hours] for back pain. **When removing old patch, wrap in tissue and flush down toilet or put in sharps container.**" R7's Fentanyl patches were administered from and stored in the West medication cart. R55's admission record dated 7/27/11, indicated diagnosis including generalized pain. R55's physician orders dated 4/7/15, included an order for Fentanyl patch 50 mcg to be applied transdermally every 72 hours, with special instruction, "When removing old patch, wrap in tissue and flush down toilet or put in sharps container.**" R55's Fentanyl patches were administered from and stored in the North medication cart. During an interview on 6/8/15, at 7:15 p.m., trained medical assistant (TMA)-A indicated the policy when removing and disposing of Fentanyl patches, was for two staff to witness the destruction by putting them in the sharps container attached to the medication cart, and for both to initial on the Medication Administration Record (MAR). During an observation on 6/10/15, at 8:40 a.m., of medication administration from the West medication cart, the locking door on the sharps container attached to the cart was observed to be unlocked and could easily be opened, exposing the content in the sharps container. The sharps container was easily removed from the compartment by sliding it forward and removing from the cart. The door to the compartment had several pieces of old tape on the front and several pieces of tape on the right side of the	F 431	State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls. The facility provides separately locked and permanently affixed compartments for storage of controlled drugs. The facility utilizes only persons authorized under state requirements to administer medications and have access to medication room keys/security codes. Outdated and expired drugs and biologicals are routinely discarded according to accepted practice standards. The procedure for disposing of controlled substances was reviewed and revised; all Fentanyl patches will now be wrapped in tissue and flushed into the sewer system in the presence of two nurses. All medication storage areas were checked for discontinued and unlabeled/undated/expired medications and biologicals. The doors securing the sharps containers were inspected; all were found in good order with a functional locking mechanism. Any problems with the function/condition of the doors will be reported to Weber and Judd Pharmacy who owns the carts. During the mandatory meetings July 14, 15, and 17, 2015, the licensed nurses and trained medication assistants were 1) reinstructed on the procedures for processing discontinued and outdated medications and biologicals including the destruction of used Fentynal patches 2) reminded that the doors securing the	

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F 431	Continued From page 73 compartment. During a review of medication storage on 6/10/15, at 8:50 a.m., the East medication cart sharps container compartment door, was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. Licensed practical nurse (LPN)-A verified the door was unlocked and the sharps container could be removed. During a review of medication storage on 6/10/15, at 8:55 a.m., the North medication cart sharps container compartment door, was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. Registered nurse (RN)-B verified the door was unlocked and the sharps container could be removed. During a review of medication storage on 6/10/15, at 9:10 a.m., the lower level medication cart sharps container compartment door was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. LPN-L verified the door was unlocked and stated, "The door should be locked." During an interview on 6/10/15, at 9:15 a.m., LPN-B stated when removing Fentanyl patches from the residents for disposal , the policy was for two staff to witness the destruction of the patch, by either flushing the patch in the sewer system or by putting the used patch in the sharps container. LPN-B stated, "I always put it in the	F 431	sharps container should be locked at all times 3) that multiple dose medication vials must be dated when first used and 4) refrigerator temperatures must be monitored and recorded on the designated sheet. To monitor compliance, a licensed nurse/trained medication aide will audit the medication storage areas monthly to check for undated/expired/outdated medications and biologicals and monitoring of refrigerator temperatures. The consultant pharmacist will continue to randomly check refrigerator temperatures and monitor for outdated/unlabeled/outdated medications. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting and ongoing.	

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F 431	Continued From page 74	F 431		

sharps container," pointing to the sharps container attached to the side of the West medication cart. When asked about the door to the sharps container compartment being unlocked and the ease of removing the sharps container, LPN-B verified the door was unlocked and attempted to use a key to lock it, but was unable to get it locked. LPN-B stated, "This key fits, but doesn't turn to lock the door."

During an interview on 6/10/15, at 10:05 a.m., director of nursing (DON) stated he was aware that the sharps container compartments were found to be unlocked during observation, and stated, "They should be locked." DON verified the unlocked doors on the compartments holding the sharps containers, allowed access to the sharps containers where used Fentanyl patches were disposed, and this had the potential for diversion. DON indicated he would be ordering a new door for the West medication cart because the door was cracked, and the doors were to be locked.

A policy was requested for ensuring safe and secure disposal of Fentanyl patches, and was not provided. A memo written by DON, to "ALL NURSES," dated 12/16/13, was provided, and directed staff to add, "When removing old patch, wrap in tissue and flush down toilet or put in sharps container," when receiving Fentanyl patch orders.

LACK OF REMOVAL OF OUTDATED MEDICATIONS OR TO DATE MEDICATIONS WHEN OPENED TO DETERMINE WHEN IT WILL BE OUTDATED:

During an observation on 06/10/2015, at 2:22 p.m. of the north medication cart with registered nurse (RN)-B, R29's 10 milliliter (ml) multidose

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F 431	Continued From page 75 novolin regular was outdated for 5-2-15, lantus 10 ml multidose vile outdated for 5-1-15. RN-B stated the policy indicated multidose vials expire 28 days after being opened. An observation on 06/10/2015, at 2:56 p.m. of the first floor medication room and the following was found and verified by RN-G: R29's coumadin (a blood thinner) 1 mg one (1) pill outdated for 4-15; R4's coumadin 1 mg one (1) pill outdated for 4-15; R4's coumadin 2.5 mg two (2) pills out outdated for 4/15; R65's jantoven (a blood thinner) 2.5 mg six (6) pills outdated for 4-15; R65's jantoven 1 mg five (5) pills outdated for 4-15; R42's jantoven 1 mg five (5) pills outdated for 4-15; R46's jantoven 1 mg two (2) pills, outdated for 4-15; R10's jantoven 2.5 mg five (5) pills outdated for 4-15; In the medication refrigerator was a two (2) multidose influenza virus vaccine (fluvirin) 5 ml vials which were outdated for a manufacturers expiration of 5-15. A multidose tuberculin bottle had been opened but not dated to determine when it would become outdated. On the west medication cart on 6/10/15 at 2:29 p.m. with LPN-B found R71's C-amitr cream (ketam 2%) with manufacturers expiration dated 5-25-15. An interview on 6/10/2015, The director of nursing stated they should be monitoring for	F 431		

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F 431	Continued From page 76 outdates and he was not aware that the refrigerator temperatures were not being monitored. A undated policy entitled labeling/data of drugs & biologicals indicated "Insulin-Dispose of 28 days after opening" and Tuberculin - Refrigerate - Dispose of 30 days after opening."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441		7/17/15

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F 441	Continued From page 77 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure glucometer equipment was disinfected according to the bactericide sanitizer wipe manufacturers directions for a glucometer used for 3 of 4 residents (R29, R11 & R24) glucose tests observed. In addition the facility failed to ensure containment of used incontinent products and soiled gloves to prevent the spread of infection which could affect several residents. Findings include: R29 had blood glucose testing done on 6/10/15 at 9:22 a.m. registered nurse (RN)-B was observed doing glucose test. After completion of the monitoring, RN-B wiped the glucometer for 20 seconds with the Super Sani-Cloth wipe. RN-B stated, "I guess we wipe it a while." However, the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R11 was observed to have glucose test done on 6/10/15 at 6:20 p.m. licensed practical nurse (LPN)-A perform glucose monitoring for R11. The glucometer was removed from the medication	F 441	Stewartville Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment for the residents and to prevent the development and transmission of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility has comprehensive infection control policies and procedures consistent with the current state and federal infection control regulations and recommendations. The policies address the surveillance and investigation of infections and the maintenance of accurate and comprehensive records of resident/employee infections.	

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F 441	Continued From page 78 cart and taken directly into R11's room. LPN-A stated the facility and not the resident owned and maintained the monitors. When LPN-A returned to the medication cart following the performance of the glucose testing, She used the PDI Super Sani-Cloth wipe to clean the meter. The wipe remained in contact with the meter for less than one minute and the damp monitor was placed on top of the medication cart. LPN-A stated that she did not know how long to keep the disinfectant in contact with the meter. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R24 had just completed glucose test on 6/10/15 at 6:30 p.m. LPN-B was observed to clean the glucometer after use. LPN-B used the PDI Super Sani Cloth wipe and left the wipe in contact with the monitor for less than one minute. When finished LPN-B placed the damp monitor on top of the narcotic book. LPN-B stated the disinfectant wipe needed to be in contact with the monitor for 10 to 15 second. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." The undated facility policy entitled Blood Glucose Meters Clean and Disinfect read, "To disinfect the meter, wipe down the meter with an EPA registered and approved premoistened towelette....Follow the product label instructions to disinfect the meter." The director of nursing was interviewed on 6/10/15 at 9:57 a.m. and stated staff need to follow the directions on the PDI package to disinfect the glucometer. LACK OF PROPER DISPOSAL OF SOILED	F 441	During the July 14, 15 and 16, 2015 mandatory meetings, the licensed nurses were re-instructed on the procedures for sanitizing glucometer machines; the nursing staff will sign to verify knowledge of the glucometer sanitizing procedure. All nursing staff were re-instructed on the proper handling of soiled incontinent products and gloves. Compliance will be monitored by the Director of Nurses/designee through direct observation of the nurses¿ glucometer sanitizing techniques. The charge nurses will observe for proper handling of soiled incontinent products/gloves when supervising resident cares and performing other tasks/treatments in the resident care areas. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	

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F 441	Continued From page 79 PADS AND GLOVES TO PREVENT THE SPREAD OF INFECTIONS: During an observation on 6/8/15, at 6:18 p.m. a soiled incontinent pad and gloves were laying on the bathroom floor between resident rooms number 39 and 40. During an interview on 6/8/15, at 6:22 p.m. licensed practical nurse (LPN)-B verified the soiled incontinent product on the floor. LPN-B stated should have not been left on the floor, LPN-B donned gloves and placed the incontinent pad in the garbage bag and removed from room. An undated facility policy AM Cares (Early Morning Care) read, "Leave bedside area clean, and dispose of disposable equipment and soiled linen appropriately." An undated facility policy P.M. Care (Bedtime Care) read, Leave room clean and tidy." An undated facility policy Incontinence Care Guidelines instructed, "Discard disposable items in a plastic trash bag and secure."	F 441		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe comfortable environment free from rust and paint chips of bathroom door frames for 4 of 4 resident (R95, R96, R75, R87) rooms and in addition the grout around a toilet used by R11 was soiled and	F 465	It is the policy of Stewartville Care Center to provide a safe, functional, sanitary and comfortable environment for residents, staff, and the public. As part of an ongoing process to provide	7/16/15

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F 465	Continued From page 80 the wheelchair used by (R1) was soiled. Findings include: During an environmental facility tour on 06/11/2015 at 10:14 a.m. with maintenance manager (MM)-A the following was observed. R95's room, the bathroom door jam near the floor,and the light switch in the bathroom had chipped paint exposing the metal which was rusty colored. The heat register in her room also had chipped paint. MM-A stated the door jams need painting, the area around the light switch and the heat register are rusty and need painting. R96's room the bathroom door jams and around the light switch had paint chipped and were rusty. Verified by MM-A who said he will paint. 75's bathroom door frame the paint was chipped. MM-A agreed of the chipped area's and the need for painting those areas. R87's bathroom door frame near the bottom was chipped. MM-A verified the chipped paint on the metal door frame. R1's wheelchair was soiled, the poles under the chair had a thick layer of dust, MM-A verified the dust/soiled areas. MM-A stated I suppose its been a long time since the wheelchair was cleaned. He said the process is the staff bring the wheelchair to his office with a note asking maintenance to wash it. MM-A stated they don't keep track of which wheelchairs are washed and there was no schedule for cleaning wheelchairs. R11's bathroom in room had scratched up door	F 465	a pleasant, homelike environment, Stewartville Care Center has a schedule for routine cleaning, repairs, and maintenance of the facility. All staff members are expected to report environmental concerns to the appropriate administrative/supervisory staff. An additional maintenance check list has been implemented for inspection of resident rooms at the time of discharge and at least yearly for all long term residents. The condition of the walls, ceilings, bathroom fixtures, and resident care equipment will be checked. Repair and repainting will be done as needed. The condition of the bathroom door jambs, light switches and heat registers will be observed and any areas with rust/chipped paint will be repainted. The door jambs in the bathrooms used by residents number 95, 96, 75, 87, and 11 have been repainted. The light switches in the bathrooms used by residents number 95 and 96 have been repainted. The heat register in the room used by resident number 96 was repainted. The caulk around the toilet in the bathroom used by resident number 11 has been replaced. The brown discoloration on the bathroom floor of resident number 11 is the outline of the previous toilet. A new toilet will be installed which has a larger base that covers the discolorations. Several staff members have checked the bathroom used by resident 11 during varying times of the day and no unpleasant ambient or pervasive odors were detected.	

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F 465	Continued From page 81 jam. The toilet's caulking was yellow and there was a yellowish discoloration on the floor around the toilet. The bathroom had a strong, old urine smell. MM-A agreed that the caulk and flooring was yellow and the bathroom smelled like urine. An interview on 06/11/2015 at 10:54 a.m. the director of nursing (DON) said the wheelchairs were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair cleaning schedule. A maintenance policy in regards to general cleaning/repairs were requested but not received.	F 465	The wheelchair of resident number 1 was cleaned. A schedule will be developed to ensure routine cleaning of all wheelchairs. During the mandatory meetings July 14, 15 and 16, 2015, the staff will be reminded to observe for equipment/furnishings/structures that need to be repaired, cleaned, or replaced. The procedures for reporting work items to the Maintenance Director were reviewed. Compliance will be monitored by the administrator through direct observation and review of the room maintenance and wheelchair cleaning checklists monthly for three months. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with	F 497		7/27/15

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F 497	Continued From page 82 cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing assistants received 12 hours of training annually for 13 of 13 employees (EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L, EE-M, EE-N) who worked in the capacity of nursing assistants and were reviewed who had been employed greater than 12 months by the facility. Findings include: Records provided indicated the facility provided annual training in the Healthcare Academy that included Tuberculosis, Fire Safety, Environmental safety, Client Behaviors, and Caring for the Alzheimer's Client. EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L, EE-M, EE-N records were reviewed. EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L had received a performance review during the past 2 months, but the performance review did not identify areas for improvement or lack of 12-hour training. EE-M, EE-N had not received a performance review, but had been on medical leave during the time the reviews were completed according to the director of nursing. Medical Records (MR)-A on 6/16/15 at 12:45 p.m. provided total hours of in-service training for 2013 and 2014 for the 13 employees reviewed as follows:	F 497	Stewartville Care Center completes a performance review of every nurse aide at least once every 12 months, and provides regular in-service education based on the outcome of these reviews. The in-service training ¿ (I) Is sufficient to ensure the continuing competence of nurse aides; (ii) Addresses areas of weakness as determined in nurse aides¿ performance reviews as well as any special needs of residents; and (iii) Addresses the care of the cognitively impaired. The staff training related policies and procedures were reviewed and revised to ensure 12 hours of nursing assistant training per year including the training topics of abuse/neglect, fire safety, emergency procedures, tuberculosis, and caring for residents with dementia related behaviors. The Health Care Academy online program allows for tracking of training hours. All certified nursing assistants were required to complete 12 hours of training before July 27, 2015. The required training addressed caring for residents with	

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F 497	Continued From page 83 EE-A was hired in 2009 and had received 4.8 hours of training in 2014 and 8.12 hours of training in 2013. EE-B was hired in 2010 and had received 2.2 hours of training in 2014 and 2.7 hours of training in 2013. EE-C was hired in 2002 and had received 0 hours of training in 2014 and 2.7 hours of training in 2013. In addition EE-C did not receive annual dementia training . Tuberculosis (TB) training, fire safety or emergency procedures training in 2014. EE-D was hired in 2011 and had received 01.5 hours of training in 2014 and 2.2 hours of training in 2013. EE-F was hired in 2007 and had received 3.1 hours of training in 2014 and 3.2 hours of training in 2013. EE-G was hired in 2002 and had received 0 hours of training in 2014 and 2.9 hours of training in 2013. In addition EE-G did not receive annual dementia training . TB training, fire safety or emergency procedures training in 2014. EE-H was hired in 2002 and had received 9.1 hours of training in 2014 and 0 hours of training in 2013. EE-I was hired in 2012 and had received 2.3 hours of training in 2014 and 0 hours of training in 2013. EE-J was hired in 2013 and had received 6.3 hours of training in 2014. EE-K was hired in 1996 and had received 0 hours of training in 2014 and 4.8 hours of training in 2013. In addition EE-K did not receive annual dementia training. TB training, fire safety or emergency procedures training in 2014. EE-L was hired in 2022 and had received 2.3 hours of training in 2014 and 0 hours of training in 2013.	F 497	cognitive impairments and dementia related behaviors. During the mandatory meetings on July 14, 15 and 16, 2015, the nursing assistants were instructed on the regulatory requirements and facility policies regarding continuing education. They were informed that participating in the required training is a condition of employment. The Business Office Assistant with human resource responsibilities will monitor compliance by auditing the dates of the nursing assistants¿ required annual performance reviews and the required 12 hours of continuing education hours prior to their employment anniversary date. If necessary, a specific time will be scheduled for the nursing assistant to complete the required training. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	

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F 497	Continued From page 84	F 497		

EE-M was hired in 1980 and had received 2.6 hours of training in 2014 and 4.32 hours of training in 2013.
EE-N was hired in 2010 and had received 0 hours of training in 2014 and 0 hours of training in 2013. In addition EE-N did not receive annual dementia training . TB training, fire safety or emergency procedures training in 2014.

Training records provided for employees hired since February 2015 showed that EE-R, EE-U, EE-X had not completed the two Health Academy programs entitled Client Behaviors and Caring for Alzheimer's Client as follows:

EE-R was hired as a nursing assistant on 3/25/15. EE-R's training record did not document completion of dementia training.
EE-U was hired as a nursing assistant on 4/28/15. EE-U's training record did not document completion of dementia training.
EE-X was hired as a nursing assistant on 5/12/15. EE-X'w training record did not document completion of dementia training.

During an interview on entrance on 6/8/15 at 3:00 p.m. the director of nursing (DON) stated the assistant director of nursing (ADON) was responsible for staff development. DON also stated records were kept per calendar year.

During an interview on 6/10/15 at 2:00 p.m. the ADON stated the administrator would assign the training programs to be viewed by staff through the Healthcare Academy online program. ADON stated the Tuberculosis training program and dementia/behavior training program were offered as part of orientation and annual training program. The ADON was interviewed again on

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F 497	Continued From page 85 6/10/15 at 2:10 p.m. and stated she was responsible to monitor staff training, but she did not do so. During an interview on 6/15/15 at 1:30 p.m. the administrator stated he felt staff was completing the training programs since he offered and paid a financial incentive to employees to do so. Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. A designated dead line for completion would be determined by administration and department heads. In addition to the assigned courses, additional courses could be added on an as needed basis. The procedure also noted the employee and administration could track the training progress and generate reports related to the learning.	F 497		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 8, 2015 through June 17, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing assistants received 12 hours of training annually for 13 of 13 employees (EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L, EE-M, EE-N) who worked in the capacity of nursing assistants and were reviewed who had been employed greater than 12 months by the facility. Findings include: Records provided indicated the facility provided	2 285	See POC for F497	7/27/15

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2 285	Continued From page 3 annual training in the Healthcare Academy that included Tuberculosis, Fire Safety, Environmental safety, Client Behaviors, and Caring for the Alzheimer's Client. EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L, EE-M, EE-N records were reviewed. EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L had received a performance review during the past 2 months, but the performance review did not identify areas for improvement or lack of 12-hour training. EE-M, EE-N had not received a performance review, but had been on medical leave during the time the reviews were completed according to the director of nursing. Medical Records (MR)-A on 6/16/15 at 12:45 p.m. provided total hours of in-service training for 2013 and 2014 for the 13 employees reviewed as follows: EE-A was hired in 2009 and had received 4.8 hours of training in 2014 and 8.12 hours of training in 2013. EE-B was hired in 2010 and had received 2.2 hours of training in 2014 and 2.7 hours of training in 2013. EE-C was hired in 2002 and had received 0 hours of training in 2014 and 2.7 hours of training in 2013. In addition EE-C did not receive annual dementia training . Tuberculosis (TB) training, fire safety or emergency procedures training in 2014. EE-D was hired in 2011 and had received 01.5 hours of training in 2014 and 2.2 hours of training in 2013. EE-F was hired in 2007 and had received 3.1 hours of training in 2014 and 3.2 hours of training in 2013. EE-G was hired in 2002 and had received 0	2 285		

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2 285	Continued From page 4	2 285		

hours of training in 2014 and 2.9 hours of training in 2013. In addition EE-G did not receive annual dementia training . TB training, fire safety or emergency procedures training in 2014.
EE-H was hired in 2002 and had received 9.1 hours of training in 2014 and 0 hours of training in 2013.
EE-I was hired in 2012 and had received 2.3 hours of training in 2014 and 0 hours of training in 2013.
EE-J was hired in 2013 and had received 6.3 hours of training in 2014.
EE-K was hired in 1996 and had received 0 hours of training in 2014 and 4.8 hours of training in 2013. In addition EE-K did not receive annual dementia training. TB training, fire safety or emergency procedures training in 2014.
EE-L was hired in 2022 and had received 2.3 hours of training in 2014 and 0 hours of training in 2013.
EE-M was hired in 1980 and had received 2.6 hours of training in 2014 and 4.32 hours of training in 2013.
EE-N was hired in 2010 and had received 0 hours of training in 2014 and 0 hours of training in 2013. In addition EE-N did not receive annual dementia training . TB training, fire safety or emergency procedures training in 2014.

Training records provided for employees hired since February 2015 showed that EE-R, EE-U, EE-X had not completed the two Health Academy programs entitled Client Behaviors and Caring for Alzheimer's Client as follows:

EE-R was hired as a nursing assistant on 3/25/15. EE-R's training record did not document completion of dementia training.
EE-U was hired as a nursing assistant on 4/28/15. EE-U's training record did not document

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2 285	Continued From page 5	2 285		

completion of dementia training.
EE-X was hired as a nursing assistant on 5/12/15. EE-X's training record did not document completion of dementia training.

During an interview on entrance on 6/8/15 at 3:00 p.m. the director of nursing (DON) stated the assistant director of nursing (ADON) was responsible for staff development. DON also stated records were kept per calendar year.

During an interview on 6/10/15 at 2:00 p.m. the ADON stated the administrator would assign the training programs to be viewed by staff through the Healthcare Academy online program. ADON stated the Tuberculosis training program and dementia/behavior training program were offered as part of orientation and annual training program. The ADON was interviewed again on 6/10/15 at 2:10 p.m. and stated she was responsible to monitor staff training, but she did not do so.

During an interview on 6/15/15 at 1:30 p.m. the administrator stated he felt staff was completing the training programs since he offered and paid a financial incentive to employees to do so.

Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. A designated dead line for completion would be determined by administration and department heads. In addition to the assigned courses, additional courses could be added on an as needed basis. The procedure also noted the employee and administration could track the training progress and generate reports related to the learning.

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2 285	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The administrator could monitor for compliance in regards to staff having ongoing education to meet the needs of all residents especially in regards to dealing with difficult resident behavior and dementia management. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with	2 302		7/27/15

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2 302	Continued From page 7 this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 10 of 10 employees (EE-0, EE-P, EE-R, EE-S, EE-T, EE-U, EE-W, EE-X, EE-Y, EE-Z) reviewed for having received dementia training were found to have not received timely dementia training. Findings include: Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. The procedure read, "J. In-service TB [tuberculosis] it's a Cough Away" also "Client Behavior" and "Caring for Alzheimer's Client" must be completed before starting work." Review of the information provided the facility (CMS671 and CMS672) noted the facility had 68 residents currently in the facility and that included 23 residents with dementia and 20 residents that demonstrated behaviors. The training records were reviewed for the following new hires: EE-O hired 2/19/15 as a licensed practical nurse. Records provided indicated neither of the two courses had been completed. EE-P hired 3/17/15 as a dietary staff member. Records provided indicated neither of the two courses had been completed. EE-R hired 3/25/15 as a nursing assistant.	2 302	See POC for F497	

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2 302	Continued From page 8 Records provided indicated neither of the two courses had been completed. EE-S hired 3/19/15 as a dietary staff member. Records provided indicated neither of the two courses had been completed. EE-T hired 4/8/15 as a dietary staff member. Records provided indicated neither of the two courses had been completed. EE-U hired 4/28/15 as a nursing assistant. Records provided indicated neither of the two courses had been completed. EE-W hired 5/5/15 as a medical record employee. Records provided indicated neither of the two courses had been completed. EE-X hired 5/12/15 as a nursing assistant. Records provided indicated neither of the two courses had been completed. EE-Y hired 6/3/15 as a registered nurse. EE-Y was observed during the survey working on the floor as a new employee with another nurse. Records provided indicated neither of the two courses had been completed. EE-Z was hired 1/12/15 as a licensed practical nurse. Records provided indicated neither of the two courses had been completed. The assistant director of nursing (ADON) was interviewed on 6/10/15 at 2:10 p.m. ADON stated she was responsible to monitor staff training. ADON stated she was not aware that the ten new employees had not been trained in caring for the cognitively impaired resident. The director of nursing was interviewed on 6/10/15 at 2:20 p.m. and stated that all new employees were to be trained on dementia. He added the residents with dementia were dispersed on all the wings and not in just one area.	2 302		

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2 302	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop an orientation program and monitoring system that would ensure new employees receive education and inservice training related to caring for cognitively impaired residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive care plan for mood, behavior and psychotropic drug use for 1 of 5 residents (R45) who received psychotropic medications. Findings include: R45 was admitted to the facility 6/12/14 according to the facility admission record with diagnoses that included but was not limited to bipolar disorder. R45's significant change Minimum Data Set (MDS) dated 3/12/15 indicated moderate depression with a PHQ-9 (resident mood	2 560	See POC for F280	7/17/15

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2 560	Continued From page 10 interview) score of 9, identified diagnosis of bipolar disorder, and indicated behavior status, care rejection, and wondering had worsened when compared to previous assessment. In addition, the MDS indicated R45 received antipsychotic and antidepressant medications. Care Area Assessment (CAA's) were triggered based off of the MDS assessment information that required a plan of care. The CAA's triggered as a result of the MDS assessment included: mood state, behavioral symptoms, and psychotropic drug use. R45's physician orders provided by the facility on 6/10/15 included Lexapro (antidepressant medication) 20 milligrams (mg) once per day, Wellbutrin XL (antidepressant medication) 300 mg per day, Depakene (anti-seizure medication used as a mood stabilizer) 250 mg two times per day, and Zyprexa (antipsychotic medication) 5 mg at bedtime. R45's care plan did not include a plan of care that included individualized goals and interventions for the triggered care areas for behavioral symptoms and psychotropic drug use. Although depression was identified; the care plan lacked interventions in regards to care and services associated with depression and associated mood state concerns. During an interview on 6/10/15 at 1:00 p.m., the MDS coordinator licensed practical nurse (LPN)-G verified the care plan did not reflect the CAA's triggered by the MDS. LPN-G stated mood state, behavioral symptoms, and psychotropic drug use should have been included in the care plan. The facility policy Minimum Data Set/Resident Assessment Protocol/Care Planning that was not dated does not reflect current standards. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and	2 560		

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2 560	Continued From page 11 procedures to ensure care plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revised the plan of care to include the dietician's recommendations for 1 of 1 resident (R65) reviewed. Findings include: R65 received house supplement however, the supplement was given to the resident but the amount consumed was not documented and the	2 570	See POC for F325	7/17/15

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2 570	Continued From page 12 amount consumed of meals was not documented to determine if there was an effective intervention in stabilizing weight loss. The registered dietician (RD)-B's progress note dated 5/7/15, indicated staff to monitor intake; although, The need for monitoring food and supplement intake was not indicated on the care plan. R65's care plan dated 2/2/15, indicated R65 "Is able to feed self after setup is provided and needs observing if she is eating and assist as needed." The listed approach is "One staff to provide setup for reach meal-open containers, apply condiments, cut foods and butter breads." An interview on 06/10/2015 at 12:32 a.m. with certified dietary manager (CDM) who said R65 wanders up and down the hallway. She lost weight this month, currently she weighs 114 lbs. The nurses gave her a house supplement three times a day. No one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. registered dietician (RD)-B said R65 consumes her meals well and takes a supplement three times a day. R65 expels a lot of energy by walking so much. In May 2015, she had a weight loss of 9.2% for the past six months. As of today her weight loss is 11.6% for the past six months. "She is on the risk list and being monitored for months now." RD-B continued to say I haven't looked at what the nurses are signing out for her supplement. An interview on 06/11/2015, at 9:09 a.m. with registered nurse (RN)-G who said R65 takes her house supplement three times a day but said no one records how much is consumed.	2 570		

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2 570	Continued From page 13 A policy dated 4/2000, entitled supplements read, "...Nursing service record intake of supplement" and "Need for an intake of supplement will be monitored by nursing personnel." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
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:	2 830		7/16/15

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2 830	Continued From page 14 Based on observation, interview and record review, the facility failed to reassess pain after a change in condition for 2 of 2 residents (R11 & R2) with chronic pain. Findings include: R11 was interviewed on 06/09/2015 at 10:26 a.m. and stated she had lots of pain in her back and shoulders. R11 stated she took a lot of pain medication for it and stated that she currently had pain in the area that she would rate almost a 10 (scale 0 no pain and 10 severe pain). Stated that she used Ultram (pain medication), but felt that she had "out-grown it." R11 stated that she needed to have both rotator cuffs (shoulders) repaired, but did not want surgery again. On 6/11/15 at 6:15 p.m. R11 was observed sitting in her chair and eating her meal. R11 stated her shoulder pain was at a 10 out of 10 and that nothing was being done for her. R11 was admitted to the facility in 2006 and had diagnoses listed on the physician orders that included: chronic pain and osteoarthrosis. Physician orders of 6/11/15 included: scheduled Ultram twice a day and as needed (PRN), scheduled Tylenol extra strength twice a day, scheduled Narco (narcotic medication) three times a day. On 3/18/15 the physician note read, "Patient otherwise continues to have symptoms in regards to her arthritis in her shoulders. Patient also has failed all conservative therapies for that." Assessment read,"degenerative joint disease - shoulder - quite symptomatic." The quarterly Minimum Data Set (MDS) indicated R11 had a BIMS (brief interview of mental status)	2 830	See POC for F309	

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2 830	Continued From page 15 of 15 or no cognitive impairment and indicated R11 had rated her pain at 6 out of 10 but that an assessment for pain was not necessary. The care area assessment (CAA) completed 7/9/14 indicated the resident would rate her pain at 10 in the shoulders and arms, that she received scheduled and as needed (PRN) pain medications, had limited bilateral functional range of motion. The CAA read, "She may be at risk for increased sx [symptoms] of pain limiting her quality of life, for falls and injury." The Pain Interview section for MDS 3.0 section J. dated 3/23/15 noted the resident had occasional pain, that made it hard to sleep, and would rate the pain at a 8 out of 10. No further assessment/s was found. During an interview on 6/11/15 at 6:24 p.m. licensed practical nurse (LPN)-J stated R11 usually had pain and that the physician only wanted her to have pain medications for control. The facility would also provide warm packs. LPN-J stated she thought the pain was related to the "gas" (air in bowels) in the abdomen and that the facility could use a rectal tube and anti-gas pills. During an interview on 6/11/15 at 11:30 a.m. in regards to a pain assessment for R11, RN-F stated that she was just starting to do pain assessments and any pain assessment would be in the hard copy chart. However, none was located nor provided when requested. R2 was interviewed on 6/8/15 at 6:29 p.m. and stated that her legs ached. R2 also stated that her bottom was sore because of cancer and use of the Hoyer mechanical lift. R2 stated her pain	2 830		

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2 830	Continued From page 16 level was up to 7 out of 10 scale, but currently did not have any. The care conference on 4/7/15 documentation indicated R2 stated she was having more pain than usual. Physician documentation of 4/20/15 noted right ankle pain and swelling for R2. The nursing documentation of 5/20/15 through 6/11/15 did not document the resident having pain. The annual MDS dated 12/23/14 indicated a BIMS of 14 or no cognitive impairment, the pain section was left undone. The quarterly MDS dated 3/24/15 indicated a pain intensity of 7 on a scale of 10. R2's care plan dated 4/6/15 indicate the resident had pain due to gout and generalized pain usually in back and shoulders. On 06/11/2015 at 11:30 a.m. RN-F, the MDS coordinator, stated that she was just starting to do pain assessments and had not done any for R2 yet. The facility's undated policy entitled Resident Pain Evaluation Protocol directed the resident's pain was to be reassessed quarterly and when condition indicates the need. On 06/11/2015 at 12:03 p.m. the director of nursing stated he would expect pain assessments be completed and that he knew the assessments had not been done for R2. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff who give direct care the need to assess and provide ongoing assessments and cares related to	2 830		

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2 830	Continued From page 17 current health needs. Also to monitor for staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess nutritional status for 1 of 3 residents (R65) reviewed for nutritional status. Findings include: R65 had a significant weight loss over the past 180 days however, interventions put in place were not monitored/assessed if appropriate to maintain or gain weight. R65 received house supplement however, the supplement was given to the resident but the actual amount consumed was not documented and the amount consumed of meals was not documented to determine if there was an effective intervention in stabilizing weight loss.	2 965	See POC for F325	7/17/15

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2 965	Continued From page 18 R65's most recent weight from dietary resident progress note dated 6/10/2015, was 114 pounds reflected weight loss of four pounds (3.4 percent) past 30 days, six pounds (5 percent) past 90 days and 16 pounds (12.3 percent) past 180 days. Weight loss is significant past 180 days. Dietary progress notes authored by the registered dietician (RD)-B dated 5/7/15, indicated resident's current weight is 118 pounds and weight six months ago, 130 pounds. This reflects weight loss of 9.2 percent in 6 months. Recommended house supplement be increased to four ounces three times a day to prevent further weight loss was initiated and staff to monitor intake. R65 was admitted with diagnoses that included dementia and CVA (cerebral vascular accident). A quarterly Minimum Data Set (MDS) dated 4/28/15, identified R65 required supervision for eating. the MDS also indicated R65 had no problems with coughing/choking during meals or complaints of difficult chewing or swallowing. The significant change MDS dated 1/28/15, R65 required supervision, oversight, encouragement or cueing during meal time. R65's weight was 128 pounds at that time. Nursing progress notes reviewed from 3/17/15, to 6/9/15, with the only time when the amount of meals consumed was mentioned was on 5/12/15, which indicated an "increase in house supplement to 4 oz with each meal for weight loss." On 5/22/15, the progress note read, "Up around 6 hours wandering up and down halls. ...offered food, fluids and activity as appropriate." No other mention of food consumed was available nor was any provided when requested.	2 965		

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2 965	Continued From page 19 Medication flow sheets reviewed from 3/1/15, until 6/10/15, indicate R65 given four ounces of house supplement but no monitoring of amount consumed. The medication flow sheet for 3/1/15, until 5/31/15, indicate once a day house supplement with three times a day started on 6/1/15. Monthly weights also listed on medication sheet during this period. A dietary nutritional assessment dated 1/28/15, indicated no concerns at that time and no further nutritional assessments were provided since that time. Computer generated weight variance report received from certified dietary manager (CDM), weight on 1/5/15, 127.8 pounds (lbs); 2/2/15, 124 lbs; 3/1/15, 120.4 lbs; 4/1/15, 120 lbs; 5/1/15, 118.4 lbs; 6/1/15, 114 lbs. Observations on 6/10/15, at 12:06 p.m. R65 ate 75% of her meal. On 6/11/15, at 12:03 p.m. R65 ate 50% of meal. An interview on 06/10/2015 at 12:32 a.m. with CDM who said R65 wanders up and down the hallway. She lost weight this month, currently she weighs 114 lbs. The nurses give her a house supplement three times a day. However, no one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. RD-B said R65 consumes her meals well and takes a supplement three times a day. She expels a lot of energy by walking so much. In May 2015, she had a weight loss of 9.2% for the past six months. As of today her weight loss is 11.6% for the past six months. "She is on the risk list and being monitored for months now" and I haven't looked	2 965		

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2 965	Continued From page 20 at what the nurses are signing out for her nutritional supplement. An interview on 06/11/2015, at 9:09 a.m. with registered nurse (RN)-G who said R65 takes her house supplement three times a day but said does not measures how much is given nor does anyone record how much is consumed by R65. An interview with RD and CDM on 06/11/2015, at 9:14 a.m. both said they have not assessed how much supplement the resident consumes. They validated they can not assess effectiveness of the treatment when it is not monitored. An interview on 06/11/2015, at 9:55 a.m. with director of nurses (DON) who stated my expectation is the dietary staff monitor how much of the meal R65 eats and nursing needs to monitor how much supplement R65 consumes of her supplement when they give it to her. R65's care plan dated 2/2/15, read, "Is able to feed self after setup is provided and needs observing if she is eating and assist as needed." The listed approach is "One staff to provide setup for reach meal-open containers, apply condiments, cut foods and butter breads." A undated policy entitled monitoring and preventing ongoing weight loss read, "All residents in the facility will be weighed monthly. If they exhibit an unexpected continual weight loss for two month, they will be addressed as a risk and risk interventions will begin." A policy dated 4/2000, entitled residents at nutritional risk read, "Residents with any of the following conditions should be considered at Nutritional risk: Low body weight and increased	2 965		

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2 965	Continued From page 21 caloric and/or nutrient needs related to medical condition." A policy dated 4/2000, entitled supplements read, "...Nursing service record intake of supplement" and "Need for an intake of supplement will be monitored by nursing personnel." SUGGESTED METHOD OF CORRECTION: The registered dietician could in-service employees responsible for resident nutritional needs on the need to monitor and follow interventions advised by the dietician and the doctor to maintain weight or prevent weight loss. Then to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure glucometer equipment was disinfected according to the bactericide sanitizer wipe manufacturers directions for a glucometer used for 3 of 4 residents (R29, R11 & R24) glucose tests observed. In addition the facility failed to ensure containment of used incontinent products and	21375	See POC for F441	7/17/15

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21375	Continued From page 22 soiled gloves to prevent the spread of infection which could affect several residents. Findings include: R29 had blood glucose testing done on 6/10/15 at 9:22 a.m. registered nurse (RN)-B was observed doing glucose test. After completion of the monitoring, RN-B wiped the glucometer for 20 seconds with the Super Sani-Cloth wipe. RN-B stated, "I guess we wipe it a while." However, the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R11 was observed to have glucose test done on 6/10/15 at 6:20 p.m. licensed practical nurse (LPN)-A perform glucose monitoring for R11. The glucometer was removed from the medication cart and taken directly into R11's room. LPN-A stated the facility and not the resident owned and maintained the monitors. When LPN-A returned to the medication cart following the performance of the glucose testing, She used the PDI Super Sani-Cloth wipe to clean the meter. The wipe remained in contact with the meter for less than one minute and the damp monitor was placed on top of the medication cart. LPN-A stated that she did not know how long to keep the disinfectant in contact with the meter. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R24 had just completed glucose test on 6/10/15 at 6:30 p.m. LPN-B was observed to clean the glucometer after use. LPN-B used the PDI Super Sani Cloth wipe and left the wipe in contact with the monitor for less than one minute. When finished LPN-B placed the damp monitor on top of the narcotic book. LPN-B stated the	21375		

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21375	Continued From page 23 disinfectant wipe needed to be in contact with the monitor for 10 to 15 second. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." The undated facility policy entitled Blood Glucose Meters Clean and Disinfect read, "To disinfect the meter, wipe down the meter with an EPA registered and approved premoistened towelette....Follow the product label instructions to disinfect the meter." The director of nursing was interviewed on 6/10/15 at 9:57 a.m. and stated staff need to follow the directions on the PDI package to disinfect the glucometer. LACK OF PROPER DISPOSAL OF SOILED PADS AND GLOVES TO PREVENT THE SPREAD OF INFECTIONS: During an observation on 6/8/15, at 6:18 p.m. a soiled incontinent pad and gloves were laying on the bathroom floor between resident rooms number 39 and 40. During an interview on 6/8/15, at 6:22 p.m. licensed practical nurse (LPN)-B verified the soiled incontinent product on the floor. LPN-B stated should have not been left on the floor, LPN-B donned gloves and placed the incontinent pad in the garbage bag and removed from room. An undated facility policy AM Cares (Early Morning Care) read, "Leave bedside area clean, and dispose of disposable equipment and soiled linen appropriately." An undated facility policy P.M. Care (Bedtime Care) read, Leave room clean and tidy." An undated facility policy Incontinence Care Guidelines instructed, "Discard disposable items in a plastic trash bag and secure."	21375		

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21375	Continued From page 24 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for infection control of glucometer meters. Housekeeping staff could be educated as necessary to the importance of correct cleaning procedures of waste materials. The administrator and housekeeping director could audit resident areas on a regular basis to ensure a compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
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		7/27/15

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21426	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all employees received annual Tuberculosis (TB) training for 6 of 50 nursing department employees (EE-AA, EE-CC, EE-DD, EE-FF, EE-HH, EE-LL). In addition the policy did not contain annual TB training. Findings include: Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. The procedure read, "J. In-service TB [tuberculosis] it's a Cough Away" also "Client Behavior" and "Caring for Alzheimer's Client" must be completed before starting work." The policy did not include the staff were to be evaluated to need annual training for tuberculosis. Medical Records (MR)-A was interviewed on 6/16/15 at 12:45 p.m. and had provided hours of in-service training related to TB for all employees. Training records were provided for 50 nursing staff and 6 of these staff records had not received annual training as follows: EE-AA was hired as a registered nurse (RN) on 6/18/12 EE-CC was hired as a nursing assistant (NA) on 10/6/92 EE-DD was hired as an RN on 9/29/09 EE=FF was hired as a NA on 6/15/11	21426	See POC for F497	

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21426	Continued From page 26 EE-HH was hired as a licensed practical nurse (LPN) on 4/7/98 EE-LL was hired as an NA on 5/15/96 Nine nursing department staff had been hired in 2014 and 2015. The Orientation Program included a hand out related to TB, however, these nine employees had not completed "It's Just a Cough Away" training as directed in the policy/procedure as follows: EE-GG was hired as a NA on 6/17/14 EE-JJ was hired as an RN on 9/9/14 EE-kk was hired as an NA on 11/25/14 EE-MM was hired as an NA on 11/12/14 EE-NN was hired as an NA on 3/25/15 EE-OO was hired as an NA on 4/28/15 EE-PP was hired as an NA on 8/11/14 EE-BB was hired as an NA on 5/12/15 EE-II was hired as RN on 6/3/15 The assistant director of nursing (ADON) was interviewed on 6/10/15 at 2:10 p.m. ADON stated she was responsible to monitor staff training and had missed these nine staff TB training. SUGGESTED METHOD OF CORRECTION: The medical director or director of nursing could in-service staff responsible for TB to follow the most current MDH guidance on TB program for nursing home. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of	21495		7/27/15

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21495	Continued From page 27 identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. Findings include: R26 was admitted to the facility on 4/29/14 according to the facility admission record. R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with activities of daily living. During an interview on 6/9/15, at 8:26 a.m. in an answer to the question "Have there been any concerns or problems with a roommate or any other resident," R26 stated, "Yes.!" R26 went on to say that she had problems with R1 (R1's quarterly MDS dated 4/8/15 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that her roommate (R68 who had moderate cognitive impairment according to the quarterly MDS dated 5/6/15). R26 stated R1 had yelled and cursed at her on multiple occasions over the past months and kept R26's bathroom door locked so she had to go into the other residents room to unlock it to use on several occasions. R26 then said her roommate (R68)	21495	See POC for F247 and F250	

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	00429	A. BUILDING: _____ B. WING _____	06/17/2015

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21495	Continued From page 28 daily told her when to go to bed, when she could watch television, where to put her walker, and when and how to get dressed. R26 stated R68 seemed to want more space in the shared room for her things. In response to the question, "How does that make you feel to have someone telling you what to do?" R26 stated, "She is kinda bossy, I feel like I'm walking on eggshells around her, she's always telling me what to do. I've reported it to the social worker about the concerns, I'm not sure if the same social worker is still here...I'm not aware if she followed up with my concerns. They come and go fast. I more or less just got used to it, so I don't even say anything more." R26 further stated R68 snored very loud at night and kept her awake often. R26 stated she did not want to be treated the way she had been treated (in reference to both R1 and R68) and was not expecting anything to change because nothing had changed despite asking for help from the facility. R26 stated it would be nice not to deal with it, however had learned to deal with it. During a follow up interview on 6/10/15, at. 1:30 p.m. R26 indicated she had not been able to cope well with problems with neighbor (R1) and roommate (R68) and said, "I try not to let it bother me now... It still hurts my feelings, and I'm frustrated, I'm not a child you know." In response to the question, "How do you deal with it?" R26 stated, "When [R68] starts in, I just say "I don't know what I did, but I'm sorry." R26 stated she dealt with the neighbor bathroom issue by having a bedside commode at night to avoid confrontation with. R26 stated she would preferred to use the bathroom vs. the bed side commode. R26 stated, "I can't even move a little bit without one of them questioning me on what I am doing." R26 stated she had asked for a room change several months ago, stated the social	21495		

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worker had not ever come in to talk with her. R26 stated, " I am tired of reporting the concerns and nothing changes, so what's the point? I've just learned to deal with it."
R26's care plan provided by the facility on 6/11/15 read, "Has occasional difficulties in dealing with her roommate and others that she share a common bathroom with but seeks out staff support with is as needed. Care plan also included intervention of "provide on-going support to resident and encourage resident to share her concerns and feeling." The care plan lacked explanation of difficulties and interventions to resolve the concerns.
Social service progress note dated 12/5/14 read, "[R26] came to social work office late in the day on 12/5/14 seeking support due to conflicts with other residents. She describes one resident being particularly cruel on an ongoing basis and said that hurt was compounded when her roommate, whom she has previously shared a good relationship with, aligned with the other party and has been also making hurtful remarks over the past month....she has tried to speak back more often but that appears to be making things worse for her. She is adjusting her bathroom routines to avoid confrontation... The comments also take place in the hallways and dining room. I spoke with the supervisors about the situation and the pros and cons of a room change and was advised to speak with roommate to ascertain her thoughts on the interactions reported to be taken place." The progress note further indicated social services would continue to offer emotional support and indicated if problem persisted the social worker would attempt mediation.
R1's progress notes were reviewed, no evidence of follow-up performed related to the concerns of R26 shared with social worker on 12/5/14. R1's care plan read, "Does present with an

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argumentative disposition at times with other residents. She has verbal behaviors toward other..." The care plan also indicated she is confrontational with residents and has had multiple room changes. The care plan did not reflect the issue with the shared bathroom with R1.
R68's progress notes were reviewed, no evidence of follow-up performed related to the concerns of R26. R68's care plan did not reflect or identify any concerns, interventions, or problems with roommate.
R26's progress notes did not reflect follow-up or monitoring had been performed as a result of voiced concerns at the 12/5/15 meeting and no further mention of the issues until 4/29/15 when the resident brought the same concerns forward again in her care conference.
Care conference progress note dated 4/29/15 read, "We provided [R26] the opportunity to vent about her interactions with her roommate and next door neighbor, mainly bathroom sharing issues. She reports that these issues remain the same but she had grown to better deal with them. She tends to accommodate others but also has spoken up."
No follow-up was evident in R26's, R1's, or R68's medical record as a result of the again mentioned concerns and issues at the 4/29/15 care conference.
During an interview on 6/9/15, at 3:30 p.m. licensed social worker (LSW) explained nursing staff reported to her with any concerns pertaining to the residents and "every morning I see what is going on" however, LSW stated she was not aware of the concerns despite the concerns documented in the medical record. LSW stated the facility had turned over three social workers in the last year. LSW stated the social worker who had been assigned to that wing, left in May 2015.

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21495	Continued From page 31 LSW stated a grievance had not been filed. During an interview on 6/9/15, at 4:00 p.m. director of nursing (DON) stated a grievance had not been filed. DON stated a grievance should have been filled out in regards to R26's concern with roommate (R68) and neighbor (R1). Stated he had not been aware of the problem with the roommate despite the concerns documented in the medical record. DON stated the concerns should have been followed up on. DON indicated his expectation would have been re-evaluation of a situation for a possible room change and social worker involvement. During an interview on 6/10/15, at 2:08 p.m., family member (F)-A indicated awareness of roommate and neighbor problems. Stated the roommate had always been complaining and telling [R26] what to do, "[R68] tells her to turn the TV off, when to go to bed, and where to put things... I hear it. [R68] is always saying smart thing, sarcastic things to [R26]. [R26] says she doesn't want to listen to her. She [R26] seems really frustrated, everyday there is something. Every time I call she expresses frustration with her roommate. I haven't noticed a big change is [R26's] mood but I do know she is frustrated." F-A stated had not been notified by the facility of the ongoing issues concerning the roommate or the neighbor. F-A explained had offered assistance to R26, but had been told by R26 she had been handling the problems. To the question, "Do you think [R26] is happy?" F-A stated, "No, I don't think she is happy. I would think if those people were not around she would have a better quality of life. [R26] was never a person who let people know if she was upset about something. She will deal with it and deal with it until it explodes, takes a while before she reports anything. She doesn't want to create waves, she wants to just do her thing and mind her own business."	21495		

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21495	Continued From page 32 During an interview on 6/11/15, at 2:32 p.m., nursing assistant (NA)-K stated R1 tends to be judgmental of people and had been aware of R26's bathroom concerns related to R1 locking the door so R26 cannot enter from her room. NA-K further stated knowledge of the issues with the roommate, "[R68] is always arguing about the line [which divides room in half] of where things go...and they have some issues with the curtains. [R26] was shutting the curtains too far." NA-K explained R26 was not the type of person to voice concerns, "she would wait and wait until it's really bad." NA-K explained when there had been resident concerns, they would be reported to social worker. During an interview on 6/11/15, at 2:46 p.m., licensed practical nurse (LPN)-J stated she had not been aware of the concerns with the roommate despite the concerns documented in the medical record. LPN-J stated, "Everybody knew about the whole bathroom thing, [R1] made sure everybody knew about it." LPN-J stated a commode had been placed in R26's as a compromise to the bathroom problem with R1. During an interview on 6/11/15, at 3:13 p.m., NA-E stated "[R1] tends to be more aggressive...she tends to pick on people that are a little more vulnerable ....she really goes after [R26] about the bathroom ...and is very vocal about letting people know." NA-E stated, "[R68] wants things a certain way even if it's on [R26's] side...R26 will just shrug it off and ignore it. I have seen her get upset and frustrated. She's the type of person that holds things in. She is the type that tries to get along with everyone, she is quiet and keeps to herself." NA-E explained an example, where R68 had attempted to take R26's calendar down and had to be redirected. During an interview on 6/11/15, at 3:35 p.m., NA-A stated had witnessed arguments between	21495		

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21495	Continued From page 33 R26 and R1 in the past. Stated everybody knew of the problems with R1 not wanting to share the bathroom with R26. An undated policy entitled filing grievances/complaints indicated "Grievances and/or complaints may be submitted orally or in writing." "The administrator has delegated the responsibility of grievance and/or complaint investigation to Social Services." Upon receipt of a grievance and/or complaint, Social Services will investigate the allegation and submit a written report of such finding to the administrator within (5) working days of receiving the grievance and/or complaint. An undated facility policy entitled Content Of The Clinical Record read, "Records of Social Service. Records of each resident's pertinent social data about personal and family problems medically related to the resident's illness and care and of action taken to meet these needs, will be entered in the clinical record." SUGGESTED METHOD OF CORRECTION: The director of nursing and social worker could ensure arrangements were made to provide residents with medically necessary social services related to roommate issues and resident to resident confrontations in the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21495		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have	21610		7/17/15

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21610	Continued From page 34 access to the keys. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure safe and secure disposal of used Fentanyl (topical narcotic analgesic medication) patches according to currently accepted principles to prevent potential diversion for 2 of 2 residents (R7 & R55)reviewed with prescribed Fentanyl patches. Also medications that were outdated were not removed to prevent accidental use and medications opened lacked open date to determine when it would be outdated this had the potential to affect several residents including (R29, R4, R65, R42, R46, R10, & R71) who utilized stock medications and prescription medications. Findings include: R7's admission record dated 4/9/10, indicated diagnosis including lumbago and abnormal sensation with pain in the left leg. R7's physician orders dated 5/14/15, included an order for Fentanyl patch 25 micrograms (mcg) to be applied transdermal (to the skin) every 72 hours, with special instructions, "Apply 1 patch and change patch q [every] 72 h [hours] for back pain. **When removing old patch, wrap in tissue and flush down toilet or put in sharps container.**" R7's Fentanyl patches were administered from and stored in the West medication cart. R55's admission record dated 7/27/11, indicated diagnosis including generalized pain. R55's physician orders dated 4/7/15, included an order for Fentanyl patch 50 mcg to be applied	21610	See POC for F431	

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21610	Continued From page 35 transdermal every 72 hours, with special instruction, "When removing old patch, wrap in tissue and flush down toilet or put in sharps container.**" R55's Fentanyl patches were administered from and stored in the North medication cart. During an interview on 6/8/15, at 7:15 p.m., trained medical assistant (TMA)-A indicated the policy when removing and disposing of Fentanyl patches, was for two staff to witness the destruction by putting them in the sharps container attached to the medication cart, and for both to initial on the Medication Administration Record (MAR). During an observation on 6/10/15, at 8:40 a.m., of medication administration from the West medication cart, the locking door on the sharps container attached to the cart was observed to be unlocked and could easily be opened, exposing the content in the sharps container. The sharps container was easily removed from the compartment by sliding it forward and removing from the cart. The door to the compartment had several pieces of old tape on the front and several pieces of tape on the right side of the compartment. During a review of medication storage on 6/10/15, at 8:50 a.m., the East medication cart sharps container compartment door, was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. Licensed practical nurse (LPN)-A verified the door was unlocked and the sharps container could be removed. During a review of medication storage on 6/10/15,	21610		

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21610	Continued From page 36 at 8:55 a.m., the North medication cart sharps container compartment door, was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. Registered nurse (RN)-B verified the door was unlocked and the sharps container could be removed. During a review of medication storage on 6/10/15, at 9:10 a.m., the lower level medication cart sharps container compartment door was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. LPN-L verified the door was unlocked and stated, "The door should be locked." During an interview on 6/10/15, at 9:15 a.m., LPN-B stated when removing Fentanyl patches from the residents for disposal , the policy was for two staff to witness the destruction of the patch, by either flushing the patch in the sewer system or by putting the used patch in the sharps container. LPN-B stated, "I always put it in the sharps container," pointing to the sharps container attached to the side of the West medication cart. When asked about the door to the sharps container compartment being unlocked and the ease of removing the sharps container, LPN-B verified the door was unlocked and attempted to use a key to lock it, but was unable to get it locked. LPN-B stated, "This key fits, but doesn't turn to lock the door." During an interview on 6/10/15, at 10:05 a.m., director of nursing (DON) stated he was aware that the sharps container compartments were found to be unlocked during observation, and	21610		

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21610	Continued From page 37 stated, "They should be locked." DON verified the unlocked doors on the compartments holding the sharps containers, allowed access to the sharps containers where used Fentanyl patches were disposed, and this had the potential for diversion. DON indicated he would be ordering a new door for the West medication cart because the door was cracked, and the doors were to be locked. A policy was requested for ensuring safe and secure disposal of Fentanyl patches, and was not provided. A memo written by DON, to "ALL NURSES," dated 12/16/13, was provided, and directed staff to add, "When removing old patch, wrap in tissue and flush down toilet or put in sharps container," when receiving Fentanyl patch orders. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program.	21685		7/16/15

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21685	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe comfortable environment free from rust and paint chips of bathroom door frames for 4 of 4 resident (R95, R96, R75, R87) rooms and in addition the grout around a toilet used by R11 was soiled and the wheelchair used by (R1) was soiled. Findings include: During an environmental facility tour on 06/11/2015 at 10:14 a.m. with maintenance manager (MM)-A the following was observed. R95's room, the bathroom door jam near the floor,and the light switch in the bathroom had chipped paint exposing the metal which was rusty colored. The heat register in her room also had chipped paint. MM-A stated the door jams need painting, the area around the light switch and the heat register are rusty and need painting. R96's room the bathroom door jams and around the light switch had paint chipped and were rusty. Verified by MM-A who said he will paint. 75's bathroom door frame the paint was chipped. MM-A agreed of the chipped area's and the need for painting those areas. R87's bathroom door frame near the bottom was chipped. MM-A verified the chipped paint on the metal door frame. R1's wheelchair was soiled, the poles under the chair had a thick layer of dust, MM-A verified the	21685	See POC for F465	

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21685	Continued From page 39 dust/soiled areas. MM-A stated I suppose its been a long time since the wheelchair was cleaned. He said the process is the staff bring the wheelchair to his office with a note asking maintenance to wash it. MM-A stated they don't keep track of which wheelchairs are washed and there was no schedule for cleaning wheelchairs. R11's bathroom in room had scratched up door jam. The toilet's caulking was yellow and there was a yellowish discoloration on the floor around the toilet. The bathroom had a strong, old urine smell. MM-A agreed that the caulk and flooring was yellow and the bathroom smelled like urine. An interview on 06/11/2015 at 10:54 a.m. the director of nursing (DON) said the wheelchairs were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair cleaning schedule. A maintenance policy in regards to general cleaning/repairs were requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could work with the director of maintenance to develop a maintenance program to ensure damaged walls, floors, ceilings, and bedroom and bathroom fixtures are managed/repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		

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21880	Continued From page 40	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		7/16/15

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21880	Continued From page 41 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 observation, interview and document review, the facility failed to ensure resident grievances were resolved promptly for 4 of 4 residents (R53, R46, R7 & R66) who expressed a grievance to the facility staff. Findings include: During an interview with R53 on 6/8/15, at 6:05 p.m. R53 reported her roommate hollers all night long. R53 stated, "She sleeps all day, hollers all night. I've told all the nurses. Nothing gets done. I've asked if they can give her a private room, but nothing happens. They try different stuff, it doesn't work. She keeps me up all night. They don't do anything for me." Documentation in R53's medical record dated 5/3/15, at 1:39 a.m. indicated R53 had reported, "can't sleep with her hollering." Another note from 5/3/15 at 1:46 a.m. indicated, "message left on ss [social services] telephone in regards to that incident." On 5/3/15 at 5:13 a.m. a nurse's note entry included, "asked her [R53] what she was doing over by [R30's] bed during the night and she states she was giving her a stuffed animal to hold so she wouldn't holler" R53's quarterly Minimum Data Set (MDS) dated 3/18/15, identified intact cognition with no behavioral or communication issues.	21880	See POC for F166	

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21880	Continued From page 42 During an interview with R46 on 6/9/15, at 09:23 a.m. R46 state, "at different times someone hollers. It keeps me up at night." An entry in R46's medical record dated 5/16/15, at 4:43 a.m. included, "States she can't sleep during the night because her roommate keeps her awake which usually sets off the alarm and that makes her nervous... Message left for SS." R46's annual Minimum Data Set (MDS) dated 4/29/15, indicated the resident had intact cognition with no behavioral or communication issues. During an interview with R7 on 6/8/15, at 6:36 p.m. R7 stated, "we have a person (R30) next door that yells before she goes to bed." During an interview with R7 on 6/11/15, at 3:40 p.m. R7 said she had complained to the director of nursing (DON) about the noise R30 made at night, so the DON had moved R30 to another room, "but she is now in the room next to me." R7's annual MDS dated 3/31/15, identified R7 had intact cognition with no behavioral or communication issues. During an interview with R66 on 6/8/15, at 06:44 p.m. R66 said, "It is noisy because another lady is yelling for help a lot at night." R66's quarterly MDS dated 4/22/15, identified the resident was cognitively intact with no behavioral or communication issues. During an interview with nursing assistant (NA)-D on 6/11/15 at 2:32 p.m., NA-D said, "I have heard	21880		

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21880	Continued From page 43 [R30] yells a lot at night from the night staff." During an interview on 6/11/15, at 2:41 p.m. licensed practical nurse (LPN)-J said, "(R30) has a problem yelling and cries at night. The staff will try to medicate her and sit with her. This happens at least a couple times a week. Her roommate has said she (R30) has kept her up all night. Everybody is aware of it, social services (SS), the director of nursing (DON). I don't know why we can't fix it." During an interview with LPN-K on 6/12/15 at 9:55 a.m., LPN-K stated, "(R30) slept last night but it has been a problem with her yelling in the night. She cries out at night or at least makes noise, about 1-2 times a week. SS and the DON know about it but it is a difficult issue to resolve." During an interview with SS-A on 6/11/15 at 2:56 p.m., SS-A stated, "I don't have any written grievances for the past six months. I have heard about (R30) crying out but I have not gotten a grievance form about it. Everyone is given a grievance form on admission. We do not remind residents to use the grievance form. The staff try to get to her (R30) as fast as they can but she still hollers and cries out." During an interview on 6/11/15 at 5:24 p.m., the DON said he was not aware [R30] was keeping people awake at night but acknowledged, "I was aware of the daytime noises." The DON stated he knew the grievance process needed to be "repaired." An undated facility policy entitled, Filing Grievances/Complaints indicated: "Grievances and/or complaints may be submitted orally or in writing...the administrator has delegated the	21880		

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21880	Continued From page 44 responsibility of grievance and/or complaint investigation to Social Services. Upon receipt of a grievance and/or complaint, Social Services will investigate the allegation and submit a written report of such finding to the administrator within (5) working days of receiving the grievance and/or complaint. 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 complaint/concern. 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 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	21980		7/16/15

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21980	Continued From page 45 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 (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 observation, interview and document review, the facility failed to immediately report allegations of maltreatment to the common entry point (CEP) for 5 of 6 residents (R75, R65. R64, R99 and R98) reviewed for allegations of maltreatment. Findings include:	21980	See POC for F490	

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21980	Continued From page 46 Although R75 was observed by staff to be yelled at by licensed practical nurse (LPN)-E on 4/24/15 following the supper meal, and LPN-E was subsequently observed to be verbally and physically abusive to R65 that same evening, however, the incidents were not immediately reported to the the State agency, nor were interventions initiated to prevent further abuse. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C dated 4/25/15. The concern included: "EMPLOYEE NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." R75's quarterly minimum data set (MDS) dated 5/12/15 indicated R75 had a brief interview for mental status (BIMS) score of 4 which indicated R75 was severely cognitively impaired. The MDS also indicated R4 could hear with minimal difficulty. During an interview and observations on 6/9/15 at 9:51 a.m., R75 was observed during an interview with family (F)-A. R75 conversed with F-A and the surveyor without hearing difficulty and surveyor did not have to speak loudly for resident to hear. R75's care plan directed staff to provide, "Clear,	21980		

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21980	Continued From page 47 careful, explanations to facilitate her comprehension...repeat/rephrase words as needed to facilitate hearing and comprehension." Information provided by the DON related to the investigation of these incidents, included a typed interview conducted 4/25/15 at 10:00 a.m., by the DON with NA-L. The interview documentation included, "Spoke to [NA-L] concerning incident Friday 4-24-15 p.m. shift. She stated he [LPN-E] was talking to [R75]. [R75] was repeating questions and as [LPN-E] was answering questions he was becoming more upset and yelling, and was probably yelling more than he should. [R65] was standing nearby with her walker but did not say anything. Stated she (NA-L) heard a little later from another CNA (certified nursing assistant) that [R65] was hitting at staff, kicking and attempting to hit them with her walker." LPN-E was observed on 6/9/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility. During an interview on 6/12/15, at 9:30 a.m., the DON was asked to provide all information regarding the immediate reporting of the allegations of abuse between LPN-E and the residents to the administrator or State agency, and any interventions taken to protect R75 or other residents, or any investigation of the abuse incident. The DON confirmed he had not reported the allegation involving R75 to the State agency because he had been more focused on the physical abuse allegation between LPN-E and R65. The facility COMPLAINT/CONCERN FORM	21980		

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21980	Continued From page 48 REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up." During an interview on 6/11/15, at 9:34 a.m. in regards to when he was notified of the abuse incident with R65 which occurred on 4/24/15 after evening meal, DON stated staff had placed a phone message on his home phone following the incident but he did not listen to it until the next morning (Saturday 4/25/15) at which time he had come to the facility to follow-up on the incident. The DON stated it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit any internal investigative reports to the State designated agency. Following the surveyor's inquiry about the reporting of these alleged incidents of verbal/physical abuse, the DON made a report to the State agency (OHFC) regarding the verbal abuse R75 had sustained on 4/24/15. The report was made on 6/12/15, as part of the immediate plan of correction following the facility having been informed that an immediate jeopardy situation existed. The incident description sent to the State agency included: "During routine MDH [Minnesota Department of Health], it was brought to this writer's attention that on 4/24/15, staff LPN [LPN-E] was yelling at resident [R75]. An incident was initially reported on 4/25/15 regarding	21980		

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21980	Continued From page 49 another demented resident [however, R65 was the main focus of that OHFC report and information in regards to R75 was to support the investigation of R65. During this incident [R75] was also agitated and following the nurse and not responding to re-direction. Nurse [LPN-E] did yell at resident due to his frustration with resident [R75] and her continued agitation. This writer initially combined both of these actions by the nurse [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident ..." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies." The facility had submitted a report to the state agency on 4/16/15, indicating a nurse had witnessed R64 being hit on the forearm by family (F)-B on 4/15/15, around 4:40 p.m. The report indicated, "[R64] was sitting in a reclining chair next to [F-B]...As he was attempting to get up and out of the chair, [F-B] struck him on the forearm..." R64's diagnosis, according to the resident admission record dated 1/21/15, included debility with functional decline and dementia. The quarterly Minimum Data Set (MDS) dated 3/25/15, identified R64 had severe cognitive impairment and required extensive assistance from one person for all activities of daily living (ADL)'s.	21980		

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21980	Continued From page 50 A review of the nursing progress notes dated 4/15/15, included a note from 4:30 p.m., "Nurse observed resident attempting to get out of a recliner chair. [F-B] attempted to tell resident to sit back down. Nurse noted agitation in the [F-B ' s] voice. Nurse then observed resident's [F-B] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well." Although the facility was aware of the family member striking R64 on 4/15/15, the incident was not reported to the State agency until the next day, 4/16/15. Although R99 sustained an injury of unknown origin on 8/19/14, the facility failed to ensure the administrator and state agency were notified immediately. An incident report for R99 had been submitted to the State agency on 8/20/14 for an incident that had occurred the previous day, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident..was lying on the floor...[R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..." R99's record was reviewed. The resident admission record dated 2/26/10, identified diagnoses including: senile dementia and osteoporosis. The quarterly MDS dated 8/12/14, identified R99 as having severe cognitive impairment and requiring limited assistance from one person for transferring and walking.	21980		

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21980	Continued From page 51 A review of the nursing progress notes dated 8/19/14 at 10:30 a.m. included, "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]." A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident had been reported to the administrator on "8/20/14, AM," and had been reported to the State licensing agency on "8/20/14, PM." Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and state agency were notified immediately. The facility had submitted a report to the State agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's disease." R98's record was reviewed and the resident admission record dated 12/5/08 indicated the resident had diagnoses including: dementia and Alzheimer's disease. A quarterly MDS dated 11/18/14, identified R98 had severe cognitive impairment and was totally dependent on staff for all activities of daily living. A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning	21980		

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21980	Continued From page 52 cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. The progress notes also indicated R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved. A Skin Integrity Events Report dated 8/10/14, indicated the purplish-black bruise on R98's left medial forearm extending to the side of the thumb and index finger, was mildly painful and was swollen. A review of the facility's Alleged Resident Abuse Investigation Report Form, signed as reviewed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on resident's L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." The investigative report also indicated the administrator had not been notified of the 8/10/14 incident until 8/12/14. During interview on 6/11/15 at 9:34 a.m., the DON stated administrative staff were to submit reports to the State agency, "Other staff can, but I want them to call me." The DON stated he carried a cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. The DON verified the reports that were submitted for R64, R99, and R98, had not all been submitted immediately to the administrator or State agency as required. The DON confirmed he was aware the reports needed	21980		

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	00429	A. BUILDING: _____ B. WING _____	06/17/2015

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21980	Continued From page 53 to be submitted immediately and stated, "We have a system problem." Review of the facility's undated policy Reporting Abuse to State Agencies and Other Entities/Individuals included: "Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be suspected, it must be immediately reported to the administrator and to proper State agencies." SUGGESTED METHOD OF CORRECTION: The administrator and designee could review abuse prohibition policies and procedures and revise as necessary, could educate all staff on the policies and procedures, and monitor all incidents and vulnerable adult reports for compliance with reporting. TIME PERIOD FOR CORRECTION: Seven (7) 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 internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced	21995		6/17/15

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21995	Continued From page 54 by: Based on observation, interview and document review, the facility failed to immediately report allegations of maltreatment to the Common Entry Point (CEP) for 5 of 6 residents (R75, R65. R64, R99 and R98) reviewed for allegations of maltreatment. Findings include: Although R75 was observed by staff to be yelled at by licensed practical nurse (LPN)-E on 4/24/15 following the supper meal, and LPN-E was subsequently observed to be verbally and physically abusive to R65 that same evening, however, the incidents were not immediately reported to the the State agency, nor were interventions initiated to prevent further abuse. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C dated 4/25/15. The concern included: "EMPLOYEE NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." R75's quarterly minimum data set (MDS) dated 5/12/15 indicated R75 had a brief interview for mental status (BIMS) score of 4 which indicated R75 was severely cognitively impaired. The MDS also indicated R4 could hear with minimal difficulty.	21995	See POC for F223	

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21995	Continued From page 55 During an interview and observations on 6/9/15 at 9:51 a.m., R75 was observed during an interview with family (F)-A. R75 conversed with F-A and the surveyor without hearing difficulty and surveyor did not have to speak loudly for resident to hear. R75's care plan directed staff to provide, "Clear, careful, explanations to facilitate her comprehension...repeat/rephrase words as needed to facilitate hearing and comprehension." Information provided by the DON related to the investigation of these incidents, included a typed interview conducted 4/25/15 at 10:00 a.m., by the DON with NA-L. The interview documentation included, "Spoke to [NA-L] concerning incident Friday 4-24-15 p.m. shift. She stated he [LPN-E] was talking to [R75]. [R75] was repeating questions and as [LPN-E] was answering questions he was becoming more upset and yelling, and was probably yelling more than he should. [R65] was standing nearby with her walker but did not say anything. Stated she (NA-L) heard a little later from another CNA (certified nursing assistant) that [R65] was hitting at staff, kicking and attempting to hit them with her walker." LPN-E was observed on 6/9/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility. During an interview on 6/12/15, at 9:30 a.m., the DON was asked to provide all information regarding the immediate reporting of the allegations of abuse between LPN-E and the residents to the administrator or State agency,	21995		

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21995	Continued From page 56	21995		

and any interventions taken to protect R75 or other residents, or any investigation of the abuse incident. The DON confirmed he had not reported the allegation involving R75 to the State agency because he had been more focused on the physical abuse allegation between LPN-E and R65.

The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up."

During an interview on 6/11/15, at 9:34 a.m. in regards to when he was notified of the abuse incident with R65 which occurred on 4/24/15 after evening meal, DON stated staff had placed a phone message on his home phone following the incident but he did not listen to it until the next morning (Saturday 4/25/15) at which time he had come to the facility to follow-up on the incident. The DON stated it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit any internal investigative reports to the State designated agency.

Following the surveyor's inquiry about the reporting of these alleged incidents of verbal/physical abuse, the DON made a report to the State agency (OHFC) regarding the verbal abuse R75 had sustained on 4/24/15. The report

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21995	Continued From page 57 was made on 6/12/15, as part of the immediate plan of correction following the facility having been informed that an immediate jeopardy situation existed. The incident description sent to the State agency included: "During routine MDH [Minnesota Department of Health], it was brought to this writer's attention that on 4/24/15, staff LPN [LPN-E] was yelling at resident [R75]. An incident was initially reported on 4/25/15 regarding another demented resident [however, R65 was the main focus of that OHFC report and information in regards to R75 was to support the investigation of R65. During this incident [R75] was also agitated and following the nurse and not responding to re-direction. Nurse [LPN-E] did yell at resident due to his frustration with resident [R75] and her continued agitation. This writer initially combined both of these actions by the nurse [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident ..." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies." The facility had submitted a report to the state agency on 4/16/15, indicating a nurse had witnessed R64 being hit on the forearm by family (F)-B on 4/15/15, around 4:40 p.m. The report indicated, "[R64] was sitting in a reclining chair next to [F-B]...As he was attempting to get up and out of the chair, [F-B] struck him on the forearm..."	21995		

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21995	Continued From page 58 R64's diagnosis, according to the resident admission record dated 1/21/15, included debility with functional decline and dementia. The quarterly Minimum Data Set (MDS) dated 3/25/15, identified R64 had severe cognitive impairment and required extensive assistance from one person for all activities of daily living (ADL)'s. A review of the nursing progress notes dated 4/15/15, included a note from 4:30 p.m., "Nurse observed resident attempting to get out of a recliner chair. [F-B] attempted to tell resident to sit back down. Nurse noted agitation in the [F-B ' s] voice. Nurse then observed resident's [F-B] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well." Although the facility was aware of the family member striking R64 on 4/15/15, the incident was not reported to the State agency until the next day, 4/16/15. Although R99 sustained an injury of unknown origin on 8/19/14, the facility failed to ensure the administrator and state agency were notified immediately. An incident report for R99 had been submitted to the State agency on 8/20/14 for an incident that had occurred the previous day, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident..was lying on the floor...[R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..."	21995		

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21995	Continued From page 59 R99's record was reviewed. The resident admission record dated 2/26/10, identified diagnoses including: senile dementia and osteoporosis. The quarterly MDS dated 8/12/14, identified R99 as having severe cognitive impairment and requiring limited assistance from one person for transferring and walking. A review of the nursing progress notes dated 8/19/14 at 10:30 a.m. included, "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]." A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident had been reported to the administrator on "8/20/14, AM," and had been reported to the State licensing agency on "8/20/14, PM." Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and state agency were notified immediately. The facility had submitted a report to the State agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's disease." R98's record was reviewed and the resident	21995		

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21995	Continued From page 60	21995		

admission record dated 12/5/08 indicated the resident had diagnoses including: dementia and Alzheimer's disease. A quarterly MDS dated 11/18/14, identified R98 had severe cognitive impairment and was totally dependent on staff for all activities of daily living.

A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. The progress notes also indicated R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved.

A Skin Integrity Events Report dated 8/10/14, indicated the purplish-black bruise on R98's left medial forearm extending to the side of the thumb and index finger, was mildly painful and was swollen.

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed as reviewed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on resident's L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." The investigative report also indicated the administrator had not been notified of the 8/10/14 incident until 8/12/14.

During interview on 6/11/15 at 9:34 a.m., the DON stated administrative staff were to submit reports

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21995	Continued From page 61 to the State agency, "Other staff can, but I want them to call me." The DON stated he carried a cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. The DON verified the reports that were submitted for R64, R99, and R98, had not all been submitted immediately to the administrator or State agency as required. The DON confirmed he was aware the reports needed to be submitted immediately and stated, "We have a system problem." Review of the facility's undated policy Reporting Abuse to State Agencies and Other Entities/Individuals included: "Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be suspected, it must be immediately reported to the administrator and to proper State agencies." SUGGESTED METHOD OF CORRECTION: The administrator and designee could review abuse prohibition policies and procedures and revise as necessary, could educate all staff on the policies and procedures, and monitor all incidents and vulnerable adult reports for compliance with reporting. TIME PERIOD FOR CORRECTION: Seven (7) days.	21995		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse	22000		7/16/15

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22000	Continued From page 62	22000		

prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the

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22000	Continued From page 63 vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policies and procedures related to immediate reporting of alleged abuse/neglect to the administrator and State agency, protecting resident/s from ongoing abuse, and completing a thorough investigation following an allegation of abuse/neglect for 5 of 26 residents (R75, R65, R64, R99, R98) who were reviewed for abuse prohibition. This had the potential to affect all 68 residents currently residing in the facility. Findings include: On 6/11/15 the facility provided a package of undated Policy and Procedure Standards related to Abuse Prohibition: The undated policy entitled Recognizing Signs and Symptoms of Abuse/Neglect read, "...all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services and immediately to the Administrator." The procedure directed signs and symptoms of abuse should be reported promptly. The procedure lists signs of actual physical abuse, signs of actual physical neglect, and signs/symptoms of psychological abuse/neglect. The undated policy entitled Reporting/Investigating Resident	22000	See POC for F490	

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22000	Continued From page 64 Accidents/Incidents read, "All accidents/incidents involving residents must be report to the director of nursing services and immediately to the administrator." The procedure directed staff that "all accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing." The undated policy entitled Abuse and/or Neglect Investigation read, "All reports of resident abuse or neglect shall be promptly and thoroughly investigated." The procedure directed the administrator would appoint a designee to investigate the incident and that person would report daily to the administrator the progress of the investigation. The procedure also directed that employees that had been accused of resident abuse would be reassigned to nonresident care duties or put on leave until the results of the investigation had been reviewed by the administrator. The undated policy entitled Protection of Residents During Abuse Investigation read, "Our facility will protect residents from harm during investigations of abuse allegations." The procedure directed that during abuse investigations, employees accused of resident abuse would be reassigned to nonresident care duties or put on leave; and that if employees were reassigned to non-resident care duties, such assignments would not be in any part of the building which the resident frequents. The procedure read, "Should the results indicate that abuse occurred, appropriate authorities will be notified." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals	22000		

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22000	Continued From page 65 read, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate state agencies. The procedure directed "A. Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of unknown source, or abuse to be suspected. It must be immediately reported to the administrator and to proper state agencies 1. Olmsted County Social Services 2. Minnesota Department of Health/OHFC. B. Verbal/written notices to the above agencies will be made immediately following the incident if possible...C. The administrator, or his/her designee, will submit internal investigation report to OHFC website 5 working days of the occurrence of the incident." R75 was observed to have been verbally abused by licensed practical nurse (LPN)-E on 4/24/15. The incident was not immediately reported to the administrator or designated State agency, nor was R75 protected following this incident, or a thorough investigation completed. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C 4/25/15. The concern included: "EMPLOYEE NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..."	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 66 During an interview on 6/12/15, at 9:30 a.m., the DON was asked for all information regarding the immediate reporting of the verbal abuse to the administrator, OHFC, and interventions taken to protect R75 from further abuse as well as other residents and a thorough investigation of the abuse incident. None was provided and the DON stated he did not report this incident with R75 separately but was with the report sent to OHFC in regards to the physical abuse to R65. Then the DON stated he was more focused on the physical abuse incident with R65 at the time. Again the physical abuse of R65 occurred shortly after the verbal abuse of R75 by LPN-E on 4/24/25 after the evening meal as LPN-E was passing medications. Progress note was not entered into the medical record until two days later on 4/27/15 and read, "Several staff members were in the south conference room when a staff nurse heard raising voice towards resident." The progress note also indicated notification of DON, ADON, and Social services, however did not indicate when the notifications were given. The DON reported the verbal abuse of R75 to the OHFC and to the Common Entry Point (CEP) on 6/12/15 after the survey team had informed the facility an immediate jeopardy (IJ) related to abuse existed. R65 had been verbally and physically abused by LPN-E on 4/24/15 however, this was not immediately reported to the administrator or OHFC. The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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22000	Continued From page 67 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up." A typed witness account of the physical abuse that occurred on 4/24/15 as part of the investigation for R65 completed on 4/25/15 by LPN-J read, "On Friday 4/24/15 I was here for staff potluck, ...He [LPN-E] was finishing up a medication admin at cart when [R65] came up grabbed the water pitcher and tried to hit him with it. He grabbed it out of her hands and set it back on cart. She then raised up her walker, as if to hit him with it, not sure if he knocked it down or she dropped it but it fell on the floor. [LPN-E] picked it up and [R65] went as if to hit him with a closed fist at which time I got between them and asked [R65] to leave the area which she did. [LPN-E] left shortly after that." The facility provided the incident report, submission report to the State agency (the Office of Health Facility Complaints-OHFC), and all investigative notes. According to the OHFC complaint, the allegation of verbal/physical abuse to R65 had not been not immediately reported but had been reported the following day 4/25/15. R64 had an allegation of physical abuse by a family (F) member which occurred on 4/15/15 however, it was not reported to the State agency until the next day. The facility submitted a report to the State agency on 4/16/15 indicating a nurse witnessed R64 being hit on the forearm by [F-A] on 4/15/15,	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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22000	Continued From page 68 around 4:40 p.m. "[R64] was sitting in a reclining chair next to [F-A]... As he was attempting to get up and out of the chair, [F-A] struck him on the forearm..." A review of the nursing progress notes, dated 4/15/15, at 4:30 p.m., included, "Nurse observed resident attempting to get out of a recliner chair. [F-A] attempted to tell resident to sit back down. Nurse noted agitation in the [F-A]'s voice. Nurse then observed resident's [F-A] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well." R99 had received an injury of unknown origin causing a fracture the facility did not immediately report the incident to the state agency. An incident report for R99, submitted to the State agency on 8/20/14 indicated, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident ...was lying on the floor... [R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..." A review of the nursing progress notes dated 8/19/14 at 10:30 a.m., included: "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]." A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 69 administrator and director of nursing on 8/20/14, indicated the incident from 8/19/14 had first been reported to the administrator on "8/20/14, AM," and had subsequently been reported to the State Licensing Agency on "8/20/14, PM." R98 was found to have a large bruise on her left forearm which was found to be a fracture however, this was not immediately reported to the State agency or the administrator as directed by the facility abuse policy and procedure. The facility submitted a report to the state agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's Disease." A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. Also included, R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved. A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on residents L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM [range of motion]. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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22000	Continued From page 70 comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." Also included, the administrator was not notified until 8/12/14. Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and State agency were notified immediately. During interview on 6/11/15, at 9:34 a.m. the director of nursing (DON) indicated the administrative staff were to submit reports to the State agency and stated, "Other staff can, but I want them to call me." DON stated he carried a cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem." SUGGESTED CORRECTION: The administrator and designee could review abuse prohibition policies and procedures and revise as necessary, could educate all staff on the policies and procedures, and monitor all incidents and vulnerable adult reports for compliance with reporting. TIME PERIOD FOR CORRECTION: Seven (7) days.	22000		

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
245349 Y1	A. Building B. Wing Y2	8/11/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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 F0166	Correction	ID Prefix F0223	Correction	ID Prefix F0225	Correction
Reg. # 483.10(f)(2)	Completed	Reg. # 483.13(b), 483.13(c)(1)(i)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed
LSC	07/16/2015	LSC	06/17/2015	LSC	06/17/2015
ID Prefix F0226	Correction	ID Prefix F0247	Correction	ID Prefix F0250	Correction
Reg. # 483.13(c)	Completed	Reg. # 483.15(e)(2)	Completed	Reg. # 483.15(g)(1)	Completed
LSC	06/17/2015	LSC	07/27/2015	LSC	07/27/2015
ID Prefix F0279	Correction	ID Prefix F0280	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25	Completed
LSC	07/17/2015	LSC	07/17/2015	LSC	07/16/2015
ID Prefix F0323	Correction	ID Prefix F0325	Correction	ID Prefix F0431	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	07/17/2015	LSC	07/17/2015	LSC	07/17/2015
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix F0497	Correction
Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed	Reg. # 483.75(e)(8)	Completed
LSC	07/17/2015	LSC	07/16/2015	LSC	07/27/2015

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
6/17/2015	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00429 Y1	A. Building B. Wing Y2	8/11/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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	20285	Correction	ID Prefix	20302	Correction	ID Prefix	20560	Correction
Reg. #	MN Rule 4658.0100 Subp. 2	Completed	Reg. #	MN State Statute 144.6503	Completed	Reg. #	MN Rule 4658.0405 Subp. 2	Completed
LSC		07/27/2015	LSC		07/27/2015	LSC		07/17/2015
ID Prefix	20570	Correction	ID Prefix	20830	Correction	ID Prefix	20965	Correction
Reg. #	MN Rule 4658.0405 Subp. 4	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed	Reg. #	MN Rule 4658.0600 Subp. 2	Completed
LSC		07/17/2015	LSC		07/16/2015	LSC		07/17/2015
ID Prefix	21375	Correction	ID Prefix	21426	Correction	ID Prefix	21495	Correction
Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	MN Rule 4658.1005 Subp. 5	Completed
LSC		07/17/2015	LSC		08/11/2015	LSC		07/27/2015
ID Prefix	21610	Correction	ID Prefix	21685	Correction	ID Prefix	21880	Correction
Reg. #	MN Rule 4658.1340 Subp. 1	Completed	Reg. #	MN Rule 4658.1415 Subp. 2	Completed	Reg. #	MN St. Statute 144.651 Subd. 20	Completed
LSC		07/17/2015	LSC		08/11/2015	LSC		07/16/2015
ID Prefix	21980	Correction	ID Prefix	21995	Correction	ID Prefix	22000	Correction
Reg. #	MN St. Statute 626.557 Subd. 3	Completed	Reg. #	MN St. Statute 626.557 Subd. 4a	Completed	Reg. #	MN St. Statute 626.557 Subd. 14 (a)-(c)	Completed
LSC		06/17/2015	LSC		06/17/2015	LSC		06/17/2015

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/17/2015	☐ YES ☐ NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

December 18, 2015

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

RE: Docket OAH 60-0900-32874

Dear Ms. Coffin:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by Stewartville Care Center in Stewartville, MN, regarding five federal deficiencies issued as a result of a recertification survey, exit date June 17, 2015. The IIDR was held before Administrative Law Judge James E. LaFave. The Department received Judge LaFave's recommended decision the afternoon of December 8, 2015.

Decision

After careful review of Judge LaFave's recommendation and the material submitted to the Judge in support of each party's position, I do not concur with rescinding tags F223, F225 or F226, and uphold them as written. F223 and F225 were written at a scope and severity of Level K, and F226 was issued at a scope and severity of F. I concur with rescinding tags F490 and F493.

Rationale

During Stage 1 of the survey, the Abuse Task was triggered. When a task is triggered, a surveyor follows a specific pathway – an established and computer directed set of investigative protocols, to investigate whether there was a deficient practice in the task area. The tags issued in this survey are a result of the extended survey that was conducted as a result of the triggering of the Abuse Task.

It is not disputed that the incidents in this IIDR occurred. What is disputed is the conclusion of Stewartville's internal investigation of the incidents, the incomplete manner in which the internal investigations were conducted, the sequence and timing of reporting the incidents to the State Agency (Office of Health Facility Complaints - OHFC), and the accuracy of the

information on the reports to the OHFC when compared to the information in the facility's incident files.

Tag F223 requires a resident has *the right* to be free from *verbal,* sexual, *physical and mental abuse,* corporal punishment, and involuntary seclusion. The intent of the regulation is that residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. Interpretive Guidelines include a definition of abuse: "abuse" means the willful infliction of injury, unreasonable confinement, *intimidation,* or punishment with resulting physical harm, pain or *mental anguish.*" (42 CFR §488.301) The Interpretive Guidelines, further define types of abuse: verbal abuse, sexual abuse, physical abuse, mental abuse and involuntary seclusion. "Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse *include, but are not limited to*: threats of harm; *saying things to frighten a resident*, such as telling a resident that he/she will never be able to see his/her family again. "Mental abuse" *includes, but is not limited to humiliation*, harassment, and threats of punishment or deprivation.

The surveyor found two facility incident reports involving R65 and R75 with allegations of physical and verbal abuse involving LPN-E. Both incidents occurred on April 24, 2015.

R65 was a cognitively impaired resident, who exhibited short and long term memory loss. R65 exhibited behavioral symptoms including paranoia and at times was physically resistive with cares. R65 could usually make her needs known and could walk independently with a wheeled walker.

R75 was cognitively impaired with short and long term memory loss. R75 did not have a history of abusing others, had adequate hearing at a normal level of conversation and was able to express her needs verbally.

The facility contends that LPN-E did not verbally abuse R75, rather he was speaking loudly so R75 could hear him. The facility noted it suspended LPN-E pending further investigation of R65 and reported the incident to the OHFC. After conducting its internal investigation, Stewartville concluded LPN-E was trying to keep R65 safe and prevent her from harming herself or others. They concluded that LPN-E did not abuse R65 or intend to harm her in any way.

The Centers for Medicare and Medicaid (CMS) require surveyors to follow Interpretive Guidelines when determining whether a deficient practice exits. When looking at allegations of potential abuse to residents, all possible types of abuse must be considered. While the term "willful infliction of" is used in the definition of abuse, it is not further defined in the Interpretive Guidelines at F223. "Willful" is defined in the State Operations Manual in Appendix

PP, Interpretive Guidelines for an abuse and supervision tag as: "means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish." The New World Dictionary of the American Language defines "willful" as: "1. said or done deliberately or 2. Following one's own will unreasoningly; obstinate; stubborn." Raising one's voice very loudly, or yelling at a resident to be heard, seeing the resident is further distressed as a result of that action and yet continuing the action is a willful act, it is an action committed unreasoningly. Moreover, there were several staff onsite (RN-H, LPN-J, NA-E, NA-C) at the time who overheard the loud interaction between LPN-E and R75. These staff were concerned enough by the interaction to leave areas they were working in such as the dining room, hallway, and other resident rooms, to check out what was happening. These other staff who were familiar with LPN-E and R75, did not consider the interaction to be "normal", that is, that LPN-E was speaking loudly in an attempt to allow R75 to hear him. RN-H was concerned enough by this observation that she immediately called the assistant director of nursing to report she was concerned about LPN-E's "mental state." The other staff were concerned enough about the incident to file facility Complaint/Concern Forms Regarding Employee, one included: "Upon returning from bringing residents from supper, co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at [R75]. We tried to take her to her room. She [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation around 7:40. I went to go ask nurse [LPN- J] a question and noticed [R65] standing by med cart arguing with [LPN-E]. She attempted to grab water pitcher and he grabbed her from behind like choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident down afterwards but she was too worked up."

The nursing assistant who documented the Complaint/Concern report noted above was listed as a witness in the investigative report the facility sent into the OHFC as required; however, that report did not provide this firsthand witnesses' account as stated above. Instead the report to OHFC included: "During routine MDH survey it was brought to this writer's attention that on 4-24-15, staff [LPN-E] was yelling at [R75]. This incident was initially reported regarding another demented resident. During this incident [R75] was also agitated and following the nurse and not responding to redirection. [LPN-E] did yell at resident due to his frustration with [R65] and her continued agitation. This writer initially combined both of these actions by [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident. [R75] has not suffered any negative effects from this situation and continues to wander the facility in her w/c as usual."

The other nursing assistant who had witnessed this incident, and who was referenced in the Complaint/Concern report, was not interviewed by the facility during the investigation of the incident. According to the CMS 2567, Statement of Deficiencies, R75 conversed with survey staff during the survey and was able to do so without hearing difficulty. Additionally, the

facility's care plan indicated that although R75 had some hearing loss, her hearing was adequate at a normal level of conversation.

The initial incident report related to R65, submitted by the facility on 4/25/15 omitted the above interaction between LPN-E and R75 entirely. In addition, there was no reference to eyewitness NA-C's description of R65 having been placed in a "choke hold". The initial incident report also indicated R65 experienced no injuries, however facility progress notes indicated R65 had swelling and pain in her left thumb and had received pain medications for the discomfort. R65 was examined by her nurse practitioner for an "evaluation after physical assault" on 4/28/15 when bruising was noted to R65's left thumb web space.

LPN-E was observed in the facility on 6/9/15 during a medication pass. This observation occurred three days prior to the survey team identifying the immediate jeopardy on 6/12/15. This statement is included in the CMS 2567 to verify LPN-E was observed at the time of survey and had continued to remain a direct patient caregiver. LPN-E was not interviewed after the IJ was called because he had been removed from the facility's work schedule after 6/11/15. The facility was in an immediate jeopardy (IJ) and working to abate the IJ by conducting its own internal investigation, which involved LPN-E. The MDH could not interfere with that investigation. In addition, written statements by LPN-E about the incidents provided to the survey team acknowledge LPN-E was frustrated at the time the incidents occurred and that he could have handled the situation better, confirming that his loud volume was not appropriate and the resident responded negatively. In an undated document provided by LPN-E to the facility as part of the initial investigation into R65's incident LPN-E stated, "I know confronting anyone in her [R65's] condition is not the way to handle these situations but sometimes cercomstances [sic] prevent the ideal situation." The follow up investigation report submitted to OHFC by the DON on 4/29/15 indicated LPN-E "admits he could have handled the situation differently, and understands that his response was inappropriate."

This deficiency is properly cited at a Level K: the scope is a pattern where more than a limited number of residents are/could be affected, and the severity is an immediate jeopardy to resident health or safety.

Tag F225 requires that 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* to other officials in accordance with state law through established procedures (including to the state survey and certification agency), and 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 facility's investigation into R65's incident of alleged physical abuse included written statements and interviews with some, but *not all*, staff present at the time of the incident. The

investigation included an interview with R65, who was unable to recall the details of the incident. This investigation was submitted to OHFC on 4/29/15. The investigation minimized the severity of the situation by indicating R65 had not experienced any injuries as a result, lacked information concerning an allegation of mistreatment towards R75 on the same evening, and lacked an eyewitness description from NA-C describing R65 being put in a choke hold. The investigative report indicated LPN-E had not had any prior allegations of abuse, however LPN-E had a verbal allegation of abuse that very same evening just prior to R65's incident. No interviews were conducted with other residents LPN-E cared for, to determine the extent of his misconduct or if other residents had been affected in the past or if there was indeed a history of inappropriate behavior on LPN-E's part. R75's incident of alleged mistreatment was not investigated by the facility until it was identified by the survey team.

R98 exhibited bruising and signs of injury to her left forearm on 8/10/14. R98 was physically dependent on staff in all aspects of her care, was cognitively impaired and required a mechanical lift for transfers. An x-ray taken after the injury was identified revealed a comminuted fracture of the distal radius. The facility investigative report submitted to OHFC on 8/15/14 included interviews with the resident's roommate, and staff who had cared for R98 for the previous 24 hours. The investigative report concluded: "Reasonable explanation of comprehensive investigation results indicates that resident's incident was a result of therapeutic conduct during the normal course of care." The investigative report lacked interviews with other staff members beyond the immediate 24 hour window, and assumed the care plan was followed without a review of all of the circumstances present. The investigative report also lacked a review of the medical record, to identify whether R98 had signs of pain prior to the incident or any other details in an attempt to identify a specific timeframe for when the injury had occurred.

R99 sustained a fractured left shoulder on 8/19/14. R99 was a cognitively impaired individual who was independent in ambulation with the use of a walker, and was determined by the facility not to be a reliable reporter of maltreatment. R99 did not have a history of abuse towards others. R99 had been found by facility staff in her room holding her left shoulder. Another resident, a friend of R99's was found on the floor lying alongside her. The facility's investigative report, submitted to OHFC on 9/21/14 indicated the facility interviewed R99's friend, who also was cognitively impaired and stated R99 "fell in the yard the other day." The investigative report indicated other residents and family in the area were interviewed and did not notice anything out of the ordinary. The investigative report does not include interviews with facility staff that had contact with R99 at the time of the incident or prior to the event, and concludes that "Comprehensive investigation results indicate that resident was injured in the course of attempting to help her friend." There is no evidence to suggest there was a review of circumstances surrounding the incident, including a review of the immediate environment to further identify how R99 may have fallen or injured herself.

There is no evidence in the facility records that these incidents were thoroughly investigated. Stewartville Care Center's policies, entitled Abuse and/or Neglect Investigation indicate investigations *should include interviews with other residents in which the employee provides care or services, review of all circumstances surrounding the incident, interviews with all staff having contact with the resident during the period of the alleged incident,* and *interviews with the resident's roommate, family member and visitors and a review of the resident's medical record.*

This deficiency is properly cited at a level K: the scope is a pattern where more than a limited number of residents are/could be affected, and the severity is an immediate jeopardy to resident health or safety.

F226 requires that the facility must develop and *implement* written policies and procedures that *prohibit mistreatment*, neglect, and *abuse* of residents and misappropriation of resident property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences of resident *abuse*, neglect, *mistreatment* and misappropriation of property.

R65's investigative report which was submitted to OHFC on 4/29/15, indicated LPN-E would have follow up with the facility social worker related to his approach in caring for cognitively impaired residents with behaviors. There is no evidence this follow up took place to ensure LPN-E's conduct with R65 remained appropriate. The facility's policy, entitled Preventing Resident Abuse included an intervention of including "scheduled in-service training programs designed to teach staff how to better understand the resident's abusive actions." There was no evidence this training was provided to LPN-E, or to newly hired staff whose employment files had been reviewed during the survey. LPN-E did not receive specific training related to care of residents with behaviors until 4/25/15 although he had been employed at the facility since 1/14.

F226 was cited as an "independent but associated deficiency" citation. The MDH is expected to cite deficient practices at all appropriate regulatory requirements. F226 was cited for the facility's failure to *fully operationalize* its abuse/neglect policy with respect to the immediate reporting of abuse, neglect, mistreatment and misappropriation of property, failure to educate staff related to management of residents with behaviors, failure to fully investigate incidents of alleged abuse and failure to protect residents after alleged incidents of abuse occurred. This was evidenced by the failure to immediately *report* the allegation of mistreatment towards R75 to OHFC and complete a *thorough* investigation in a timely manner. Additionally, the facility failed to remove LPN-E from direct patient care after this incident occurred. This constituted a failure to *protect* residents from further abuse, and resulted in a second allegation the same evening with R65. In R65's situation, the facility failed to *conduct a thorough investigation*, including interviewing all potential witnesses to the events and other residents to determine

the extent of LPN-E's misconduct. Subsequent investigative reports to OHFC lacked pertinent, critical details related to eyewitness descriptions of the incidents and injury to the resident. R98 and R99 sustained fractures that were not *thoroughly investigated* as discussed at F225 and directed by the facility's policies. Lastly, Stewartville Care Center failed to ensure LPN-E and other direct caregivers employed at the facility received the necessary *training* related to management of behaviors, in an attempt to *prevent* abuse from occurring within the facility. Evaluation of the facts and the staff's actions related to these incidents represents a systemic failure on the part of the facility to implement their policies at multiple levels.

The deficiency is properly cited as an independent but associated deficiency at Level F: a widespread practice with no actual harm, and potential for more than minimal harm that is not immediate jeopardy.

F490 and F493 were cited as "independent but associated deficiencies." There were undated policies in place for all of the components of tags F223, F225 and F226. While the internal investigations were not thorough and the information submitted to OHFC was not comprehensive and reflective of the information the facility had in its file, the administrator and governing body were receiving notification of alleged incidents and investigative reports that appeared to be timely and complete. The expectation that the administrator and governing body would have knowledge, prior to this survey, of the inadequacy of the investigations, and the timeliness and sequencing of reporting and investigating, is not supported by the record. These deficiencies should be rescinded.

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

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

cc: Judge James LaFave
Jan M. Suzuki, CMS Region V
Cheryl Hennen
Darcy Miner
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Monica Larson

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OAH 60-0900-32874

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the IIDR of Stewartville Care Center

RECOMMENDED DECISION

This matter came before Administrative Law Judge James E. LaFave for an independent informal dispute resolution (IIDR) meeting on November 20, 2015. The meeting concluded on that date.

Holly Kranz and Mary Cahill appeared on behalf of the Minnesota Department of Health (Department). The following individuals also participated in the IIDR on behalf of the Department: Lisa Carey, Gary Nederhoff and Maria King.

Rebecca K. Coffin, Voigt, Klegon & Rode, LLC, appeared on behalf of the Stewartville Care Center (Stewartville or the facility). The following individuals also participated in the IIDR on behalf of the facility: Joseph Owens, Sandi Vrieze and Brad Haugen.

Based on the exhibits and arguments made at the IIDR and for the reasons set forth in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

(a) The deficiency identified in Tag F-223 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.

(b) The deficiency identified in Tag F-225 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.

(c) The deficiency identified in Tag F-226 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.

(d) The deficiency identified in Tag F-490 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.

(e) The deficiency identified in Tag F-493 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.

Dated: December 8, 2015

s/James E. LaFave
JAMES E. LAFAVE
Administrative Law Judge

NOTICE

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

MEMORANDUM

This matter arises out of a recertification survey conducted at Stewartville between June 8 and 17, 2015.[1] Pursuant to the IIDR process set forth in Minn. Stat. § 144A.10, subd. 16 (2014), Stewartville challenges the Surveyor's identification of five alleged deficiencies related to the care of its residents.[2]

Background

The Department issued a Statement of Deficiencies[3] in which it asserted that the facility had failed to meet federal regulatory requirements for participation in the Medicare and Medicaid programs in five specific respects:

1. F-Tag[4] 223: 42 C.F.R. § 483.13(b) and § 483.13(c)(i) provide:

   The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

   The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

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[1] Exhibit (Ex.) E at 1.
[2] The residents' names have been omitted to safeguard their privacy. References to residents are denoted as "R[number]".
[3] Ex. E.
[4] Deficiency findings are noted in a Statement of Deficiencies under numbered "tags." Each tag corresponds to a specific regulatory requirement.

2. F-Tag 225: 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) provide:

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 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.

3. F-Tag 226: 42 C.F.R. § 483.13(c) provides:

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

4. F-Tag 490: 42 C.F.R. § 483.75 provides:

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

5. F-Tag 493: 42 C.F.R. § 483.75(d)(1)-(2) provide:

The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for

establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility.

Relying upon the U.S. Department of Health & Human Services' Centers for Medicare and & Medicaid Services' (CMS) Scope and Severity Grid,[5] the Department assigned F-Tag 223 and F-Tag 225 each a seriousness level of "K."[6] The Department assigned F-Tag 226, F-Tag 490 and F-Tag 493 each a seriousness level of "F."[7]

A regulated facility is subject to remedial action if it is not in "substantial compliance" with one or more regulatory standards.[8] A facility is not in substantial compliance if there is a deficiency that creates at least the "potential for more than minimal harm" to one or more residents.[9] Such harms result in a rating of "D" or above on the CMS Grid. Upon a finding of a lack of substantial compliance, CMS may require the facility to correct the deficiencies pursuant to a correction plan and impose other sanctions, including decertification from the Medicare and Medicaid programs.[10]

The deficiencies alleged by the Surveyor are interrelated and stem from two events that occurred on April 24, 2015. The remaining elements of the deficiencies alleged by the Surveyor revolve around whether Stewartville properly investigated and reported incidents regarding R64, R98 and R99.

The Events of April 24, 2015

a. The incident with R75

LPN-E is an LPN at Stewartville.[11] After dinner on April 24, R75, a 98-year-old woman with Dementia who is hard of hearing,[12] started asking questions of LPN-E.[13] LPN-E had to raise his voice to respond.[14] R75 kept repeating her questions.[15] LPN-5 was talking loud but he was not yelling at R75.[16] Others who

[5] The CMS Grid is a three-column, four-level matrix that provides 12 alphabetically designated ("A" through "G") categories used by compliance surveyors to rate, for each identified deficiency tag, both the severity of possible or actual harm and the scope of those actually or potentially harmed.
[6] On the CMS Grid, a "K" designation indicates that a cited deficiency presented "immediate jeopardy to resident health or safety" in a "pattern" scope.
[7] On the CMS Grid, an "F" designation indicates that a cited deficiency presented "no actual harm with potential for more than minimal harm that is not immediate jeopardy" in a "widespread" scope.
[8] 42 C.F.R. § 488.400.
[9] 42 C.F.R. § 488.301.
[10] 42 C.F.R. §§ 488.402, 488.405, 488.408, 488.412, 488.440.
[11] Comments of LPN-E at IIDR.
[12] Ex. 1; Ex. 2 at 10, LPN-E
[13] Comments of LPN-E at IIDR.
[14] Comments of LPN-5 at IIDR.
[15] Ex. L at 23.
[16] Comments of LPN-5 at IIDR.

overheard the conversation described it as "yelling"[17] or "yelling and screaming."[18] The interaction lasted several minutes.[19] When interviewed by the Surveyor, R75 in recounting the incident, asked "Why was he ([redacted]) yelling at me?"[20]

[redacted], RN, overheard the conversation between R75 and [redacted] and reported the incident to [redacted] Director of Nursing at Stewartville.[21] [redacted] was not available so she left a voice mail describing the matter.[22] [redacted] then called [redacted] the Assistant Director of Nursing for Stewartville, to report the incident.[23] [redacted] called [redacted], another LPN at Stewartville, to discuss the situation.[24] It was decided that [redacted] should go home for the evening.[25] [redacted] also stated that [redacted] felt the incident was serious enough to call it in as a "V.A. incident."[26]

b. The incident with R65

After the call with [redacted] went upstairs to talk with [redacted]. As she approached the location where [redacted] was working, he was being followed by another facility resident, R65. R65 is an 87-year-old woman with cognitive impairment and dementia.[27]

During the evening of April 24, 2015, R65 was increasingly agitated.[28] She was following [redacted] around and walking in and out of other residents' rooms.[29] A nurse assistant tried to intervene and tried to tell R65 she needed to stay out of other people's rooms.[30] At this suggestion, R65 became more agitated.[31] [redacted] went in and escorted R65 out of the room.[32]

R65 was arguing with [redacted].[33] She said "I'm going to hit you! I'm going to kick your ass!"[34] [redacted] had left a container of applesauce on the handrail outside of that room.[35] R65 picked it up and attempted to swing it at [redacted].[36] [redacted]

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17 Ex. L at 23.
18 Ex. L. at 22.
19 Ex. 42. (The "interaction between [redacted] and Resident 75 lasted no more than two to five minutes.")
20 Comments of [redacted] at IIDR.
21 Comments of [redacted] at IIDR.
22 *Id.*
23 *Id.*
24 Ex. L. at 17.
25 *Id.*
26 Comments of [redacted] at IIDR.
27 Ex. L at 80; Ex. 3 at 1.
28 Ex. L. at 10.
29 *Id.*
30 *Id.*
31 *Id.*
32 *Id.*
33 *Id.*
34 Comments of [redacted] at IIDR.
35 Ex. L. at 10.

was able to get the container of applesauce out of R65's hand, made sure she was stable with her walker, and asked her to go down the hall.[37]

As [redacted] made his way to the medicine cart and R65 returned. [redacted] offered to give R65 her medications, but she refused.[38] R65 grabbed a nearly full pitcher of water off the medicine cart and lifted it as though to hit [redacted][39] [redacted] stepped behind R65, and grabbed her right forearm, tipping the walker over in the process.[40] He put his left arm around her waist and was able to get her to put the pitcher down.[41] [redacted] then secured R65's left arm and picked up the walker.[42] While [redacted] was bending over to pick up the walker, [redacted] saw R65 made a fist as if to hit [redacted].[43] [redacted] set the walker upright and convinced R65 to walk away.[44] [redacted] primary concern during the incident was to make sure R65 did not hurt herself or others.[45]

[redacted] left Stewartville immediately after the incident.[46]

R65 was examined at the Mayo Clinic on April 28, 2015.[47] The charge nurse from Stewartville reported to the Mayo Clinic staff that R65 had some mild swelling on the left thumb web space with a bruise occurring after the incident.[48] On April 28, 2015, it was observed that R65 had some resolving bruising on her left hand and no further swelling of her left thumb.[49]

The Investigations

Investigation regarding R75 and R65

The staff at Stewartville notified [redacted], Director of Nursing for Stewartville, of the incidents with R75 and R65 the evening of April 24, 2015, shortly after the incidents occurred by leaving him a voice mail.[50] In addition, the staff immediately called [redacted] the Assistant Director of Nursing who determined that [redacted] should be sent home.[51]

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[36] *Id.*
[37] *Id.* at 11.
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] Comments of [redacted] at IIDR.
[46] Ex. 12. at 3.
[47] Ex. L. at 80.
[48] *Id.*
[49] *Id.*
[50] Comments of [redacted] at IIDR.
[51] *Id.*

DON retrieved the voice mail message at approximately 8:30 a.m. on April 25, 2015, and immediately went to the facility.[52] On his way to Stewartville, DON called the Administrator, [redacted], to inform him about the events that had transpired the previous evening.[53]

When he arrived at Stewartville, DON submitted a report to the Minnesota Department of Health, Office of Health Facility Complaints (OHFC).[54] He then began his investigation.[55]

DON interviewed LPN-E.[56] DON removed LPN-E from the schedule until the investigation was complete.[57] DON ordered that upon his return, LPN-E would be required to complete:

- Health Care Academy Inservcies;
- Right on Target: Respecting Resident Rights;
- Caring for Alzheimer Client,
- Client Behaviors: Assessment and Interventions in the Resident with Dementia; and
- Vulnerable Adult Protection (Abuse Prohibition).[58]

DON then interviewed R75 and R65. He also interviewed witnesses to the incidents, including: [redacted] LPN, LPN-J, EE-HACNA, CAN; and [redacted], CAN.[59] DON obtained written statements from [redacted],[60] [redacted],[61] [redacted],[62] [redacted],[63] and [redacted].[64] LPN-E, LPN-J, Dietary aide-A, NA-C, DON, RN-J

Based upon his investigation, [redacted] filed a report regarding the incident with the Minnesota Board of Nursing and Nursing Administration.[65] On April 29, 2015, as required by law,[66] he filed an Investigative Report with the OHFC.[67] On May 5, 2015, OHFC acknowledged receipt of the report, indicated they had reviewed it and determined no further action by their office was necessary.[68]

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[52] Comments of DON at IIDR.
[53] *Id.*
[54] Ex. 9.
[55] Comments of DON at IIDR.
[56] Ex. L. at 10.
[57] *Id.* at 15.
[58] *Id.*
[59] Comments of DON at IIDR; *see* Ex. L at 23.
[60] *See* Ex. L. at 26.
[61] *See* Ex. L. at 17.
[62] *See* Ex. L at 18-19.
[63] Ex. L. 22.
[64] Ex. L. 25.
[65] Ex. L. at 21.
[66] *See* 42 C.F.R. § 483.13(c)(4).
[67] Ex. L. at 10-12.
[68] Ex. 16.

Investigation regarding R64

On April 15, 2015, at approximately 4:30 p.m., staff at Stewartville noted R64 sitting in his recliner, attempting to get out of a seated position.[69] R64's wife was with him and told him to stop.[70] When R64 continued trying to lift himself out of the recliner, staff observed R64's wife grab the recliner control and hit him on the arm.[71] Staff immediately intervened, separated R64 from his wife and examined R64.[72] There were no visible injuries noted and R64 denied any pain.[73]

Social Services and the Administrator were immediately notified.[74] Stewartville also contacted R64's son to inform him of the incident and R64's son did not voice any concerns.[75] Stewartville reported the incident to OHFC and Olmsted County on April 16, 2015.[76] The investigative report was submitted to OHFC the following day,[77] and OHFC responded to Stewartville informing the facility that OHFC determined no further action was needed at this time.[78]

Investigation regarding R99

On the morning of August 19, 2014, upon entering R99's room, a nursing assistant noted R99's friend (another resident) was lying on the floor and R99 was standing nearby and holding her left arm close to her chest.[79] Staff assisted R99 to her wheelchair and brought her out to the nurse's desk.[80] When staff attempted range of motion on R99's left arm, R99 verbally expressed pain.[81] After being assessed by nursing staff, R99 was assessed by the certified nurse practitioner (CNP), who wrote an order to send R99 to the hospital for still further evaluation.[82] Later that night, Stewartville learned R99 had fractured her left shoulder and was going to be receiving an additional x-ray and CT scan.[83]

Stewartville investigated the incident involving R99.[84] Because of R99's Dementia,[85] she was unable to inform the facility how she injured her arm. However,

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[69] Ex. 18
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*4/15/15 at 20:32.
[76] Ex. 19.
[77] Ex. 20.
[78] Ex. 21.
[79] Ex. 22; Ex. 23.
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] Ex. 22.
[84] Ex. 24.
[85] Ex. 25.

based on the investigation Stewartville determined R99's friend, another resident of Stewartville, fell in R99's room and R99 either attempted to catch her or tried to pick her off the floor which resulted in R99 injuring herself.[86] Stewartville reported the matter to OHFC on August 20, 2014,[87] and submitted their investigative report the following day.[88] OHFC notified Stewartville on August 27, 2014, that they had reviewed the report and determined there would be no further action.[89]

Investigation regarding R98

R98 has been a resident of Stewartville since December 15, 2008, and her diagnoses include Dementia and Alzheimer's.[90] Because R98 uses aspirin on a daily basis, she is at risk for bruising and staff is directed to observe her for any bruising or hematuria.[91] On the morning of August 10, 2014, staff noticed a bruise R98's left medial forearm, extending along the left thumb and index finger.[92] Stewartville immediately assessed R98's bruise, applied cold packs and tubi-grip to the area and notified R98's physician.[93]

Because R98's bruising was of an unknown origin, Stewartville immediately initiated an internal investigation which included interviewing employees and getting staff statements.[94] Stewartville learned nothing was out of the ordinary for R98 the day before the bruising was noted and was unable to determine the cause of the bruising.[95] The incident was reported to OHFC.[96] OHFC notified Stewartville that it determined no further action was needed by the department.[97]

The Deficiencies

F-Tag 223 – Residents must be free from abuse

Under the quality care regulations, "the resident has the right to be free from verbal ... (or) ... physical ... abuse."[98] The Surveyor claims Stewartville violated that provision because it failed to ensure an environment free from abuse for R65, R75 and other residents on the floor where [redacted] worked. It asserts this is a pattern of deficiency that resulted in immediate jeopardy and has affected or has the potential to affect a number of residents. The evidence in the record does not support those claims.

LPN-E

[86] *Id.*
[87] Ex. 26.
[88] Ex. 27.
[89] Ex. 28.
[90] Ex. 29.
[91] Ex. 30.
[92] Ex. 31.
[93] Ex. 32.
[94] Ex. 33; Ex. 34.
[95] Ex. 35.
[96] Ex. 36.
[97] Ex. 38.
[98] 42 C.F.R. § 483.13(b).

"Abuse" is defined to mean "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.[99] "Verbal abuse" is defined in pertinent part: "as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . . . . Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident such as telling a resident that he/she will never be able to see his/her family again."[100]

LPN-E

The Department asserts that R75's statement during the recertification survey, "Why was he yelling at me" and R75's apparent anxiety over the incident coupled with observations that [redacted] was "yelling and screaming" support the charge of "verbal abuse." In the view of the Administrative Law Judge, the Department overlooks key elements in the definition of "verbal abuse." "Verbal abuse" by definition, includes an element of intent. The comments must be "willful" and they must be "derogatory" or "disparaging." There is nothing in the record to indicate [redacted] made "willful," "derogatory" or "disparaging" remarks directed at R75. The definition of "verbal abuse" has not been met.

LPN-E

LPN-E

Similarly, there has been no "physical abuse." The Department claims that [redacted] "physically abused" R65. "Physical abuse" includes, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.[101] The reports indicate R65 had bruising on her left hand. That fact, by itself, does not support a finding of "physical abuse." R65 had a water pitcher in her hand. She was holding it in a threatening manner. A careful review of the record indicates that [redacted] took necessary and proper steps to ensure that R65 did not hurt herself or others. The facts do not support a finding that Stewartville violated 42 C.F.R. § 483.13(b) and § 483.13(c)(i). F-Tag 223 should be set aside.

LPN-E

F-Tag 225 – The facility must fully investigate and report allegations of abuse

Under the quality of care regulations, the facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse ... are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures."[102] The Interpretive Guidelines for § 483.13(c)(2) state that ""immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident."[103] The Surveyor found that Stewartville failed to thoroughly investigate allegations of abuse and report them to the administrator and state agency immediately. This finding is not supported by the record.

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[99] Ex. F. at 2.
[100] *Id.*
[101] Ex. F. at 2.
[102] 42 C.F.R. § 483.13(c)(2).
[103] Ex. G. at 3.

During the evening of April 24, 2015, after the incidents involving R65 and R75, the staff at Stewartville immediately telephoned the Director of Nursing. Unable to reach the Director of Nursing, the staff then contacted the Assistant Director of Nursing, who promptly determined that [redacted] should be sent home for the evening.

LPN-E

On the morning of April 25, 2015, the Director of Nursing picked-up his voice mail, notified Stewartville's Administrator, and went to the facility. He submitted a report to OHFC, conducted interviews, requested and collected written statements. All of this occurred within 24 hours of the incidents involving R65 and R75.

The law requires that allegations of abuse must be reported "immediately" to the administrator and other officials.[104] Here, the incidents involving R65 and R75 occurred during the evening of April 24, 2015. Stewartville's Director of Nursing and the Assistant Director of Nursing were contacted that night. The Stewartville Administrator and the OHFC were notified the next morning. In addition, Stewartville notified the Minnesota Board of Nursing and the Nursing Administration. Finally, Stewartville timely filed its Investigation Report with OHFC. Similarly, with regard to the matters involving R64, R98 and R99, each incident was investigated and properly reported within 24 hours.

The facts do not support a finding that Stewartville violated 42 C.F.R. § 483.13(c)(2). F-Tag 225 should be set aside.

F-Tag 226 – The facility must implement the policies to prohibit abuse

Under the quality care regulations, "the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . ."[105] The Surveyor determined this requirement was not met because the facility failed to operationalize its abuse prohibition policies related to timely reporting, thorough investigation of incidents, training of facility staff and protection of residents. It asserts this deficiency had the potential to affect all residents. The Administrative Law Judge disagrees.

Stewartville developed and implemented policies and procedures to prevent resident abuse and neglect.[106] Stewartville requires its employees to look for signs of abuse and neglect[107] and immediately report and investigate incidents or accidents involving residents.[108] During the investigation, the accused individual will not be employed.[109] The facts demonstrate Stewartville followed its policies and procedures. In the cases of R64 and R75, the alleged verbal and physical abuse by [redacted] was reported to Stewartville administration and investigated. [redacted] was removed from the schedule during the investigation. Reports were filed with OHFC, the Minnesota

LPN-E

LPN-E

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[104] 42 C.F.R. § 483.13(c)(2).
[105] 42 C.F.R. § 483.13(c).
[106] Ex. 39 (Vulnerable Adult Policies and Procedures).
[107] *Id.* at Recognizing Signs and Symptoms of Abuse/Neglect.
[108] *Id.*
[109] *Id.*

Board of Nursing and the Nursing Administration. In addition, Stewartville also followed its policies and procedures and immediately investigated and reported the incidents with R65, R64, R98 and R99.

The facts do not support a finding Stewartville violated 42 C.F.R. § 483.13(c). F-Tag 226 should be set aside.

F-Tag 490- Effective Administration

The Department claims Stewartville violated 42 C.F.R. § 483.75 because Stewartville's administrator failed to ensure the abuse prohibition policies were carried out and that there was inadequate oversight of services to ensure residents were free from abuse. The Department asserts this deficiency has the potential to affect all resident. The Administrative Law Judge disagrees.

The Department cites the deficiencies asserted in F-Tag 223, F-Tag 225 and F-Tag 226 as the basis for this deficiency.[110] As discussed above, the evidence in the record does not support the deficiencies alleged in F-Tag 223, F-Tag 225 and F-Tag 226. Further, Stewartville has a Quality Assurance and Assessment Committee (QAAC) which meets quarterly to review issues related to resident care.[111] The QAAC reviews matters involving resident safety, vulnerable adult reports, incidents and grievances.[112] Stewartville also meets monthly with its Medical Director to review items related to resident care.[113]

The record demonstrates that Stewartville substantially complied with 42 C.F.R. § 483.75. F-Tag 490 should be set aside.

F-Tag 493 – Governing Body

Under the quality of care regulations, the facility "must have a governing body . . . that is legally responsible for establishing and implementing policies."[114] The regulations further require that the governing body appoint an administrator who is "responsible for the management of the facility."[115] The Department claims Stewartville violated those provisions because Stewartville's governing body did not ensure abuse policies and procedures were carried out by the administrator and that Stewartville's governing body did not perform adequate oversight of services to ensure resident were free from abuse. The Administrative Law Judge disagrees.

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[110] Ex. E at 80-82.
[111] *See* Ex. 40 (Quality Assurance and Assessment Committee Minutes).
[112] *Id.*
[113] Ex. 41.
[114] 42 C.F.R. § 483.75(d)(1).
[115] *Id.*

The Department supports this deficiency by again citing to the record underlying F-Tag 223, F-Tag 225 and F-Tag 226. As the record does not support those tags, there is no support for this tag. F-tag 493 should be set aside.

Conclusion

The incident between [redacted] and R75 and the incident between [redacted] and R65 form the basis for the Surveyor's findings of abuse. Those findings of abuse, set forth in F-Tag 223, provide the foundation for the remaining deficiencies found by the Surveyor. F-Tag 223 is specifically cited as one of the grounds for F-Tag 490[116] and for F-Tag 493.[117] In this context, it is important to note that the Survey Team did not interview [redacted] as part of the recertification survey or the extended survey.[118] The Survey Team did not even ask to interview [redacted].[119] In the view of the Administrative Law Judge, that omission undermined the reliability of the Surveyor's inquiries and conclusions regarding F-Tag 223 and the findings in the other deficiencies.

The Administrative Law Judge respectfully recommends that the Commissioner set aside F-Tag 223, F-Tag 225, F-Tag 226, F-Tag 490 and F-Tag 493.

J. E. L.

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[116] *See* Ex. E at 80.

[117] *See* Ex. E. at 83.

[118] Comments by Lisa Carey in response to questions from the facility at IIDR. The Survey Team observed [redacted] at Stewartville on June 15, 2015. *See* Stewartville Care Center Survey Exit June 17, 2015 at p. 6 (" LPN-E [redacted] was observed on 6/19/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility"). Presumably, he was available for questioning.

[119] *Id.*

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

December 18, 2015

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

RE: Docket OAH 60-0900-32874

Dear Ms. Coffin:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by Stewartville Care Center in Stewartville, MN, regarding five federal deficiencies issued as a result of a recertification survey, exit date June 17, 2015. The IIDR was held before Administrative Law Judge James E. LaFave. The Department received Judge LaFave's recommended decision the afternoon of December 8, 2015.

Decision

After careful review of Judge LaFave's recommendation and the material submitted to the Judge in support of each party's position, I do not concur with rescinding tags F223, F225 or F226, and uphold them as written. F223 and F225 were written at a scope and severity of Level K, and F226 was issued at a scope and severity of F. I concur with rescinding tags F490 and F493.

Rationale

During Stage 1 of the survey, the Abuse Task was triggered. When a task is triggered, a surveyor follows a specific pathway – an established and computer directed set of investigative protocols, to investigate whether there was a deficient practice in the task area. The tags issued in this survey are a result of the extended survey that was conducted as a result of the triggering of the Abuse Task.

It is not disputed that the incidents in this IIDR occurred. What is disputed is the conclusion of Stewartville's internal investigation of the incidents, the incomplete manner in which the internal investigations were conducted, the sequence and timing of reporting the incidents to the State Agency (Office of Health Facility Complaints - OHFC), and the accuracy of the

information on the reports to the OHFC when compared to the information in the facility's incident files.

Tag F223 requires a resident has *the right* to be free from *verbal,* sexual, *physical and mental abuse,* corporal punishment, and involuntary seclusion. The intent of the regulation is that residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. Interpretive Guidelines include a definition of abuse: "abuse" means the willful infliction of injury, unreasonable confinement, *intimidation,* or punishment with resulting physical harm, pain or *mental anguish.*" (42 CFR §488.301) The Interpretive Guidelines, further define types of abuse: verbal abuse, sexual abuse, physical abuse, mental abuse and involuntary seclusion. "Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse *include, but are not limited to*: threats of harm; *saying things to frighten a resident*, such as telling a resident that he/she will never be able to see his/her family again. "Mental abuse" *includes, but is not limited to humiliation*, harassment, and threats of punishment or deprivation.

The surveyor found two facility incident reports involving R65 and R75 with allegations of physical and verbal abuse involving LPN-E. Both incidents occurred on April 24, 2015.

R65 was a cognitively impaired resident, who exhibited short and long term memory loss. R65 exhibited behavioral symptoms including paranoia and at times was physically resistive with cares. R65 could usually make her needs known and could walk independently with a wheeled walker.

R75 was cognitively impaired with short and long term memory loss. R75 did not have a history of abusing others, had adequate hearing at a normal level of conversation and was able to express her needs verbally.

The facility contends that LPN-E did not verbally abuse R75, rather he was speaking loudly so R75 could hear him. The facility noted it suspended LPN-E pending further investigation of R65 and reported the incident to the OHFC. After conducting its internal investigation, Stewartville concluded LPN-E was trying to keep R65 safe and prevent her from harming herself or others. They concluded that LPN-E did not abuse R65 or intend to harm her in any way.

The Centers for Medicare and Medicaid (CMS) require surveyors to follow Interpretive Guidelines when determining whether a deficient practice exits. When looking at allegations of potential abuse to residents, all possible types of abuse must be considered. While the term "willful infliction of" is used in the definition of abuse, it is not further defined in the Interpretive Guidelines at F223. "Willful" is defined in the State Operations Manual in Appendix

PP, Interpretive Guidelines for an abuse and supervision tag as: "means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish." The New World Dictionary of the American Language defines "willful" as: "1. said or done deliberately or 2. Following one's own will unreasoningly; obstinate; stubborn." Raising one's voice very loudly, or yelling at a resident to be heard, seeing the resident is further distressed as a result of that action and yet continuing the action is a willful act, it is an action committed unreasoningly. Moreover, there were several staff onsite (RN-H, LPN-J, NA-E, NA-C) at the time who overheard the loud interaction between LPN-E and R75. These staff were concerned enough by the interaction to leave areas they were working in such as the dining room, hallway, and other resident rooms, to check out what was happening. These other staff who were familiar with LPN-E and R75, did not consider the interaction to be "normal", that is, that LPN-E was speaking loudly in an attempt to allow R75 to hear him. RN-H was concerned enough by this observation that she immediately called the assistant director of nursing to report she was concerned about LPN-E's "mental state." The other staff were concerned enough about the incident to file facility Complaint/Concern Forms Regarding Employee, one included: "Upon returning from bringing residents from supper, co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at [R75]. We tried to take her to her room. She [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation around 7:40. I went to go ask nurse [LPN- J] a question and noticed [R65] standing by med cart arguing with [LPN-E]. She attempted to grab water pitcher and he grabbed her from behind like choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident down afterwards but she was too worked up."

The nursing assistant who documented the Complaint/Concern report noted above was listed as a witness in the investigative report the facility sent into the OHFC as required; however, that report did not provide this firsthand witnesses' account as stated above. Instead the report to OHFC included: "During routine MDH survey it was brought to this writer's attention that on 4-24-15, staff [LPN-E] was yelling at [R75]. This incident was initially reported regarding another demented resident. During this incident [R75] was also agitated and following the nurse and not responding to redirection. [LPN-E] did yell at resident due to his frustration with [R65] and her continued agitation. This writer initially combined both of these actions by [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident. [R75] has not suffered any negative effects from this situation and continues to wander the facility in her w/c as usual."

The other nursing assistant who had witnessed this incident, and who was referenced in the Complaint/Concern report, was not interviewed by the facility during the investigation of the incident. According to the CMS 2567, Statement of Deficiencies, R75 conversed with survey staff during the survey and was able to do so without hearing difficulty. Additionally, the

facility's care plan indicated that although R75 had some hearing loss, her hearing was adequate at a normal level of conversation.

The initial incident report related to R65, submitted by the facility on 4/25/15 omitted the above interaction between LPN-E and R75 entirely. In addition, there was no reference to eyewitness NA-C's description of R65 having been placed in a "choke hold". The initial incident report also indicated R65 experienced no injuries, however facility progress notes indicated R65 had swelling and pain in her left thumb and had received pain medications for the discomfort. R65 was examined by her nurse practitioner for an "evaluation after physical assault" on 4/28/15 when bruising was noted to R65's left thumb web space.

LPN-E was observed in the facility on 6/9/15 during a medication pass. This observation occurred three days prior to the survey team identifying the immediate jeopardy on 6/12/15. This statement is included in the CMS 2567 to verify LPN-E was observed at the time of survey and had continued to remain a direct patient caregiver. LPN-E was not interviewed after the IJ was called because he had been removed from the facility's work schedule after 6/11/15. The facility was in an immediate jeopardy (IJ) and working to abate the IJ by conducting its own internal investigation, which involved LPN-E. The MDH could not interfere with that investigation. In addition, written statements by LPN-E about the incidents provided to the survey team acknowledge LPN-E was frustrated at the time the incidents occurred and that he could have handled the situation better, confirming that his loud volume was not appropriate and the resident responded negatively. In an undated document provided by LPN-E to the facility as part of the initial investigation into R65's incident LPN-E stated, "I know confronting anyone in her [R65's] condition is not the way to handle these situations but sometimes cercomstances [sic] prevent the ideal situation." The follow up investigation report submitted to OHFC by the DON on 4/29/15 indicated LPN-E "admits he could have handled the situation differently, and understands that his response was inappropriate."

This deficiency is properly cited at a Level K: the scope is a pattern where more than a limited number of residents are/could be affected, and the severity is an immediate jeopardy to resident health or safety.

Tag F225 requires that 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* to other officials in accordance with state law through established procedures (including to the state survey and certification agency), and 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 facility's investigation into R65's incident of alleged physical abuse included written statements and interviews with some, but *not all*, staff present at the time of the incident. The

investigation included an interview with R65, who was unable to recall the details of the incident. This investigation was submitted to OHFC on 4/29/15. The investigation minimized the severity of the situation by indicating R65 had not experienced any injuries as a result, lacked information concerning an allegation of mistreatment towards R75 on the same evening, and lacked an eyewitness description from NA-C describing R65 being put in a choke hold. The investigative report indicated LPN-E had not had any prior allegations of abuse, however LPN-E had a verbal allegation of abuse that very same evening just prior to R65's incident. No interviews were conducted with other residents LPN-E cared for, to determine the extent of his misconduct or if other residents had been affected in the past or if there was indeed a history of inappropriate behavior on LPN-E's part. R75's incident of alleged mistreatment was not investigated by the facility until it was identified by the survey team.

R98 exhibited bruising and signs of injury to her left forearm on 8/10/14. R98 was physically dependent on staff in all aspects of her care, was cognitively impaired and required a mechanical lift for transfers. An x-ray taken after the injury was identified revealed a comminuted fracture of the distal radius. The facility investigative report submitted to OHFC on 8/15/14 included interviews with the resident's roommate, and staff who had cared for R98 for the previous 24 hours. The investigative report concluded: "Reasonable explanation of comprehensive investigation results indicates that resident's incident was a result of therapeutic conduct during the normal course of care." The investigative report lacked interviews with other staff members beyond the immediate 24 hour window, and assumed the care plan was followed without a review of all of the circumstances present. The investigative report also lacked a review of the medical record, to identify whether R98 had signs of pain prior to the incident or any other details in an attempt to identify a specific timeframe for when the injury had occurred.

R99 sustained a fractured left shoulder on 8/19/14. R99 was a cognitively impaired individual who was independent in ambulation with the use of a walker, and was determined by the facility not to be a reliable reporter of maltreatment. R99 did not have a history of abuse towards others. R99 had been found by facility staff in her room holding her left shoulder. Another resident, a friend of R99's was found on the floor lying alongside her. The facility's investigative report, submitted to OHFC on 9/21/14 indicated the facility interviewed R99's friend, who also was cognitively impaired and stated R99 "fell in the yard the other day." The investigative report indicated other residents and family in the area were interviewed and did not notice anything out of the ordinary. The investigative report does not include interviews with facility staff that had contact with R99 at the time of the incident or prior to the event, and concludes that "Comprehensive investigation results indicate that resident was injured in the course of attempting to help her friend." There is no evidence to suggest there was a review of circumstances surrounding the incident, including a review of the immediate environment to further identify how R99 may have fallen or injured herself.

There is no evidence in the facility records that these incidents were thoroughly investigated. Stewartville Care Center's policies, entitled Abuse and/or Neglect Investigation indicate investigations *should include interviews with other residents in which the employee provides care or services, review of all circumstances surrounding the incident, interviews with all staff having contact with the resident during the period of the alleged incident,* and *interviews with the resident's roommate, family member and visitors and a review of the resident's medical record.*

This deficiency is properly cited at a level K: the scope is a pattern where more than a limited number of residents are/could be affected, and the severity is an immediate jeopardy to resident health or safety.

F226 requires that the facility must develop and *implement* written policies and procedures that *prohibit mistreatment*, neglect, and *abuse* of residents and misappropriation of resident property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences of resident *abuse*, neglect, *mistreatment* and misappropriation of property.

R65's investigative report which was submitted to OHFC on 4/29/15, indicated LPN-E would have follow up with the facility social worker related to his approach in caring for cognitively impaired residents with behaviors. There is no evidence this follow up took place to ensure LPN-E's conduct with R65 remained appropriate. The facility's policy, entitled Preventing Resident Abuse included an intervention of including "scheduled in-service training programs designed to teach staff how to better understand the resident's abusive actions." There was no evidence this training was provided to LPN-E, or to newly hired staff whose employment files had been reviewed during the survey. LPN-E did not receive specific training related to care of residents with behaviors until 4/25/15 although he had been employed at the facility since 1/14.

F226 was cited as an "independent but associated deficiency" citation. The MDH is expected to cite deficient practices at all appropriate regulatory requirements. F226 was cited for the facility's failure to *fully operationalize* its abuse/neglect policy with respect to the immediate reporting of abuse, neglect, mistreatment and misappropriation of property, failure to educate staff related to management of residents with behaviors, failure to fully investigate incidents of alleged abuse and failure to protect residents after alleged incidents of abuse occurred. This was evidenced by the failure to immediately *report* the allegation of mistreatment towards R75 to OHFC and complete a *thorough* investigation in a timely manner. Additionally, the facility failed to remove LPN-E from direct patient care after this incident occurred. This constituted a failure to *protect* residents from further abuse, and resulted in a second allegation the same evening with R65. In R65's situation, the facility failed to *conduct a thorough investigation,* including interviewing all potential witnesses to the events and other residents to determine

the extent of LPN-E's misconduct. Subsequent investigative reports to OHFC lacked pertinent, critical details related to eyewitness descriptions of the incidents and injury to the resident. R98 and R99 sustained fractures that were not *thoroughly investigated* as discussed at F225 and directed by the facility's policies. Lastly, Stewartville Care Center failed to ensure LPN-E and other direct caregivers employed at the facility received the necessary *training* related to management of behaviors, in an attempt to *prevent* abuse from occurring within the facility. Evaluation of the facts and the staff's actions related to these incidents represents a systemic failure on the part of the facility to implement their policies at multiple levels.

The deficiency is properly cited as an independent but associated deficiency at Level F: a widespread practice with no actual harm, and potential for more than minimal harm that is not immediate jeopardy.

F490 and F493 were cited as "independent but associated deficiencies." There were undated policies in place for all of the components of tags F223, F225 and F226. While the internal investigations were not thorough and the information submitted to OHFC was not comprehensive and reflective of the information the facility had in its file, the administrator and governing body were receiving notification of alleged incidents and investigative reports that appeared to be timely and complete. The expectation that the administrator and governing body would have knowledge, prior to this survey, of the inadequacy of the investigations, and the timeliness and sequencing of reporting and investigating, is not supported by the record. These deficiencies should be rescinded.

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

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

cc: Judge James LaFave
Jan M. Suzuki, CMS Region V
Cheryl Hennen
Darcy Miner
Holly Kranz
Monica Larson

Protecting, Maintaining and Improving the Health of Minnesotans

IIDR

Independent Informal Dispute Requested

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

Facility (City) HFID#	Exit Date Being Disputed	Tag# - Scope/Severity Disputed
Stewartville Care Center 00429	**6/17/2015**	**F223 = K** **F225 = K** **F226 = F** **F490 = F** **F493 = F**

VOIGT, RODÈ & BOXETH, LLC

ATTORNEYS AT LAW

2550 UNIVERSITY AVENUE WEST
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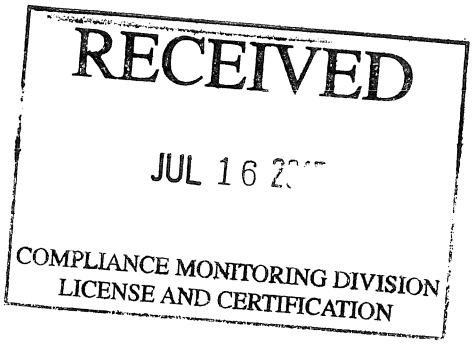
July 15, 2015



21463-004

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

Re: Independent Informal Dispute Resolution for Stewartville Care Center for Survey Exit Date June 17, 2015

Dear Health Department Reviewer:

Please be advised this firm represents Stewartville Care Center ("Stewartville") with respect to the deficiencies issued during its extended survey completed on June 17, 2015. Pursuant to 42 CFR § 488.331, Stewartville requests an independent informal dispute resolution ("IIDR"). Stewartville disputes the deficiencies cited at F223, scope and severity level "K," F225, scope and severity level "K," F226, scope and severity level "F," F490, scope and severity level "F," F493, scope and severity level "F," and the corresponding state licensing correction orders issued regarding the same. Stewartville requests the IIDR process pursuant to Minnesota Statutes § 144A.10, subd. 16.

Stewartville disputes F223, F225 and F226 because it did report and follow up on allegations of mistreatment, conducted internal investigations, interviewed and provided education to staff, and notified the appropriate parties of the incidents. Stewartville followed its abuse prohibition policies in reviewing and investigating these incidents.

Stewartville disputes F490 and F493 because it does have an Administrator and governing body who provide oversight of cares delivered by the facility, facility practices, and the development and implementation of facility policies, including abuse prohibition.

The findings cited on CMS Form 2567 are incorrect and do not support the deficiencies issued F223, F225, F226, F490 and F493. Stewartville will submit additional information to

support its appeal through the IIDR process. We would like a face-to-face meeting through the Office of Administrative Hearings. Thank you for your consideration.

Sincerely,

Rebecca Coffin

Rebecca K. Coffin

RKC/ams

cc: Mr. Gene Gustason

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LEHX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00429

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245349**
2.STATE VENDOR OR MEDICAID NO.
(L2) **334740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STEWARTVILLE CARE CENTER**
(L4) **120 FOURTH STREET NORTHEAST**
(L5) **STEWARTVILLE, MN** (L6) **55976**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/11/2015** (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)
04/30

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

12.Total Facility Beds **73** (L18)

13.Total Certified Beds **73** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	73			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Carey (Krebs), HFE NE II 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/26/2015 (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
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245349

August 26, 2015

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, Minnesota 55976

Dear Mr. Gustason:

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 27, 2015 the above facility is certified for or recommended for:

73 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 73 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 25, 2015

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, Minnesota 55976

RE: Project Number S5349025

Dear Mr. Gustason:

On July 7, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 12, 2015. (42 CFR 488.422)

In addition, this Department recommended the following remedy to the CMS Region V Office for imposition:

- Per instance civil money penalty for the deficiencies cited at F323, F225, and F226. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on June 17, 2015. At the time of the extended survey, conditions in the facility constituted Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health or safety. The survey found the most serious deficiencies to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On August 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on June 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 27, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on June 17, 2015, as of July 27, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 27, 2015.

In addition, this Department recommended the following action related to the remedy in our letter of of

July 7, 2015:

- Per instance civil money penalty for the deficiencies cited at F323, F225, and F226 remain in effect. (42 CFR 488.430 through 488.444).

As we notified you in our letter of July 7, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 17, 2015.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245349	A. Building B. Wing	8/11/2015

Name of Facility	Street Address, City, State, Zip Code
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0166 Reg. # 483.10(f)(2) LSC	Correction Completed 07/16/2015	ID Prefix F0223 Reg. # 483.13(b), 483.13(c)(1)(i) LSC	Correction Completed 06/17/2015	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	Correction Completed 06/17/2015
ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 06/17/2015	ID Prefix F0247 Reg. # 483.15(e)(2) LSC	Correction Completed 07/27/2015	ID Prefix F0250 Reg. # 483.15(g)(1) LSC	Correction Completed 07/27/2015
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 07/17/2015	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 07/17/2015	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 07/16/2015
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 07/17/2015	ID Prefix F0325 Reg. # 483.25(i) LSC	Correction Completed 07/17/2015	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 07/17/2015
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 07/17/2015	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 07/16/2015	ID Prefix F0490 Reg. # 483.75 LSC	Correction Completed 07/16/2015

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	08/25/2015	34985	08/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245349	A. Building B. Wing	8/11/2015

Name of Facility	Street Address, City, State, Zip Code
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0493 Reg. # 483.75(d)(1)-(2) LSC	Correction Completed 07/16/2015	ID Prefix F0497 Reg. # 483.75(e)(8) LSC	Correction Completed 07/27/2015		

Reviewed By State Agency	Reviewed By MDH	Date: 8-15-15	Signature of Surveyor: 34985	Date: 08/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/17/2015				

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245349	A. Building B. Wing 01 - MAIN BUILDING 01	7/21/2015

Name of Facility	Street Address, City, State, Zip Code
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	07/15/2015	ID Prefix Reg. # NFPA 101 LSC K0025	06/15/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/9/2015

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 25, 2015

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, Minnesota 55976

Re: Reinspection Results - Project Number S5349025

Dear Mr. Gustason:

On August 11, 2015 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 August 11, 2015. 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,

Kamala Fiske-Downing

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00429	A. Building B. Wing	8/11/2015

Name of Facility	Street Address, City, State, Zip Code
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20130** Reg. # **MN Rule 4658.0050 Subp.** LSC	Correction Completed **07/16/2015**	ID Prefix **20285** Reg. # **MN Rule 4658.0100 Subp.** LSC	Correction Completed **07/27/2015**	ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **07/27/2015**
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **07/17/2015**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **07/17/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **07/16/2015**
ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp.** LSC	Correction Completed **07/17/2015**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **07/17/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Sul** LSC	Correction Completed **08/11/2015**
ID Prefix **21495** Reg. # **MN Rule 4658.1005 Subp.** LSC	Correction Completed **07/27/2015**	ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp.** LSC	Correction Completed **07/17/2015**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **08/11/2015**
ID Prefix **21880** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **07/16/2015**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **06/17/2015**	ID Prefix **21995** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **06/17/2015**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GNP/kfd	08/25/2015	34985	08/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00429	A. Building B. Wing	8/11/2015

Name of Facility	Street Address, City, State, Zip Code
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **22000** Reg. # **MN St. Statute 626.557 Su** LSC	Correction Completed **06/17/2015**				

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/17/2015	_____	**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: LEHX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00429

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245349**
2.STATE VENDOR OR MEDICAID NO.
(L2) **334740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STEWARTVILLE CARE CENTER**
(L4) **120 FOURTH STREET NORTHEAST**
(L5) **STEWARTVILLE, MN** (L6) **55976**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/17/2015** (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)
04/30

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

12.Total Facility Beds **73** (L18)

13.Total Certified Beds **73** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	73			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 07/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/30/2015 (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
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 07/31/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
July 7, 2015

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, Minnesota 55976

RE: Project Number S5349025

Dear Mr. Gustason:

On June 17, 2015, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on June 16, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective July 12, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Per instance civil money penalty for the deficiencies cited at F323, F225, and F226. (42 CFR 488.430 through 488.444)

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Stewartville Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 17, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 17, 2015 (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 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	06/17/2015

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Minnesota Department of Health on June 8, 9, 10, 11, 12, 13, 15, 16 & 17, 2015. The survey resulted in an Immediate Jeopardy (IJ) at F223 and F225 related to the facility's failure to comprehensively assess, investigate, report allegations of abuse immediately to the administrator and state agency and then implement interventions to ensure residents were free from abuse which resulted in the high potential for harm or death. Facility staff were notified of the IJ on June 12, 2015 at 3:00 p.m. The IJ was removed on June 16, 2015 at 2:40 p.m., however non-compliance remained at a scope and severity of isolated with actual harm that is not immediate jeopardy. An extended survey was conducted by the Minnesota Department of Health on June 12, 13, 15, 16 & 17, 2015. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		7/16/15

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

Electronically Signed | 07/17/2015

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F 166	Continued From page 1 A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident grievances were resolved promptly for 4 of 4 residents (R53, R46, R7 & R66) who expressed a grievance to the facility staff. Findings include: During an interview with R53 on 6/8/15, at 6:05 p.m. R53 reported her roommate hollers all night long. R53 stated, "She sleeps all day, hollers all night. I've told all the nurses. Nothing gets done. I've asked if they can give her a private room, but nothing happens. They try different stuff, it doesn't work. She keeps me up all night. They don't do anything for me." Documentation in R53's medical record dated 5/3/15, at 1:39 a.m. indicated R53 had reported, "can't sleep with her hollering." Another note from 5/3/15 at 1:46 a.m. indicated, "message left on ss [social services] telephone in regards to that incident." On 5/3/15 at 5:13 a.m. a nurse's note entry included, "asked her [R53] what she was doing over by [R30's] bed during the night and she states she was giving her a stuffed animal to hold so she wouldn't holler" R53's quarterly Minimum Data Set (MDS) dated 3/18/15, identified intact cognition with no behavioral or communication issues.	F 166	Stewartville Care Center staff respects the residents¿ right to autonomy and choice and protects and promotes the residents¿ legal rights as well as their right to privacy and a dignified existence. The staff encourage the residents to voice concerns about care and/or services and respect their right to have prompt staff attention to help resolve grievances including concerns about the behavior of other residents. The policies and procedures for responding to residents¿ grievances were reviewed and found appropriate. After receiving a complaint/grievance, the facility seeks a resolution in a timely manner and keeps the resident appropriately apprised of the progress toward resolution. The residents/families are asked about care concerns during the quarterly interdisciplinary care conferences. The grievance reporting procedure is explained to the resident at the time of admission and grievance forms are provided in the admission packets. Grievance forms are also available at the nursing desks and first floor reception area. Concerns expressed orally or using	

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F 166	Continued From page 2 During an interview with R46 on 6/9/15, at 09:23 a.m. R46 state, "at different times someone hollers. It keeps me up at night." An entry in R46's medical record dated 5/16/15, at 4:43 a.m. included, "States she can't sleep during the night because her roommate keeps her awake which usually sets off the alarm and that makes her nervous... Message left for SS." R46's annual Minimum Data Set (MDS) dated 4/29/15, indicated the resident had intact cognition with no behavioral or communication issues. During an interview with R7 on 6/8/15, at 6:36 p.m. R7 stated, "we have a person (R30) next door that yells before she goes to bed." During an interview with R7 on 6/11/15, at 3:40 p.m. R7 said she had complained to the director of nursing (DON) about the noise R30 made at night, so the DON had moved R30 to another room, "but she is now in the room next to me." R7's annual MDS dated 3/31/15, identified R7 had intact cognition with no behavioral or communication issues. During an interview with R66 on 6/8/15, at 06:44 p.m. R66 said, "It is noisy because another lady is yelling for help a lot at night." R66's quarterly MDS dated 4/22/15, identified the resident was cognitively intact with no behavioral or communication issues. During an interview with nursing assistant (NA)-D	F 166	the comment form is reviewed by the social worker and addressed in a timely manner. Residents¿ grievances and concerns are routinely reviewed during the shift-to-shift reports, quarterly care conferences, and the Quality Assessment and Assurance Committee meetings. During the mandatory meetings July 14, 15 and 16, 2015, the staffs were reminded of the residents¿ right to report grievances and care concerns and their responsibility to respond appropriately and in a timely manner. Discussion will include the residents¿ right to have 1) customary routines respected and accommodated to fullest extent possible and 2) a quiet environment that promotes restful sleep. The staff were reminded of the procedures to alert the social worker and other appropriate staff of their concerns/observations and the concerns expressed by the residents/families. Residents¿ rights are reviewed with the staff annually and are included as part of new employee orientation. Satisfaction with cares and services will continue to be discussed during each resident¿s care conference and more often as necessary. Residents will be asked about their satisfaction with noise levels during the night during the next three resident council meetings. The record of resident number 30 was reviewed; there was no recent documentation of incidences of night time	

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F 166	Continued From page 3 on 6/11/15 at 2:32 p.m., NA-D said, "I have heard [R30] yells a lot at night from the night staff." During an interview on 6/11/15, at 2:41 p.m. licensed practical nurse (LPN)-J said, "(R30) has a problem yelling and cries at night. The staff will try to medicate her and sit with her. This happens at least a couple times a week. Her roommate has said she (R30) has kept her up all night. Everybody is aware of it, social services (SS), the director of nursing (DON). I don't know why we can't fix it." During an interview with LPN-K on 6/12/15 at 9:55 a.m., LPN-K stated, "(R30) slept last night but it has been a problem with her yelling in the night. She cries out at night or at least makes noise, about 1-2 times a week. SS and the DON know about it but it is a difficult issue to resolve." During an interview with SS-A on 6/11/15 at 2:56 p.m., SS-A stated, "I don't have any written grievances for the past six months. I have heard about (R30) crying out but I have not gotten a grievance form about it. Everyone is given a grievance form on admission. We do not remind residents to use the grievance form. The staff try to get to her (R30) as fast as they can but she still hollers and cries out." During an interview on 6/11/15 at 5:24 p.m., the DON said he was not aware [R30] was keeping people awake at night but acknowledged, "I was aware of the daytime noises." The DON stated he knew the grievance process needed to be "repaired." An undated facility policy entitled, Filing Grievances/Complaints indicated: "Grievances	F 166	yelling. The Assistant Director of Nursing will meet with the nurses on the night staff to discuss the past behavior of resident number 30 disturbing the sleep of near by residents. The resident will be reassessed for symptoms of pain and her sleep habits will be monitored and documented for nightly for 14 nights. If there are continued incidences of yelling, the interdisciplinary team will meet to assess the resident¿s behavior and discuss further interventions to promote a restful environment; the resident¿s attending physician/nurse practitioner will be notified of behavior symptoms adversely impacting other residents. Resident number 53 - The staff have been informed of the resident¿s concern regarding the sleep disturbing behavior of resident number 30. The staff will monitor the night time behavior patterns of resident number 30 and implement interventions to minimize the disturbance of near by residents. The social worker will interview the resident at least weekly for three weeks to determine whether there are ongoing concerns regarding the night time noise levels. If concerns are voiced, additional monitoring will be done and alternative interventions attempted/implemented. Resident number 46 - The staff have been informed of the resident¿s concern regarding the sleep disturbing behavior of resident number 30 and the safety alarms used by her roommate. The staff will monitor the night time behavior patterns of	

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F 166	Continued From page 4 and/or complaints may be submitted orally or in writing...the administrator has delegated the responsibility of grievance and/or complaint investigation to Social Services. Upon receipt of a grievance and/or complaint, Social Services will investigate the allegation and submit a written report of such finding to the administrator within (5) working days of receiving the grievance and/or complaint.	F 166	resident number 30 and the use her roommate¿s safety alarms. The social worker will interview the resident at least weekly for three weeks to determine whether there are ongoing concerns regarding the night time noise levels. Interventions to minimize the noise levels will be discussed/implemented and the resident¿s ongoing satisfaction with the staff responses to concerns will be addressed as necessary. The resident was visited by the social worker July 14, 2015 and she expressed interest in moving to a different room. She is ¿content and agreeable¿ with the plan to be offered the first window beds that become available. Resident number 7 - The staff have been informed of the resident¿s concern regarding the sleep disturbing behavior of resident number 30. When questioned during her care conference July 14, 2015, the resident stated that the behaviors of resident number 30 were not disturbing her sleep. The social worker will interview the resident at least weekly for three weeks to determine whether there are ongoing concerns regarding the night time noise levels. If concerns are voiced, additional monitoring will be done and alternative interventions attempted/implemented. Resident number 66 - The staff have been informed of the resident¿s concern regarding the sleep disturbing behavior of resident number 30. The staff will monitor the night time behavior patterns of	

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F 166	Continued From page 5	F 166	resident number 30 and implement interventions to minimize the disturbance of near by residents. The resident resides across and down the hall from resident number 30 and has a very severe hearing deficit when not wearing her hearing aides which she removes at night. The social worker will interview the resident at least weekly for three weeks to determined whether there are ongoing concerns regarding the night time noise levels. If concerns are voiced, additional monitoring will be done and alternative interventions attempted/implemented. The night nurses will document the behaviors of resident number 30 nightly for 14 nights; the data will be assessed to determine whether additional interventions are necessary to address night time behaviors. The Social Worker will monitor resident satisfaction with a restful sleep environment during one-to-one visits, care conferences, and resident council meetings for the next 90 days and randomly thereafter.	
F 223 SS=K	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223		6/17/15

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F 223	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R75 and R65) reviewed for abuse, were free from verbal and physical abuse by staff. Although facility staff were aware of the abuse, the staff did not immediately report/intervene to prevent further abuse from occurring. The facility's failure to implement interventions to prevent continued abuse resulted in an immediate jeopardy (IJ) for R75, R65 and other residents residing on the main and lower floor levels where the alleged perpetrator worked.. The IJ began on 4/24/15, when facility staff had observed the abuse but failed to implement preventative interventions, failed to provide initial and ongoing education to staff for use of therapeutic interventions when dealing with residents with cognitive deficits, and failed to immediately report the abuse as efforts to prevent abuse from reoccurring. The director of nursing (DON) and administrator were notified of the immediate jeopardy at 3:00 p.m. on 6/12/15. The immediate jeopardy was removed on 6/16/15, but noncompliance remained at a lower scope and severity level of G, isolated scope and severity level, actual harm (bruising and swelling of R65's hand) that is not immediate jeopardy. Findings include: Although R75 was observed by staff to be yelled at by licensed practical nurse (LPN)-E on 4/24/15 following the supper meal, and LPN-E was subsequently observed to be verbally and physically abusive to R65 that same evening, the incidents were not immediately reported to the	F 223	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply with all applicable state and feral regulatory requirements and constitutes the facility¿s allegation of compliance. Stewartville Care Center policy requires that each resident be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The resident will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, or other individuals. The facility¿s policies and procedures for investigating/reporting of incidents were reviewed and found appropriate. The facility¿s Vulnerable Adult Abuse policies were distributed to all staff on June 16 and June 17, 2015. The staff were required to sign to verify that they received the information. On June 16, 2015, all Stewartville Care Center staff including management staff	

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F 223	Continued From page 7 administrator or the State agency, nor were interventions initiated to prevent further abuse. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C dated 4/25/15. The concern read, "EMPLOYEE NAME: [LPN-E's first name]..." "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." R75's quarterly minimum data set (MDS) dated 5/12/15 indicated R75 had a brief interview for mental status (BIMS) score of 4 which indicated R75 was severely cognitively impaired. The MDS also indicated R4 could hear with minimal difficulty. During an interview and observations on 6/9/15 at 9:51 a.m., R75 was observed during an interview with family (F)-A. R75 conversed with F-A and the surveyor without hearing difficulty. R75's care plan directed staff to provide, "Clear, careful, explanations to facilitate her comprehension...repeat/rephrase words as needed to facilitate hearing and comprehension." Information provided by the DON related to the investigation of these incidents, included a typed interview conducted 4/25/15 at 10:00 a.m., by the DON with NA-L. The interview documentation	F 223	were instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirements of immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies and 5) forms and procedures for appropriate and timely reporting. The staff is educated on vulnerable adult issues at least every twelve months; vulnerable adult investigation and reporting are addressed during new employee orientation. The employee (LPN-E) involved in the April 24, 2015 incidents with residents number 65 and 75 was initially suspended for three days pending an investigation of the alleged abuse. After returning to work, he was assigned to another care unit. After the June 2015 state review of the issue, the LPN-e was requested to complete a Health Professional Services Program evaluation as a condition of continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has had no further practice/performance issues. Resident number 65 ¿ The resident continues to wander throughout the first floor of the facility. She has had no recent	

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F 223	Continued From page 8 included, "Spoke to [NA-L] concerning incident Friday 4-24-15 p.m. shift. She stated he [LPN-E] was talking to [R75]. [R75] was repeating questions and as [LPN-E] was answering questions he was becoming more upset and yelling, and was probably yelling more than he should. [R65] was standing nearby with her walker but did not say anything. Stated she (NA-L) heard a little later from another CNA (certified nursing assistant) that [R65] was hitting at staff, kicking and attempting to hit them with her walker." Another typed account of these incidents had been documented by LPN-J on 4/25/15. LPN-J's account included, "On Friday 4/24/15 I was here for staff potluck, overheard loud voice of a staff member [LPN-E] addressing a resident. I did not see who it was but another staff stated it was [R75]. Went out for a smoke break after eating, when a staff member came out and said [LPN-E] had stated 'could just kill them all'. When I came back in I asked [LPN-E] if he was ok, he stated 'we had a call in for night shift', (he also said his grandson was back in the hospital.) I offered to call to see if I could get someone to come in for night shift, he said that would be great. Received page from another staff [registered nurse (RN)-H], had me come down to the breakroom and talk with [assistant director of nursing (ADON) RN-A]. Discussed issue regarding [LPN-E] and it was decided [LPN-E] would be asked to go home." According to interviews and written witness statements, following the verbal altercation with R75, LPN-E was instructed to go home. However, LPN-E continued to remain in the facility without continuous supervision or	F 223	altercations with staff; her usual resistiveness to bathing continues. The resident has severe cognitive impairments and believes that she works at the facility and is a care taker for her grandparents. She does not recall the incident from April 2015. The social worker frequently interacts with the resident as she walks by the social service office several times a day. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The care plan was reviewed and found appropriate. Resident number 75 ¿ The resident has cognitive deficits and self-propels her wheelchair around the facility. She has occasional negative interactions with other residents which require staff intervention. She does not recall the incident from April 2015. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The resident frequently visits the Social Worker¿s office work to obtain a piece of candy from the candy bowl. The care plan was reviewed and found appropriate. The Social Worker will monitor compliance by auditing incident reports for timely and appropriate notification of the administrator and government offices for the next three months. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee	

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 223	Continued From page 9 immediate removal from resident access. LPN-E verbally and physically abused R65 after the altercation with R76. During that altercation R65 sustained an injury to her left hand. The facility's time clock records indicated LPN-E had punched out from his shift at 7:37 p.m., approximately one hour after the incident of verbal abuse with R75 had occurred. RN- H had documented a late entry progress note in R75's medical record on 4/27/15 at 19:38 (7:38 p.m.) which included, "Late entry from 4/24/15. Several staff members were in the south conference room when a staff nurse was heard raising his [LPN-E] voice towards resident. This writer came out in attempts to ascertain what the resident [R75] needed. Asked if she wanted to go to her room." The notes indicated LPN-E had stated, "she can drive herself wherever she wants to go," and had then made some comments about arguing with her. RN-H further documented, "Able to redirect the resident and diffuse the situation. DON, ADON and social services all notified of incident." LPN-E was observed on 6/9/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility. LPN-E's personnel record was reviewed. LPN-E had an active Minnesota Nursing License and had been employed at the facility since January 2015. Review of LPN-E's in-service training record indicated that LPN-E had received initial Abuse Protocol training during orientation, but had not received training on dealing with cognitively impaired residents since hire until after the incidents of alleged abuse on 4/24/15. LPN-E had completed online education related to Abuse	F 223	quarterly meeting and ongoing.	

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F 223	Continued From page 10 Prohibition/Resident rights/Caring for the Alzheimer's client on 4/28/15. During an interview with NA-C on 6/11/15 at 5:41 p.m., NA-C recalled the incident form 4/24/15 and stated, "I was sitting in the back nursing area, we heard [LPN-E] yelling and screaming at [R75]." NA-C then explained she had walked up the hallway near the nurse's station and was able to re-direct R75, "We started walking away with her but then she [R75] asked him [LPN-E] another question and he started yelling and screaming at her again. We were finally able to remove her from the situation." NA-C stated she could not remember what LPN-E was yelling and screaming about. During an interview on 6/11/15 at 6:00 p.m., NA-E indicated she could not recall all of the events that had taken place the evening of 4/24/15. However, she stated she could remember she'd heard LPN-E yelling at R75. NA-E could not remember what had been said during the confrontation but stated the yelling had lasted at least 10 minutes. NA-E also stated she had never been interviewed about the incident and was not aware she could report abuse to the State agency. During an interview on 6/12/15, at 9:30 a.m., the DON was asked to provide all information regarding the immediate reporting of the allegations of abuse between LPN-E and the residents to the administrator or State agency, and any interventions taken to protect R75 or other residents, or any investigation of the abuse incident. The DON confirmed he had not reported the allegation involving R75 to the State agency because he had been more focused on the	F 223		

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physical abuse allegation between LPN-E and R65.

During a follow-up interview with NA-C on 6/12/15 at 2:34 p.m., NA-C stated the yelling had started after dinner which was around 6:30 p.m. NA-C stated, "[LPN-E] was really loud, we could hear him down the hallway. We went to see what the yelling was all about, when we went up there, he was in her face yelling at her, she was sitting in the wheelchair, and I think [R75] was more confused than usual." NA-C further explained that after the incident R75 had kept repeating, "That man was yelling at me, why was he yelling at me?" until she went to bed. NA-C stated that besides the repeated question, R75 had been anxious and quiet the rest of the night until she went to bed. NA-C stated she could not recall who she'd told about the incident.

The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up."

A typed witness account of the physical abuse that occurred on 4/24/15, as part of the investigation for R65, had been documented on 4/25/15 by LPN-J and included: "Discussed issue regarding [LPN-E] and it was decided [LPN-E] would be asked to go home. He was finishing up a medication admin at cart when [R65] came up,

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grabbed the water pitcher, and tried to hit him with it. He grabbed it out of her hands and set it back on cart. She then raised up her walker, as if to hit him with it, not sure if he knocked it down or she dropped it but it fell on the floor. [LPN-E] picked it up and [R65] went as if to hit him with a closed fist at which time I got between them and asked [R65] to leave the area which she did. [LPN-E] left shortly after that."

Another witness statement regarding the alleged physical abuse of R65 had been documented by RN-H on 4/25/15 and included: "I did not witness the interaction between [LPN-E] and [R65] on 4/24/15 as I was on phone [symbol for with] [RN-A]. I was informed by [LPN-J] that [R65] had gotten in [LPN-E's] face but was unaware of the fact that [LPN-E] had put his arm and hand around [R65] until 11 p.m. on 4/24/15. CNA [NA-C] is filling out an incident report stating it was reported to myself and [LPN-H]. I was made aware of this situation 4 hours [symbol for after] it had occurred by [LPN-B]. I reported incident as soon as able."

R65's quarterly MDS dated 4/28/15, indicated R65 had a BIMS score of 4 indicating severe cognitive impairment.

R65's care plan verified the resident demonstrated behavioral problems and interventions included: "She is much more receptive when she has familiar staff working with her using calm, direct approach."

Review of R65's medical record indicated a certified nurse practitioner (CNP)-D had been requested to conduct an assessment of R65 on 4/28/15. The CNP's assessment was

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F 223	Continued From page 13 documented as an "Evaluation of patient after physical assault." The documented assessment included: "Charge nurse has informed me that patient was physically assaulted by a staff nurse on April 24, 2015. According to the charge nurse, the patient had been placed in a chokehold per another eyewitness. No bruising was noted after the event. Patient had no difficulty breathing, no laryngeal edema, stridor, or tracheal deviation. Director of nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from assault. Patient has no evidence of any trauma to her neck. There is no bruising, abrasions, evidence of finger prints on her neck or shoulder area. She has some resolving bruising noted on her left hand and nurse reported that she has some mild soft tissue swelling of her left thumb after the incident which has now resolved ..." An additional entry written by CNP-D on 4/28/15 at 6:18 p.m. included, "... Charge nurse has informed me that patient [R65] had an altercation with a staff nurse on April 24, 2015. The patient was agitated and attempted to throw her water pitcher at the nurse. The nurse reached and grabbed the patient's wrist with one hand and the water pitcher with the other hand. There was some mild swelling noted on the patient's left thumb web space with a bruise occurring after the incident. Today she has some resolving bruising noted on her left hand and no further swelling of her left thumb after the incident which has now resolved. Director of Nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from the altercation. She [R65] denies all complaints of	F 223		

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pain today. Patient has no evidence of any trauma to her body with no bruising or abrasions, or change in her functional status..."

During an interview on 6/11/15, at 9:34 a.m. in regards to when he was notified of the abuse incident with R65 which occurred on 4/24/15 after evening meal, DON stated staff had placed a phone message on his home phone following the incident but he did not listen to it until the next morning (Saturday 4/25/15) at which time he had come to the facility to follow-up on the incident. The DON stated it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit any internal investigative reports to the State designated agency.

The facility provided the incident report, a submission report to the State agency (Office of Health Facility Complaints-OHFC), and all investigative notes regarding these allegations. According to the report submitted to OHFC, the allegations were not immediately reported. The allegation of physical abuse against R65 had been reported the day after it had occurred, 4/25/15. There had been no report of the allegation of verbal abuse against R75. The documentation indicated an investigative report had been submitted to the OHFC on 4/29/15. The report included LPN-E's account of the physical abuse of R65 however, it lacked other eye witness accounts of the physical abuse testimony and accounts from all of the witnesses. Despite the CNP's assessment, the investigative report indicated R65 had suffered no harm or injury. However, nurses reported swelling in the hand area that was grabbed by LPN-E during abuse altercation and CNP-D's physical and functional

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assessment completed on 4/28/15 verified there had been swelling and bruising of R65's left wrist. The investigative report also documented a personal improvement plan for LPN-E that included education re., vulnerable adult and dementia training, follow up with social worker, report to the board of nursing, and reassignment to another unit.

During an interview with the DON on 6/12/15 at 9:45 a.m., the DON stated LPN-E receiving counseling, education on dealing with difficult behaviors especially residents with dementia who might become agitated and combative. However, the DON stated the social worker who had followed-up with LPN-E after the alleged abuse incidents for R75 and R65 was no longer employed by the facility and there was no documentation as to what improvements LPN-E was working on in regards to his performance improvement, competence of handling agitated dementia related behaviors, or dealing with personal stress in a healthy manner to prevent abuse situations from redeveloping.

RN-A was interviewed on 6/12/15, at 11:57 a.m. she verified that LPN-E had received initial Abuse Protocol training during orientation, but had not received training on dealing with cognitively impaired residents since hire until after the incidents of alleged abuse on 4/24/15.
RN-A verified that following the incidents, LPN-E had been required to complete online education related to Abuse Prohibition/Resident rights/Caring for the Alzheimer's client on 4/28/15.

Following the surveyor's inquiry about the reporting of these alleged incidents of verbal/physical abuse, the DON made a report to

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F 223	Continued From page 16 the State agency (OHFC) regarding the verbal abuse R75 had sustained on 4/24/15. The report was made on 6/12/15, as part of the immediate plan of correction following the facility having been informed that an immediate jeopardy situation existed. The incident description sent to the State agency included: "During routine MDH [Minnesota Department of Health], it was brought to this writer's attention that on 4/24/15, staff LPN [LPN-E] was yelling at resident [R75]. An incident was initially reported on 4/25/15 regarding another demented resident [however, R65 was the main focus of that OHFC report and information in regards to R75 was to support the investigation of R65. During this incident [R75] was also agitated and following the nurse and not responding to re-direction. Nurse [LPN-E] did yell at resident due to his frustration with resident [R75] and her continued agitation. This writer initially combined both of these actions by the nurse [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident ..." On 6/16/15 all staff received a copy of the facility's abuse protocol packet (forms undated) from the assistant director of nursing as they reported for work. The staff were requested to read the packet of information in regards to abuse protocol. The packet included specific policies entitled: Background Screening Investigations, In-Service Training, Preventing Resident Abuse, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting/Investigating Resident Accidents/Incidents. Abuse and/or Neglect Investigation, Protection of Residents During Abuse Investigation, Report Abuse to State Agencies and Other Entities/Individuals,	F 223		

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Reporting Suspected Cases and/or Incidents of Rape, Vulnerable Adult Reporting of Alleged Misappropriation of Residents Personal Property, Investigating Unexplained Injuries, Resident-to-Resident Abuse, and reporting forms. In addition the packet of information included undated facility policies for Visitation, Quality of Life-Dignity, Employee In-Service Program, Six Keys to Resident Loyalty, Indicators of Abuse, and Indicators of Neglect.
Interviews were conducted by survey staff with direct care staff, activities staff, pool nursing staff, and supervisory nursing from day and evening shifts on 6/16/15 between 2:20 p.m. and 2:40 p.m. to verify receipt of education prior to starting their shifts. Each staff person interviewed verified they had received a packet of information and were in the process of reading it as detailed in the facility's IJ removal plan.

RN-A was interviewed on 6/16/17 at 2:45 p.m.. RN-A stated all staff were provided training as described as they reported to work.

Facility policies related to Abuse Prohibition were reviewed. An undated policy entitled Reporting/Investigating Resident Accidents/Incidents included: "All accidents/incidents involving residents must be reported to the director of nursing services and immediately to the administrator...All accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing."

An undated policy entitled Abuse and/or Neglect Investigation included: "All reports of resident abuse or neglect shall be promptly and thoroughly

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F 223	Continued From page 18 investigated." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies." The immediate jeopardy that began on 4/24/15, was removed on 6/16/15 when it could be determined the facility had operationalized their plan for removal in regards to educating all staff as they reported to work regarding the facility's policies related to abuse, neglect, maltreatment and reporting prior to allowing staff to work with residents. In addition, montioring systems had been developed and initiated to ensure continued complaince with facility protocols. However, non-compliance remained.	F 223		
F 225 SS=K	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,	F 225		6/17/15

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F 225	Continued From page 19 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and 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 observation, interview and document review, the facility failed to immediately report allegations of verbal and physical abuse to the administrator and State agency, failed to thoroughly investigate allegations of staff abuse, neglect, and/or mistreatment for 2 of 5 residents (R75, R65) reviewed for abuse, and failed to ensure residents were protected from further abuse. The facility's failure to operationalize their abuse/neglect/maltreatment policy/procedures following identification of abuse to R75 and R65, resulted in an immediate jeopardy (IJ) situation for R75 and R65 as well as for other residents who resided on the main and lower floor living units where the alleged perpetrator worked,	F 225	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply with all applicable state and feral regulatory requirements and constitutes the facility¿s allegation of compliance. Stewartville Care Center policy requires	

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F 225	Continued From page 20 presenting a risk of additional staff abuse, neglect, and/or mistreatment. In addition the facility failed to operationalize their abuse/neglect policy that clearly identified reporting, investigation, and protection of residents if allegation/s of staff abuse, neglect, and mistreatment for 3 of 6 other allegations reviewed (R64, R99, and R98). The immediate jeopardy began on 4/24/15 when facility staff witnessed licensed practical nurse (LPN)-E verbally abuse R75 and then physically abuse R65. The director of nursing (DON) and administrator were notified of the immediate jeopardy at 3:00 p.m. on 6/12/15. The immediate jeopardy was removed on 6/16/15 but noncompliance remained at the lower scope and severity level of an E, a pattern scope, with severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Although R75 was observed by staff to be yelled at by licensed practical nurse (LPN)-E on 4/24/15 following the supper meal, and LPN-E was subsequently observed to be verbally and physically abusive to R65 that same evening, however, the incidents were not immediately reported to the administrator or the State agency, nor were interventions initiated to prevent further abuse. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C dated 4/25/15. The concern included: "EMPLOYEE	F 225	that all alleged violations involving resident mistreatment, neglect, abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator and appropriate state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process. Stewartville Care Center does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service in a resident care position is investigated and reported to the State nurse aid registry or licensing authorities. The facility¿s policies and procedures for investigation/reporting of incidents were reviewed and found appropriate. The facility¿s Vulnerable Adult Abuse policies were distributed to all staff on June 16 and June 17, 2015. The staff were required to sign to verify that they received the information. On June 16, 2015, all Stewartville Care Center staff including management staff were instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation	

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F 225	Continued From page 21 NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." R75's quarterly minimum data set (MDS) dated 5/12/15 indicated R75 had a brief interview for mental status (BIMS) score of 4 which indicated R75 was severely cognitively impaired. The MDS also indicated R4 could hear with minimal difficulty. During an interview and observations on 6/9/15 at 9:51 a.m., R75 was observed during an interview with family (F)-A. R75 conversed with F-A and the surveyor without hearing difficulty and surveyor did not have to speak loudly for resident to hear. R75's care plan directed staff to provide, "Clear, careful, explanations to facilitate her comprehension...repeat/rephrase words as needed to facilitate hearing and comprehension." Information provided by the DON related to the investigation of these incidents, included a typed interview conducted 4/25/15 at 10:00 a.m., by the DON with NA-L. The interview documentation included, "Spoke to [NA-L] concerning incident Friday 4-24-15 p.m. shift. She stated he [LPN-E] was talking to [R75]. [R75] was repeating questions and as [LPN-E] was answering questions he was becoming more upset and	F 225	of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirements of immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies and 5) forms and procedures for appropriate and timely reporting. The staff is educated on vulnerable adult issues at least every twelve months; vulnerable adult investigation and reporting are addressed during new employee orientation. The employee (LPN-E) involved in the April 24, 2015 incidents with residents number 65 and 75 was initially suspended for three days pending an investigation of the alleged abuse. After returning to work, he was assigned to another care unit. After the June 2015 state review of the issue, the LPN-e was requested to complete a Health Professional Services Program evaluation as a condition of continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has had no further practice/performance issues. Resident number 75 ¿ The resident has cognitive deficits and self-propels her wheelchair around the facility. She has occasional negative interactions with other residents which require staff intervention. She does not recall the incident from April 2015. The social worker will meet with the resident weekly for four weeks and then	

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F 225	Continued From page 22 yelling, and was probably yelling more than he should. [R65] was standing nearby with her walker but did not say anything. Stated she (NA-L) heard a little later from another CNA (certified nursing assistant) that [R65] was hitting at staff, kicking and attempting to hit them with her walker." Another typed account of these incidents had been documented by LPN-J on 4/25/15. LPN-J's account included, "On Friday 4/24/15 I was here for staff potluck, overheard loud voice of a staff member [LPN-E] addressing a resident. I did not see who it was but another staff stated it was [R75]. Went out for a smoke break after eating, when a staff member came out and said [LPN-E] had stated 'could just kill them all'. When I came back in I asked [LPN-E] if he was ok, he stated 'we had a call in for night shift', (he also said his grandson was back in the hospital.) I offered to call to see if I could get someone to come in for night shift, he said that would be great. Received page from another staff [registered nurse (RN)-H], had me come down to the breakroom and talk with [assistant director of nursing (ADON) RN-A]. Discussed issue regarding [LPN-E] and it was decided [LPN-E] would be asked to go home." According to interviews and written witness statements, following the verbal altercation with R75, LPN-E was instructed to go home. However, LPN-E continued to remain in the facility without continuous supervision or immediate removal from resident access. LPN-E verbally and physically abused R65 after the altercation with R76. During that altercation R65 sustained an injury to her left hand. The facility's time clock records indicated LPN-E had	F 225	monthly for six months to assess mood and behavior. The resident frequently visits the Social Worker¿s office to obtain a piece of candy from the candy bowl. The care plan was reviewed and found appropriate. Resident number 65 ¿ The resident continues to wander throughout the first floor of the facility. She has had no recent altercations with staff; her usual resistiveness to bathing continues. The resident has severe cognitive impairments and believes that she works at the facility and is a care taker for her grandparents. She does not recall the incident from April 2015. The social worker frequently interacts with the resident as she walks by the social service office several times a day. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The care plan was reviewed and found appropriate. Residents number 64 ¿ The alleged abuse by the resident¿s spouse was observed 4/15/15 at 4:40 pm and was not reported to the State agency until the next day. The related facility policy and the regulatory requirements for immediate reporting were reviewed by the administrative and social service staff for quality improvement purposes. Resident number 99 ¿ The resident died at the facility September 15, 2014. The circumstances of the Alleged Resident Abuse Investigation Report Form for an	

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F 225	Continued From page 23 punched out from his shift at 7:37 p.m., approximately one hour after the incident of verbal abuse with R75 had occurred. RN- H had documented a late entry progress note in R75's medical record on 4/27/15 at 19:38 (7:38 p.m.) which included, "Late entry from 4/24/15. Several staff members were in the south conference room when a staff nurse was heard raising his [LPN-E] voice towards resident. This writer came out in attempts to ascertain what the resident [R75] needed. Asked if she wanted to go to her room." The notes indicated LPN-E had stated, "she can drive herself wherever she wants to go," and had then made some comments about arguing with her. RN-H further documented, "Able to redirect the resident and diffuse the situation. DON, ADON and social services all notified of incident." LPN-E was observed on 6/9/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility. LPN-E's personnel record was reviewed. LPN-E had an active Minnesota Nursing License and had been employed at the facility since January 2015. Review of LPN-E's in-service training record indicated that LPN-E had received initial Abuse Protocol training during orientation, but had not received training on dealing with cognitively impaired residents since hire until after the incidents of alleged abuse on 4/24/15. LPN-E had completed online education related to Abuse Prohibition/Resident rights/Caring for the Alzheimer's client on 4/28/15. During an interview with NA-C on 6/11/15 at 5:41 p.m., NA-C recalled the incident form 4/24/15 and	F 225	incident during the morning of August 20, 2014 not being submitted until the afternoon was reviewed by the management staff for continuing quality improvement purposes. Resident number 98 ¿ The resident died at the facility December 29, 2014. The circumstances regarding the 48-hour delay in reporting a bruise to the administrator and State agency were reviewed by the management staff for continuing quality improvement purposes. The Social Worker will monitor compliance by auditing incident reports for timely and appropriate notification of the administrator and State agencies for the next three months. If noncompliance is noted, additional auditing and training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting and ongoing.	

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stated, "I was sitting in the back nursing area, we heard [LPN-E] yelling and screaming at [R75]." NA-C then explained she had walked up the hallway near the nurse's station and was able to re-direct R75, "We started walking away with her but then she [R75] asked him [LPN-E] another question and he started yelling and screaming at her again. We were finally able to remove her from the situation." NA-C stated she could not remember what LPN-E was yelling and screaming about.

During an interview on 6/11/15 at 6:00 p.m., NA-E indicated she could not recall all of the events that had taken place the evening of 4/24/15. However, she stated she could remember she'd heard LPN-E yelling at R75. NA-E could not remember what had been said during the confrontation but stated the yelling had lasted at least 10 minutes. NA-E also stated she had never been interviewed about the incident and was not aware she could report abuse to the State agency.

During an interview on 6/12/15, at 9:30 a.m., the DON was asked to provide all information regarding the immediate reporting of the allegations of abuse between LPN-E and the residents to the administrator or State agency, and any interventions taken to protect R75 or other residents, or any investigation of the abuse incident. The DON confirmed he had not reported the allegation involving R75 to the State agency because he had been more focused on the physical abuse allegation between LPN-E and R65.

During a follow-up interview with NA-C on 6/12/15 at 2:34 p.m., NA-C stated the yelling had started

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after dinner which was around 6:30 p.m. NA-C stated, "[LPN-E] was really loud, we could hear him down the hallway. We went to see what the yelling was all about, when we went up there, he was in her face yelling at her, she was sitting in the wheelchair, and I think [R75] was more confused than usual." NA-C further explained that after the incident R75 had kept repeating, "That man was yelling at me, why was he yelling at me?" until she went to bed. NA-C stated that besides the repeated question, R75 had been anxious and quiet the rest of the night until she went to bed. NA-C stated she could not recall who she'd told about the incident.

The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up."

A typed witness account of the physical abuse that occurred on 4/24/15, as part of the investigation for R65, had been documented on 4/25/15 by LPN-J and included: "Discussed issue regarding [LPN-E] and it was decided [LPN-E] would be asked to go home. He was finishing up a medication admin at cart when [R65] came up, grabbed the water pitcher, and tried to hit him with it. He grabbed it out of her hands and set it back on cart. She then raised up her walker, as if to hit him with it, not sure if he knocked it down or she dropped it but it fell on the floor. [LPN-E]

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picked it up and [R65] went as if to hit him with a closed fist at which time I got between them and asked [R65] to leave the area which she did. [LPN-E] left shortly after that."

Another witness statement regarding the alleged physical abuse of R65 had been documented by RN-H on 4/25/15 and included: "I did not witness the interaction between [LPN-E] and [R65] on 4/24/15 as I was on phone [symbol for with] [RN-A]. I was informed by [LPN-J] that [R65] had gotten in [LPN-E's] face but was unaware of the fact that [LPN-E] had put his arm and hand around [R65] until 11 p.m. on 4/24/15. CNA [NA-C] is filling out an incident report stating it was reported to myself and [LPN-H]. I was made aware of this situation 4 hours [symbol for after] it had occurred by [LPN-B]. I reported incident as soon as able."

R65's quarterly MDS dated 4/28/15, indicated R65 had a BIMS score of 4 indicating severe cognitive impairment.

R65's care plan verified the resident demonstrated behavioral problems and interventions included: "She is much more receptive when she has familiar staff working with her using calm, direct approach."

Review of R65's medical record indicated a certified nurse practitioner (CNP)-D had been requested to conduct an assessment of R65 on 4/28/15. The CNP's assessment was documented as an "Evaluation of patient after physical assault." The documented assessment included: "Charge nurse has informed me that patient was physically assaulted by a staff nurse on April 24, 2015. According to the charge nurse,

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the patient had been placed in a chokehold per another eyewitness. No bruising was noted after the event. Patient had no difficulty breathing, no laryngeal edema, stridor, or tracheal deviation. Director of nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from assault. Patient has no evidence of any trauma to her neck. There is no bruising, abrasions, evidence of finger prints on her neck or shoulder area. She has some resolving bruising noted on her left hand and nurse reported that she has some mild soft tissue swelling of her left thumb after the incident which has now resolved ..."

An additional entry written by CNP-D on 4/28/15 at 6:18 p.m. included, "... Charge nurse has informed me that patient [R65] had an altercation with a staff nurse on April 24, 2015. The patient was agitated and attempted to throw her water pitcher at the nurse. The nurse reached and grabbed the patient's wrist with one hand and the water pitcher with the other hand. There was some mild swelling noted on the patient's left thumb web space with a bruise occurring after the incident. Today she has some resolving bruising noted on her left hand and no further swelling of her left thumb after the incident which has now resolved. Director of Nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from the altercation. She [R65] denies all complaints of pain today. Patient has no evidence of any trauma to her body with no bruising or abrasions, or change in her functional status..."

During an interview on 6/11/15, at 9:34 a.m. in

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regards to when he was notified of the abuse incident with R65 which occurred on 4/24/15 after evening meal, DON stated staff had placed a phone message on his home phone following the incident but he did not listen to it until the next morning (Saturday 4/25/15) at which time he had come to the facility to follow-up on the incident. The DON stated it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit any internal investigative reports to the State designated agency.

The facility provided the incident report, a submission report to the State agency (Office of Health Facility Complaints-OHFC), and all investigative notes regarding these allegations. According to the report submitted to OHFC, the allegations were not immediately reported. The allegation of physical abuse against R65 had been reported the day after it had occurred, 4/25/15. There had been no report of the allegation of verbal abuse against R75. The documentation indicated an investigative report had been submitted to the OHFC on 4/29/15. The report included LPN-E's account of the physical abuse of R65 however, it lacked other eye witness accounts of the physical abuse testimony and accounts from all of the witnesses. Despite the CNP's assessment, the investigative report indicated R65 had suffered no harm or injury. However, nurses reported swelling in the hand area that was grabbed by LPN-E during abuse altercation and CNP-D's physical and functional assessment completed on 4/28/15 verified there had been swelling and bruising of R65's left wrist. The investigative report also documented a personal improvement plan for LPN-E that included education re., vulnerable adult and

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dementia training, follow up with social worker, report to the board of nursing, and reassignment to another unit.

During an interview with the DON on 6/12/15 at 9:45 a.m., the DON stated LPN-E receiving counseling, education on dealing with difficult behaviors especially residents with dementia who might become agitated and combative. However, the DON stated the social worker who had followed-up with LPN-E after the alleged abuse incidents for R75 and R65 was no longer employed by the facility and there was no documentation as to what improvements LPN-E was working on in regards to his performance improvement, competence of handling agitated dementia related behaviors, or dealing with personal stress in a healthy manner to prevent abuse situations from redeveloping.

RN-A was interviewed on 6/12/15, at 11:57 a.m. she verified that LPN-E had received initial Abuse Protocol training during orientation, but had not received training on dealing with cognitively impaired residents since hire until after the incidents of alleged abuse on 4/24/15.
RN-A versified that following the incidents, LPN-E had been required to complete online education related to Abuse Prohibition/Resident rights/Caring for the Alzheimer's client on 4/28/15.

Following the surveyor's inquiry about the reporting of these alleged incidents of verbal/physical abuse, the DON made a report to the State agency (OHFC) regarding the verbal abuse R75 had sustained on 4/24/15. The report was made on 6/12/15, as part of the immediate plan of correction following the facility having been informed that an immediate jeopardy

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situation existed. The incident description sent to the State agency included: "During routine MDH [Minnesota Department of Health], it was brought to this writer's attention that on 4/24/15, staff LPN [LPN-E] was yelling at resident [R75]. An incident was initially reported on 4/25/15 regarding another demented resident [however, R65 was the main focus of that OHFC report and information in regards to R75 was to support the investigation of R65. During this incident [R75] was also agitated and following the nurse and not responding to re-direction. Nurse [LPN-E] did yell at resident due to his frustration with resident [R75] and her continued agitation. This writer initially combined both of these actions by the nurse [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident ..."

On 6/16/15 all staff received a copy of the facility's abuse protocol packet (forms undated) from the assistant director of nursing as they reported for work. The staff were requested to read the packet of information in regards to abuse protocol. The packet included specific policies entitled: Background Screening Investigations, In-Service Training, Preventing Resident Abuse, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting/Investigating Resident Accidents/Incidents. Abuse and/or Neglect Investigation, Protection of Residents During Abuse Investigation, Report Abuse to State Agencies and Other Entities/Individuals, Reporting Suspected Cases and/or Incidents of Rape, Vulnerable Adult Reporting of Alleged Misappropriation of Residents Personal Property, Investigating Unexplained Injuries, Resident-to-Resident Abuse, and reporting forms.

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F 225	Continued From page 31 In addition the packet of information included undated facility policies for Visitation, Quality of Life-Dignity, Employee In-Service Program, Six Keys to Resident Loyalty, Indicators of Abuse, and Indicators of Neglect. Interviews were conducted by survey staff with direct care staff, activities staff, pool nursing staff, and supervisory nursing from day and evening shifts on 6/16/15 between 2:20 p.m. and 2:40 p.m. to verify receipt of education prior to starting their shifts. Each staff person interviewed verified they had received a packet of information and were in the process of reading it as detailed in the facility's IJ removal plan. RN-A was interviewed on 6/16/17 at 2:45 p.m.. RN-A stated all staff were provided training as described as they reported to work. Facility policies related to Abuse Prohibition were reviewed. An undated policy entitled Reporting/Investigating Resident Accidents/Incidents included: "All accidents/incidents involving residents must be reported to the director of nursing services and immediately to the administrator...All accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing." An undated policy entitled Abuse and/or Neglect Investigation included: "All reports of resident abuse or neglect shall be promptly and thoroughly investigated." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all	F 225		

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substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies."

The immediate jeopardy that began on 4/24/15, was removed on 6/16/15 when it could be determined the facility had operationalized their plan for removal in regards to educating all staff as they reported to work regarding the facility's policies related to abuse, neglect, maltreatment and reporting prior to allowing staff to work with residents. In addition, montioring systems had been developed and initiated to ensure continued complaince with facility protocols. However, non-compliance remained.

Additional incidents of failure to follow facility policies for reporting/investigating:

The facility had submitted a report to the state agency on 4/16/15, indicating a nurse had witnessed R64 being hit on the forearm by family (F)-B on 4/15/15, around 4:40 p.m. The report indicated, "[R64] was sitting in a reclining chair next to [F-B]...As he was attempting to get up and out of the chair, [F-B] struck him on the forearm..."

R64's diagnosis, according to the resident admission record dated 1/21/15, included debility with functional decline and dementia. The quarterly Minimum Data Set (MDS) dated 3/25/15, identified R64 had severe cognitive impairment and required extensive assistance from one person for all activities of daily living (ADL)'s.

A review of the nursing progress notes dated

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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4/15/15, included a note from 4:30 p.m., "Nurse observed resident attempting to get out of a recliner chair. [F-B] attempted to tell resident to sit back down. Nurse noted agitation in the [F-B ' s] voice. Nurse then observed resident's [F-B] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well."

Although the facility was aware of the family member striking R64 on 4/15/15, the incident was not reported to the State agency until the next day, 4/16/15.

Although R99 sustained an injury of unknown origin on 8/19/14, the facility failed to ensure the administrator and state agency were notified immediately.

An incident report for R99 had been submitted to the State agency on 8/20/14 for an incident that had occurred the previous day, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident..was lying on the floor...[R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..."

R99's record was reviewed. The resident admission record dated 2/26/10, identified diagnoses including: senile dementia and osteoporosis. The quarterly MDS dated 8/12/14, identified R99 as having severe cognitive impairment and requiring limited assistance from one person for transferring and walking.

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A review of the nursing progress notes dated 8/19/14 at 10:30 a.m. included, "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]."

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident had been reported to the administrator on "8/20/14, AM," and had been reported to the State licensing agency on "8/20/14, PM."

Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and state agency were notified immediately.

The facility had submitted a report to the State agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's disease."

R98's record was reviewed and the resident admission record dated 12/5/08 indicated the resident had diagnoses including: dementia and Alzheimer's disease. A quarterly MDS dated 11/18/14, identified R98 had severe cognitive impairment and was totally dependent on staff for all activities of daily living.

A review of the nursing progress notes dated

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8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. The progress notes also indicated R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved.

A Skin Integrity Events Report dated 8/10/14, indicated the purplish-black bruise on R98's left medial forearm extending to the side of the thumb and index finger, was mildly painful and was swollen.

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed as reviewed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on resident's L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." The investigative report also indicated the administrator had not been notified of the 8/10/14 incident until 8/12/14.

During interview on 6/11/15 at 9:34 a.m., the DON stated administrative staff were to submit reports to the State agency, "Other staff can, but I want them to call me." The DON stated he carried a cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. The DON verified the reports that were submitted for R64, R99, and R98, had not all been submitted immediately to the

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F 225	Continued From page 36 administrator or State agency as required. The DON confirmed he was aware the reports needed to be submitted immediately and stated, "We have a system problem." Review of the facility's undated policy Reporting Abuse to State Agencies and Other Entities/Individuals included: "Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be suspected, it must be immediately reported to the administrator and to proper State agencies."	F 225		
F 226 SS=F	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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policies and procedures related to immediate reporting of alleged abuse/neglect to the administrator and State agency, protecting resident/s from ongoing abuse, and completing a thorough investigation following an allegation of abuse/neglect for 5 of 26 residents (R75, R65, R64, R99, R98) who were reviewed for abuse prohibition. This had the potential to affect all 68 residents currently residing in the facility. Findings include:	F 226	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply with all applicable state and feral regulatory requirements and constitutes the facility¿s allegation of compliance.	6/17/15

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F 226	Continued From page 37 On 6/11/15 the facility provided a package of undated Policy and Procedure Standards related to Abuse Prohibition: The undated policy entitled Recognizing Signs and Symptoms of Abuse/Neglect read, "...all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services and immediately to the Administrator." The procedure directed signs and symptoms of abuse should be reported promptly. The procedure lists signs of actual physical abuse, signs of actual physical neglect, and signs/symptoms of psychological abuse/neglect. The undated policy entitled Reporting/Investigating Resident Accidents/Incidents read, "All accidents/incidents involving residents must be report to the director of nursing services and immediately to the administrator." The procedure directed staff that "all accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing." The undated policy entitled Abuse and/or Neglect Investigation read, "All reports of resident abuse or neglect shall be promptly and thoroughly investigated." The procedure directed the administrator would appoint a designee to investigate the incident and that person would report daily to the administrator the progress of the investigation. The procedure also directed that employees that had been accused of resident abuse would be reassigned to nonresident care duties or put on leave until the	F 226	Stewartville Care Center has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures address the seven following components: screening, training, prevention, identification, investigation, protection, and reporting/response. Stewartville Care Center staff recognizes and respects each resident¿s right to be free from maltreatment, neglect, and misappropriation of property and does all that is within its control to prevent such occurrences. The facility staff 1) identifies residents who are at risk for abuse, neglect, and/or misappropriation of property 2) develops intervention strategies to prevent occurrences and 3) routinely reassesses the effectiveness of the interventions. During the mandatory staff training July 14, 15 and 16, 2015, the facility policies related to abuse prevention/ reporting were reviewed and the staff were instructed on 1) the types of incidents/accidents that need to be immediately reported to the administrative/supervisory staff 2) procedures for notifying the administrative staff and the appropriate government agencies of the incident/accident and 3) necessary documentation related to incidents/accidents.	

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F 226	Continued From page 38 results of the investigation had been reviewed by the administrator. The undated policy entitled Protection of Residents During Abuse Investigation read, "Our facility will protect residents from harm during investigations of abuse allegations." The procedure directed that during abuse investigations, employees accused of resident abuse would be reassigned to nonresident care duties or put on leave; and that if employees were reassigned to non-resident care duties, such assignments would not be in any part of the building which the resident frequents. The procedure read, "Should the results indicate that abuse occurred, appropriate authorities will be notified." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals read, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate state agencies. The procedure directed "A. Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of unknown source, or abuse to be suspected. It must be immediately reported to the administrator and to proper state agencies 1. Olmsted County Social Services 2. Minnesota Department of Health/OHFC. B. Verbal/written notices to the above agencies will be made immediately following the incident if possible...C. The administrator, or his/her designee, will submit internal investigation report to OHFC website 5 working days of the occurrence of the incident." R75 was observed to have been verbally abused	F 226	Resident number 75 ¿ The resident has cognitive deficits and self-propels her wheelchair around the facility. She has occasional negative interactions with other residents which require staff intervention. She does not recall the incident from April 2015. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The resident frequently visits the Social Worker¿s office to obtain a piece of candy from the candy bowl. The care plan was reviewed and found appropriate. Resident number 65 ¿ The resident continues to wander throughout the first floor of the facility. She has had no recent altercations with staff; her usual resistiveness to bathing continues. The resident has severe cognitive impairments and believes that she works at the facility and is a care taker for her grandparents. She does not recall the incident from April 2015. The social worker frequently interacts with the resident as she walks by the social service office several times a day. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The care plan was reviewed and found appropriate. Residents number 64 ¿ The alleged abuse by the resident¿s spouse was observed 4/15/15 at 4:40 p.m. and was not reported to the State agency until the next day. The related facility policy and the regulatory requirements for immediate	

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F 226	Continued From page 39 by licensed practical nurse (LPN)-E on 4/24/15. The incident was not immediately reported to the administrator or designated State agency, nor was R75 protected following this incident, or a thorough investigation completed. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C 4/25/15. The concern included: "EMPLOYEE NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." During an interview on 6/12/15, at 9:30 a.m., the DON was asked for all information regarding the immediate reporting of the verbal abuse to the administrator, OHFC, and interventions taken to protect R75 from further abuse as well as other residents and a thorough investigation of the abuse incident. None was provided and the DON stated he did not report this incident with R75 separately but was with the report sent to OHFC in regards to the physical abuse to R65. Then the DON stated he was more focused on the physical abuse incident with R65 at the time. Again the physical abuse of R65 occurred shortly after the verbal abuse of R75 by LPN-E on 4/24/25 after the evening meal as LPN-E was passing medications. Progress note was not entered into the medical	F 226	reporting were reviewed by the administrative and social service staff for continued quality improvement purposes. Resident number 99 ¿ The resident died at the facility September 15, 2014. The circumstances of the Alleged Resident Abuse Investigation Report Form for an incident during the morning of August 20, 2014 not being submitted until the afternoon was reviewed by the management staff for continuing quality improvement purposes. Resident number 98 ¿ The resident died at the facility December 29, 2014. The circumstances regarding a bruise observed 8/10/14 and the 48-hour delay in reporting the bruise to the administrator and State agency were reviewed by the management staff for continuing quality improvement purposes. The Social Worker will monitor compliance by auditing incident reports for timely and appropriate notification of the administrator and State agencies for the next three months. If noncompliance is noted, additional auditing and training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee meeting and ongoing.	

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record until two days later on 4/27/15 and read, "Several staff members were in the south conference room when a staff nurse heard raising voice towards resident." The progress note also indicated notification of DON, ADON, and Social services, however did not indicate when the notifications were given.

The DON reported the verbal abuse of R75 to the OHFC and to the Common Entry Point (CEP) on 6/12/15 after the survey team had informed the facility an immediate jeopardy (IJ) related to abuse existed.

R65 had been verbally and physically abused by LPN-E on 4/24/15 however, this was not immediately reported to the administrator or OHFC.

The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up."

A typed witness account of the physical abuse that occurred on 4/24/15 as part of the investigation for R65 completed on 4/25/15 by LPN-J read, "On Friday 4/24/15 I was here for staff potluck, ...He [LPN-E] was finishing up a medication admin at cart when [R65] came up grabbed the water pitcher and tried to hit him with it. He grabbed it out of her hands and set it back

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F 226	Continued From page 41 on cart. She then raised up her walker, as if to hit him with it, not sure if he knocked it down or she dropped it but it fell on the floor. [LPN-E] picked it up and [R65] went as if to hit him with a closed fist at which time I got between them and asked [R65] to leave the area which she did. [LPN-E] left shortly after that." The facility provided the incident report, submission report to the State agency (the Office of Health Facility Complaints-OHFC), and all investigative notes. According to the OHFC complaint, the allegation of verbal/physical abuse to R65 had not been not immediately reported but had been reported the following day 4/25/15. R64 had an allegation of physical abuse by a family (F) member which occurred on 4/15/15 however, it was not reported to the State agency until the next day. The facility submitted a report to the State agency on 4/16/15 indicating a nurse witnessed R64 being hit on the forearm by [F-A] on 4/15/15, around 4:40 p.m. "[R64] was sitting in a reclining chair next to [F-A]... As he was attempting to get up and out of the chair, [F-A] struck him on the forearm..." A review of the nursing progress notes, dated 4/15/15, at 4:30 p.m., included, "Nurse observed resident attempting to get out of a recliner chair. [F-A] attempted to tell resident to sit back down. Nurse noted agitation in the [F-A]'s voice. Nurse then observed resident's [F-A] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well." R99 had received an injury of unknown origin	F 226		

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causing a fracture the facility did not immediately report the incident to the state agency.

An incident report for R99, submitted to the State agency on 8/20/14 indicated, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident ...was lying on the floor... [R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..."

A review of the nursing progress notes dated 8/19/14 at 10:30 a.m., included: "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]."

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident from 8/19/14 had first been reported to the administrator on "8/20/14, AM," and had subsequently been reported to the State Licensing Agency on "8/20/14, PM."

R98 was found to have a large bruise on her left forearm which was found to be a fracture however, this was not immediately reported to the State agency or the administrator as directed by the facility abuse policy and procedure.

The facility submitted a report to the state agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm

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extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's Disease."

A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. Also included, R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved.

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on residents L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM [range of motion]. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." Also included, the administrator was not notified until 8/12/14.

Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and State agency were notified immediately.

During interview on 6/11/15, at 9:34 a.m. the director of nursing (DON) indicated the administrative staff were to submit reports to the State agency and stated, "Other staff can, but I want them to call me." DON stated he carried a

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F 226	Continued From page 44 cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem."	F 226		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide prior notice of a new roommate for 2 of 2 residents (R11, R40) reviewed for admission, transfer, and discharge. Findings Include: R11 was interviewed and asked about any roommate changes on 6/09/2015 at 10:41 a.m. R11 stated she has had several temporary roommates after her family member (F)-Q died. R11 stated she knew she would have to get one, but was not told in advance of them coming. R11 also stated she was not told when her current roommate moved into their shared room. R11's quarterly Minimum Data Set (MDS) dated 3/24/15 indicated R11 had intact cognition based	F 247	The staff at Stewartville Care Center respect the residents¿ right to receive notice before the resident¿s room or roommate is changed. The staff is sensitive to the trauma that a move or change of roommate causes some residents and attempt to be as accommodating as possible. The resident is asked about his/her preferences which are than taken into account when discussing changes of rooms or roommates and the timing of such changes. When a resident is moved at the facility¿s request, an explanation of the reason for the move is provided. The resident is given the opportunity to see the new location, ask questions about the	7/27/15

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F 247	Continued From page 45 on a score of fifteen on the brief interview for mental status (BIMS). R11's diagnoses included anemia, depression and diabetes mellitus. SS progress note dated 3/26/15 read, "Resident survey done recently and I followed up on concerns. R11 said that she was not informed of getting a new roommate after her [F-Q] died, which was some time ago. I apologized for that..." On 6/09/2015 2:54 p.m. social services (SS)-A shared R11 had new roommates move into her shared room on 4/29/14, 7/24/14 and her current roommate moved in on 8/18/14. The SS-A verified she was unable to find documentation of new roommate notifications in the medical record for the above dates she received a new roommate. R40 was asked about roommate changes recently on 6/08/2015 at 6:58:56 p.m. R40 stated he had a new roommate move in two weeks ago and was not told in advance he would be getting a new roommate. R40's quarterly Minimum Data Set (MDS) dated 4/21/15 indicated R40 had intact cognition based on a score of fifteen on the BIMS. R40's diagnoses included Parkinson's disease and anemia. On 6/09/2015 2:54 p.m. SS-A verified R40 did have a recent roommate move into his shared room on 5/20/14. The SS-A verified she was unable to find documentation of notification of a new roommate in R40's medical record. SS-A stated when a resident in the facility will be having a new roommate move in, the social service department documented a progress note in the	F 247	move, and meet the new roommate when possible. When a resident receives a new roommate, the resident is given as much notice and information about the new person as possible, while maintaining confidentiality regarding medical information. The facility provides support to a resident whose roommate has died, and whenever possible provides time for adjustment before moving another person into the room. On June 24, 2015, the facility¿s medical record consultant met with the social worker who started employment June 22, 2015 to discuss the required resident notifications including the resident¿s right to be informed prior to changes in rooms and roommates. A copy of the related regulations was provided for reference. The updated policy addressing new roommate notification was reviewed with the social service staff. The situation regarding lack of documentation verifying that residents number 11 and 40 were notified of new roommates was also reviewed as part of the ongoing continuing education and quality improvement procedures/process. The administrator will monitor compliance weekly for four weeks through staff interview and record review verifying that residents received notice prior to receiving a new roommate. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the September Quality	

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F 247	Continued From page 46 resident's medical record the resident had received notification they would be having a new roommate move in to their shared room. A facility policy was requested on resident notification of having a new roommate move in to a shared room, but was not received from the facility.	F 247	Assessment and Assurance Committee quarterly meeting.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. Findings include: R26 was admitted to the facility on 4/29/14 according to the facility admission record. R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with activities of daily living. During an interview on 6/9/15, at 8:26 a.m. in an answer to the question "Have there been any	F 250	The Stewartville Care Center interdisciplinary team is committed to provide residents with comprehensive services to attain or maintain their highest practicable physical, mental and psychosocial well-being. The interdisciplinary team address residents¿ concerns with the goal to provide social supports, physical care, and an enriched environment that meet the residents¿ individual needs and preferences. All residents are routinely assessed by qualified staff, including a social worker, to assure they are effectively coping with changes in health status, admission to the facility, current family relationships, etc. Medically-related social service needs are	7/27/15

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F 250	Continued From page 47 concerns or problems with a roommate or any other resident," R26 stated, "Yes.!" R26 went on to say that she had problems with R1 (R1's quarterly MDS dated 4/8/15 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that her roommate (R68 who had moderate cognitive impairment according to the quarterly MDS dated 5/6/15). R26 stated R1 had yelled and cursed at her on multiple occasions over the past months and kept R26's bathroom door locked so she had to go into the other residents room to unlock it to use on several occasions. R26 then said her roommate (R68) daily told her when to go to bed, when she could watch television, where to put her walker, and when and how to get dressed. R26 stated R68 seemed to want more space in the shared room for her things. In response to the question, "How does that make you feel to have someone telling you what to do?" R26 stated, "She is kinda bossy, I feel like I'm walking on eggshells around her, she's always telling me what to do. I've reported it to the social worker about the concerns, I'm not sure if the same social worker is still here...I'm not aware if she followed up with my concerns. They come and go fast. I more or less just got used to it, so I don't even say anything more." R26 further stated R68 snored very loud at night and kept her awake often. R26 stated she did not want to be treated the way she had been treated (in reference to both R1 and R68) and was not expecting anything to change because nothing had changed despite asking for help from the facility. R26 stated it would be nice not to deal with it, however had learned to deal with it. During a follow up interview on 6/10/15, at. 1:30 p.m. R26 indicated she had not been able to cope	F 250	identified through completion of resident assessment tools, quality indicator report results, review of the medical history, information from family/direct care staff, and social service interviews/evaluations. The staff follow up on situations/behaviors that impact the resident¿s psychosocial well-being; referrals are made to the attending physician or other clinical practitioners as indicated. The interdisciplinary team will review significant resident incidents, behaviors, changes in condition, etc. on a weekly basis and during the quarterly care conferences. A nursing communication tool will be developed to alert the social worker to resident incidents/moods/behaviors and facilitate appropriate follow up. During the mandatory meetings July 14, 15 and 16, 2015, the nursing staff will be 1) oriented to use of the new communication tool and 2) reminded to be alert for and report any resident behaviors/conditions/statements and/or family concerns that indicate need for interventions to meet the resident¿s medically-related social service needs. Resident number 26 - The social worker met with the resident on June 10, 2015 to discuss her concerns regarding her roommate. The social worker noted, ¿(resident) states she gets along fine with roommate . . . neither roommate wants to move or have the other roommate move out.¿ The resident did not mention any problems with the shared	

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F 250	Continued From page 48 well with problems with neighbor (R1) and roommate (R68) and said, "I try not to let it bother me now... It still hurts my feelings, and I'm frustrated, I'm not a child you know." In response to the question, "How do you deal with it?" R26 stated, "When [R68] starts in, I just say "I don't know what I did, but I'm sorry." R26 stated she dealt with the neighbor bathroom issue by having a bedside commode at night to avoid confrontation with. R26 stated she would preferred to use the bathroom vs. the bed side commode. R26 stated, "I can't even move a little bit without one of them questioning me on what I am doing." R26 stated she had asked for a room change several months ago, stated the social worker had not ever come in to talk with her. R26 stated, " I am tired of reporting the concerns and nothing changes, so what's the point? I've just learned to deal with it." R26's care plan provided by the facility on 6/11/15 read, "Has occasional difficulties in dealing with her roommate and others that she share a common bathroom with but seeks out staff support with is as needed. Care plan also included intervention of "provide on-going support to resident and encourage resident to share her concerns and feeling." The care plan lacked explanation of difficulties and interventions to resolve the concerns. Social service progress note dated 12/5/14 read, "[R26] came to social work office late in the day on 12/5/14 seeking support due to conflicts with other residents. She describes one resident being particularly cruel on an ongoing basis and said that hurt was compounded when her roommate, whom she has previously shared a good relationship with, aligned with the other party and has been also making hurtful remarks over the past month....she has tried to speak back more	F 250	bathroom. The social worker met with the resident on July 10, 2015. The social work note states, ¿Visited with resident regarding her roommate. She reports that things have been `straightened out¿, and that they are getting along together in the room. Resident reports that she feels as though she has enough room for all of her belongings. She also reports that she independently uses the commode instead of the adjoining bathroom in her room at night, and she is satisfied with this arrangement. Resident reports that she is satisfied with her current room and would not like to switch at this time.¿ The resident¿s care plan was reviewed and updated. The care plans of residents number 1 and number 65 have been reviewed and updated to address issues regarding shared space. The resident was visited by the social worker July 14, 2015 and reported that ¿things are going well.¿ She declined an offer for a room change and stated she is happy with her current room. To monitor compliance, the RN medical record consultant will randomly audit records twice monthly for two months and randomly thereafter for appropriate documentation and follow up to medically-related psychosocial issues. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting and ongoing.	

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often but that appears to be making things worse for her. She is adjusting her bathroom routines to avoid confrontation... The comments also take place in the hallways and dining room. I spoke with the supervisors about the situation and the pros and cons of a room change and was advised to speak with roommate to ascertain her thoughts on the interactions reported to be taken place." The progress note further indicated social services would continue to offer emotional support and indicated if problem persisted the social worker would attempt mediation.

R1's progress notes were reviewed, no evidence of follow-up performed related to the concerns of R26 shared with social worker on 12/5/14. R1's care plan read, "Does present with an argumentative disposition at times with other residents. She has verbal behaviors toward other..." The care plan also indicated she is confrontational with residents and has had multiple room changes. The care plan did not reflect the issue with the shared bathroom with R1.

R68's progress notes were reviewed, no evidence of follow-up performed related to the concerns of R26. R68's care plan did not reflect or identify any concerns, interventions, or problems with roommate.

R26's progress notes did not reflect follow-up or monitoring had been performed as a result of voiced concerns at the 12/5/15 meeting and no further mention of the issues until 4/29/15 when the resident brought the same concerns forward again in her care conference.

Care conference progress note dated 4/29/15 read, "We provided [R26] the opportunity to vent about her interactions with her roommate and next door neighbor, mainly bathroom sharing issues. She reports that these issues remain the

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same but she had grown to better deal with them. She tends to accommodate others but also has spoken up."
No follow-up was evident in R26's, R1's, or R68's medical record as a result of the again mentioned concerns and issues at the 4/29/15 care conference.
During an interview on 6/9/15, at 3:30 p.m. licensed social worker (LSW) explained nursing staff reported to her with any concerns pertaining to the residents and "every morning I see what is going on" however, LSW stated she was not aware of the concerns despite the concerns documented in the medical record. LSW stated the facility had turned over three social workers in the last year. LSW stated the social worker who had been assigned to that wing, left in May 2015. LSW stated a grievance had not been filed.
During an interview on 6/9/15, at 4:00 p.m. director of nursing (DON) stated a grievance had not been filed. DON stated a grievance should have been filled out in regards to R26's concern with roommate (R68) and neighbor (R1). Stated he had not been aware of the problem with the roommate despite the concerns documented in the medical record. DON stated the concerns should have been followed up on. DON indicated his expectation would have been re-evaluation of a situation for a possible room change and social worker involvement.
During an interview on 6/10/15, at 2:08 p.m., family member (F)-A indicated awareness of roommate and neighbor problems. Stated the roommate had always been complaining and telling [R26] what to do, "[R68] tells her to turn the TV off, when to go to bed, and where to put things... I hear it. [R68] is always saying smart thing, sarcastic things to [R26]. [R26] says she doesn't want to listen to her. She [R26] seems

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really frustrated, everyday there is something. Every time I call she expresses frustration with her roommate. I haven't noticed a big change is [R26's] mood but I do know she is frustrated." F-A stated had not been notified by the facility of the ongoing issues concerning the roommate or the neighbor. F-A explained had offered assistance to R26, but had been told by R26 she had been handling the problems. To the question, "Do you think [R26] is happy?" F-A stated, "No, I don't think she is happy. I would think if those people were not around she would have a better quality of life. [R26] was never a person who let people know if she was upset about something. She will deal with it and deal with it until it explodes, takes a while before she reports anything. She doesn't want to create waves, she wants to just do her thing and mind her own business."

During an interview on 6/11/15, at 2:32 p.m., nursing assistant (NA)-K stated R1 tends to be judgmental of people and had been aware of R26's bathroom concerns related to R1 locking the door so R26 cannot enter from her room. NA-K further stated knowledge of the issues with the roommate, "[R68] is always arguing about the line [which divides room in half] of where things go...and they have some issues with the curtains. [R26] was shutting the curtains too far." NA-K explained R26 was not the type of person to voice concerns, "she would wait and wait until it's really bad." NA-K explained when there had been resident concerns, they would be reported to social worker.

During an interview on 6/11/15, at 2:46 p.m., licensed practical nurse (LPN)-J stated she had not been aware of the concerns with the roommate despite the concerns documented in the medical record. LPN-J stated, "Everybody knew about the whole bathroom thing, [R1] made

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sure everybody knew about it." LPN-J stated a commode had been placed in R26's as a compromise to the bathroom problem with R1.
During an interview on 6/11/15, at 3:13 p.m., NA-E stated "[R1] tends to be more aggressive...she tends to pick on people that are a little more vulnerable ....she really goes after [R26] about the bathroom ...and is very vocal about letting people know." NA-E stated, "[R68] wants things a certain way even if it's on [R26's] side...R26 will just shrug it off and ignore it. I have seen her get upset and frustrated. She's the type of person that holds things in. She is the type that tries to get along with everyone, she is quiet and keeps to herself." NA-E explained an example, where R68 had attempted to take R26's calendar down and had to be redirected.
During an interview on 6/11/15, at 3:35 p.m., NA-A stated had witnessed arguments between R26 and R1 in the past. Stated everybody knew of the problems with R1 not wanting to share the bathroom with R26.
An undated policy entitled filing grievances/complaints indicated "Grievances and/or complaints may be submitted orally or in writing." "The administrator has delegated the responsibility of grievance and/or complaint investigation to Social Services." Upon receipt of a grievance and/or complaint, Social Services will investigate the allegation and submit a written report of such finding to the administrator within (5) working days of receiving the grievance and/or complaint.
An undated facility policy entitled Content Of The Clinical Record read, "Records of Social Service. Records of each resident's pertinent social data about personal and family problems medically related to the resident's illness and care and of action taken to meet these needs, will be entered

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F 250	Continued From page 53 in the clinical record."	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive care plan for mood, behavior and psychotropic drug use for 1 of 5 residents (R45) who received psychotropic medications. Findings include: R45 was admitted to the facility 6/12/14 according to the facility admission record with diagnoses that included but was not limited to bipolar disorder.	F 279	Stewartville Care Center uses the results of the comprehensive assessment to develop, review and revise the resident¿s comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident¿s needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the	7/17/15

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F 279	Continued From page 54 R45's significant change Minimum Data Set (MDS) dated 3/12/15 indicated moderate depression with a PHQ-9 (resident mood interview) score of 9, identified diagnosis of bipolar disorder, and indicated behavior status, care rejection, and wondering had worsened when compared to previous assessment. In addition, the MDS indicated R45 received antipsychotic and antidepressant medications. Care Area Assessment (CAA's) were triggered based off of the MDS assessment information that required a plan of care. The CAA's triggered as a result of the MDS assessment included: mood state, behavioral symptoms, and psychotropic drug use. R45's physician orders provided by the facility on 6/10/15 included Lexapro (antidepressant medication) 20 milligrams (mg) once per day, Wellbutrin XL (antidepressant medication) 300 mg per day, Depakene (anti-seizure medication used as a mood stabilizer) 250 mg two times per day, and Zyprexa (antipsychotic medication) 5 mg at bedtime. R45's care plan did not include a plan of care that included individualized goals and interventions for the triggered care areas for behavioral symptoms and psychotropic drug use. Although depression was identified; the care plan lacked interventions in regards to care and services associated with depression and associated mood state concerns. During an interview on 6/10/15 at 1:00 p.m., the MDS coordinator licensed practical nurse (LPN)-G verified the care plan did not reflect the CAA's triggered by the MDS. LPN-G stated mood state, behavioral symptoms, and psychotropic drug use should have been included in the care plan. The facility policy Minimum Data Set/Resident Assessment Protocol/Care Planning that was not	F 279	resident¿s highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents¿ right to refuse cares/services. The care plan and MDS (minimum data set) related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and revised. Within seven days of completion of the comprehensive assessment, an interdisciplinary care plan is developed. During the mandatory meetings on June 14, 15, and 16, 2015, the licensed nursing staff were 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents¿ care plans must be current at all times and 3) instructed that care plans must address the MDS triggered care areas that are assessed as needing to be included in the plan of care. The care plan for resident number 45 was reviewed and revised to more comprehensively address the triggered care areas of ¿behavioral symptoms¿ and ¿psychotropic drug use.¿ The care area ¿mood state¿ was not triggered on the significant change MDS with an assessment reference date of June 10, 2015; the resident reported only two symptoms indicative of depressed mood. As part of the quarterly care conference process, the interdisciplinary team reviews	

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F 279	Continued From page 55 dated does not reflect current standards.	F 279	the care plans for completeness, accuracy, and relevancy. For the next quarter, the MDS Coordinator will conduct focused audits on the care plans for residents who trigger the care areas of behavior symptoms, mood state and psychotropic drug use. If noncompliance is noted, additional monitoring will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		7/17/15

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F 280	Continued From page 56 Based on observation, interview and document review, the facility failed to revised the plan of care to include the dietician's recommendations for 1 of 1 resident (R65) reviewed. Findings include: R65 received house supplement however, the supplement was given to the resident but the amount consumed was not documented and the amount consumed of meals was not documented to determine if there was an effective intervention in stabilizing weight loss. The registered dietician (RD)-B's progress note dated 5/7/15, indicated staff to monitor intake; although, The need for monitoring food and supplement intake was not indicated on the care plan. R65's care plan dated 2/2/15, indicated R65 "Is able to feed self after setup is provided and needs observing if she is eating and assist as needed." The listed approach is "One staff to provide setup for reach meal-open containers, apply condiments, cut foods and butter breads." An interview on 06/10/2015 at 12:32 a.m. with certified dietary manager (CDM) who said R65 wanders up and down the hallway. She lost weight this month, currently she weighs 114 lbs. The nurses gave her a house supplement three times a day. No one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. registered dietician (RD)-B said R65 consumes her meals well and takes a supplement three times a day. R65 expels a lot of energy by walking so much. In May 2015, she had a weight	F 280	Stewartville Care Center staff routinely develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents¿ functional abilities and quality of life. The residents and their family/legal representative are encouraged to participate in the care planning process and care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary. During mandatory meetings July 14, 15, and 16, 2015, the care staff will be 1) reinstructed on the facility¿s policies for care plan reviews and updates 2) informed of the regulatory requirement that the residents¿ care plans be current at all times and 3) reminded of the importance of facilitating accurate care plans by communicating resident care/condition changes to the departmental supervisors, including the dietary department, in a timely manner. The Nutritional Care Plan Policy was reviewed and revised. The Nutritional Supplement Policy was updated to address tracking the amount of supplement consumed other than at meal time. The procedure for tracking	

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F 280	Continued From page 57 loss of 9.2% for the past six months. As of today her weight loss is 11.6% for the past six months. "She is on the risk list and being monitored for months now." RD-B continued to say I haven't looked at what the nurses are signing out for her supplement. An interview on 06/11/2015, at 9:09 a.m. with registered nurse (RN)-G who said R65 takes her house supplement three times a day but said no one records how much is consumed. A policy dated 4/2000, entitled supplements read, "...Nursing service record intake of supplement" and "Need for an intake of supplement will be monitored by nursing personnel."	F 280	supplement intake at meal time was reviewed and found appropriate. The care plan of resident number 65 reflects the May 12, 2015 physician¿s order for an increase in the nutritional supplement from four ounces once per day to three times per day due her recent weight loss related to increased calorie expenditure from physical activity (continually walks throughout the first floor of the facility). The nutrition care plan was updated to include offering the resident snacks and finger foods as the resident walks about the facility. The resident¿s weight will be monitored on a monthly basis and her supplement intake will be monitored on a daily basis. The resident currently weighs 114.8 pounds showing a slight weight gain in the past month. She weighed 105 pounds when admitted to the facility April 30, 2013. After an initial weight gain of ten pounds in 2013, she gained an addition fifteen pounds last year after an extended period of reduced physical activity related to non weight bearing status while recovering from a fracture. After a successful recovery and resumption of her usual physical activity, she is now back to her September 1, 2013 baseline weight of 114.0 pounds. The resident¿s care plan will continue to be reviewed at least quarterly and revised as needed. The physician/nurse practitioner and consultant dietitian will be informed of any further weight loss.	

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F 280	Continued From page 58	F 280	To monitor compliance, the dietary manager will audit the care plans of residents receiving nutritional supplements to assure that supplements are appropriately addressed. The dietary manager will monitor intake tracking of liquid supplements ordered for increased calories/protein weekly for four weeks and monthly thereafter. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to reassess pain after a change in condition for 2 of 2 residents (R11 & R2) with chronic pain. Findings include: R11 was interviewed on 06/09/2015 at 10:26 a.m. and stated she had lots of pain in her back and shoulders. R11 stated she took a lot of pain medication for it and stated that she currently had	F 309	Stewartville Care Center provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident¿s condition indicates. The	7/16/15

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F 309	Continued From page 59 pain in the area that she would rate almost a 10 (scale 0 no pain and 10 severe pain). Stated that she used Ultram (pain medication), but felt that she had "out-grown it." R11 stated that she needed to have both rotator cuffs (shoulders) repaired, but did not want surgery again. On 6/11/15 at 6:15 p.m. R11 was observed sitting in her chair and eating her meal. R11 stated her shoulder pain was at a 10 out of 10 and that nothing was being done for her. R11 was admitted to the facility in 2006 and had diagnoses listed on the physician orders that included: chronic pain and osteoarthrosis. Physician orders of 6/11/15 included: scheduled Ultram twice a day and as needed (PRN), scheduled Tylenol extra strength twice a day, scheduled Narco (narcotic medication) three times a day. On 3/18/15 the physician note read, "Patient otherwise continues to have symptoms in regards to her arthritis in her shoulders. Patient also has failed all conservative therapies for that." Assessment read,"degenerative joint disease - shoulder - quite symptomatic." The quarterly Minimum Data Set (MDS) indicated R11 had a BIMS (brief interview of mental status) of 15 or no cognitive impairment and indicated R11 had rated her pain at 6 out of 10 but that an assessment for pain was not necessary. The care area assessment (CAA) completed 7/9/14 indicated the resident would rate her pain at 10 in the shoulders and arms, that she received scheduled and as needed (PRN) pain medications, had limited bilateral functional range of motion. The CAA read, "She may be at	F 309	resident¿s condition and needs including effective pain management are evaluated. When a resident experiences pain, a plan of care is developed, implemented, routinely reevaluated, and revised as necessary based on the physician¿s analgesic orders and continuing assessments. In April 2015, the facility reviewed and revised the pain assessment policies and procedures to include 1) a Pain Flow Sheet tool to track the location, intensity, precipitating factors for pain as well as pharmacological and nonpharmacological interventions and their effectiveness and 2) the Comprehensive Pain Assessment Form to evaluate the resident¿s history of pain, type of pain, causes of pain, and interventions to alleviate pain. The residents who flagged the pain quality indicator on the MDS 3.0 Resident Level Quality Measure Report were first to have the Pain Flow Sheet and the Comprehensive Assessment Form completed. Based on findings from the pain assessment, the pain management plan will be reassessed. The physician/nurse practitioner will be notified regarding ongoing pain symptoms. The care plan will be revised as necessary to reflect current pharmacological and nonpharmacological interventions to alleviate pain. During the mandatory meetings, July 14, 15, and 16, 2015, the nursing staff will be reminded 1) to be alert to pain symptoms and 2) of the need to complete the pain	

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F 309	Continued From page 60 risk for increased sx [symptoms] of pain limiting her quality of life, for falls and injury." The Pain Interview section for MDS 3.0 section J. dated 3/23/15 noted the resident had occasional pain, that made it hard to sleep, and would rate the pain at a 8 out of 10. No further assessment/s was found. During an interview on 6/11/15 at 6:24 p.m. licensed practical nurse (LPN)-J stated R11 usually had pain and that the physician only wanted her to have pain medications for control. The facility would also provide warm packs. LPN-J stated she thought the pain was related to the "gas" (air in bowels) in the abdomen and that the facility could use a rectal tube and anti-gas pills. During an interview on 6/11/15 at 11:30 a.m. in regards to a pain assessment for R11, RN-F stated that she was just starting to do pain assessments and any pain assessment would be in the hard copy chart. However, none was located nor provided when requested. R2 was interviewed on 6/8/15 at 6:29 p.m. and stated that her legs ached. R2 also stated that her bottom was sore because of cancer and use of the Hoyer mechanical lift. R2 stated her pain level was up to 7 out of 10 scale, but currently did not have any. The care conference on 4/7/15 documentation indicated R2 stated she was having more pain than usual. Physician documentation of 4/20/15 noted right ankle pain and swelling for R2. The nursing	F 309	tracking forms. The MDS Coordinator will continue to initiate the pain flow sheets and complete pain assessments for residents flagging the pain indicator on the Resident Level Quality Measure Report and for residents who report a significant increase in pain or have uncontrolled pain. The physician/nurse practitioner will be notified and reassessments will be done as indicated. Resident number 2 ¿ A 5-day pain tracking tool has been initiated to help identify pain frequency, location, intensity and effectiveness of interventions. A reassessment of the pain management plan will be done after a review of the collected data, resident/staff interviews, and review of the nurses and physician/nurse practitioner progress notes. (The physician was called July 7, 2015 regarding uncontrolled pain and a visit is scheduled for June 14, 2015). During the June 23, 2015 MDS pain interview, the resident indicated her pain was a ¿ten¿ on a ten-point intensity scale, but stated her pain did not impact her sleep or day-to-day activities. Evaluation of the resident¿s pain and the effectiveness of the interventions will be ongoing. The care plan will continue to be updated to reflect the resident¿s pain symptoms and interventions. Resident number 11 ¿ A 5-day pain tracking tool has been initiated to help identify pain frequency, location, intensity and effectiveness of interventions. A	

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F 309	Continued From page 61 documentation of 5/20/15 through 6/11/15 did not document the resident having pain. The annual MDS dated 12/23/14 indicated a BIMS of 14 or no cognitive impairment, the pain section was left undone. The quarterly MDS dated 3/24/15 indicated a pain intensity of 7 on a scale of 10. R2's care plan dated 4/6/15 indicate the resident had pain due to gout and generalized pain usually in back and shoulders. On 06/11/2015 at 11:30 a.m. RN-F, the MDS coordinator, stated that she was just starting to do pain assessments and had not done any for R2 yet. The facility's undated policy entitled Resident Pain Evaluation Protocol directed the resident's pain was to be reassessed quarterly and when condition indicates the need. On 06/11/2015 at 12:03 p.m. the director of nursing stated he would expect pain assessments be completed and that he knew the assessments had not been done for R2.	F 309	reassessment of the pain management plan will be done after a review of the collected data, resident/staff interviews, and a review of the nurses¿ and physician/nurse practitioner progress notes (a physician visit is scheduled for June 14, 2015). The June 9, 2015 social service note states, ¿reports that her mood is improving and she is starting to feel better.¿ The July 10, 2015 nurse¿s note states, ¿No complaint of pain on evening shift.¿ The pain management plan of care will be reviewed and updated as necessary. Evaluation of the resident¿s pain and the effectiveness of the interventions will be ongoing. Compliance will be monitored by the Assistant Director of Nurses/Designee by auditing for pain assessments for residents flagging the indicator measuring pain on the Monthly Resident Level Quality Measure Report for three months. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		7/17/15

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F 323	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess a resident's fall risk following multiple falls for 1 of 3 residents (R73) reviewed for accidents and the facility failed to ensure a safe environment free from fall hazards in the facility for 3 of 3 residents (R68, R46, R26) reviewed for falls history. Findings include: R73 was observed on 6/8/15 at 5:22 p.m. sitting in his wheelchair at the dining room table with his shoulders rounded and leaning forward to the table. At 5:27 p.m. R73 was observed to independently wheel the chair away from the table using his feet on the floor. The wheelchair foot rests were in the down position with R73 using his feet in between the foot rests. The quarterly Minimum Data Set (MDS) dated 3/3/15 was reviewed. R73 had a BIMS (brief interview of mental status) of 12 or mild cognitive loss, no history of recent falls, required extensive assist with bed mobility and transfer, required limit assistance with mobility, and had a diagnosis of traumatic brain injury (TBI). The incident report dated 5/22/15 read On 5/19/15 at 6:10 p.m. the nursing assistant found R73 on his knees attempting a self transfer from the chair. No injuries were noted. The progress notes of 5/20/15 indicated R22 understood the needs of waiting for help to transfer. He wanted to go to the attached assisted living to visit his wife.	F 323	Stewartville Care Center has policies and procedures to ensure that the residents¿ environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues with interventions to enhance mobility and promote safety. The policies and procedures related to assessing the resident¿s risk of falls were reviewed and found appropriate. An assessment of fall risk will continue to be done at the time of admission. A reassessment will be done as part the quarterly interdisciplinary assessment process and whenever there is a change in the resident¿s behavior, physical condition, and/or mental function. The resident¿s care plan is modified as necessary to ensure maximum safety and minimal risk of injury. During the mandatory meetings July 14, 15, and 16, 2015, the licensed nurses and direct care staff were reinstructed on 1) the importance of providing a safe environment for residents 2) the procedures for completing the fall risk assessments and 3) the need to assess the resident¿s need for safety	

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F 323	Continued From page 63 The incident report of 5/22/15 read On 5/20/15 at 6:;26 p.m. R73 was found self transferring from his wheelchair into bed after supper. As resident is independent in the facility and able to visit his wife at assisted living on his own, pin alarm is not effective. He is alert and oriented x 3 and has the ability to take the pin alarm off. Floor alarm placed next to resident's bed to prevent further attempts of resident self transferring in and out of his wheelchair. The facility had completed a fall report dated 4/10/15 at 9:06 a.m. The report noted the nursing assistant had heard a noise while in the next room, and found the resident on the floor next to the bed. The resident attempted put himself to bed. R73 reported hitting his buttock, but no injury found. No further incidents after 8/14/14 were found. The resident's care plan dated 3/17/15 noted R73 was a fall risk and that R73 was a greater than normal risk for falls secondary to recent fall resulting in hip fracture, history of falls, mildly impaired cognition. Interventions include: strips on floor for safety and one staff to assist with all transfers. Fall Risk Evaluation/Physical Devices Assessment were dated 8/14/15, 11/11/14, 2/11/15 were found in the chart. All assessments scored a 17 or moderate risk for falls. Physical therapist (PT)-A was interviewed on 6/11/15 at 3:15 p.m. to discuss the fall risk. He had told her that no one came in when he put the call light on and that he required assist with all transfer. PT-A stated R73 was last seen by	F 323	interventions/devices and routinely evaluate their effectiveness. All the floor nonskid safety strips have been inspected and either removed or replaced. The Environmental Director will include monitoring of the condition of floor nonskid safety strips as part of the routine safety inspection process. Resident number 73 - The resident¿s risk and history of falls were reassessed. Due to the resident¿s recent increase in falls and impulsiveness (related to a history of traumatic brain injury and fracture hip with ataxic gait) a physical therapy referral was made. After therapy goals are met, a nursing restorative program will be implemented to maintain strength and ambulation abilities and reduce the risk of falls. The care plan was reviewed and updated accordingly. Resident number 68 ¿ The use of floor nonskid safety strips was reassessed; safety strips will continue to be used in front of the resident¿s bed. New strips have been installed. Resident number 46 ¿ The use of floor nonskid safety strips was reassessed. The strips were removed. Resident number 26, The use of floor nonskid safety strips was reassessed. The strips were removed. The Director of Nurses/designee will monitor compliance with post-fall	

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F 323	Continued From page 64 therapy in May 2014. PT-A stated she had not been notified of further falls. PT-A added that R73 was at a high fall risk related to his impulsiveness, history of hip fracture and medical history of TBI that affects his balance. PT-A felt that R73 could work with physical therapy for balance safety and sequency. PT-A stated R73 needed contact guard and lacked impulse control. The director of nursing (DON) was interviewed on 6/11/15 at 5:28 p.m. and stated R73 should probably be reassessed following the falls to determine the cause. DON added R73 could use physical therapy but needed to first be assessed for need. LACK OF SECURED SAFETY STRIPS TO PREVENT SLIPPING: During an environmental facility tour on 06/11/15, at 10:14 a.m. with maintenance manager (MM)-A the following was observed: R68's room had anti slip strips which were originally stuck to the floor to prevent slipping were loose and frayed. The strips were located in the middle of the residents room about 2 feet in front of the resident's bed. MM-A agreed that its a trip hazard and agreed the strips need to be removed and said, "those are a trip hazard" as he preceded to remove one of loose strips from the floor. R68's care plan dated 5/19/15, indicated "... greater than normal risk for falls secondary to her diagnosis of dizziness and stroke and has a history of falls." The approach listed on the care plan read, "Review the environment to make sure	F 323	assessments through record review weekly for four weeks. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	

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F 323	Continued From page 65 it is free from hazards such as poor lighting, obstacles, items on the floor..." R46's room had non slip strips adhered to her floor which were curling up around the edges located in front of her recliner. MM-A again agreed they were a trip hazard. R46's care plan dated 5/12/15, read, "...comprehensive assessment reveals a greater than normal risk for falls ... is on an antipsychotic increasing her fall risk." The approach listed on the care plan read, "Review the environment to make sure it is free from hazards such as poor lighting, obstacles, items on the floor..." R26's room had three non skid strips which were attached to the floor in the middle of the room about two feet in front of the bed. The middle and the ends of these strips were loose and curling up. MM-A again agreed they were a trip hazard. R26's care plan dated 4/28/15, read, "...comprehensive assessment reveals a greater than normal risk for falls secondary to: heart failure and use of demodex and pain..." The approach listed on the care plan read, "Review the environment to make sure it is free from hazards such as poor lighting, obstacles, items on the floor..." On 06/11/15, at 10:44 a.m. MM-A said two weeks ago he did a safety inspection but he did not document his findings from the inspection. MM-A also said he does not document any concerns during these inspections. An interview on 06/11/15, at 10:54 a.m. the	F 323		

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F 323	Continued From page 66 director of nursing (DON) said he was not aware there is any documentation of safety inspections but did agree the peeling non slip strips need to be removed. A safety policy was requested but not received.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess nutritional status for 1 of 3 residents (R65) reviewed for nutritional status. Findings include: R65 had a significant weight loss over the past 180 days however, interventions put in place were not monitored/assessed if appropriate to maintain or gain weight. R65 received house supplement however, the supplement was given to the resident but the	F 325	Based on a resident¿s comprehensive assessment, Stewartville Care Center ensures that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident¿s clinical condition demonstrates that this is not possible. Therapeutic diets are provided as ordered by the physician. The Nutritional Care Plan Policy was reviewed and revised. The Nutritional Supplement Policy was updated to address tracking the amount of	7/17/15

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F 325	Continued From page 67 actual amount consumed was not documented and the amount consumed of meals was not documented to determine if there was an effective intervention in stabilizing weight loss. R65's most recent weight from dietary resident progress note dated 6/10/2015, was 114 pounds reflected weight loss of four pounds (3.4 percent) past 30 days, six pounds (5 percent) past 90 days and 16 pounds (12.3 percent) past 180 days. Weight loss is significant past 180 days. Dietary progress notes authored by the registered dietician (RD)-B dated 5/7/15, indicated resident's current weight is 118 pounds and weight six months ago, 130 pounds. This reflects weight loss of 9.2 percent in 6 months. Recommended house supplement be increased to four ounces three times a day to prevent further weight loss was initiated and staff to monitor intake. R65 was admitted with diagnoses that included dementia and CVA (cerebral vascular accident). A quarterly Minimum Data Set (MDS) dated 4/28/15, identified R65 required supervision for eating. the MDS also indicated R65 had no problems with coughing/choking during meals or complaints of difficult chewing or swallowing. The significant change MDS dated 1/28/15, R65 required supervision, oversight, encouragement or cueing during meal time. R65's weight was 128 pounds at that time. Nursing progress notes reviewed from 3/17/15, to 6/9/15, with the only time when the amount of meals consumed was mentioned was on 5/12/15, which indicated an "increase in house supplement to 4 oz with each meal for weight loss." On 5/22/15, the progress note read, "Up	F 325	supplement consumed other than at meal time. A designated space was added to the medication administration record (MAR) to document the amount of supplement consumed. The procedure for tracking supplement intake at meal time was reviewed and found appropriate. The staff will continue to assess the residents¿ condition, including nutritional needs/risks upon admission, when a significant change occurs, and no less than once every three months. Based on the (re)assessments, a comprehensive plan of care is developed that addresses the resident¿s nutritional needs and preferences; the plan is reviewed at least quarterly and revised as necessary. The policies and procedures for recording and monitoring weights have been reviewed and found appropriate. Residents are weighed monthly and more often as ordered by the physician or as requested by the dietitian or licensed nurse. If the resident has had nontherapeutic weight changes or is at risk of weight loss, the resident¿s nutritional status is reassessed and the attending physician and consultant dietitian are notified. During mandatory meetings July 14, 15, and 16, 2015, the licensed nurses will be instructed on the changes in procedures related to recording the amount of supplement consumed on the MAR. The nursing assistants will be reminded of the importance of recording the amount of	

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F 325	Continued From page 68 around 6 hours wandering up and down halls. ...offered food, fluids and activity as appropriate." No other mention of food consumed was available nor was any provided when requested. Medication flow sheets reviewed from 3/1/15, until 6/10/15, indicate R65 given four ounces of house supplement but no monitoring of amount consumed. The medication flow sheet for 3/1/15, until 5/31/15, indicate once a day house supplement with three times a day started on 6/1/15. Monthly weights also listed on medication sheet during this period. A dietary nutritional assessment dated 1/28/15, indicated no concerns at that time and no further nutritional assessments were provided since that time. Computer generated weight variance report received from certified dietary manager (CDM), weight on 1/5/15, 127.8 pounds (lbs); 2/2/15, 124 lbs; 3/1/15, 120.4 lbs; 4/1/15, 120 lbs; 5/1/15, 118.4 lbs; 6/1/15, 114 lbs. Observations on 6/10/15, at 12:06 p.m. R65 ate 75% of her meal. On 6/11/15, at 12:03 p.m. R65 ate 50% of meal. An interview on 06/10/2015 at 12:32 a.m. with CDM who said R65 wanders up and down the hallway. She lost weight this month, currently she weighs 114 lbs. The nurses give her a house supplement three times a day. However, no one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. RD-B said R65 consumes her meals well and takes a	F 325	supplements consumed at meal times on the Food Acceptance Record flow sheet. The care plan of resident number 65 reflects the May 12, 2015 physician¿s order for an increase in the nutritional supplement from four ounces once per day to three times per day due her recent weight loss related to increased calorie expenditure from physical activity (continually walks throughout the first floor of the facility). The nutrition care plan was updated to include offering the resident snacks and finger foods as the resident walks about the facility. The resident¿s weight will be monitored on a monthly basis and her supplement intake will be monitored on a daily basis. The resident currently weighs 114.8 pounds showing a slight weight gain in the past month. She weighed 105 pounds when admitted to the facility April 30, 2013. After an initial weight gain of ten pounds in 2013, she gained an addition fifteen pounds last year after an extended period of reduced physical activity related to non weight bearing status while recovering from a fracture. After a successful recovery and resumption of her usual physical activity, she is now back to her September 1, 2013 baseline weight of 114.0 pounds. The resident¿s care plan will continue to be reviewed at least quarterly and revised as needed. The physician/nurse practitioner and consultant dietitian will be informed of any further weight loss.	

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F 325	Continued From page 69 supplement three times a day. She expels a lot of energy by walking so much. In May 2015, she had a weight loss of 9.2% for the past six months. As of today her weight loss is 11.6% for the past six months. "She is on the risk list and being monitored for months now" and I haven't looked at what the nurses are signing out for her nutritional supplement. An interview on 06/11/2015, at 9:09 a.m. with registered nurse (RN)-G who said R65 takes her house supplement three times a day but said does not measures how much is given nor does anyone record how much is consumed by R65. An interview with RD and CDM on 06/11/2015, at 9:14 a.m. both said they have not assessed how much supplement the resident consumes. They validated they can not assess effectiveness of the treatment when it is not monitored. An interview on 06/11/2015, at 9:55 a.m. with director of nurses (DON) who stated my expectation is the dietary staff monitor how much of the meal R65 eats and nursing needs to monitor how much supplement R65 consumes of her supplement when they give it to her. R65's care plan dated 2/2/15, read, "Is able to feed self after setup is provided and needs observing if she is eating and assist as needed." The listed approach is "One staff to provide setup for reach meal-open containers, apply condiments, cut foods and butter breads." A undated policy entitled monitoring and preventing ongoing weight loss read, "All residents in the facility will be weighed monthly. If they exhibit an unexpected continual weight loss	F 325	To monitor compliance, the dietary manager will audit the care plans of residents receiving nutritional supplements to assure that supplements are appropriately addressed. The dietary manager will also monitor intake tracking of liquid supplements ordered for increased calories/protein weekly for four weeks and monthly thereafter. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	

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F 325	Continued From page 70 for two month, they will be addressed as a risk and risk interventions will begin." A policy dated 4/2000, entitled residents at nutritional risk read, "Residents with any of the following conditions should be considered at Nutritional risk: Low body weight and increased caloric and/or nutrient needs related to medical condition." A policy dated 4/2000, entitled supplements read, "...Nursing service record intake of supplement" and "Need for an intake of supplement will be monitored by nursing personnel."	F 325		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		7/17/15

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F 431	Continued From page 71 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure safe and secure disposal of used Fentanyl (topical narcotic analgesic medication) patches according to currently accepted principles to prevent potential diversion for 2 of 2 residents (R7 & R55)reviewed with prescribed Fentanyl patches. Also medications that were outdated were not removed to prevent accidental use and medications opened lacked open date to determine when it would be outdated this had the potential to affect several residents including (R29, R4, R65, R42, R46, R10, & R71) who utilized stock medications and prescription medications. Findings include: R7's admission record dated 4/9/10, indicated diagnosis including lumbago and abnormal sensation with pain in the left leg. R7's physician orders dated 5/14/15, included an order for Fentanyl patch 25 micrograms (mcg) to be applied transdermally (to the skin) every 72	F 431	Stewartville Care Center provides pharmaceutical services to meet the needs of each resident. The facility contracts with a licensed consultant pharmacist who collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of related procedures to ensure the accurate acquiring, receiving, dispensing, storing and administering of all drugs and biologicals. The pharmacist has established a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals are labeled in accordance with currently accepted professional principles, and include the appropriate instructions and expiration dates when applicable. In accordance with	

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F 431	Continued From page 72 hours, with special instructions, "Apply 1 patch and change patch q [every] 72 h [hours] for back pain. **When removing old patch, wrap in tissue and flush down toilet or put in sharps container.**" R7's Fentanyl patches were administered from and stored in the West medication cart. R55's admission record dated 7/27/11, indicated diagnosis including generalized pain. R55's physician orders dated 4/7/15, included an order for Fentanyl patch 50 mcg to be applied transdermally every 72 hours, with special instruction, "When removing old patch, wrap in tissue and flush down toilet or put in sharps container.**" R55's Fentanyl patches were administered from and stored in the North medication cart. During an interview on 6/8/15, at 7:15 p.m., trained medical assistant (TMA)-A indicated the policy when removing and disposing of Fentanyl patches, was for two staff to witness the destruction by putting them in the sharps container attached to the medication cart, and for both to initial on the Medication Administration Record (MAR). During an observation on 6/10/15, at 8:40 a.m., of medication administration from the West medication cart, the locking door on the sharps container attached to the cart was observed to be unlocked and could easily be opened, exposing the content in the sharps container. The sharps container was easily removed from the compartment by sliding it forward and removing from the cart. The door to the compartment had several pieces of old tape on the front and several pieces of tape on the right side of the	F 431	State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls. The facility provides separately locked and permanently affixed compartments for storage of controlled drugs. The facility utilizes only persons authorized under state requirements to administer medications and have access to medication room keys/security codes. Outdated and expired drugs and biologicals are routinely discarded according to accepted practice standards. The procedure for disposing of controlled substances was reviewed and revised; all Fentanyl patches will now be wrapped in tissue and flushed into the sewer system in the presence of two nurses. All medication storage areas were checked for discontinued and unlabeled/undated/expired medications and biologicals. The doors securing the sharps containers were inspected; all were found in good order with a functional locking mechanism. Any problems with the function/condition of the doors will be reported to Weber and Judd Pharmacy who owns the carts. During the mandatory meetings July 14, 15, and 17, 2015, the licensed nurses and trained medication assistants were 1) reinstructed on the procedures for processing discontinued and outdated medications and biologicals including the destruction of used Fentynal patches 2) reminded that the doors securing the	

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F 431	Continued From page 73 compartment. During a review of medication storage on 6/10/15, at 8:50 a.m., the East medication cart sharps container compartment door, was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. Licensed practical nurse (LPN)-A verified the door was unlocked and the sharps container could be removed. During a review of medication storage on 6/10/15, at 8:55 a.m., the North medication cart sharps container compartment door, was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. Registered nurse (RN)-B verified the door was unlocked and the sharps container could be removed. During a review of medication storage on 6/10/15, at 9:10 a.m., the lower level medication cart sharps container compartment door was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. LPN-L verified the door was unlocked and stated, "The door should be locked." During an interview on 6/10/15, at 9:15 a.m., LPN-B stated when removing Fentanyl patches from the residents for disposal , the policy was for two staff to witness the destruction of the patch, by either flushing the patch in the sewer system or by putting the used patch in the sharps container. LPN-B stated, "I always put it in the	F 431	sharps container should be locked at all times 3) that multiple dose medication vials must be dated when first used and 4) refrigerator temperatures must be monitored and recorded on the designated sheet. To monitor compliance, a licensed nurse/trained medication aide will audit the medication storage areas monthly to check for undated/expired/outdated medications and biologicals and monitoring of refrigerator temperatures. The consultant pharmacist will continue to randomly check refrigerator temperatures and monitor for outdated/unlabeled/outdated medications. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting and ongoing.	

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F 431	Continued From page 74 sharps container," pointing to the sharps container attached to the side of the West medication cart. When asked about the door to the sharps container compartment being unlocked and the ease of removing the sharps container, LPN-B verified the door was unlocked and attempted to use a key to lock it, but was unable to get it locked. LPN-B stated, "This key fits, but doesn't turn to lock the door." During an interview on 6/10/15, at 10:05 a.m., director of nursing (DON) stated he was aware that the sharps container compartments were found to be unlocked during observation, and stated, "They should be locked." DON verified the unlocked doors on the compartments holding the sharps containers, allowed access to the sharps containers where used Fentanyl patches were disposed, and this had the potential for diversion. DON indicated he would be ordering a new door for the West medication cart because the door was cracked, and the doors were to be locked. A policy was requested for ensuring safe and secure disposal of Fentanyl patches, and was not provided. A memo written by DON, to "ALL NURSES," dated 12/16/13, was provided, and directed staff to add, "When removing old patch, wrap in tissue and flush down toilet or put in sharps container," when receiving Fentanyl patch orders. LACK OF REMOVAL OF OUTDATED MEDICATIONS OR TO DATE MEDICATIONS WHEN OPENED TO DETERMINE WHEN IT WILL BE OUTDATED: During an observation on 06/10/2015, at 2:22 p.m. of the north medication cart with registered nurse (RN)-B, R29's 10 milliliter (ml) multidose	F 431		

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F 431	Continued From page 75 novolin regular was outdated for 5-2-15, lantus 10 ml multidose vile outdated for 5-1-15. RN-B stated the policy indicated multidose vials expire 28 days after being opened. An observation on 06/10/2015, at 2:56 p.m. of the first floor medication room and the following was found and verified by RN-G: R29's coumadin (a blood thinner) 1 mg one (1) pill outdated for 4-15; R4's coumadin 1 mg one (1) pill outdated for 4-15; R4's coumadin 2.5 mg two (2) pills out outdated for 4/15; R65's jantoven (a blood thinner) 2.5 mg six (6) pills outdated for 4-15; R65's jantoven 1 mg five (5) pills outdated for 4-15; R42's jantoven 1 mg five (5) pills outdated for 4-15; R46's jantoven 1 mg two (2) pills, outdated for 4-15; R10's jantoven 2.5 mg five (5) pills outdated for 4-15; In the medication refrigerator was a two (2) multidose influenza virus vaccine (fluvirin) 5 ml vials which were outdated for a manufacturers expiration of 5-15. A multidose tuberculin bottle had been opened but not dated to determine when it would become outdated. On the west medication cart on 6/10/15 at 2:29 p.m. with LPN-B found R71's C-amitr cream (ketam 2%) with manufacturers expiration dated 5-25-15. An interview on 6/10/2015, The director of nursing stated they should be monitoring for	F 431		

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F 431	Continued From page 76 outdates and he was not aware that the refrigerator temperatures were not being monitored. A undated policy entitled labeling/data of drugs & biologicals indicated "Insulin-Dispose of 28 days after opening" and Tuberculin - Refrigerate - Dispose of 30 days after opening."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441		7/17/15

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F 441	Continued From page 77 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure glucometer equipment was disinfected according to the bactericide sanitizer wipe manufacturers directions for a glucometer used for 3 of 4 residents (R29, R11 & R24) glucose tests observed. In addition the facility failed to ensure containment of used incontinent products and soiled gloves to prevent the spread of infection which could affect several residents. Findings include: R29 had blood glucose testing done on 6/10/15 at 9:22 a.m. registered nurse (RN)-B was observed doing glucose test. After completion of the monitoring, RN-B wiped the glucometer for 20 seconds with the Super Sani-Cloth wipe. RN-B stated, "I guess we wipe it a while." However, the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R11 was observed to have glucose test done on 6/10/15 at 6:20 p.m. licensed practical nurse (LPN)-A perform glucose monitoring for R11. The glucometer was removed from the medication	F 441	Stewartville Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment for the residents and to prevent the development and transmission of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility has comprehensive infection control policies and procedures consistent with the current state and federal infection control regulations and recommendations. The policies address the surveillance and investigation of infections and the maintenance of accurate and comprehensive records of resident/employee infections.	

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F 441	Continued From page 78 cart and taken directly into R11's room. LPN-A stated the facility and not the resident owned and maintained the monitors. When LPN-A returned to the medication cart following the performance of the glucose testing, She used the PDI Super Sani-Cloth wipe to clean the meter. The wipe remained in contact with the meter for less than one minute and the damp monitor was placed on top of the medication cart. LPN-A stated that she did not know how long to keep the disinfectant in contact with the meter. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R24 had just completed glucose test on 6/10/15 at 6:30 p.m. LPN-B was observed to clean the glucometer after use. LPN-B used the PDI Super Sani Cloth wipe and left the wipe in contact with the monitor for less than one minute. When finished LPN-B placed the damp monitor on top of the narcotic book. LPN-B stated the disinfectant wipe needed to be in contact with the monitor for 10 to 15 second. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." The undated facility policy entitled Blood Glucose Meters Clean and Disinfect read, "To disinfect the meter, wipe down the meter with an EPA registered and approved premoistened towelette....Follow the product label instructions to disinfect the meter." The director of nursing was interviewed on 6/10/15 at 9:57 a.m. and stated staff need to follow the directions on the PDI package to disinfect the glucometer. LACK OF PROPER DISPOSAL OF SOILED	F 441	During the July 14, 15 and 16, 2015 mandatory meetings, the licensed nurses were re-instructed on the procedures for sanitizing glucometer machines; the nursing staff will sign to verify knowledge of the glucometer sanitizing procedure. All nursing staff were re-instructed on the proper handling of soiled incontinent products and gloves. Compliance will be monitored by the Director of Nurses/designee through direct observation of the nurses¿ glucometer sanitizing techniques. The charge nurses will observe for proper handling of soiled incontinent products/gloves when supervising resident cares and performing other tasks/treatments in the resident care areas. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	

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F 441	Continued From page 79 PADS AND GLOVES TO PREVENT THE SPREAD OF INFECTIONS: During an observation on 6/8/15, at 6:18 p.m. a soiled incontinent pad and gloves were laying on the bathroom floor between resident rooms number 39 and 40. During an interview on 6/8/15, at 6:22 p.m. licensed practical nurse (LPN)-B verified the soiled incontinent product on the floor. LPN-B stated should have not been left on the floor, LPN-B donned gloves and placed the incontinent pad in the garbage bag and removed from room. An undated facility policy AM Cares (Early Morning Care) read, "Leave bedside area clean, and dispose of disposable equipment and soiled linen appropriately." An undated facility policy P.M. Care (Bedtime Care) read, Leave room clean and tidy." An undated facility policy Incontinence Care Guidelines instructed, "Discard disposable items in a plastic trash bag and secure."	F 441		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe comfortable environment free from rust and paint chips of bathroom door frames for 4 of 4 resident (R95, R96, R75, R87) rooms and in addition the grout around a toilet used by R11 was soiled and	F 465	It is the policy of Stewartville Care Center to provide a safe, functional, sanitary and comfortable environment for residents, staff, and the public. As part of an ongoing process to provide	7/16/15

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F 465	Continued From page 80 the wheelchair used by (R1) was soiled. Findings include: During an environmental facility tour on 06/11/2015 at 10:14 a.m. with maintenance manager (MM)-A the following was observed. R95's room, the bathroom door jam near the floor,and the light switch in the bathroom had chipped paint exposing the metal which was rusty colored. The heat register in her room also had chipped paint. MM-A stated the door jams need painting, the area around the light switch and the heat register are rusty and need painting. R96's room the bathroom door jams and around the light switch had paint chipped and were rusty. Verified by MM-A who said he will paint. 75's bathroom door frame the paint was chipped. MM-A agreed of the chipped area's and the need for painting those areas. R87's bathroom door frame near the bottom was chipped. MM-A verified the chipped paint on the metal door frame. R1's wheelchair was soiled, the poles under the chair had a thick layer of dust, MM-A verified the dust/soiled areas. MM-A stated I suppose its been a long time since the wheelchair was cleaned. He said the process is the staff bring the wheelchair to his office with a note asking maintenance to wash it. MM-A stated they don't keep track of which wheelchairs are washed and there was no schedule for cleaning wheelchairs. R11's bathroom in room had scratched up door	F 465	a pleasant, homelike environment, Stewartville Care Center has a schedule for routine cleaning, repairs, and maintenance of the facility. All staff members are expected to report environmental concerns to the appropriate administrative/supervisory staff. An additional maintenance check list has been implemented for inspection of resident rooms at the time of discharge and at least yearly for all long term residents. The condition of the walls, ceilings, bathroom fixtures, and resident care equipment will be checked. Repair and repainting will be done as needed. The condition of the bathroom door jambs, light switches and heat registers will be observed and any areas with rust/chipped paint will be repainted. The door jambs in the bathrooms used by residents number 95, 96, 75, 87, and 11 have been repainted. The light switches in the bathrooms used by residents number 95 and 96 have been repainted. The heat register in the room used by resident number 96 was repainted. The caulk around the toilet in the bathroom used by resident number 11 has been replaced. The brown discoloration on the bathroom floor of resident number 11 is the outline of the previous toilet. A new toilet will be installed which has a larger base that covers the discolorations. Several staff members have checked the bathroom used by resident 11 during varying times of the day and no unpleasant ambient or pervasive odors were detected.	

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F 465	Continued From page 81 jam. The toilet's caulking was yellow and there was a yellowish discoloration on the floor around the toilet. The bathroom had a strong, old urine smell. MM-A agreed that the caulk and flooring was yellow and the bathroom smelled like urine. An interview on 06/11/2015 at 10:54 a.m. the director of nursing (DON) said the wheelchairs were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair cleaning schedule. A maintenance policy in regards to general cleaning/repairs were requested but not received.	F 465	The wheelchair of resident number 1 was cleaned. A schedule will be developed to ensure routine cleaning of all wheelchairs. During the mandatory meetings July 14, 15 and 16, 2015, the staff will be reminded to observe for equipment/furnishings/structures that need to be repaired, cleaned, or replaced. The procedures for reporting work items to the Maintenance Director were reviewed. Compliance will be monitored by the administrator through direct observation and review of the room maintenance and wheelchair cleaning checklists monthly for three months. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the administrator failed to adequately oversee and monitor care and services related to the	F 490	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or	7/16/15

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F 490	Continued From page 82 implementation, and evaluation of abuse prohibition policies and procedures in the facility. This had the potential to affect all 68 residents currently residing in the facility. Findings include: Refer to F223, as the facility administration failed to ensure 2 of 2 residents (R75 and R65) with allegations of staff abuse, neglect, and/or mistreatment were protected and provided follow up and resolution to prevent further staff abuse from occurring. The facility's lack of identification of staff mistreatment to residents, resulting in lack of protection for residents from staff neglect, mistreatment, and abuse, as well as the lack of developing interventions to prevent further staff abuse, resulted in an immediate jeopardy for all 68 residents currently residing in the facility who remained at risk of potential staff abuse, neglect, and/or mistreatment. Refer to F225, as the facility administration failed to report immediately to the administrator and state agency, and investigate all allegations of staff abuse, neglect, and/or mistreatment for 2 of 2 residents (R75, R65) with allegations of staff abuse, neglect, and/or mistreatment. The facility's failure to ensure policies and procedures were implemented to protect residents from mistreatment, immediate notification of administrator and state designated agency (Office of Health Facility Complaints-OHFC) of the mistreatment and completion of a thorough investigation of the mistreatment resulted in an immediate jeopardy for all 68 residents currently residing in the facility who remained at risk of potential staff abuse, neglect, and/or mistreatment.	F 490	agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply with all applicable state and feral regulatory requirements and constitutes the facility¿s allegation of compliance. Stewartville Care Center is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility¿s policies and procedures for investigating/reporting of incidents were reviewed and found appropriate. Stewartville Care Center policy requires that each resident be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The resident will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, or other individuals. Stewartville Care Center policy requires that all alleged violations involving resident mistreatment, neglect, abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator	

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F 490	Continued From page 83 In addition of the facility administration failed to ensure a system was in place regarding all allegations of staff abuse, neglect, and mistreatment were reported to the administrator and state agency immediately and were thoroughly investigated. The facility failed to ensure allegations of abuse were reported immediately to the facility administrator and state agency for 4 of 26 allegations reviewed (R64, R99, R98, R97). Refer to F226, as the facility administration failed to implement its abuse prohibition policy and procedure related to resident protection, investigation of an alleged incident of maltreatment, and immediately reporting to the administrator and state designated agency (Office of Health Facility complaints-OHFC) for (R65, R75) residents reviewed for abuse and for 4 of 26 residents (R64, R99, R98, R97) abuse allegation reports reviewed. This had the potential to affect all 68 residents currently residing in the facility. Facility policies related to Abuse Prohibition were reviewed. The undated policy entitled Reporting/Investigating Resident Accidents/Incidents stated,"All accidents/incidents involving residents must be report to the director of nursing services and immediately to the administrator." The related procedure directed that "All accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing." The undated policy entitled Abuse and/or Neglect Investigation read, "All reports of resident abuse or neglect shall be promptly and thoroughly investigated."	F 490	and appropriate state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action is taken. The facility intervenes to prevent further potential abuse while the investigation is in process. Stewartville Care Center does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service in a resident care position is investigated and reported to the State nurse aid registry or licensing authorities. Stewartville Care Center staff recognizes and respects each resident¿s right to be free from maltreatment, neglect, and misappropriation of property and does all that is within its control to prevent such occurrences. The facility staff 1) identifies residents who are at risk for abuse, neglect, and/or misappropriation of property 2) develops intervention strategies to prevent occurrences and 3) routinely reassesses the effectiveness of the interventions. During the June 16, 2015 mandatory staff training, the facility policies related to abuse prevention/reporting were reviewed and all Stewartville Care Center staff including management staff were instructed on the following: 1) the definition of a vulnerable adult 2) who is a	

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F 490	Continued From page 84 The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals read, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate state agencies." The director of nursing (DON) was interviewed on 6/11/15 at 9:34 a.m. and stated that it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit initial reports and the internal investigative reports to the state designated agency. The DON stated that he would call the administrator. DON stated he knew reports were to be made immediately to administrator and state agency. DON stated "We have a system problem." in regards to immediately reporting to administrator and state agency. On 6/11/15 at 11:45 a.m. the licensed social worker (LSW) was interviewed. LSW stated she would usually talk to the administrator or director or nursing if something had been reported to her. Together they decided if it was a reportable incident and then report it to OHFC. LSW stated she could call them on the phone if they were not in the building and would always reach them. LSW stated she could report to OHFC herself if needed. LSW stated she knew that the administrator had been notified by phone and that he would come in to file the report. LSW stated the policy was to report immediately. On 6/15/14 at 2:24 p.m. the administrator was interviewed. The administrator stated he would not always document his investigations or conversations with residents and staff related to complaints and did not report every single	F 490	mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents/accidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirement to immediately reporting alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies 5) forms and procedures for appropriate and timely reporting and 6) necessary documentation related to incidents/accidents. The staff is educated on vulnerable adult issues at least every twelve months; vulnerable adult investigation and reporting are addressed during new employee orientation. The facility¿s Vulnerable Adult Abuse policies were distributed to all staff on June 16 and June 17, 2015. The staff were required to sign to verify that they received the information. During the mandatory meetings July 14, 15 and 16, 2015, all staff were reminded of the vulnerable adult investigative and reporting requirements and policies. The employee (LPN-E) involved with the April 24, 2015 incidents with residents number 65 and 75 was initially suspended for three days pending an investigation of the alleged abuse. After returning to work, he was assigned to another care unit. After the June 2015 state review of the issue, the LPN-e was requested to complete a Health Professional Services Program evaluation as a condition of	

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F 490	Continued From page 85 complaint to the state agency.	F 490	continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has had no further practice/performance issues. Resident number 65 ¿ The resident continues to wander throughout the first floor of the facility. She has had no recent altercations with staff; her usual resistiveness to bathing continues. The resident has severe cognitive impairments and believes that she works at the facility and is a care taker for her grandparents. She does not recall the incident from April 2015. The social worker frequently interacts with the resident as she walks by the social service office several times a day. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The care plan was reviewed and found appropriate. Resident number 75 ¿ The resident has cognitive deficits and self-propels her wheelchair around the facility. She has occasional negative interactions with other residents which require staff intervention. She does not recall the incident from April 2015. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The resident frequently visits the Social Worker¿s office work to obtain a piece of candy from the candy bowl. The care plan was reviewed and found appropriate.	

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F 490	Continued From page 86	F 490	Residents number 64 ¿ The alleged abuse by the resident¿s spouse was observed 4/15/15 at 4:40 p.m. and was not reported to the State agency until the next day. The related facility policy and the regulatory requirements for immediate reporting were reviewed by the administrative and social service staff for continued quality improvement purposes. Resident number 99 ¿ The resident died at the facility September 15, 2014. The circumstances of the Alleged Resident Abuse Investigation Report Form for an incident during the morning of August 20, 2014 not being submitted until the afternoon was reviewed by the management staff for continuing quality improvement purposes. Resident number 98 ¿ The resident died at the facility December 29, 2014. The circumstances regarding a bruise observed 8/10/14 and the 48-hour delay in reporting the bruise to the administrator and State agency were reviewed by the management staff for continuing quality improvement purposes. The Social Worker will monitor compliance by auditing incident reports for timely and appropriate notification of the administrator and government offices for the next three months. If noncompliance is noted, additional auditing and training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting and ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	06/17/2015

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F 493 SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and document review, the governing body failed to adequately oversee and manage cares and services related to the implementation, and evaluation of abuse prohibition policies and procedures in the facility. This had the potential to affect all 68 residents currently residing in the facility. Findings include: Refer to F223, as the facility administration failed to ensure 2 of 2 residents (R75 and R65) with allegations of staff abuse, neglect, and/or mistreatment were protected and provided follow up and resolution to prevent further staff abuse from occurring. The facility's lack of identification of staff mistreatment to residents, resulting in lack of protection for residents from staff neglect, mistreatment, and abuse, as well as the lack of developing interventions to prevent further staff abuse, resulted in an immediate jeopardy for all 68 residents currently residing in the facility who remained at risk of potential staff abuse, neglect, and/or mistreatment.	F 493	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply with all applicable state and feral regulatory requirements and constitutes the facility¿s allegation of compliance. Stewartville Care Center has a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. The governing body appoints an administrator who is 1) licensed by the State and 2) responsible for the management of the facility. The facility¿s policies and procedures for	7/16/15

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F 493	Continued From page 88 Refer to F225, as the facility administration failed to report immediately to the administrator and state agency, and investigate all allegations of staff abuse, neglect, and/or mistreatment for 2 of 2 residents (R75, R65) with allegations of staff abuse, neglect, and/or mistreatment. The facility's failure to ensure policies and procedures were implemented to protect residents from mistreatment, immediate notification of administrator and state designated agency (Office of Health Facility Complaints-OHFC) of the mistreatment and completion of a thorough investigation of the mistreatment resulted in an immediate jeopardy for all 68 residents currently residing in the facility who remained at risk of potential staff abuse, neglect, and/or mistreatment. In addition of the facility administration failed to ensure a system was in place regarding all allegations of staff abuse, neglect, and mistreatment were reported to the administrator and state agency immediately and were thoroughly investigated. The facility failed to ensure allegations of abuse were reported immediately to the facility administrator and state agency for 4 of 26 allegations reviewed (R64, R99, R98, R97). Refer to F226, as the facility administration failed to implement its abuse prohibition policy and procedure related to resident protection, investigation of an alleged incident of maltreatment, and immediately reporting to the administrator and state designated agency (Office of Health Facility complaints-OHFC) for (R65, R75) residents reviewed for abuse and for 4 of 26	F 493	investigating/reporting of incidents were reviewed and found appropriate. Stewartville Care Center policy requires that each resident be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The resident will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, or other individuals. Stewartville Care Center policy requires that all alleged violations involving resident mistreatment, neglect, abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator and appropriate state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action is taken. The facility intervenes to prevent further potential abuse while the investigation is in process. Stewartville Care Center does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service in a resident care position is investigated and reported to the State nurse aid registry or licensing authorities.	

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F 493	Continued From page 89 residents (R64, R99, R98, R97) abuse allegation reports reviewed. This had the potential to affect all 68 residents currently residing in the facility. Facility policies related to Abuse Prohibition were reviewed. The undated policy entitled Reporting/Investigating Resident Accidents/Incidents stated,"All accidents/incidents involving residents must be report to the director of nursing services and immediately to the administrator." The related procedure directed that "All accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing." The undated policy entitled Abuse and/or Neglect Investigation read, "All reports of resident abuse or neglect shall be promptly and thoroughly investigated." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals read, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate state agencies." The director of nursing (DON) was interviewed on 6/11/15 at 9:34 a.m. and stated that it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit initial reports and the internal investigative reports to the state designated agency. The DON stated that he would call the administrator. DON stated he knew reports were to be made immediately to administrator and state agency. DON stated "We have a system problem." in regards to immediately reporting to administrator and state agency. On 6/11/15 at 11:45 a.m. the licensed social	F 493	Stewartville Care Center staff recognizes and respects each resident¿s right to be free from maltreatment, neglect, and misappropriation of property and does all that is within its control to prevent such occurrences. The facility staff 1) identifies residents who are at risk for abuse, neglect, and/or misappropriation of property 2) develops intervention strategies to prevent occurrences and 3) routinely reassesses the effectiveness of the interventions. During the June 16, 2015 mandatory staff training, the facility policies related to abuse prevention/reporting were reviewed and all Stewartville Care Center staff including management staff were instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents/accidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirement to immediately report alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies 5) forms and procedures for appropriate and timely reporting and 6) necessary documentation related to incidents/accidents. The staff is educated on vulnerable adult issues at least every twelve months; vulnerable adult investigation and reporting are addressed during new employee orientation. The	

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F 493	Continued From page 90 worker (LSW) was interviewed. LSW stated she would usually talk to the administrator or director or nursing if something had been reported to her. Together they decided if it was a reportable incident and then report it to OHFC. LSW stated she could call them on the phone if they were not in the building and would always reach them. LSW stated she could report to OHFC herself if needed. LSW stated she knew that the administrator had been notified by phone and that he would come in to file the report. LSW stated the policy was to report immediately. On 6/15/14 at 2:24 p.m. the administrator was interviewed. The administrator stated he would not always document his investigations or conversations with residents and staff related to complaints and did not report every single complaint to the state agency.	F 493	facility¿s Vulnerable Adult Abuse policies were distributed to all staff on June 16 and June 17, 2015. The staff were required to sign to verify that they received the information. During the mandatory meetings July 14, 15 and 16, 2015, all staff were reminded of the vulnerable adult investigative and reporting requirements and policies. The employee (LPN-E) involved with the April 24, 2015 incidents with residents number 65 and 75 was initially suspended for three days pending an investigation of the alleged abuse. After returning to work, he was assigned to another care unit. After the June 2015 state review of the issue, the LPN-e was requested to complete a Health Professional Services Program evaluation as a condition of continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has had no further practice/performance issues. Resident number 65 ¿ The resident continues to wander throughout the first floor of the facility. She has had no recent altercations with staff; her usual resistiveness to bathing continues. The resident has severe cognitive impairments and believes that she works at the facility and is a care taker for her grandparents. She does not recall the incident from April 2015. The social worker frequently interacts with the resident as she walks by the social service office several times a day. The social worker will meet with the	

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F 493	Continued From page 91	F 493	resident weekly for four weeks and then monthly for six months to assess mood and behavior. The care plan was reviewed and found appropriate. Resident number 75 ¿ The resident has cognitive deficits and self-propels her wheelchair around the facility. She has occasional negative interactions with other residents which require staff intervention. She does not recall the incident from April 2015. The social worker will meet with the resident weekly for four weeks and then monthly for six months to assess mood and behavior. The resident frequently visits the Social Worker¿s office work to obtain a piece of candy from the candy bowl. The care plan was reviewed and found appropriate. Resident number 64 ¿ The alleged abuse by the resident¿s spouse was observed 4/15/15 at 4:40 p.m. and was not reported to the State agency until the next day. The related facility policy and the regulatory requirements for immediate reporting were reviewed by the administrative and social service staff for continued quality improvement purposes. Resident number 99 ¿ The resident died at the facility September 15, 2014. The circumstances of the Alleged Resident Abuse Investigation Report Form for an incident during the morning of August 20, 2014 not being submitted until the afternoon was reviewed by the management staff for continuing quality improvement purposes.	

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F 493	Continued From page 92	F 493	Resident number 98 ¿ The resident died at the facility December 29, 2014. The circumstances regarding a bruise observed 8/10/14 and the 48-hour delay in reporting the bruise to the administrator and State agency were reviewed by the management staff for continuing quality improvement purposes. The Social Worker will monitor compliance by auditing incident reports for timely and appropriate notification of the administrator and government offices for the next three months. If noncompliance is noted, additional auditing and training will be done. Compliance will be reviewed during the September Quality Assessment and Assurance Committee quarterly meeting and ongoing.	
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497		7/27/15

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F 497	Continued From page 93 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing assistants received 12 hours of training annually for 13 of 13 employees (EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L, EE-M, EE-N) who worked in the capacity of nursing assistants and were reviewed who had been employed greater than 12 months by the facility. Findings include: Records provided indicated the facility provided annual training in the Healthcare Academy that included Tuberculosis, Fire Safety, Environmental safety, Client Behaviors, and Caring for the Alzheimer's Client. EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L, EE-M, EE-N records were reviewed. EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L had received a performance review during the past 2 months, but the performance review did not identify areas for improvement or lack of 12-hour training. EE-M, EE-N had not received a performance review, but had been on medical leave during the time the reviews were completed according to the director of nursing. Medical Records (MR)-A on 6/16/15 at 12:45 p.m. provided total hours of in-service training for 2013 and 2014 for the 13 employees reviewed as follows: EE-A was hired in 2009 and had received 4.8 hours of training in 2014 and 8.12 hours of	F 497	Stewartville Care Center completes a performance review of every nurse aide at least once every 12 months, and provides regular in-service education based on the outcome of these reviews. The in-service training ¿ (I) Is sufficient to ensure the continuing competence of nurse aides; (ii) Addresses areas of weakness as determined in nurse aides¿ performance reviews as well as any special needs of residents; and (iii) Addresses the care of the cognitively impaired. The staff training related policies and procedures were reviewed and revised to ensure 12 hours of nursing assistant training per year including the training topics of abuse/neglect, fire safety, emergency procedures, tuberculosis, and caring for residents with dementia related behaviors. The Health Care Academy online program allows for tracking of training hours. All certified nursing assistants were required to complete 12 hours of training before July 27, 2015. The required training addressed caring for residents with cognitive impairments and dementia related behaviors.	

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F 497	Continued From page 94 training in 2013. EE-B was hired in 2010 and had received 2.2 hours of training in 2014 and 2.7 hours of training in 2013. EE-C was hired in 2002 and had received 0 hours of training in 2014 and 2.7 hours of training in 2013. In addition EE-C did not receive annual dementia training . Tuberculosis (TB) training, fire safety or emergency procedures training in 2014. EE-D was hired in 2011 and had received 01.5 hours of training in 2014 and 2.2 hours of training in 2013. EE-F was hired in 2007 and had received 3.1 hours of training in 2014 and 3.2 hours of training in 2013. EE-G was hired in 2002 and had received 0 hours of training in 2014 and 2.9 hours of training in 2013. In addition EE-G did not receive annual dementia training . TB training, fire safety or emergency procedures training in 2014. EE-H was hired in 2002 and had received 9.1 hours of training in 2014 and 0 hours of training in 2013. EE-I was hired in 2012 and had received 2.3 hours of training in 2014 and 0 hours of training in 2013. EE-J was hired in 2013 and had received 6.3 hours of training in 2014. EE-K was hired in 1996 and had received 0 hours of training in 2014 and 4.8 hours of training in 2013. In addition EE-K did not receive annual dementia training. TB training, fire safety or emergency procedures training in 2014. EE-L was hired in 2022 and had received 2.3 hours of training in 2014 and 0 hours of training in 2013. EE-M was hired in 1980 and had received 2.6 hours of training in 2014 and 4.32 hours of training in 2013.	F 497	During the mandatory meetings on July 14, 15 and 16, 2015, the nursing assistants were instructed on the regulatory requirements and facility policies regarding continuing education. They were informed that participating in the required training is a condition of employment. The Business Office Assistant with human resource responsibilities will monitor compliance by auditing the dates of the nursing assistants¿ required annual performance reviews and the required 12 hours of continuing education hours prior to their employment anniversary date. If necessary, a specific time will be scheduled for the nursing assistant to complete the required training. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.	

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EE-N was hired in 2010 and had received 0 hours of training in 2014 and 0 hours of training in 2013. In addition EE-N did not receive annual dementia training . TB training, fire safety or emergency procedures training in 2014.

Training records provided for employees hired since February 2015 showed that EE-R, EE-U, EE-X had not completed the two Health Academy programs entitled Client Behaviors and Caring for Alzheimer's Client as follows:

EE-R was hired as a nursing assistant on 3/25/15. EE-R's training record did not document completion of dementia training.
EE-U was hired as a nursing assistant on 4/28/15. EE-U's training record did not document completion of dementia training.
EE-X was hired as a nursing assistant on 5/12/15. EE-X'w training record did not document completion of dementia training.

During an interview on entrance on 6/8/15 at 3:00 p.m. the director of nursing (DON) stated the assistant director of nursing (ADON) was responsible for staff development. DON also stated records were kept per calendar year.

During an interview on 6/10/15 at 2:00 p.m. the ADON stated the administrator would assign the training programs to be viewed by staff through the Healthcare Academy online program. ADON stated the Tuberculosis training program and dementia/behavior training program were offered as part of orientation and annual training program. The ADON was interviewed again on 6/10/15 at 2:10 p.m. and stated she was responsible to monitor staff training, but she did not do so.

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F 497	Continued From page 96 During an interview on 6/15/15 at 1:30 p.m. the administrator stated he felt staff was completing the training programs since he offered and paid a financial incentive to employees to do so. Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. A designated dead line for completion would be determined by administration and department heads. In addition to the assigned courses, additional courses could be added on an as needed basis. The procedure also noted the employee and administration could track the training progress and generate reports related to the learning.	F 497		

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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 - State Fire Marshal Division. At the time of this survey, Stewartville Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/16/2015

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Stewartville Care Center is a 2-story building. The building was constructed at 2 different times. The original building was constructed in 1970 and was determined to be of Type II(111) construction. In 1976, addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 68 at the time of the survey.	K 000		

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	245349	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/09/2015**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not have a corridor door that meets the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. The deficient practice could affect 2 out of 68 residents.	K 018	Doors stops have been installed on the doors to resident rooms number 36 and 38. The stops will serve to prevent the doors from slamming shut due to air currents when the residents open their windows. The plan is to install door stops on all doors of resident rooms.	7/15/15

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K 018	Continued From page 3 Findings include: On facility tour between 10:00 AM and 12:30 PM on 06/09/2015, it was observed that the Lower Level - resident rooms # 36 and 38, have trash containers holding door open due to the doors are not balanced. NOTE: Check the whole facility for this deficiency This deficient practice was confirmed by the Facility Maintenance Director (DH) at the time of discovery.	K 018	The staff will be alert to residents physically propping their doors open and will counsel with residents as necessary regarding the fire hazard related to this practice. The Maintenance Director will monitor completion of the door stop installation.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, 8.3.2 and 8.3.6. The deficient practice could affect 10 out of 68 residents.	K 025	The open penetration in the fire wall above the lay ceiling by resident room number 39 has been sealed with intumescent fire stop caulk. All other smoke barrier walls will be inspected for open penetrations and caulked as	6/15/15

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K 025	Continued From page 4 Findings include: On facility tour between 10:00 AM and 12:30 PM on 06/09/2015, observation revealed that the Lower Level - smoke barrier wall by resident room # 39, open penetration above lay in ceiling. NOTE: All smoke barriers need to be checked from exterior wall to exterior wall. This deficient practice was confirmed by the Facility Maintenance Director (DH) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 025	necessary. The integrity of the fire wall will be checked after subcontractor work near fire wall barriers.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 7, 2015

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, Minnesota 55976

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5349025

Dear Mr. Gustason:

The above facility was surveyed on June 8, 2015 through June 17, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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,

, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: Fax:

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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	00429	A. BUILDING: _____ B. WING _____	06/17/2015

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 8, 2015 through June 17, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the administrator failed to adequately oversee and monitor care and services related to the implementation, and evaluation of abuse prohibition policies and procedures in the facility. This had the potential to affect all 68 residents currently residing in the facility. Findings include: Refer to F223, as the facility administration failed to ensure 2 of 2 residents (R75 and R65) with allegations of staff abuse, neglect, and/or mistreatment were protected and provided follow up and resolution to prevent further staff abuse from occurring. The facility's lack of identification of staff mistreatment to residents, resulting in lack	2 130	See POC for F223, F225 and F226	6/17/15

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2 130	Continued From page 3 of protection for residents from staff neglect, mistreatment, and abuse, as well as the lack of developing interventions to prevent further staff abuse, resulted in an immediate jeopardy for all 68 residents currently residing in the facility who remained at risk of potential staff abuse, neglect, and/or mistreatment. Refer to F225, as the facility administration failed to report immediately to the administrator and state agency, and investigate all allegations of staff abuse, neglect, and/or mistreatment for 2 of 2 residents (R75, R65) with allegations of staff abuse, neglect, and/or mistreatment. The facility's failure to ensure policies and procedures were implemented to protect residents from mistreatment, immediate notification of administrator and state designated agency (Office of Health Facility Complaints-OHFC) of the mistreatment and completion of a thorough investigation of the mistreatment resulted in an immediate jeopardy for all 68 residents currently residing in the facility who remained at risk of potential staff abuse, neglect, and/or mistreatment. In addition of the facility administration failed to ensure a system was in place regarding all allegations of staff abuse, neglect, and mistreatment were reported to the administrator and state agency immediately and were thoroughly investigated. The facility failed to ensure allegations of abuse were reported immediately to the facility administrator and state agency for 4 of 26 allegations reviewed (R64, R99, R98, R97). Refer to F226, as the facility administration failed to implement its abuse prohibition policy and	2 130		

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2 130	Continued From page 4	2 130		

procedure related to resident protection, investigation of an alleged incident of maltreatment, and immediately reporting to the administrator and state designated agency (Office of Health Facility complaints-OHFC) for (R65, R75) residents reviewed for abuse and for 4 of 26 residents (R64, R99, R98, R97) abuse allegation reports reviewed. This had the potential to affect all 68 residents currently residing in the facility.

Facility policies related to Abuse Prohibition were reviewed. The undated policy entitled Reporting/Investigating Resident Accidents/Incidents stated,"All accidents/incidents involving residents must be report to the director of nursing services and immediately to the administrator." The related procedure directed that "All accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing." The undated policy entitled Abuse and/or Neglect Investigation read, "All reports of resident abuse or neglect shall be promptly and thoroughly investigated." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals read, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate state agencies."

The director of nursing (DON) was interviewed on 6/11/15 at 9:34 a.m. and stated that it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit initial reports and the internal investigative reports to the state designated agency. The DON stated that he would call the administrator. DON stated he knew reports were to be made immediately to administrator and

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2 130	Continued From page 5 state agency. DON stated "We have a system problem." in regards to immediately reporting to administrator and state agency. On 6/11/15 at 11:45 a.m. the licensed social worker (LSW) was interviewed. LSW stated she would usually talk to the administrator or director or nursing if something had been reported to her. Together they decided if it was a reportable incident and then report it to OHFC. LSW stated she could call them on the phone if they were not in the building and would always reach them. LSW stated she could report to OHFC herself if needed. LSW stated she knew that the administrator had been notified by phone and that he would come in to file the report. LSW stated the policy was to report immediately. On 6/15/14 at 2:24 p.m. the administrator was interviewed. The administrator stated he would not always document his investigations or conversations with residents and staff related to complaints and did not report every single complaint to the state agency. SUGGESTED METHOD OF CORRECTION: The Governing Board or designee could develop and implement policies and procedures related to the administrator role and educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee and have effective oversight of the functions of the home related to abuse/maltreatment/cares/services for residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 130		

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2 285	Continued From page 6	2 285		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing assistants received 12 hours of training annually for 13 of 13 employees (EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L, EE-M, EE-N) who worked in the capacity of nursing assistants and were reviewed who had been employed greater than 12 months by the facility. Findings include: Records provided indicated the facility provided annual training in the Healthcare Academy that included Tuberculosis, Fire Safety, Environmental safety, Client Behaviors, and Caring for the Alzheimer's Client. EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L, EE-M, EE-N records	2 285	See POC for F497	7/27/15

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2 285	Continued From page 7 were reviewed. EE-A, EE-B, EE-C, EE-D, EE-F, EE-G, EE-H, EE-I, EE-J. EE-K, EE-L had received a performance review during the past 2 months, but the performance review did not identify areas for improvement or lack of 12-hour training. EE-M, EE-N had not received a performance review, but had been on medical leave during the time the reviews were completed according to the director of nursing. Medical Records (MR)-A on 6/16/15 at 12:45 p.m. provided total hours of in-service training for 2013 and 2014 for the 13 employees reviewed as follows: EE-A was hired in 2009 and had received 4.8 hours of training in 2014 and 8.12 hours of training in 2013. EE-B was hired in 2010 and had received 2.2 hours of training in 2014 and 2.7 hours of training in 2013. EE-C was hired in 2002 and had received 0 hours of training in 2014 and 2.7 hours of training in 2013. In addition EE-C did not receive annual dementia training . Tuberculosis (TB) training, fire safety or emergency procedures training in 2014. EE-D was hired in 2011 and had received 01.5 hours of training in 2014 and 2.2 hours of training in 2013. EE-F was hired in 2007 and had received 3.1 hours of training in 2014 and 3.2 hours of training in 2013. EE-G was hired in 2002 and had received 0 hours of training in 2014 and 2.9 hours of training in 2013. In addition EE-G did not receive annual dementia training . TB training, fire safety or emergency procedures training in 2014. EE-H was hired in 2002 and had received 9.1 hours of training in 2014 and 0 hours of training in 2013.	2 285		

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2 285	Continued From page 8 EE-I was hired in 2012 and had received 2.3 hours of training in 2014 and 0 hours of training in 2013. EE-J was hired in 2013 and had received 6.3 hours of training in 2014. EE-K was hired in 1996 and had received 0 hours of training in 2014 and 4.8 hours of training in 2013. In addition EE-K did not receive annual dementia training. TB training, fire safety or emergency procedures training in 2014. EE-L was hired in 2022 and had received 2.3 hours of training in 2014 and 0 hours of training in 2013. EE-M was hired in 1980 and had received 2.6 hours of training in 2014 and 4.32 hours of training in 2013. EE-N was hired in 2010 and had received 0 hours of training in 2014 and 0 hours of training in 2013. In addition EE-N did not receive annual dementia training . TB training, fire safety or emergency procedures training in 2014. Training records provided for employees hired since February 2015 showed that EE-R, EE-U, EE-X had not completed the two Health Academy programs entitled Client Behaviors and Caring for Alzheimer's Client as follows: EE-R was hired as a nursing assistant on 3/25/15. EE-R's training record did not document completion of dementia training. EE-U was hired as a nursing assistant on 4/28/15. EE-U's training record did not document completion of dementia training. EE-X was hired as a nursing assistant on 5/12/15. EE-X's training record did not document completion of dementia training. During an interview on entrance on 6/8/15 at 3:00 p.m. the director of nursing (DON) stated the	2 285		

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2 285	Continued From page 9 assistant director of nursing (ADON) was responsible for staff development. DON also stated records were kept per calendar year. During an interview on 6/10/15 at 2:00 p.m. the ADON stated the administrator would assign the training programs to be viewed by staff through the Healthcare Academy online program. ADON stated the Tuberculosis training program and dementia/behavior training program were offered as part of orientation and annual training program. The ADON was interviewed again on 6/10/15 at 2:10 p.m. and stated she was responsible to monitor staff training, but she did not do so. During an interview on 6/15/15 at 1:30 p.m. the administrator stated he felt staff was completing the training programs since he offered and paid a financial incentive to employees to do so. Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. A designated dead line for completion would be determined by administration and department heads. In addition to the assigned courses, additional courses could be added on an as needed basis. The procedure also noted the employee and administration could track the training progress and generate reports related to the learning. SUGGESTED METHOD OF CORRECTION: The administrator could monitor for compliance in regards to staff having ongoing education to meet the needs of all residents especially in regards to dealing with difficult resident behavior and dementia management.	2 285		

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2 285	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 302	See POC for F497	7/27/15

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2 302	Continued From page 11 facility failed to ensure that 10 of 10 employees (EE-0, EE-P, EE-R, EE-S, EE-T, EE-U, EE-W, EE-X, EE-Y, EE-Z) reviewed for having received dementia training were found to have not received timely dementia training. Findings include: Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. The procedure read, "J. In-service TB [tuberculosis] it's a Cough Away" also "Client Behavior" and "Caring for Alzheimer's Client" must be completed before starting work." Review of the information provided the facility (CMS671 and CMS672) noted the facility had 68 residents currently in the facility and that included 23 residents with dementia and 20 residents that demonstrated behaviors. The training records were reviewed for the following new hires: EE-O hired 2/19/15 as a licensed practical nurse. Records provided indicated neither of the two courses had been completed. EE-P hired 3/17/15 as a dietary staff member. Records provided indicated neither of the two courses had been completed. EE-R hired 3/25/15 as a nursing assistant. Records provided indicated neither of the two courses had been completed. EE-S hired 3/19/15 as a dietary staff member. Records provided indicated neither of the two courses had been completed. EE-T hired 4/8/15 as a dietary staff member. Records provided indicated neither of the two	2 302		

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2 302	Continued From page 12 courses had been completed. EE-U hired 4/28/15 as a nursing assistant. Records provided indicated neither of the two courses had been completed. EE-W hired 5/5/15 as a medical record employee. Records provided indicated neither of the two courses had been completed. EE-X hired 5/12/15 as a nursing assistant. Records provided indicated neither of the two courses had been completed. EE-Y hired 6/3/15 as a registered nurse. EE-Y was observed during the survey working on the floor as a new employee with another nurse. Records provided indicated neither of the two courses had been completed. EE-Z was hired 1/12/15 as a licensed practical nurse. Records provided indicated neither of the two courses had been completed. The assistant director of nursing (ADON) was interviewed on 6/10/15 at 2:10 p.m. ADON stated she was responsible to monitor staff training. ADON stated she was not aware that the ten new employees had not been trained in caring for the cognitively impaired resident. The director of nursing was interviewed on 6/10/15 at 2:20 p.m. and stated that all new employees were to be trained on dementia. He added the residents with dementia were dispersed on all the wings and not in just one area. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop an orientation program and monitoring system that would ensure new employees receive education and inservice training related to caring for cognitively impaired residents.	2 302		

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2 302	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive care plan for mood, behavior and psychotropic drug use for 1 of 5 residents (R45) who received psychotropic medications. Findings include: R45 was admitted to the facility 6/12/14 according to the facility admission record with diagnoses that included but was not limited to bipolar disorder. R45's significant change Minimum Data Set (MDS) dated 3/12/15 indicated moderate depression with a PHQ-9 (resident mood interview) score of 9, identified diagnosis of bipolar disorder, and indicated behavior status, care rejection, and wondering had worsened when compared to previous assessment. In addition, the MDS indicated R45 received antipsychotic and antidepressant medications. Care Area Assessment (CAA's) were triggered	2 560	See POC for F280	7/17/15

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2 560	Continued From page 14 based off of the MDS assessment information that required a plan of care. The CAA's triggered as a result of the MDS assessment included: mood state, behavioral symptoms, and psychotropic drug use. R45's physician orders provided by the facility on 6/10/15 included Lexapro (antidepressant medication) 20 milligrams (mg) once per day, Wellbutrin XL (antidepressant medication) 300 mg per day, Depakene (anti-seizure medication used as a mood stabilizer) 250 mg two times per day, and Zyprexa (antipsychotic medication) 5 mg at bedtime. R45's care plan did not include a plan of care that included individualized goals and interventions for the triggered care areas for behavioral symptoms and psychotropic drug use. Although depression was identified; the care plan lacked interventions in regards to care and services associated with depression and associated mood state concerns. During an interview on 6/10/15 at 1:00 p.m., the MDS coordinator licensed practical nurse (LPN)-G verified the care plan did not reflect the CAA's triggered by the MDS. LPN-G stated mood state, behavioral symptoms, and psychotropic drug use should have been included in the care plan. The facility policy Minimum Data Set/Resident Assessment Protocol/Care Planning that was not dated does not reflect current standards. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance.	2 560		

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2 560	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revised the plan of care to include the dietician's recommendations for 1 of 1 resident (R65) reviewed. Findings include: R65 received house supplement however, the supplement was given to the resident but the amount consumed was not documented and the amount consumed of meals was not documented to determine if there was an effective intervention in stabilizing weight loss. The registered dietician (RD)-B's progress note dated 5/7/15, indicated staff to monitor intake; although, The need for monitoring food and supplement intake was not indicated on the care plan.	2 570	See POC for F325	7/17/15

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2 570	Continued From page 16 R65's care plan dated 2/2/15, indicated R65 "Is able to feed self after setup is provided and needs observing if she is eating and assist as needed." The listed approach is "One staff to provide setup for reach meal-open containers, apply condiments, cut foods and butter breads." An interview on 06/10/2015 at 12:32 a.m. with certified dietary manager (CDM) who said R65 wanders up and down the hallway. She lost weight this month, currently she weighs 114 lbs. The nurses gave her a house supplement three times a day. No one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. registered dietician (RD)-B said R65 consumes her meals well and takes a supplement three times a day. R65 expels a lot of energy by walking so much. In May 2015, she had a weight loss of 9.2% for the past six months. As of today her weight loss is 11.6% for the past six months. "She is on the risk list and being monitored for months now." RD-B continued to say I haven't looked at what the nurses are signing out for her supplement. An interview on 06/11/2015, at 9:09 a.m. with registered nurse (RN)-G who said R65 takes her house supplement three times a day but said no one records how much is consumed. A policy dated 4/2000, entitled supplements read, "...Nursing service record intake of supplement" and "Need for an intake of supplement will be monitored by nursing personnel." SUGGESTED METHOD OF CORRECTION:	2 570		

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2 570	Continued From page 17 The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to reassess pain after a change in condition for 2 of 2 residents (R11 & R2) with chronic pain. Findings include:	2 830	See POC for F309	7/16/15

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2 830	Continued From page 18 R11 was interviewed on 06/09/2015 at 10:26 a.m. and stated she had lots of pain in her back and shoulders. R11 stated she took a lot of pain medication for it and stated that she currently had pain in the area that she would rate almost a 10 (scale 0 no pain and 10 severe pain). Stated that she used Ultram (pain medication), but felt that she had "out-grown it." R11 stated that she needed to have both rotator cuffs (shoulders) repaired, but did not want surgery again. On 6/11/15 at 6:15 p.m. R11 was observed sitting in her chair and eating her meal. R11 stated her shoulder pain was at a 10 out of 10 and that nothing was being done for her. R11 was admitted to the facility in 2006 and had diagnoses listed on the physician orders that included: chronic pain and osteoarthrosis. Physician orders of 6/11/15 included: scheduled Ultram twice a day and as needed (PRN), scheduled Tylenol extra strength twice a day, scheduled Narco (narcotic medication) three times a day. On 3/18/15 the physician note read, "Patient otherwise continues to have symptoms in regards to her arthritis in her shoulders. Patient also has failed all conservative therapies for that." Assessment read,"degenerative joint disease - shoulder - quite symptomatic." The quarterly Minimum Data Set (MDS) indicated R11 had a BIMS (brief interview of mental status) of 15 or no cognitive impairment and indicated R11 had rated her pain at 6 out of 10 but that an assessment for pain was not necessary. The care area assessment (CAA) completed 7/9/14 indicated the resident would rate her pain at 10 in the shoulders and arms, that she	2 830		

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2 830	Continued From page 19 received scheduled and as needed (PRN) pain medications, had limited bilateral functional range of motion. The CAA read, "She may be at risk for increased sx [symptoms] of pain limiting her quality of life, for falls and injury." The Pain Interview section for MDS 3.0 section J. dated 3/23/15 noted the resident had occasional pain, that made it hard to sleep, and would rate the pain at a 8 out of 10. No further assessment/s was found. During an interview on 6/11/15 at 6:24 p.m. licensed practical nurse (LPN)-J stated R11 usually had pain and that the physician only wanted her to have pain medications for control. The facility would also provide warm packs. LPN-J stated she thought the pain was related to the "gas" (air in bowels) in the abdomen and that the facility could use a rectal tube and anti-gas pills. During an interview on 6/11/15 at 11:30 a.m. in regards to a pain assessment for R11, RN-F stated that she was just starting to do pain assessments and any pain assessment would be in the hard copy chart. However, none was located nor provided when requested. R2 was interviewed on 6/8/15 at 6:29 p.m. and stated that her legs ached. R2 also stated that her bottom was sore because of cancer and use of the Hoyer mechanical lift. R2 stated her pain level was up to 7 out of 10 scale, but currently did not have any. The care conference on 4/7/15 documentation indicated R2 stated she was having more pain than usual.	2 830		

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2 830	Continued From page 20 Physician documentation of 4/20/15 noted right ankle pain and swelling for R2. The nursing documentation of 5/20/15 through 6/11/15 did not document the resident having pain. The annual MDS dated 12/23/14 indicated a BIMS of 14 or no cognitive impairment, the pain section was left undone. The quarterly MDS dated 3/24/15 indicated a pain intensity of 7 on a scale of 10. R2's care plan dated 4/6/15 indicate the resident had pain due to gout and generalized pain usually in back and shoulders. On 06/11/2015 at 11:30 a.m. RN-F, the MDS coordinator, stated that she was just starting to do pain assessments and had not done any for R2 yet. The facility's undated policy entitled Resident Pain Evaluation Protocol directed the resident's pain was to be reassessed quarterly and when condition indicates the need. On 06/11/2015 at 12:03 p.m. the director of nursing stated he would expect pain assessments be completed and that he knew the assessments had not been done for R2. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff who give direct care the need to assess and provide ongoing assessments and cares related to current health needs. Also to monitor for staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 965	Continued From page 21	2 965		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess nutritional status for 1 of 3 residents (R65) reviewed for nutritional status. Findings include: R65 had a significant weight loss over the past 180 days however, interventions put in place were not monitored/assessed if appropriate to maintain or gain weight. R65 received house supplement however, the supplement was given to the resident but the actual amount consumed was not documented and the amount consumed of meals was not documented to determine if there was an effective intervention in stabilizing weight loss. R65's most recent weight from dietary resident progress note dated 6/10/2015, was 114 pounds reflected weight loss of four pounds (3.4 percent) past 30 days, six pounds (5 percent) past 90 days and 16 pounds (12.3 percent) past 180 days. Weight loss is significant past 180 days. Dietary	2 965	See POC for F325	7/17/15

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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2 965	Continued From page 22 progress notes authored by the registered dietician (RD)-B dated 5/7/15, indicated resident's current weight is 118 pounds and weight six months ago, 130 pounds. This reflects weight loss of 9.2 percent in 6 months. Recommended house supplement be increased to four ounces three times a day to prevent further weight loss was initiated and staff to monitor intake. R65 was admitted with diagnoses that included dementia and CVA (cerebral vascular accident). A quarterly Minimum Data Set (MDS) dated 4/28/15, identified R65 required supervision for eating. the MDS also indicated R65 had no problems with coughing/choking during meals or complaints of difficult chewing or swallowing. The significant change MDS dated 1/28/15, R65 required supervision, oversight, encouragement or cueing during meal time. R65's weight was 128 pounds at that time. Nursing progress notes reviewed from 3/17/15, to 6/9/15, with the only time when the amount of meals consumed was mentioned was on 5/12/15, which indicated an "increase in house supplement to 4 oz with each meal for weight loss." On 5/22/15, the progress note read, "Up around 6 hours wandering up and down halls. ...offered food, fluids and activity as appropriate." No other mention of food consumed was available nor was any provided when requested. Medication flow sheets reviewed from 3/1/15, until 6/10/15, indicate R65 given four ounces of house supplement but no monitoring of amount consumed. The medication flow sheet for 3/1/15, until 5/31/15, indicate once a day house supplement with three times a day started on 6/1/15. Monthly weights also listed on medication	2 965		

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2 965	Continued From page 23 sheet during this period. A dietary nutritional assessment dated 1/28/15, indicated no concerns at that time and no further nutritional assessments were provided since that time. Computer generated weight variance report received from certified dietary manager (CDM), weight on 1/5/15, 127.8 pounds (lbs); 2/2/15, 124 lbs; 3/1/15, 120.4 lbs; 4/1/15, 120 lbs; 5/1/15, 118.4 lbs; 6/1/15, 114 lbs. Observations on 6/10/15, at 12:06 p.m. R65 ate 75% of her meal. On 6/11/15, at 12:03 p.m. R65 ate 50% of meal. An interview on 06/10/2015 at 12:32 a.m. with CDM who said R65 wanders up and down the hallway. She lost weight this month, currently she weighs 114 lbs. The nurses give her a house supplement three times a day. However, no one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. RD-B said R65 consumes her meals well and takes a supplement three times a day. She expels a lot of energy by walking so much. In May 2015, she had a weight loss of 9.2% for the past six months. As of today her weight loss is 11.6% for the past six months. "She is on the risk list and being monitored for months now" and I haven't looked at what the nurses are signing out for her nutritional supplement. An interview on 06/11/2015, at 9:09 a.m. with registered nurse (RN)-G who said R65 takes her house supplement three times a day but said does not measures how much is given nor does	2 965		

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2 965	Continued From page 24 anyone record how much is consumed by R65. An interview with RD and CDM on 06/11/2015, at 9:14 a.m. both said they have not assessed how much supplement the resident consumes. They validated they can not assess effectiveness of the treatment when it is not monitored. An interview on 06/11/2015, at 9:55 a.m. with director of nurses (DON) who stated my expectation is the dietary staff monitor how much of the meal R65 eats and nursing needs to monitor how much supplement R65 consumes of her supplement when they give it to her. R65's care plan dated 2/2/15, read, "Is able to feed self after setup is provided and needs observing if she is eating and assist as needed." The listed approach is "One staff to provide setup for reach meal-open containers, apply condiments, cut foods and butter breads." A undated policy entitled monitoring and preventing ongoing weight loss read, "All residents in the facility will be weighed monthly. If they exhibit an unexpected continual weight loss for two month, they will be addressed as a risk and risk interventions will begin." A policy dated 4/2000, entitled residents at nutritional risk read, "Residents with any of the following conditions should be considered at Nutritional risk: Low body weight and increased caloric and/or nutrient needs related to medical condition." A policy dated 4/2000, entitled supplements read, "...Nursing service record intake of supplement" and "Need for an intake of supplement will be monitored by nursing personnel."	2 965		

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2 965	Continued From page 25 SUGGESTED METHOD OF CORRECTION: The registered dietician could in-service employees responsible for resident nutritional needs on the need to monitor and follow interventions advised by the dietician and the doctor to maintain weight or prevent weight loss. Then to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure glucometer equipment was disinfected according to the bactericide sanitizer wipe manufacturers directions for a glucometer used for 3 of 4 residents (R29, R11 & R24) glucose tests observed. In addition the facility failed to ensure containment of used incontinent products and soiled gloves to prevent the spread of infection which could affect several residents. Findings include: R29 had blood glucose testing done on 6/10/15 at 9:22 a.m. registered nurse (RN)-B was observed	21375	See POC for F441	7/17/15

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21375	Continued From page 26 doing glucose test. After completion of the monitoring, RN-B wiped the glucometer for 20 seconds with the Super Sani-Cloth wipe. RN-B stated, "I guess we wipe it a while." However, the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R11 was observed to have glucose test done on 6/10/15 at 6:20 p.m. licensed practical nurse (LPN)-A perform glucose monitoring for R11. The glucometer was removed from the medication cart and taken directly into R11's room. LPN-A stated the facility and not the resident owned and maintained the monitors. When LPN-A returned to the medication cart following the performance of the glucose testing, She used the PDI Super Sani-Cloth wipe to clean the meter. The wipe remained in contact with the meter for less than one minute and the damp monitor was placed on top of the medication cart. LPN-A stated that she did not know how long to keep the disinfectant in contact with the meter. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R24 had just completed glucose test on 6/10/15 at 6:30 p.m. LPN-B was observed to clean the glucometer after use. LPN-B used the PDI Super Sani Cloth wipe and left the wipe in contact with the monitor for less than one minute. When finished LPN-B placed the damp monitor on top of the narcotic book. LPN-B stated the disinfectant wipe needed to be in contact with the monitor for 10 to 15 second. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." The undated facility policy entitled Blood Glucose	21375		

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21375	Continued From page 27 Meters Clean and Disinfect read, "To disinfect the meter, wipe down the meter with an EPA registered and approved premoistened towelette....Follow the product label instructions to disinfect the meter." The director of nursing was interviewed on 6/10/15 at 9:57 a.m. and stated staff need to follow the directions on the PDI package to disinfect the glucometer. LACK OF PROPER DISPOSAL OF SOILED PADS AND GLOVES TO PREVENT THE SPREAD OF INFECTIONS: During an observation on 6/8/15, at 6:18 p.m. a soiled incontinent pad and gloves were laying on the bathroom floor between resident rooms number 39 and 40. During an interview on 6/8/15, at 6:22 p.m. licensed practical nurse (LPN)-B verified the soiled incontinent product on the floor. LPN-B stated should have not been left on the floor, LPN-B donned gloves and placed the incontinent pad in the garbage bag and removed from room. An undated facility policy AM Cares (Early Morning Care) read, "Leave bedside area clean, and dispose of disposable equipment and soiled linen appropriately." An undated facility policy P.M. Care (Bedtime Care) read, Leave room clean and tidy." An undated facility policy Incontinence Care Guidelines instructed, "Discard disposable items in a plastic trash bag and secure." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for infection control of glucometer meters. Housekeeping staff could be educated as necessary to the importance of	21375		

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21375	Continued From page 28 correct cleaning procedures of waste materials. The administrator and housekeeping director could audit resident areas on a regular basis to ensure a compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all employees received annual Tuberculosis (TB) training for 6 of 50	21426	See POC for F497	7/27/15

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21426	Continued From page 29	21426		

nursing department employees (EE-AA, EE-CC, EE-DD, EE-FF, EE-HH, EE-LL). In addition the policy did not contain annual TB training.

Findings include:

Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. The procedure read, "J. In-service TB [tuberculosis] it's a Cough Away" also "Client Behavior" and "Caring for Alzheimer's Client" must be completed before starting work." The policy did not include the staff were to be evaluated to need annual training for tuberculosis.

Medical Records (MR)-A was interviewed on 6/16/15 at 12:45 p.m. and had provided hours of in-service training related to TB for all employees.

Training records were provided for 50 nursing staff and 6 of these staff records had not received annual training as follows:

EE-AA was hired as a registered nurse (RN) on 6/18/12
EE-CC was hired as a nursing assistant (NA) on 10/6/92
EE-DD was hired as an RN on 9/29/09
EE=FF was hired as a NA on 6/15/11
EE-HH was hired as a licensed practical nurse (LPN) on 4/7/98
EE-LL was hired as an NA on 5/15/96

Nine nursing department staff had been hired in 2014 and 2015. The Orientation Program included a hand out related to TB, however, these

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21426	Continued From page 30 nine employees had not completed "It's Just a Cough Away" training as directed in the policy/procedure as follows: EE-GG was hired as a NA on 6/17/14 EE-JJ was hired as an RN on 9/9/14 EE-kk was hired as an NA on 11/25/14 EE-MM was hired as an NA on 11/12/14 EE-NN was hired as an NA on 3/25/15 EE-OO was hired as an NA on 4/28/15 EE-PP was hired as an NA on 8/11/14 EE-BB was hired as an NA on 5/12/15 EE-II was hired as RN on 6/3/15 The assistant director of nursing (ADON) was interviewed on 6/10/15 at 2:10 p.m. ADON stated she was responsible to monitor staff training and had missed these nine staff TB training. SUGGESTED METHOD OF CORRECTION: The medical director or director of nursing could in-service staff responsible for TB to follow the most current MDH guidance on TB program for nursing home. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced	21495		7/27/15

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21495	Continued From page 31 by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. Findings include: R26 was admitted to the facility on 4/29/14 according to the facility admission record. R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with activities of daily living. During an interview on 6/9/15, at 8:26 a.m. in an answer to the question "Have there been any concerns or problems with a roommate or any other resident," R26 stated, "Yes.!" R26 went on to say that she had problems with R1 (R1's quarterly MDS dated 4/8/15 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that her roommate (R68 who had moderate cognitive impairment according to the quarterly MDS dated 5/6/15). R26 stated R1 had yelled and cursed at her on multiple occasions over the past months and kept R26's bathroom door locked so she had to go into the other residents room to unlock it to use on several occasions. R26 then said her roommate (R68) daily told her when to go to bed, when she could watch television, where to put her walker, and when and how to get dressed. R26 stated R68 seemed to want more space in the shared room for her things. In response to the question, "How does that make you feel to have someone telling you what to do?" R26 stated, "She is kinda	21495	See POC for F247 and F250	

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21495	Continued From page 32 bossy, I feel like I'm walking on eggshells around her, she's always telling me what to do. I've reported it to the social worker about the concerns, I'm not sure if the same social worker is still here...I'm not aware if she followed up with my concerns. They come and go fast. I more or less just got used to it, so I don't even say anything more." R26 further stated R68 snored very loud at night and kept her awake often. R26 stated she did not want to be treated the way she had been treated (in reference to both R1 and R68) and was not expecting anything to change because nothing had changed despite asking for help from the facility. R26 stated it would be nice not to deal with it, however had learned to deal with it. During a follow up interview on 6/10/15, at. 1:30 p.m. R26 indicated she had not been able to cope well with problems with neighbor (R1) and roommate (R68) and said, "I try not to let it bother me now... It still hurts my feelings, and I'm frustrated, I'm not a child you know." In response to the question, "How do you deal with it?" R26 stated, "When [R68] starts in, I just say "I don't know what I did, but I'm sorry." R26 stated she dealt with the neighbor bathroom issue by having a bedside commode at night to avoid confrontation with. R26 stated she would preferred to use the bathroom vs. the bed side commode. R26 stated, "I can't even move a little bit without one of them questioning me on what I am doing." R26 stated she had asked for a room change several months ago, stated the social worker had not ever come in to talk with her. R26 stated, " I am tired of reporting the concerns and nothing changes, so what's the point? I've just learned to deal with it." R26's care plan provided by the facility on 6/11/15 read, "Has occasional difficulties in dealing with her roommate and others that she share a	21495		

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21495	Continued From page 33 common bathroom with but seeks out staff support with is as needed. Care plan also included intervention of "provide on-going support to resident and encourage resident to share her concerns and feeling." The care plan lacked explanation of difficulties and interventions to resolve the concerns. Social service progress note dated 12/5/14 read, "[R26] came to social work office late in the day on 12/5/14 seeking support due to conflicts with other residents. She describes one resident being particularly cruel on an ongoing basis and said that hurt was compounded when her roommate, whom she has previously shared a good relationship with, aligned with the other party and has been also making hurtful remarks over the past month....she has tried to speak back more often but that appears to be making things worse for her. She is adjusting her bathroom routines to avoid confrontation... The comments also take place in the hallways and dining room. I spoke with the supervisors about the situation and the pros and cons of a room change and was advised to speak with roommate to ascertain her thoughts on the interactions reported to be taken place." The progress note further indicated social services would continue to offer emotional support and indicated if problem persisted the social worker would attempt mediation. R1's progress notes were reviewed, no evidence of follow-up performed related to the concerns of R26 shared with social worker on 12/5/14. R1's care plan read, "Does present with an argumentative disposition at times with other residents. She has verbal behaviors toward other..." The care plan also indicated she is confrontational with residents and has had multiple room changes. The care plan did not reflect the issue with the shared bathroom with R1.	21495		

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21495	Continued From page 34 R68's progress notes were reviewed, no evidence of follow-up performed related to the concerns of R26. R68's care plan did not reflect or identify any concerns, interventions, or problems with roommate. R26's progress notes did not reflect follow-up or monitoring had been performed as a result of voiced concerns at the 12/5/15 meeting and no further mention of the issues until 4/29/15 when the resident brought the same concerns forward again in her care conference. Care conference progress note dated 4/29/15 read, "We provided [R26] the opportunity to vent about her interactions with her roommate and next door neighbor, mainly bathroom sharing issues. She reports that these issues remain the same but she had grown to better deal with them. She tends to accommodate others but also has spoken up." No follow-up was evident in R26's, R1's, or R68's medical record as a result of the again mentioned concerns and issues at the 4/29/15 care conference. During an interview on 6/9/15, at 3:30 p.m. licensed social worker (LSW) explained nursing staff reported to her with any concerns pertaining to the residents and "every morning I see what is going on" however, LSW stated she was not aware of the concerns despite the concerns documented in the medical record. LSW stated the facility had turned over three social workers in the last year. LSW stated the social worker who had been assigned to that wing, left in May 2015. LSW stated a grievance had not been filed. During an interview on 6/9/15, at 4:00 p.m. director of nursing (DON) stated a grievance had not been filed. DON stated a grievance should have been filled out in regards to R26's concern with roommate (R68) and neighbor (R1). Stated he had not been aware of the problem with the	21495		

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roommate despite the concerns documented in the medical record. DON stated the concerns should have been followed up on. DON indicated his expectation would have been re-evaluation of a situation for a possible room change and social worker involvement.
During an interview on 6/10/15, at 2:08 p.m., family member (F)-A indicated awareness of roommate and neighbor problems. Stated the roommate had always been complaining and telling [R26] what to do, "[R68] tells her to turn the TV off, when to go to bed, and where to put things... I hear it. [R68] is always saying smart thing, sarcastic things to [R26]. [R26] says she doesn't want to listen to her. She [R26] seems really frustrated, everyday there is something. Every time I call she expresses frustration with her roommate. I haven't noticed a big change is [R26's] mood but I do know she is frustrated." F-A stated had not been notified by the facility of the ongoing issues concerning the roommate or the neighbor. F-A explained had offered assistance to R26, but had been told by R26 she had been handling the problems. To the question, "Do you think [R26] is happy?" F-A stated, "No, I don't think she is happy. I would think if those people were not around she would have a better quality of life. [R26] was never a person who let people know if she was upset about something. She will deal with it and deal with it until it explodes, takes a while before she reports anything. She doesn't want to create waves, she wants to just do her thing and mind her own business."
During an interview on 6/11/15, at 2:32 p.m., nursing assistant (NA)-K stated R1 tends to be judgmental of people and had been aware of R26's bathroom concerns related to R1 locking the door so R26 cannot enter from her room. NA-K further stated knowledge of the issues with the roommate, "[R68] is always arguing about the

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line [which divides room in half] of where things go...and they have some issues with the curtains. [R26] was shutting the curtains too far." NA-K explained R26 was not the type of person to voice concerns, "she would wait and wait until it's really bad." NA-K explained when there had been resident concerns, they would be reported to social worker.

During an interview on 6/11/15, at 2:46 p.m., licensed practical nurse (LPN)-J stated she had not been aware of the concerns with the roommate despite the concerns documented in the medical record. LPN-J stated, "Everybody knew about the whole bathroom thing, [R1] made sure everybody knew about it." LPN-J stated a commode had been placed in R26's as a compromise to the bathroom problem with R1.

During an interview on 6/11/15, at 3:13 p.m., NA-E stated "[R1] tends to be more aggressive...she tends to pick on people that are a little more vulnerable ....she really goes after [R26] about the bathroom ...and is very vocal about letting people know." NA-E stated, "[R68] wants things a certain way even if it's on [R26's] side...R26 will just shrug it off and ignore it. I have seen her get upset and frustrated. She's the type of person that holds things in. She is the type that tries to get along with everyone, she is quiet and keeps to herself." NA-E explained an example, where R68 had attempted to take R26's calendar down and had to be redirected.

During an interview on 6/11/15, at 3:35 p.m., NA-A stated had witnessed arguments between R26 and R1 in the past. Stated everybody knew of the problems with R1 not wanting to share the bathroom with R26.

An undated policy entitled filing grievances/complaints indicated "Grievances and/or complaints may be submitted orally or in writing." "The administrator has delegated the

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21495	Continued From page 37 responsibility of grievance and/or complaint investigation to Social Services." Upon receipt of a grievance and/or complaint, Social Services will investigate the allegation and submit a written report of such finding to the administrator within (5) working days of receiving the grievance and/or complaint. An undated facility policy entitled Content Of The Clinical Record read, "Records of Social Service. Records of each resident's pertinent social data about personal and family problems medically related to the resident's illness and care and of action taken to meet these needs, will be entered in the clinical record." SUGGESTED METHOD OF CORRECTION: The director of nursing and social worker could ensure arrangements were made to provide residents with medically necessary social services related to roommate issues and resident to resident confrontations in the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21495		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure safe and secure disposal of used Fentanyl (topical narcotic analgesic	21610	See POC for F431	7/17/15

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21610	Continued From page 38 medication) patches according to currently accepted principles to prevent potential diversion for 2 of 2 residents (R7 & R55)reviewed with prescribed Fentanyl patches. Also medications that were outdated were not removed to prevent accidental use and medications opened lacked open date to determine when it would be outdated this had the potential to affect several residents including (R29, R4, R65, R42, R46, R10, & R71) who utilized stock medications and prescription medications. Findings include: R7's admission record dated 4/9/10, indicated diagnosis including lumbago and abnormal sensation with pain in the left leg. R7's physician orders dated 5/14/15, included an order for Fentanyl patch 25 micrograms (mcg) to be applied transdermal (to the skin) every 72 hours, with special instructions, "Apply 1 patch and change patch q [every] 72 h [hours] for back pain. **When removing old patch, wrap in tissue and flush down toilet or put in sharps container.**" R7's Fentanyl patches were administered from and stored in the West medication cart. R55's admission record dated 7/27/11, indicated diagnosis including generalized pain. R55's physician orders dated 4/7/15, included an order for Fentanyl patch 50 mcg to be applied transdermal every 72 hours, with special instruction, "When removing old patch, wrap in tissue and flush down toilet or put in sharps container.**" R55's Fentanyl patches were administered from and stored in the North medication cart.	21610		

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21610	Continued From page 39 During an interview on 6/8/15, at 7:15 p.m., trained medical assistant (TMA)-A indicated the policy when removing and disposing of Fentanyl patches, was for two staff to witness the destruction by putting them in the sharps container attached to the medication cart, and for both to initial on the Medication Administration Record (MAR). During an observation on 6/10/15, at 8:40 a.m., of medication administration from the West medication cart, the locking door on the sharps container attached to the cart was observed to be unlocked and could easily be opened, exposing the content in the sharps container. The sharps container was easily removed from the compartment by sliding it forward and removing from the cart. The door to the compartment had several pieces of old tape on the front and several pieces of tape on the right side of the compartment. During a review of medication storage on 6/10/15, at 8:50 a.m., the East medication cart sharps container compartment door, was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. Licensed practical nurse (LPN)-A verified the door was unlocked and the sharps container could be removed. During a review of medication storage on 6/10/15, at 8:55 a.m., the North medication cart sharps container compartment door, was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. Registered nurse (RN)-B verified the door was unlocked and the sharps container	21610		

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21610	Continued From page 40 could be removed. During a review of medication storage on 6/10/15, at 9:10 a.m., the lower level medication cart sharps container compartment door was noted to be unlocked and could easily be opened, exposing the sharps container. The sharps container was easily removed from the compartment by sliding it forward. LPN-L verified the door was unlocked and stated, "The door should be locked." During an interview on 6/10/15, at 9:15 a.m., LPN-B stated when removing Fentanyl patches from the residents for disposal , the policy was for two staff to witness the destruction of the patch, by either flushing the patch in the sewer system or by putting the used patch in the sharps container. LPN-B stated, "I always put it in the sharps container," pointing to the sharps container attached to the side of the West medication cart. When asked about the door to the sharps container compartment being unlocked and the ease of removing the sharps container, LPN-B verified the door was unlocked and attempted to use a key to lock it, but was unable to get it locked. LPN-B stated, "This key fits, but doesn't turn to lock the door." During an interview on 6/10/15, at 10:05 a.m., director of nursing (DON) stated he was aware that the sharps container compartments were found to be unlocked during observation, and stated, "They should be locked." DON verified the unlocked doors on the compartments holding the sharps containers, allowed access to the sharps containers where used Fentanyl patches were disposed, and this had the potential for diversion. DON indicated he would be ordering a new door for the West medication cart because the door	21610		

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21610	Continued From page 41 was cracked, and the doors were to be locked. A policy was requested for ensuring safe and secure disposal of Fentanyl patches, and was not provided. A memo written by DON, to "ALL NURSES," dated 12/16/13, was provided, and directed staff to add, "When removing old patch, wrap in tissue and flush down toilet or put in sharps container," when receiving Fentanyl patch orders. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe comfortable environment free from rust and paint	21685	See POC for F465	7/16/15

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21685	Continued From page 42 chips of bathroom door frames for 4 of 4 resident (R95, R96, R75, R87) rooms and in addition the grout around a toilet used by R11 was soiled and the wheelchair used by (R1) was soiled. Findings include: During an environmental facility tour on 06/11/2015 at 10:14 a.m. with maintenance manager (MM)-A the following was observed. R95's room, the bathroom door jam near the floor,and the light switch in the bathroom had chipped paint exposing the metal which was rusty colored. The heat register in her room also had chipped paint. MM-A stated the door jams need painting, the area around the light switch and the heat register are rusty and need painting. R96's room the bathroom door jams and around the light switch had paint chipped and were rusty. Verified by MM-A who said he will paint. 75's bathroom door frame the paint was chipped. MM-A agreed of the chipped area's and the need for painting those areas. R87's bathroom door frame near the bottom was chipped. MM-A verified the chipped paint on the metal door frame. R1's wheelchair was soiled, the poles under the chair had a thick layer of dust, MM-A verified the dust/soiled areas. MM-A stated I suppose its been a long time since the wheelchair was cleaned. He said the process is the staff bring the wheelchair to his office with a note asking maintenance to wash it. MM-A stated they don't keep track of which wheelchairs are washed and there was no schedule for cleaning wheelchairs.	21685		

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21685	Continued From page 43 R11's bathroom in room had scratched up door jam. The toilet's caulking was yellow and there was a yellowish discoloration on the floor around the toilet. The bathroom had a strong, old urine smell. MM-A agreed that the caulk and flooring was yellow and the bathroom smelled like urine. An interview on 06/11/2015 at 10:54 a.m. the director of nursing (DON) said the wheelchairs were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair cleaning schedule. A maintenance policy in regards to general cleaning/repairs were requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could work with the director of maintenance to develop a maintenance program to ensure damaged walls, floors, ceilings, and bedroom and bathroom fixtures are managed/repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		
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	21880		7/16/15

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21880	Continued From page 44 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 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

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21880	Continued From page 45 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident grievances were resolved promptly for 4 of 4 residents (R53, R46, R7 & R66) who expressed a grievance to the facility staff. Findings include: During an interview with R53 on 6/8/15, at 6:05 p.m. R53 reported her roommate hollers all night long. R53 stated, "She sleeps all day, hollers all night. I've told all the nurses. Nothing gets done. I've asked if they can give her a private room, but nothing happens. They try different stuff, it doesn't work. She keeps me up all night. They don't do anything for me." Documentation in R53's medical record dated 5/3/15, at 1:39 a.m. indicated R53 had reported, "can't sleep with her hollering." Another note from 5/3/15 at 1:46 a.m. indicated, "message left on ss [social services] telephone in regards to that incident." On 5/3/15 at 5:13 a.m. a nurse's note entry included, "asked her [R53] what she was doing over by [R30's] bed during the night and she states she was giving her a stuffed animal to hold so she wouldn't holler" R53's quarterly Minimum Data Set (MDS) dated 3/18/15, identified intact cognition with no behavioral or communication issues. During an interview with R46 on 6/9/15, at 09:23 a.m. R46 state, "at different times someone hollers. It keeps me up at night." An entry in R46's medical record dated 5/16/15, at 4:43 a.m. included, "States she can't sleep	21880	See POC for F166	

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21880	Continued From page 46 during the night because her roommate keeps her awake which usually sets off the alarm and that makes her nervous... Message left for SS." R46's annual Minimum Data Set (MDS) dated 4/29/15, indicated the resident had intact cognition with no behavioral or communication issues. During an interview with R7 on 6/8/15, at 6:36 p.m. R7 stated, "we have a person (R30) next door that yells before she goes to bed." During an interview with R7 on 6/11/15, at 3:40 p.m. R7 said she had complained to the director of nursing (DON) about the noise R30 made at night, so the DON had moved R30 to another room, "but she is now in the room next to me." R7's annual MDS dated 3/31/15, identified R7 had intact cognition with no behavioral or communication issues. During an interview with R66 on 6/8/15, at 06:44 p.m. R66 said, "It is noisy because another lady is yelling for help a lot at night." R66's quarterly MDS dated 4/22/15, identified the resident was cognitively intact with no behavioral or communication issues. During an interview with nursing assistant (NA)-D on 6/11/15 at 2:32 p.m., NA-D said, "I have heard [R30] yells a lot at night from the night staff." During an interview on 6/11/15, at 2:41 p.m. licensed practical nurse (LPN)-J said, "(R30) has a problem yelling and cries at night. The staff will try to medicate her and sit with her. This happens at least a couple times a week. Her	21880		

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 47 roommate has said she (R30) has kept her up all night. Everybody is aware of it, social services (SS), the director of nursing (DON). I don't know why we can't fix it." During an interview with LPN-K on 6/12/15 at 9:55 a.m., LPN-K stated, "(R30) slept last night but it has been a problem with her yelling in the night. She cries out at night or at least makes noise, about 1-2 times a week. SS and the DON know about it but it is a difficult issue to resolve." During an interview with SS-A on 6/11/15 at 2:56 p.m., SS-A stated, "I don't have any written grievances for the past six months. I have heard about (R30) crying out but I have not gotten a grievance form about it. Everyone is given a grievance form on admission. We do not remind residents to use the grievance form. The staff try to get to her (R30) as fast as they can but she still hollers and cries out." During an interview on 6/11/15 at 5:24 p.m., the DON said he was not aware [R30] was keeping people awake at night but acknowledged, "I was aware of the daytime noises." The DON stated he knew the grievance process needed to be "repaired." An undated facility policy entitled, Filing Grievances/Complaints indicated: "Grievances and/or complaints may be submitted orally or in writing...the administrator has delegated the responsibility of grievance and/or complaint investigation to Social Services. Upon receipt of a grievance and/or complaint, Social Services will investigate the allegation and submit a written report of such finding to the administrator within (5) working days of receiving the grievance and/or complaint.	21880		

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21880	Continued From page 48 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 complaint/concern. 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 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	21980		7/16/15

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21980	Continued From page 49 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 (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 observation, interview and document review, the facility failed to immediately report allegations of maltreatment to the common entry point (CEP) for 5 of 6 residents (R75, R65. R64, R99 and R98) reviewed for allegations of maltreatment. Findings include: Although R75 was observed by staff to be yelled at by licensed practical nurse (LPN)-E on 4/24/15 following the supper meal, and LPN-E was subsequently observed to be verbally and physically abusive to R65 that same evening, however, the incidents were not immediately	21980	See POC for F490	

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21980	Continued From page 50	21980		

reported to the the State agency, nor were interventions initiated to prevent further abuse.

A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C dated 4/25/15. The concern included: "EMPLOYEE NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..."

R75's quarterly minimum data set (MDS) dated 5/12/15 indicated R75 had a brief interview for mental status (BIMS) score of 4 which indicated R75 was severely cognitively impaired. The MDS also indicated R4 could hear with minimal difficulty.

During an interview and observations on 6/9/15 at 9:51 a.m., R75 was observed during an interview with family (F)-A. R75 conversed with F-A and the surveyor without hearing difficulty and surveyor did not have to speak loudly for resident to hear.

R75's care plan directed staff to provide, "Clear, careful, explanations to facilitate her comprehension...repeat/rephrase words as needed to facilitate hearing and comprehension."

Information provided by the DON related to the investigation of these incidents, included a typed interview conducted 4/25/15 at 10:00 a.m., by the

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21980	Continued From page 51 DON with NA-L. The interview documentation included, "Spoke to [NA-L] concerning incident Friday 4-24-15 p.m. shift. She stated he [LPN-E] was talking to [R75]. [R75] was repeating questions and as [LPN-E] was answering questions he was becoming more upset and yelling, and was probably yelling more than he should. [R65] was standing nearby with her walker but did not say anything. Stated she (NA-L) heard a little later from another CNA (certified nursing assistant) that [R65] was hitting at staff, kicking and attempting to hit them with her walker." LPN-E was observed on 6/9/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility. During an interview on 6/12/15, at 9:30 a.m., the DON was asked to provide all information regarding the immediate reporting of the allegations of abuse between LPN-E and the residents to the administrator or State agency, and any interventions taken to protect R75 or other residents, or any investigation of the abuse incident. The DON confirmed he had not reported the allegation involving R75 to the State agency because he had been more focused on the physical abuse allegation between LPN-E and R65. The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to	21980		

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21980	Continued From page 52 go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up." During an interview on 6/11/15, at 9:34 a.m. in regards to when he was notified of the abuse incident with R65 which occurred on 4/24/15 after evening meal, DON stated staff had placed a phone message on his home phone following the incident but he did not listen to it until the next morning (Saturday 4/25/15) at which time he had come to the facility to follow-up on the incident. The DON stated it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit any internal investigative reports to the State designated agency. Following the surveyor's inquiry about the reporting of these alleged incidents of verbal/physical abuse, the DON made a report to the State agency (OHFC) regarding the verbal abuse R75 had sustained on 4/24/15. The report was made on 6/12/15, as part of the immediate plan of correction following the facility having been informed that an immediate jeopardy situation existed. The incident description sent to the State agency included: "During routine MDH [Minnesota Department of Health], it was brought to this writer's attention that on 4/24/15, staff LPN [LPN-E] was yelling at resident [R75]. An incident was initially reported on 4/25/15 regarding another demented resident [however, R65 was the main focus of that OHFC report and information in regards to R75 was to support the investigation of R65. During this incident [R75] was also agitated and following the nurse and not responding to re-direction. Nurse [LPN-E] did yell at resident due to his frustration with resident	21980		

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21980	Continued From page 53 [R75] and her continued agitation. This writer initially combined both of these actions by the nurse [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident ..." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies." The facility had submitted a report to the state agency on 4/16/15, indicating a nurse had witnessed R64 being hit on the forearm by family (F)-B on 4/15/15, around 4:40 p.m. The report indicated, "[R64] was sitting in a reclining chair next to [F-B]...As he was attempting to get up and out of the chair, [F-B] struck him on the forearm..." R64's diagnosis, according to the resident admission record dated 1/21/15, included debility with functional decline and dementia. The quarterly Minimum Data Set (MDS) dated 3/25/15, identified R64 had severe cognitive impairment and required extensive assistance from one person for all activities of daily living (ADL)'s. A review of the nursing progress notes dated 4/15/15, included a note from 4:30 p.m., "Nurse observed resident attempting to get out of a recliner chair. [F-B] attempted to tell resident to sit back down. Nurse noted agitation in the [F-B ' s] voice. Nurse then observed resident's [F-B] pull the chair control out of resident's hand and hit	21980		

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21980	Continued From page 54 him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well." Although the facility was aware of the family member striking R64 on 4/15/15, the incident was not reported to the State agency until the next day, 4/16/15. Although R99 sustained an injury of unknown origin on 8/19/14, the facility failed to ensure the administrator and state agency were notified immediately. An incident report for R99 had been submitted to the State agency on 8/20/14 for an incident that had occurred the previous day, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident..was lying on the floor...[R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..." R99's record was reviewed. The resident admission record dated 2/26/10, identified diagnoses including: senile dementia and osteoporosis. The quarterly MDS dated 8/12/14, identified R99 as having severe cognitive impairment and requiring limited assistance from one person for transferring and walking. A review of the nursing progress notes dated 8/19/14 at 10:30 a.m. included, "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]."	21980		

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21980	Continued From page 55 A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident had been reported to the administrator on "8/20/14, AM," and had been reported to the State licensing agency on "8/20/14, PM." Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and state agency were notified immediately. The facility had submitted a report to the State agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's disease." R98's record was reviewed and the resident admission record dated 12/5/08 indicated the resident had diagnoses including: dementia and Alzheimer's disease. A quarterly MDS dated 11/18/14, identified R98 had severe cognitive impairment and was totally dependent on staff for all activities of daily living. A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. The progress notes also indicated R98's left hand and fingers were edematous, and the area appeared to be tender,	21980		

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21980	Continued From page 56 as R98 cried out when arm was moved. A Skin Integrity Events Report dated 8/10/14, indicated the purplish-black bruise on R98's left medial forearm extending to the side of the thumb and index finger, was mildly painful and was swollen. A review of the facility's Alleged Resident Abuse Investigation Report Form, signed as reviewed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on resident's L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." The investigative report also indicated the administrator had not been notified of the 8/10/14 incident until 8/12/14. During interview on 6/11/15 at 9:34 a.m., the DON stated administrative staff were to submit reports to the State agency, "Other staff can, but I want them to call me." The DON stated he carried a cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. The DON verified the reports that were submitted for R64, R99, and R98, had not all been submitted immediately to the administrator or State agency as required. The DON confirmed he was aware the reports needed to be submitted immediately and stated, "We have a system problem." Review of the facility's undated policy Reporting Abuse to State Agencies and Other Entities/Individuals included: "Should an alleged/suspected violation or substantiated	21980		

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21980	Continued From page 57 incident of mistreatment, neglect, injuries of an unknown source, or abuse be suspected, it must be immediately reported to the administrator and to proper State agencies." SUGGESTED METHOD OF CORRECTION: The administrator and designee could review abuse prohibition policies and procedures and revise as necessary, could educate all staff on the policies and procedures, and monitor all incidents and vulnerable adult reports for compliance with reporting. TIME PERIOD FOR CORRECTION: Seven (7) 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 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 observation, interview and document review, the facility failed to immediately report allegations of maltreatment to the Common Entry Point (CEP) for 5 of 6 residents (R75, R65. R64, R99 and R98) reviewed for allegations of maltreatment.	21995	See POC for F223	6/17/15

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21995	Continued From page 58 Findings include: Although R75 was observed by staff to be yelled at by licensed practical nurse (LPN)-E on 4/24/15 following the supper meal, and LPN-E was subsequently observed to be verbally and physically abusive to R65 that same evening, however, the incidents were not immediately reported to the the State agency, nor were interventions initiated to prevent further abuse. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C dated 4/25/15. The concern included: "EMPLOYEE NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." R75's quarterly minimum data set (MDS) dated 5/12/15 indicated R75 had a brief interview for mental status (BIMS) score of 4 which indicated R75 was severely cognitively impaired. The MDS also indicated R4 could hear with minimal difficulty. During an interview and observations on 6/9/15 at 9:51 a.m., R75 was observed during an interview with family (F)-A. R75 conversed with F-A and the surveyor without hearing difficulty and surveyor did not have to speak loudly for resident to hear.	21995		

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21995	Continued From page 59 R75's care plan directed staff to provide, "Clear, careful, explanations to facilitate her comprehension...repeat/rephrase words as needed to facilitate hearing and comprehension." Information provided by the DON related to the investigation of these incidents, included a typed interview conducted 4/25/15 at 10:00 a.m., by the DON with NA-L. The interview documentation included, "Spoke to [NA-L] concerning incident Friday 4-24-15 p.m. shift. She stated he [LPN-E] was talking to [R75]. [R75] was repeating questions and as [LPN-E] was answering questions he was becoming more upset and yelling, and was probably yelling more than he should. [R65] was standing nearby with her walker but did not say anything. Stated she (NA-L) heard a little later from another CNA (certified nursing assistant) that [R65] was hitting at staff, kicking and attempting to hit them with her walker." LPN-E was observed on 6/9/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility. During an interview on 6/12/15, at 9:30 a.m., the DON was asked to provide all information regarding the immediate reporting of the allegations of abuse between LPN-E and the residents to the administrator or State agency, and any interventions taken to protect R75 or other residents, or any investigation of the abuse incident. The DON confirmed he had not reported the allegation involving R75 to the State agency because he had been more focused on the physical abuse allegation between LPN-E and R65.	21995		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 60 The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up." During an interview on 6/11/15, at 9:34 a.m. in regards to when he was notified of the abuse incident with R65 which occurred on 4/24/15 after evening meal, DON stated staff had placed a phone message on his home phone following the incident but he did not listen to it until the next morning (Saturday 4/25/15) at which time he had come to the facility to follow-up on the incident. The DON stated it was the responsibility of the director of nursing, assistant director of nursing, administrator, or social worker to submit any internal investigative reports to the State designated agency. Following the surveyor's inquiry about the reporting of these alleged incidents of verbal/physical abuse, the DON made a report to the State agency (OHFC) regarding the verbal abuse R75 had sustained on 4/24/15. The report was made on 6/12/15, as part of the immediate plan of correction following the facility having been informed that an immediate jeopardy situation existed. The incident description sent to the State agency included: "During routine MDH [Minnesota Department of Health], it was brought to this writer's attention that on 4/24/15, staff LPN	21995		

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	00429	A. BUILDING: _____ B. WING _____	06/17/2015

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21995	Continued From page 61 [LPN-E] was yelling at resident [R75]. An incident was initially reported on 4/25/15 regarding another demented resident [however, R65 was the main focus of that OHFC report and information in regards to R75 was to support the investigation of R65. During this incident [R75] was also agitated and following the nurse and not responding to re-direction. Nurse [LPN-E] did yell at resident due to his frustration with resident [R75] and her continued agitation. This writer initially combined both of these actions by the nurse [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident ..." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies." The facility had submitted a report to the state agency on 4/16/15, indicating a nurse had witnessed R64 being hit on the forearm by family (F)-B on 4/15/15, around 4:40 p.m. The report indicated, "[R64] was sitting in a reclining chair next to [F-B]...As he was attempting to get up and out of the chair, [F-B] struck him on the forearm..." R64's diagnosis, according to the resident admission record dated 1/21/15, included debility with functional decline and dementia. The quarterly Minimum Data Set (MDS) dated 3/25/15, identified R64 had severe cognitive impairment and required extensive assistance from one person for all activities of daily living	21995		

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21995	Continued From page 62 (ADL)'s. A review of the nursing progress notes dated 4/15/15, included a note from 4:30 p.m., "Nurse observed resident attempting to get out of a recliner chair. [F-B] attempted to tell resident to sit back down. Nurse noted agitation in the [F-B ' s] voice. Nurse then observed resident's [F-B] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well." Although the facility was aware of the family member striking R64 on 4/15/15, the incident was not reported to the State agency until the next day, 4/16/15. Although R99 sustained an injury of unknown origin on 8/19/14, the facility failed to ensure the administrator and state agency were notified immediately. An incident report for R99 had been submitted to the State agency on 8/20/14 for an incident that had occurred the previous day, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident..was lying on the floor...[R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..." R99's record was reviewed. The resident admission record dated 2/26/10, identified diagnoses including: senile dementia and osteoporosis. The quarterly MDS dated 8/12/14, identified R99 as having severe cognitive impairment and requiring limited assistance from	21995		

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21995	Continued From page 63 one person for transferring and walking. A review of the nursing progress notes dated 8/19/14 at 10:30 a.m. included, "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]." A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident had been reported to the administrator on "8/20/14, AM," and had been reported to the State licensing agency on "8/20/14, PM." Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and state agency were notified immediately. The facility had submitted a report to the State agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's disease." R98's record was reviewed and the resident admission record dated 12/5/08 indicated the resident had diagnoses including: dementia and Alzheimer's disease. A quarterly MDS dated 11/18/14, identified R98 had severe cognitive impairment and was totally dependent on staff for all activities of daily living.	21995		

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21995	Continued From page 64 A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. The progress notes also indicated R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved. A Skin Integrity Events Report dated 8/10/14, indicated the purplish-black bruise on R98's left medial forearm extending to the side of the thumb and index finger, was mildly painful and was swollen. A review of the facility's Alleged Resident Abuse Investigation Report Form, signed as reviewed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on resident's L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." The investigative report also indicated the administrator had not been notified of the 8/10/14 incident until 8/12/14. During interview on 6/11/15 at 9:34 a.m., the DON stated administrative staff were to submit reports to the State agency, "Other staff can, but I want them to call me." The DON stated he carried a cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. The DON verified the reports that were submitted for R64, R99, and R98, had not all been submitted immediately to the	21995		

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21995	Continued From page 65 administrator or State agency as required. The DON confirmed he was aware the reports needed to be submitted immediately and stated, "We have a system problem." Review of the facility's undated policy Reporting Abuse to State Agencies and Other Entities/Individuals included: "Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be suspected, it must be immediately reported to the administrator and to proper State agencies." SUGGESTED METHOD OF CORRECTION: The administrator and designee could review abuse prohibition policies and procedures and revise as necessary, could educate all staff on the policies and procedures, and monitor all incidents and vulnerable adult reports for compliance with reporting. TIME PERIOD FOR CORRECTION: Seven (7) days.	21995		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan	22000		7/16/15

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22000	Continued From page 66 promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by:	22000		

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22000	Continued From page 67 Based on interview and document review, the facility failed to implement their abuse prohibition policies and procedures related to immediate reporting of alleged abuse/neglect to the administrator and State agency, protecting resident/s from ongoing abuse, and completing a thorough investigation following an allegation of abuse/neglect for 5 of 26 residents (R75, R65, R64, R99, R98) who were reviewed for abuse prohibition. This had the potential to affect all 68 residents currently residing in the facility. Findings include: On 6/11/15 the facility provided a package of undated Policy and Procedure Standards related to Abuse Prohibition: The undated policy entitled Recognizing Signs and Symptoms of Abuse/Neglect read, "...all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services and immediately to the Administrator." The procedure directed signs and symptoms of abuse should be reported promptly. The procedure lists signs of actual physical abuse, signs of actual physical neglect, and signs/symptoms of psychological abuse/neglect. The undated policy entitled Reporting/Investigating Resident Accidents/Incidents read, "All accidents/incidents involving residents must be report to the director of nursing services and immediately to the administrator." The procedure directed staff that "all accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation will be kept on file by the Director of Nursing."	22000	See POC for F490	

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22000	Continued From page 68 The undated policy entitled Abuse and/or Neglect Investigation read, "All reports of resident abuse or neglect shall be promptly and thoroughly investigated." The procedure directed the administrator would appoint a designee to investigate the incident and that person would report daily to the administrator the progress of the investigation. The procedure also directed that employees that had been accused of resident abuse would be reassigned to nonresident care duties or put on leave until the results of the investigation had been reviewed by the administrator. The undated policy entitled Protection of Residents During Abuse Investigation read, "Our facility will protect residents from harm during investigations of abuse allegations." The procedure directed that during abuse investigations, employees accused of resident abuse would be reassigned to nonresident care duties or put on leave; and that if employees were reassigned to non-resident care duties, such assignments would not be in any part of the building which the resident frequents. The procedure read, "Should the results indicate that abuse occurred, appropriate authorities will be notified." The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals read, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate state agencies. The procedure directed "A. Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of unknown source, or abuse to be suspected. It	22000		

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22000	Continued From page 69 must be immediately reported to the administrator and to proper state agencies 1. Olmsted County Social Services 2. Minnesota Department of Health/OHFC. B. Verbal/written notices to the above agencies will be made immediately following the incident if possible...C. The administrator, or his/her designee, will submit internal investigation report to OHFC website 5 working days of the occurrence of the incident." R75 was observed to have been verbally abused by licensed practical nurse (LPN)-E on 4/24/15. The incident was not immediately reported to the administrator or designated State agency, nor was R75 protected following this incident, or a thorough investigation completed. A facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE had been completed by nursing assistant (NA)-C 4/25/15. The concern included: "EMPLOYEE NAME: [LPN-E's first name]... "COMPLAINT OR CONCERN: Upon returning from bringing residents from supper co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at resident [R75]. We tried to take her [R75] to her room, she [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation..." During an interview on 6/12/15, at 9:30 a.m., the DON was asked for all information regarding the immediate reporting of the verbal abuse to the administrator, OHFC, and interventions taken to protect R75 from further abuse as well as other residents and a thorough investigation of the abuse incident. None was provided and the DON stated he did not report this incident with R75	22000		

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22000	Continued From page 70	22000		

separately but was with the report sent to OHFC in regards to the physical abuse to R65. Then the DON stated he was more focused on the physical abuse incident with R65 at the time. Again the physical abuse of R65 occurred shortly after the verbal abuse of R75 by LPN-E on 4/24/25 after the evening meal as LPN-E was passing medications.

Progress note was not entered into the medical record until two days later on 4/27/15 and read, "Several staff members were in the south conference room when a staff nurse heard raising voice towards resident." The progress note also indicated notification of DON, ADON, and Social services, however did not indicate when the notifications were given.

The DON reported the verbal abuse of R75 to the OHFC and to the Common Entry Point (CEP) on 6/12/15 after the survey team had informed the facility an immediate jeopardy (IJ) related to abuse existed.

R65 had been verbally and physically abused by LPN-E on 4/24/15 however, this was not immediately reported to the administrator or OHFC.

The facility COMPLAINT/CONCERN FORM REGARDING an EMPLOYEE completed by NA-C on 4/25/15 also included: ..."Around 7:40 [p.m.] I went to go ask nurse [LPN-J] a question and noticed resident [R65] standing by the med cart arguing with [LPN-E]. She [R65] attempted to grab the water pitcher and he [LPN-E] grabbed her from behind like a choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident [R65] down afterwards but she was too worked up."

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22000	Continued From page 71 A typed witness account of the physical abuse that occurred on 4/24/15 as part of the investigation for R65 completed on 4/25/15 by LPN-J read, "On Friday 4/24/15 I was here for staff potluck, ...He [LPN-E] was finishing up a medication admin at cart when [R65] came up grabbed the water pitcher and tried to hit him with it. He grabbed it out of her hands and set it back on cart. She then raised up her walker, as if to hit him with it, not sure if he knocked it down or she dropped it but it fell on the floor. [LPN-E] picked it up and [R65] went as if to hit him with a closed fist at which time I got between them and asked [R65] to leave the area which she did. [LPN-E] left shortly after that." The facility provided the incident report, submission report to the State agency (the Office of Health Facility Complaints-OHFC), and all investigative notes. According to the OHFC complaint, the allegation of verbal/physical abuse to R65 had not been not immediately reported but had been reported the following day 4/25/15. R64 had an allegation of physical abuse by a family (F) member which occurred on 4/15/15 however, it was not reported to the State agency until the next day. The facility submitted a report to the State agency on 4/16/15 indicating a nurse witnessed R64 being hit on the forearm by [F-A] on 4/15/15, around 4:40 p.m. "[R64] was sitting in a reclining chair next to [F-A]... As he was attempting to get up and out of the chair, [F-A] struck him on the forearm..." A review of the nursing progress notes, dated 4/15/15, at 4:30 p.m., included, "Nurse observed resident attempting to get out of a recliner chair.	22000		

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22000	Continued From page 72 [F-A] attempted to tell resident to sit back down. Nurse noted agitation in the [F-A]'s voice. Nurse then observed resident's [F-A] pull the chair control out of resident's hand and hit him on the right forearm...Nurse immediately called social services to evaluate the situation. Administrator notified as well." R99 had received an injury of unknown origin causing a fracture the facility did not immediately report the incident to the state agency. An incident report for R99, submitted to the State agency on 8/20/14 indicated, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another resident ...was lying on the floor... [R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder..." A review of the nursing progress notes dated 8/19/14 at 10:30 a.m., included: "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left arm...She guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]." A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident from 8/19/14 had first been reported to the administrator on "8/20/14, AM," and had subsequently been reported to the State Licensing Agency on "8/20/14, PM." R98 was found to have a large bruise on her left forearm which was found to be a fracture	22000		

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22000	Continued From page 73	22000		

however, this was not immediately reported to the State agency or the administrator as directed by the facility abuse policy and procedure.

The facility submitted a report to the state agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's Disease."

A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. Also included, R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved.

A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on residents L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM [range of motion]. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis..." Also included, the administrator was not notified until 8/12/14.

Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and State agency were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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22000	Continued From page 74 notified immediately. During interview on 6/11/15, at 9:34 a.m. the director of nursing (DON) indicated the administrative staff were to submit reports to the State agency and stated, "Other staff can, but I want them to call me." DON stated he carried a cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem." SUGGESTED CORRECTION: The administrator and designee could review abuse prohibition policies and procedures and revise as necessary, could educate all staff on the policies and procedures, and monitor all incidents and vulnerable adult reports for compliance with reporting. TIME PERIOD FOR CORRECTION: Seven (7) days.	22000		