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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LHXK
Facility ID: 00002

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245119**

2. STATE VENDOR OR MEDICAID NO. (L2) **231247600**

3. NAME AND ADDRESS OF FACILITY
(L3) **AITKIN HEALTH SERVICES**
(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2006**

6. DATE OF SURVEY **10/17/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **44** (L18)

13. Total Certified Beds **44** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE: Teresa Ament, Unit Supervisor — Date: 10/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL: Mark Meath, Enforcement Specialist — Date: 12/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/09/1967** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/18/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245119

December 12, 2016

Ms. Michelle Hanneken, Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, Minnesota 56431

Dear Ms.. Hanneken:

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 September 27, 2016 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.
You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

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

Sincerely,

Mark Meath

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

An equal opportunity employer.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 21, 2016

Ms. Michelle Hanneken, Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, Minnesota 56431

RE: Project Number S5119024

Dear Ms. Hanneken:

On September 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 25, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 17, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 5, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 27, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 25, 2016, effective September 27, 2016 and therefore remedies outlined in our letter to you dated September 12, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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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
245119 Y1	A. Building B. Wing Y2	10/17/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 09/27/2016	ID Prefix F0167 Reg. # 483.10(g)(1) LSC	Correction Completed 09/27/2016	ID Prefix F0246 Reg. # 483.15(e)(1) LSC	Correction Completed 09/27/2016
ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 09/27/2016	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 09/27/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 09/27/2016
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 09/27/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 09/27/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 09/27/2016
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 09/27/2016	ID Prefix F0325 Reg. # 483.25(i) LSC	Correction Completed 09/27/2016	ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 09/27/2016
ID Prefix F0368 Reg. # 483.35(f) LSC	Correction Completed 09/27/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 09/27/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 09/27/2016

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) TA/mm	DATE 10/21/2016	SIGNATURE OF SURVEYOR 29433	DATE 10/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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
245119 Y1	A. Building B. Wing Y2	10/17/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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 F0465 Reg. # 483.70(h) LSC	Correction Completed 09/27/2016				

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TA/mm	10/21/2016	29433	10/17/2016

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?
8/25/2016	[ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245119	A. Building 01 - MAIN BUILDING 01 B. Wing	10/5/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 09/27/2016	ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 09/27/2016	ID Prefix Reg. # NFPA 101 LSC K0022	Correction Completed 09/27/2016
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 09/27/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 09/27/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 09/27/2016
ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 09/27/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	10/21/2016	27200	10/05/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245119	A. Building 02 - AITKIN HEALTH SERVICES B. Wing	10/5/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 09/27/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/27/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 09/27/2016
ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 09/27/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	10/21/2016	27200	10/05/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LHXK
Facility ID: 00002

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245119**

2. STATE VENDOR OR MEDICAID NO. (L2) **231247600**

3. NAME AND ADDRESS OF FACILITY
(L3) **AITKIN HEALTH SERVICES**
(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2006**

6. DATE OF SURVEY **08/25/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **02 SNF/NF/Dual** **03 SNF/NF/Distinct** **04 SNF** **05 HHA** **06 PRTF** **07 X-Ray** **08 OPT/SP** **09 ESRD** **10 NF** **11 ICF/IID** **12 RHC** **13 PTIP** **14 CORF** **15 ASC** **16 HOSPICE** **22 CLIA**

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 09/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/17/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/09/1967** (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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 12, 2016

Ms. Michelle Hanneken, Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, Minnesota 56431

RE: Project Number S5119024

Dear Ms. Hanneken:

On August 25, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 4, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 4, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 25, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156		9/27/16

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

Electronically Signed — 09/19/2016

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

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156		

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Medicare denial notices and appeal rights were provided at the end of skilled services for 2 of 3 residents (R33, R49) reviewed for liability notices. Findings include: R33's undated Face Sheet indicated R33 was admitted on 4/27/16, and received Medicare A insurance payment for skilled services received. R33was discharged to an independent living facility on 5/17/16. R49's undated Face Sheet indicated R49 was admitted to the facility on 2/25/16, and received Medicare Part A insurance payment for skilled services received. R49was discharged home on 3/19/16.	F 156	Res # 33 was discharged 5/17/16 Res # 49 was discharged 3/19/16 All residents with a Medicare A benefit with the potential to discharge can be affected by a deficient practice. MDS coordinator was re-educated on the process of issuing Medicare denials and the ABN procedure was reviewed 8-30-16. DON/designee will conduct random audits of Medicare A denials, weekly for 4 weeks, then biweekly for 2 weeks and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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F 156	Continued From page 3 On 8/25/16, at 1:59 p.m. registered nurse (RN)-F verified R33 received skilled services from 4/27/16, through 5/16/16, and was discharged on 5/17/16. RN-F verified R49 received skilled services from 2/25/16, through 3/18/16, and was discharged from the facility on 3/19/16. RN-F verified the facility was unable to locate evidence that liability notices and appeal rights notices were provided to R33 and R49. The facility undated SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice) Forms and Expedited Appeal Process, directed the Notice of Medicare Provider Non-coverage was to be given to the resident at least two days prior to the last day of Medicare Part A covered services when ending Part A services or discharging from Medicare whether staying or leaving the facility.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current, complete State survey results were	F 167	The most current complete State survey results were posted on 8-24-16	9/27/16

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F 167	Continued From page 4 posted in an area readily accessible to residents, families and visitors. This had the potential to affect all 38 residents currently residing in the facility. Findings include: On 8/22/16, at 2:30 p.m. during the initial facility tour, a white three ring binder was observed in a clear holder on the wall by the administrative offices and the Bears Den dining room. The label on the binder indicated the binder contained the Minnesota Department of Health (MDH) State Survey. The binder included the survey results dated 7/30/15, however; lacked the results of the life safety code deficiencies what had been cited during the 7/30/15, survey. On 8/24/16, at 2:30 p.m. the director of nurses reviewed the posted survey results and confirmed the life safety code survey results were not posted for the residents, visitors, or staff. The Posting of Survey Results policy dated 6/15/15, directed the facility staff members to post the survey of the most recent survey results in an area in which the individual did not have to ask for the results from a facility employee.	F 167	All residents in building have potential to be affected by deficient practice of not having life safety code survey results posted. Staff were re- educated on proper posting of survey results. Administrator/designee will conduct audits twice a month for one month, then once monthly for 2 months to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendation.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		9/27/16

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F 246	Continued From page 5	F 246		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate medical equipment for 1 of 1 bariatric resident (R31) who required an appropriate fitted wheelchair. Findings include: R31's Disease Diagnosis and Allergies report printed 8/25/16, indicated R31's diagnoses included morbid obesity, chronic pain, depression and diabetes. R31's quarterly Minimum Data Set (MDS) dated 5/24/16, indicated R31's cognition was intact; was independent with transfers, toileting and locomotion on/off the unit; and R31 utilized a wheelchair. R31's care plan dated 8/14/14, indicated R31 was independent with wheelchair mobility, utilized a walker and the assist of one with ambulation in R31's room. On 8/24/16, at 11:53 a.m. R31 was seated in a wheelchair in the dining room area. R31 was positioned in his wheelchair with each side of R31's body tightly squeezed up against the sides of the wheelchair and portions of R31's upper body overflowing over the arm rests on both sides of the wheelchair. R31's bottom covered the seat of the wheelchair with his abdomen extending beyond the seat edge of the front of the wheelchair. On 8/25/16, at 10:03 a.m. R31 was seated in a wheelchair outside in the garden area. R31 was able to propel himself around on the sidewalk in front of the facility. R31's body was positioned in the wheelchair the same as observed on 8/24/16, at 11:53 a.m. During interview with R31; R31		R#31 was referred to OT on 9/12/16 to evaluate his w/c needs All morbidly obese residents who utilize wheelchairs have the potential to be affected by a deficient practice in this area. All morbidly obese residents were reassessed to ensure that their individual needs and preferences are met r/t wheelchair seating. Bariatric Care policy and procedure was reviewed and revised as necessary. DON or designee will audit w/c seating of morbidly obese residents to ensure preferences are met. Audits will be completed 2 times per week for 4 weeks, then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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F 246	Continued From page 6 continued to adjust himself in the wheelchair, shifting his weight from side to side. R31's physician progress note dated 6/22/16, indicated R31 was continuing to gain weight despite frequent attempts at dietary modification and there were concerns regarding R31's weight and lifts ect. moving forward. R31's progress note dated 8/24/16, indicated R31's current weight was 445.8 pounds and the facility had concerns regarding being able to care for R31 at this current weight, due to difficulty if R31 required a larger wheelchair. The facility would be investigating other placement options for R31 due to R31's bariatric needs. R31's medical record lacked an evaluation/screening from rehabilitation services regarding appropriate wheelchair positioning. On 8/25/16, at 9:11 a.m. occupational therapist (OT)-A stated the rehabilitation services department gets involved with screening residents to assure they have an appropriately sized wheelchair. OT-A confirmed the occupational department had not seen R31 for wheelchair positioning. OT-A stated the facility was able to obtain bariatric equipment when needed. OT-A stated R31 appeared to be comfortable in his wheelchair and was able to get around okay. OT-A stated if R31 reached 450 pounds they would look to obtain him a different wheelchair. OT-A stated in her professional opinion, R31 should have been evaluated for a new wheelchair. On 8/25/16, at 9:25 a.m. the director of nursing (DON) confirmed R31's current wheelchair was rated up to 450 pounds. The DON confirmed R31's weight had the potential to fluctuate, however, they had not seen this happen. DON verified R31 has had a substantial weight gain in a short period of time. Within the last month	F 246		

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F 246	Continued From page 7 R31's weight had been close to the 450 pound weight limit for R31's wheelchair. The DON stated that any wheelchair they would get would be wider and would no longer be able to fit through the doors into the resident's bathroom. The DON confirmed the facility had access to immediately obtaining a bariatric wheelchair upon their request. On 8/25/16, at 10:03 a.m. R31 stated he had had his current wheelchair for about two years. R31 stated he was able to walk, but could not stand for long periods of time. R31 stated he had a rental wheelchair a few months ago when his wheelchair was getting repaired. R31 stated the rental wheelchair was not any wider. R31 confirmed the facility had not measured the wheelchair or inquired if R31 was comfortable in his wheelchair. R31 stated he had a cushion in the seat of his wheelchair, but the cushion gets squished down. R31 thought if he had a wider seat in his wheelchair then it would be better. No policy related to accommodating the needs of the bariatric resident was provided.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 1 of 3 residents	F 248	Res # 13 was reassessed for her activity needs/preference and care plan interventions were developed based upon	9/27/16

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F 248 Continued From page 8

(R13) in the sample who were reviewed for activities.

Findings include:

R13's quarterly minimum data set (MDS) dated 7/26/16, indicated R13 had diagnosis including history of stroke, hemiplegia (weakness on one side of the body) and dementia. The MDS indicated R13 displayed severe cognitive impairments, and required total assistance with all activities of daily living.

R13's Resident Activity Assessment dated 5/4/16, indicated R13 napped regularly during the day, and spent the majority of her time watching television. R13 was to participate in small groups, music events, listen to the radio, spiritual/religious activities, watch television, moving, walking/wheeling outdoors, volunteer visits, family first and bingo.

R13's care plan dated 7/29/15, indicated R13 required assistance to participate in activities. The goal revealed R13 was to participate in one activity daily. The interventions indicated R13 enjoyed music, church and book club. R13 was to have an activity calendar and the staff were to assist her to and from activities.

The activity calendar on 8/22/16, indicated at 3:30 p.m. the activity staff members were to provide one to one support in the Garden Terrace neighborhood, at 5:15 p.m. a basketball activity would occur on Garden Terrace and at 6:54 p.m. a dice game was to be conducted.

On the evening of 8/22/16, (4:00 p.m. to 8:00 p.m.) R13 was observed to eat the afternoon

F 248

the assessment.

All residents who require 1:1 activities have the potential to be impacted by a deficient practice as it relates to activities.

Activities staff or designee will reassess residents that are unable or unwilling to participate in group activities that require 1:1 activities. The care plan will be updated based upon the assessment.

Activity policy and procedure was reviewed and revised as necessary.

Activity staff were re-educated on who receives 1:1 visits as per the policy.

Activity director or designee will conduct audits of residents that require 1:1 visits to ensure visits are provided. 3 audits will be conducted weekly for 4 weeks, then 2 audits weekly for 1 month, then monthly thereafter to ensure ongoing compliance.

Audit results will be brought to the QAPI committee for review and further recommendation.

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F 248	Continued From page 9 meal at 4:30 p.m. in the Garden Terrace dining room. Following the meal R13 was assisted to her room. R13 was not observed to participate in evening activities on 8/22/16. On 8/22/16, at 7:20 p.m. R13's family member (FM)-A stated she did not feel R13 was participating in activities. FM-A stated R13 was frequently awake in her room, activities were being offered in other areas of the facility, but R13 was not assisted to the activities. The Activity Calendar for 8/23/16, indicated at 10:00 a.m. one to one visits would be conducted in the Garden Terrace neighborhood, at 1:00 p.m. there would be a "knock 'em down" activity in Garden Terrace, 2:00 p.m. Bingo, 3:00 p.m. Bowling, 3:30 p.m. one to one visits in the Garden Terrace neighborhood and 6:00 p.m. a "TS social" would be conducted. On the 8/23/16, from 8:00 a.m. to 4:30 p.m. R13 was not observed to participate in activities. The Activity Calendar for 8/24/16, indicated at 10:00 a.m. one to one visits would be conducted in the Garden Terrace neighborhood, at 1:30 p.m. Catholic Mass would be completed, at 2:00 p.m. manicures were to be provided, and at 3:30 p.m. one to one visits in the Garden Terrace dining room. On 8/24/16, at 8:37 a.m. R13 was observed to be wheeled into the activity room where church services were being conducted. R13 was observed to sit quietly with her eyes closed during the service. Following the church service, R13 was wheeled into the dayroom/television lounge in the Garden Terrace neighborhood. R13	F 248		

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Continued From page 10
continued to sit quietly with her eyes closed.

Review of the individual activity calendars/ activity documentation revealed the following information:

- June 2016, R13 had participated in activities 9 of 30 days. Five of the nine days were identified as one to one visits in the Garden Terrace Neighborhood at either 10:00 a.m. or 3:30 p.m.

- July 2016, R13 had participated in activities 20 of the 31 days. 14 of the 20 days were identified as one to one visits in the Garden Terrace neighborhood at either 10:00 a.m. or 3:30 p.m.

- August 1-24, 2016, R13 had participated in 16 of 24 days. Twelve of the 16 days were identified as one to one visits in the Garden Terrace Neighborhood at either 10:00 a.m. or 3:30 p.m.

Review of R13's 1:1 Charting documents indicated on 8/10/16, R13 received a single fifteen minute one to one visit in the past three months.

On 8/25/16, at 8:30 a.m. activity director (AD) stated the one to one visits at 10:00 a.m. and 3:30 p.m. completed by the activity staff in the Garden Terrace neighborhood consisted of the activity staff members assisting the residents to the dining room. The activity staff either pushed the resident to the dining room, assisted the resident with meal choices, or brought them a meal tray. She verified the one to one visits assisted with the meal time cares, but did not include a fifteen minute interval in which the staff and R13 were visiting one on one. Upon reviewing R13's care plan, the AD verified R13 had not been offered daily activities as directed

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 11 by the care plan. The Activity policy dated 7/2006, directed the activity department staff to provide an ongoing activity program that stimulated the resident's physical, emotion, mental social, spiritual and past life experiences desires and needs. The Activities were to be provided in a group or on an individual basis.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary condition for residents' personal room for 1 of 1 resident (R22) in the sample with a pervasive urine odor. Findings include: R22's quarterly MDS dated 7/26/16, indicated R22 had severe cognitive impairments, dementia and urinary incontinence. The assessment indicated R22 required extensive assistance with activities of daily living, and was frequently incontinent of bladder. R22 was unable to be interviewed due to her severe cognitive impairment. R22's General Nurse's Observation note dated 2/24/16, indicated R22 had a history of incontinence due to dementia and required a	F 253	Res # 22’s room was deep cleaned. Res #22’s toileting plan was reassessed and care plan updated based upon the assessment. All cognitively impaired, incontinent residents have the potential to be impacted by a deficient practice as it relates to housekeeping. Staff caring for Resident # 22 were educated on the new toileting program. All staff educated regarding process for education and management of unpleasant odors. Housekeeping and cleaning policy and procedure was reviewed and revised as	9/27/16

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F 253	Continued From page 12 scheduled toileting plan. The plan directed the staff to assist R22 to the toilet upon arising. The staff were to offer R22 to use the toilet at 10:00 a.m., 1:00 p.m., 4:00 p.m. and 8:00 p.m. and at bedtime to assist with continence. R22's care plan dated 11/4/15, identified R22 as being frequently incontinent of bowel and bladder. It directed the staff to take R22 to the bathroom upon arising, prompt to toilet prior to meals and to assist R22 to find the bathroom. On 8/24/16, at 7:00 a.m. R22 was observed to be resting in her room. R22's room was observed to have a very strong pervasive urine odor. On 8/24/16, at 8:40 a.m. the urine odor from R22's room was noted to be present in the Garden Terrace hallway approximately 10 feet from R22's room. On 8/24/16, at 8:40 a.m. nursing assistant (NA)-A was observed to assist R22 with morning cares. The urine odor was very strong in the room during cares. On 8/24/16, at 9:45 a.m. housekeeper (HSKP)-A confirmed R22's room does have a strong urine odor in it at times. HSKP-A stated he attempts to wash the floor and the bed if needed to reduce the odor. HSKP-A stated the odor is sometimes stronger than others. On 8/24/16, at 11:30 a.m. the pervasive urine odor continued to be present in the Garden Terrace hallway. On 8/24/16, at 12:00 p.m. NA-A stated R22 always had a strong urine odor. On 8/25/16, at 8:40 a.m. a strong pervasive urine odor was noted in the Garden Terrace hallway by R22's room. On 8/25/16, at 8:45 a.m. HSKP-B stated she had noticed the urine odor by R22's room. HSKP-B	F 253	needed. Environmental director or designee will conduct weekly audits on all rooms for unpleasant room odors. Audit results will be brought to the QAPI committee for review and further recommendation.	

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F 253	Continued From page 13 stated R22 was incontinent of bladder. HSKP-B stated if the nursing staff inform her that R22 had soiled the bed, she would wash the bed. On 8/25/16, at 8:50 a.m. registered nurse (RN) consultant stood by R22's room. RN consultant stated did not notice the strong urine odor in the Garden Terrace hallway, however; upon opening R22's room door, she verified the room had a strong pervasive urine odor. On 8/25/16, at 9:00 a.m. the environmental service director (ESD) stated that the housekeeping staff members wash the resident beds if they notice there is a pervasive urine odor, or if the nursing staff members let them know that the mattress has been soiled. The ESD stated if the odor is ongoing, they will spray the room with air freshener or place an air freshener in the room. At 9:03 a.m. the ESD verified R22's room had a strong pervasive urine odor that did go into the hallway. The ESD stated he would direct the housekeeping staff to clean the room and place a deodorizer in an attempt to decrease the smell. The ESD stated the nursing staff should have informed him of the odor so the housekeeping staff could attempt to reduce the odor. The Housekeeping and Cleaning Policy dated 10/3/15, directed the facility to provide a safe, clean, and appropriate development for residents and staff. It directed the housekeeping staff to clean all resident rooms and bathrooms daily. The policy lacked direction to staff as to what to do if strong pervasive odors were noted within the facility.	F 253		
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	F 280		9/27/16

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F 280	Continued From page 14 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: Based on observation, interview and document review the facility failed to inform residents to the full extent of their care planning, including when therapy appointments and the overall goals of therapy, and plans for length of stay and discharge, for 1 of 3 residents (R56) reviewed for participation in care planning. Findings include: R56's admission Minimum Data Set (MDS) dated 7/1/16, indicated R56 was cognitively intact, understood others and was understood, had no behaviors, delirium or depression symptoms. The MDS also indicated R56 was totally dependant upon staff for bed mobility, transfers, and toileting.	F 280	R # 56 care plan was updated with direction for discharge planning. R#56 will be notified every day of when her therapy time is. All short stay residents have the potential to be affected and their care plans will be reviewed to ensure there is direction for discharge planning. Discharge planning policy and procedure was reviewed and revised to include: when therapy appointments are and how residents will be made aware of the appointment time, the overall goal of therapy, the plan for length of stay and discharge and how to inform residents of	

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F 280	Continued From page 15 A physician order dated 6/23/16, indicated discharge potential was short term. A physician note dated 6/27/16, indicated R56 was admitted to the facility for ongoing rehabilitation needs after suffering left humeral and left knee fractures from a fall at home and undergoing subsequent surgeries. R56's care plan printed 8/25/16, lacked direction for discharge planning. On 8/23/16, at 8:21 a.m. R56 stated she was not included in decisions about her medicine, therapy or other treatments. R56 stated she doesn't know in advance what time her therapies are scheduled. On 8/24/16, at 8:50 a.m. physical therapist (PT)-A stated she makes up the schedule the day before and leaves a copy at the nurses stations. PT-A said the nurses know the schedule, but if residents want to know they need to ask. On 8/24/16, at 8:53 a.m. R56 was observed sitting on the edge of her bed. R56 stated she did not know what time her physical therapy and occupational therapy appointments were for that day. On 8/25/16, at 8:06 a.m. PT-A confirmed she develops the therapy schedule in the afternoon for the next working day and leaves a schedule at the nurses station. PT-A says she doesn't typically tell a resident when their next appointment is scheduled. Residents need to ask the nurses and they will tell them their appointment times. The PT-A stated they discuss goals during treatment. PT-A stated they talk	F 280	their discharge plans. Staff reeducated regarding discharge planning process. DON or designee will do random audits to ensure residents are being informed of their full extent of discharge planning r/t notification of therapy times, goals of therapy, plans for length of stay and discharge. 3 random audits will be completed weekly for 2 weeks, then 2 audits for 2 weeks, then weekly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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F 280	Continued From page 16	F 280		

Continued From page 16

about what needs to be done at home, and what they're working on.

On 8/25/16, at 8:27 a.m. licensed practical nursing (LPN)-A stated a therapy schedule is put out the night before by therapy. LPN-A stated nursing assistants check the schedule so they know what time to have a resident ready for therapy or if occupational therapy will be getting someone ready as part of their therapy session. LPN-A stated nursing assistants will tell residents their therapy times when they're helping them with their morning activities of daily living.

In an interview on 8/25/16, at 11:17 a.m. R56 stated the nursing assistants have never told her when her therapy times are for the day. When she has asked, they have said to her, "We don't know anymore than you do." R56 said she stopped asking. R56 stated there had been a care conference in the first part of July and the dietician and someone from Brainerd was there. R56 stated there was no therapy and no one from nursing, unless the person from Brainerd was nursing. R56 said she told them she wanted to go back to her apartment, but no one could give her an idea of when that would happen. R56 stated therapy sets her goals, but they don't tell her the goals. R56 stated the first time she had heard about goals was the previous week with occupational therapy. R56 stated she worked with the occupational therapist to go from her bed, to her wheelchair, to the toilet with no problems. At that time therapy said they would have to set a new goal now. R56 stated she didn't even know that toileting was a goal.

On 8/25/16, at 2:07 p.m. the director of nursing (DON) said typically the social worker would be

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F 280	Continued From page 17 the person working on discharge planning, but the facility currently doesn't have a social worker; the accountant (A)-I and the activities director (Act)-I have been helping with these tasks. At 2:14 p.m. the director of nursing (DON) confirmed therapy was not at R56's initial care conference, but had given nursing information to share. The nursing representative was a registered nurse consultant for the facility. On 8/25/16, at 2:39 p.m. RN-F stated residents and families are invited to care conferences, the first of which is scheduled a week after admission. RN-F stated that is when the facility establishes the care plan. RN-F stated nurses visit with residents about what is needed for their care plan and residents are constantly working with therapy. RN-F stated she touches base with therapy and residents often. When RN-F was asked if she has talked to R56 about discharge, RN-F stated she hasn't as R56 isn't ready for discharge yet, she is not at that point. RN-F stated therapy "posts" a schedule at the desk for staff to know when resident therapy appointments are the next day, and staff are to look at that and inform residents. On 8/25/16, at 2:41 p.m. the administrator stated the nursing assistants must not be looking at the list. The facility was unable to provide a policy on participation in care planning.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		9/27/16

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F 282	Continued From page 18 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was followed for repositioning for 5 of 6 residents (R48, R44, R3, R22, R13) identified at risk for pressure ulcers, toilet use for 4 of 5 residents (R44, R3, R22, R13) identified with incontinence, and oral hygiene for 1 of 3 residents (R22) reviewed for activities of daily living. Findings include: R48 was not repositioned according to the care plan. R48's care plan dated 4/12/16, directed nursing staff to encourage and assist R48 to turn and reposition every 2 hours and as needed for comfort. The care plan was inconsistent, as it also directed staff to turn and reposition R48 every 3 hours in bed. The care plan indicated R48 was unable to communicate his needs, and had difficulty in daily decision-making. R48's Face Sheet printed 8/25/16, indicated R48's diagnoses included dementia with behavioral disturbance, congestive heart failure, edema (fluid in the tissues of the extremities), and hypothyroidism (thyroid imbalance). R48's quarterly Minimum Data Set (MDS) assessment dated 7/6/16, indicated R48 had a severe cognitive deficit and decision-making skills, sometimes understood others, and	F 282	R# 48 will be repositioned per the plan of care. R#48 repositioning needs were reassessed and staff caring for Res # 48 were re-educated on the plan of care. R#44 will be repositioned and toileted per the plan of care. R#44 toileting needs were re-assessed and interventions were developed based upon the results of the assessment. Staff caring for R#44 were re-educated on the plan of care. R#3 will be repositioned and toileted per the plan of care. R#3 repositioning and toileting needs were re-assessed and interventions were developed based upon the results of the assessment. Staff caring for R#3 were re-educated on the plan of care. R#22 will be toileted, repositioned and will receive oral cares as per the plan of care. R#22 toileting needs were reassessed and interventions were developed based upon the results of the assessment. R#22 care plan was reviewed and revised r/t oral cares. Staff caring for R#22 were re-educated on the plan of care. R#13 will receive incontinence cares and repositioning as per the plan of care. R#13 toileting needs were reassessed and interventions were developed based	

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F 282	Continued From page 19 sometimes was understood by others. R48's MDS indicated R48 had physical behavior and rejected care one to three days during the assessment period, required extensive staff assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. R48's MDS further indicated R48 was at risk for pressure ulcers and was always incontinent of bladder and bowel. The NAR (nursing assistant-registered) Assignment Sheet dated 8/24/16, lacked direction for R48's repositioning needs. The NAR Assignment Sheet directed staff to use two staff to transfer R48 and for bed mobility. R48's Braden Scale for Predicting Pressure Sore Risk dated 6/29/16 indicated R48 was at moderate risk for pressure ulcers with a score of 14 out of 23. The Braden Scale indicated R48 was completely immobile, friction and Shearing was a problem, and probably had inadequate nutrition. The Braden Scale indicated R48 was rarely moist which contradicted the MDS, which indicated R48 was always incontinent of bladder and bowel. R48's Progress Notes dated 7/11/16, indicated R48 was able to sit or lie for 3 hours before repositioning, and was at risk for moisture-related skin breakdown due to incontinence. The progress notes indicated R48 had no skin breakdown at that time. On 8/24/16, during continuous observations from 9:10 a.m. until 12:43 p.m. R48 had not been repositioned. At 12:43 p.m. R48 was taken to his room by two staff, nursing assistant (NA)-C and NA-J, and R48 was asked if he would like to lay	F 282	upon the results of the assessment. Staff caring for R#13 were re-educated on the plan of care. All residents have plans of care that must be followed by staff caring for the residents. Care plans remain readily available for all staff providing direct care/services to residents in a manner compliant with HIPAA requirements. Staff were re-educated on the availability of the plan of care and the need to follow residents plan of care. DON/designee will conduct random observational audits to ensure plans of care related to repositioning, toileting, and oral cares are being followed. 3 audits per week for 2 weeks, then 2 audits per week for 2 weeks, then weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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F 282	Continued From page 20 down for a little bit. R48 was assisted by two staff and a stand assist lift to the bed. R48 was checked for incontinence and was cleaned of a small incontinence of bowel. R48 had reddish purple areas on the ischial tuberosities (bones of the buttocks that receive pressure while sitting) that were blanchable (had blood flow). On 8/24/16, at 12:37 p.m. NA-C stated if the assignment sheet did not direct a repositioning time, they would reposition the resident every 2 hours. NA-C verified R48 did not have a repositioning time on the assignment sheet. NA-C stated she did not know R48 well, but thought he should be repositioned every 2 hours. On 8/25/16, at 2:59 p.m. the director of nursing (DON) stated they typically determine the repositioning time based on the tissue tolerance, though there are other factors to consider, such as a history of pressure ulcers and the Braden score. DON stated the NAs would know how frequently to reposition a resident by their assignment sheet and then verified the NAR assignment sheet lacked a repositioning timeframe for R48. The DON stated R48's tissue tolerance assessment indicated he was able to sit or lay 2-3 hours, but residents who are immobile or have impaired mobility should be repositioned every 2 hours. DON verified she would expect R48 to be repositioned every 2 hours.	F 282		

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R44 was not repositioned or offered toileting according to the care plan.

R44's care plan dated 5/12/16, directed staff to turn and reposition R44 every two hours and to prompt resident to use the toilet each day at 9:00 a.m., 12:30 p.m., 5:00 p.m., and 9:00 p.m. R44's NAR Assignment Sheet (an extension of R44's care plan) directed the nursing assistant staff to reposition R44 every two hours from side to side and with the assistance of one staff member prompt R44 to utilize the toilet at the times identified above.

R44 had a recently healed stage 3 pressure ulcer (a pressure ulcer with full thickness loss of tissue. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed) on her coccyx and was not repositioned from side to side every two hours on the afternoon of 8/24/16, as directed by R44's care plan. In addition, R44 was not toileted at 12:30 p.m. on 8/24/16, as directed by R44's toileting schedule and care plan.

On 8/24/16, during continuous observation from 12:07 p.m. until 3:08 p.m. (3 hours and 1 minute) R44 remained lying in bed positioned directly on R44's back. At 3:08 p.m.
NA-H and NA-I entered R44's room, changed R44's incontinent brief and positioned R44 on to her right side.

On 8/24/16, at 3:17 p.m. licensed practical nurse

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(LPN)-A confirmed R44's care plan directed staff to reposition R44 every two hours from side to side.

On 8/25/16, at 8:22 a.m. LPN-A verified according to R44's care plan R44 required assistance with toileting and that R44 should be prompted to utilize the toilet at 9:00 a.m., 12:30 p.m., 5:00 p.m. and 9:00 p.m.

On 8/25/16, at 9:39 a.m. the DON confirmed R44 had been admitted with a pressure ulcer which had recently healed. DON confirmed R44's should be turned from side to side every two hours according to the interventions which had been implemented to prevent R44 from obtaining another pressure ulcer. DON confirmed three hours exceeded R44's turning and repositioning interventions and this was not acceptable. In addition, DON stated it was her expectation that staff offer R44 assistance with toileting at the times indicated on R44's care plan.

The facility Care Plan policy dated 9/1/15, indicated each resident's care plan would include goals to meet the identified resident needs, problems and concerns. In addition, approaches would be identified to meet the goals; including the care and services that must be provided to meet these goals.

R3 was not repositioned or provided with incontinence care according to the care plan.

R3's care plan dated 12/9/14, indicated R3 was to be repositioned by staff every two hours and assisted with incontinence cares every three hours.

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On 8/24/16, R3 was continuously observed from 7:00 a.m. until 11:40 a.m. At no time during the observation, was R3 observed to receive assistance with repositioning or incontinence cares. At 11:30 a.m. R3 was assisted from the wheelchair to bed via a full body mechanical lift (Hoyer lift) by NA-A and NA-B. R3 was observed to be incontinent of urine. Her buttocks was observed to be reddened. NA-A and NA-B verified R3 had been in the wheelchair from 6:45 a.m. to 11:30 a.m. a total of 4 hours and 45 minutes.

On 8/24/16, at 12:35 a.m. the DON verified R3 was to be assisted with repositioning and incontinence cares as directed by the care plan.

R22 did not receive assistance with toileting, repositioning, and oral cares as directed by the care plan.

R22's care plan dated 11/4/15, identified R22 as being frequently incontinent of bowel and bladder. It directed the staff to take R22 to the bathroom upon arising, prompt to toilet prior to meals and to assist R22 to find the bathroom. The plan directed the staff to encourage the resident to turn and reposition self at least every two hours. In addition, the plan directed the staff to provide oral cares twice a day.

On 8/24/16, at 8:40 a.m. R22 was observed to receive assistance with morning cares from NA-A. At no time during the cares was R22 offered to use the toilet nor were oral cares completed. R22 was observed continuously from 8:55 a.m. to 12:00 p.m. At no time was R22 encouraged to reposition herself off of her bottom

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or was R22 offered to use the toilet or offered oral cares.

On 8/24/16, at 12:00 p.m. NA-A confirmed R22 had not been offered to use the toilet or reminded to reposition herself. She confirmed R22 had last received assistance at 8:45 a.m. a total of 3 hours and 20 minutes earlier.

On 8/24/15, at 2:00 p.m. NA-A confirmed R22 had not been offered oral cares.
On 8/25/16, at 10:40 a.m. the DON stated R22 was to be provided personal cares including oral hygiene, assistance to the toilet and repositioning as directed by the care plan.

R13 did not receive assistance with bowel incontinence and repositioning as directed by the care plan.

R13's care plan dated 12/19/14, indicated R13 was at risk for skin breakdown related to incontinence. The plan directed the staff to assist R13 with incontinence cares and repositioning every three hours.

On 8/24/16, at 7:45 a.m. until 11:50 a.m. R13 was continuously observed. At 11:50 a.m. R13 was wheeled from the dining room back to her room. At 11:55 a.m. NA-A and NA-B transferred R13 from the wheelchair back to bed. R13 was observed to be incontinent of bowel and her skin was intact. At 12:00 a.m. NA-B verified R13 had been last assisted with repositioning at 7:45 a.m. a total of four hours earlier.

On 8/25/16, at 12:00 p.m. the DON verified R13 was to receive assistance with bowel cares and repositioning every three hours as directed by the

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F 282	Continued From page 25 care plan.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with oral cares for 1 of 3 residents (R22) reviewed for oral hygiene. In addition, the facility failed to provide timely assistance with bowel incontinence for 1 of 1 resident (R13) observed to be incontinent of bowels. Findings include: R22's quarterly Minimum Data Set (MDS) dated 7/26/16, indicated R22 had severe cognitive impairments, depression, dementia and urinary incontinence. The assessment indicated R22 required total assistance with activities of daily living. R22's care plan dated 6/8/16, indicated R22 did not utilize her dentures, but was to receive oral cares twice a day and as needed with oral swabs. On 8/24/16, from 8:40 a.m. to 9:00 a.m. nursing assistant (NA)-A was observed to assist R22 with morning cares. R22 was observed to be edentulous (had no teeth). At no time was NA-A	F 312	R#22's care plan was reviewed and revised r/t oral cares. Staff caring for R#22 were re-educated on the plan of care r/t oral cares. Staff caring for R#13 were re-educated on their plan of care r/t providing assistance with bowel incontinence. Residents that are totally dependent with oral cares and residents that are on a check and change bowel program have the potential to be affected by a deficient practice. All residents have plans of care that must be followed by staff caring for the residents. Care plans remain readily available for all staff providing direct care/services to residents in a manner compliant with HIPAA requirements. Staff were re-educated on the availability of the plan of care and the need to follow residents plan of care.	9/27/16

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F 312	Continued From page 26 observed to offer R22 oral cares. On 8/24/16, at 2:00 p.m. NA-A confirmed she had not offered R22 oral cares. On 8/25/16, at 10:40 a.m. the director of nursing (DON) confirmed R22 was to receive oral cares with mouth swabs as directed by the care plan. The Oral Hygiene policy dated 10/21/15, directed all residents to receive oral care as based to be appropriate and defined by the plan of care. R13 did not receive assistance with bowel cares for 4 hours on 8/24/16. R13's quarterly MDS dated 7/26/16, indicated R13 had diagnosis including status post stroke, hemiplegia and dementia. The MDS indicated R13 displayed severe cognitive impairments, required total assistance with all activities of daily living and was totally incontinent of bowel and bladder. The Bowel and Bladder Risk Assessment dated 5/1/16, indicated R13 was at a minimal restorative potential. The General Nurse's Observation note dated 5/9/16, revealed R13 had been incontinent of bowel and bladder since admission to the facility. The note indicated toileting trial had been attempted, but no improvement with bowel continence was noted with scheduled toileting plan. R13 was to be on a check and change program related to no progression with continence while on a bowel program. R13's care plan dated 12/19/14, indicated R13	F 312	DON or designee will conduct random observational audits to ensure oral cares and bowel incontinence cares are being provided per the resident’s POC. Random audits will be conducted 3 per week for 2 weeks, then 2 per week for 2 weeks, then weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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F 312	Continued From page 27 was incontinent of bowel and bladder related to functional incontinence, vascular dementia and impaired mobility. The care plan directed the staff to check and change R13 every three hours. On 8/24/16, at 7:45 a.m. until 11:50 a.m. R13 was observed continuously. At 7:45 a.m. NA-C and NA-B were observed to assist R13 to transfer from the bed to a wheelchair via a full body mechanical lift. At 8:00 a.m. R13 was wheeled from her room to the dining room. R13 was observed to receive total assistance with her meal. At 8:37 a.m. R13 was wheeled from the dining room to the activity room. At 9:35 a.m. R13 was wheeled into the Garden Terrace day room. At 10:30 a.m. R13 was wheeled into the dining room for brunch. At 11:50 a.m. R13 was wheeled from the dining room back to her room. At 11:55 a.m. NA-A and NA-B transferred R13 from the wheelchair back to bed. R13 was observed to be incontinent of bowels. At 12:00 a.m. NA-B verified R13 had been last assisted with incontinent cares at 7:45 a.m. a total of four hours earlier. On 8/25/16, at 12:00 p.m. the DON verified R13 was to receive assistance with bowel incontinence every three hours as directed by the care plan. The Bowel and Bladder Audit Policy dated 1/23/14, directed the resident's comprehensive audit will ensure that each resident with bowel or bladder incontinence will received appropriate treatment and services to restore as much bowel and bladder function as possible.	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		9/27/16

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F 314	Continued From page 28 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 5 of 6 resident (R3, R13, R22, R44, R48) in the sample identified at risk for ulcers. Findings include: R3 did not receive assistance with repositioning on 8/24/16, for 4 hours and 45 minutes. R3's annual Minimum Data Set (MDS) dated 5/12/16, indicated R3 had diagnoses including dementia, anxiety and depression. The assessment revealed R3 was totally dependent upon staff for all activities of daily living and was not able to ambulate. R3 was totally incontinent of bowel and bladder and was at risk for the development of pressure ulcers. R3's skin assessment dated 8/10/16, indicated R3 was at risk for the development of skin injuries related to physical and cognitive impairments. The assessment indicated R3 had a history of	F 314	Staff caring for Res #3,#13,#22,#44,#48 were re-educated on their individualized repositioning programs. Res #3, #13, #22, #44, and #48 plan of care were reviewed and revised as needed r/t repositioning program. All residents at moderate to high risk for pressure injury have the potential to be affected by a deficient practice. All residents with current pressure ulcers or at moderate to high risk for pressure ulcer development will be reviewed to ensure the appropriate interventions have been developed/implemented. Staff were re-educated on pressure ulcer treatment and prevention as it related to their role/responsibility. DON or designee will complete random audits to ensure repositioning programs are being implemented according to their POC. 3 audits will be completed weekly	

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F 314	Continued From page 29 healed pressure ulcers. The assessment further indicated R3 was able to sit in a wheelchair or lie in a bed for two hours before repositioning. R3 did not have the ability to display purposeful movements, was unable to communicate her needs, and the assessment indicated relied on staff for all needs. In addition, the assessment identified R3 was at risk of friction and shearing related to total dependence upon staff for all activities of daily living. R3's Braden Scale (an assessment used for the prediction of pressure sore risk) dated 5/1/16, identified R3 at high risk for the development of pressure ulcers. R3's Tissue Tolerance/Repositioning Observation (tool used to determine tissue perfusion) dated 5/4/15, indicated R3 was able to sit or lie in a bed for 2 hours. R3's care plan dated 12/9/14, indicated R3 was to be repositioned by staff every two hours. A Progress Note dated 8/10/16, indicated R3's skin was intact. On 8/24/16, from 7:00 a.m. to 11:40 a.m. R3 was continuously observed to be seated in a wheelchair. At 7:00 a.m. R3 was in the Garden Terrace dining room. At 7:40 a.m. R3 was assisted to eat her breakfast meal. At 8:25 a.m. R3 was wheeled into the Garden Terrace lounge/day room. At 8:50 a.m. R3 was wheeled into the activity room for morning exercises and church. At 9:35 a.m. R3 was wheeled back into the Garden Terrace day room. At 10:30 a.m. R3 was wheeled back to the dining room for the brunch meal. At 11:15 a.m. R3 had finished her	F 314	for 2 weeks, then 2 audits weekly for 2 weeks then weekly for 2 weeks then monthly thereafter to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendation.	

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lunch meal in the dining room. At no time during the observation, was R3 observed to receive assistance with repositioning or incontinence cares.

On 8/24/16, at 11:15 a.m. nursing assistant (NA)-A and NA-B stated R3 had been assisted with morning cares and transferred into the wheelchair at 6:45 a.m. NA-A and NA-B confirmed R3 had not been assisted out of her wheelchair since 6:45 a.m.

On 8/24/16, at 11:30 a.m. R3 was assisted from the wheelchair to bed via a full body mechanical lift (Hoyer lift) by NA-A and NA-B. R3's wheelchair was observed to be equipped with a pressure redistribution cushion. R3's skin over her buttocks was observed to be intact. NA-A and NA-B verified R3 had been in the wheelchair from 6:45 a.m. to 11:30 a.m. a total of 4 hours and 45 minutes.

On 8/24/16, at 12:35 a.m. the director of nurses verified R3 had a history of pressure ulcers and was to be repositioned every two hours in accordance with the care plan.

R13 did not receive assistance with repositioning for 4 hours on 8/24/16.

R13's quarterly MDS dated 7/26/16, indicated R13 had diagnosis including status post stroke, hemiplegia and dementia. The MDS indicated R13 displayed severe cognitive impairments, required total assistance with all activities of daily living. The assessment indicated R13 was at risk for the development of pressure ulcers.

R13's General Nurse's Observation note dated

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F 314	Continued From page 31 5/9/16, revealed R13 had a history of open areas (slit) on her coccyx. R13 had experience weight loss what increased her risk for skin issues. In addition, R13 required total assistance with repositioning every three hours. R13's Braden Scale dated 7/1/16, indicated she was at high risk for the development of pressure ulcers. R13's Tissue Tolerance- Repositioning Observation (tissue perfusion evaluation tool) completed on 5/19/16, indicated R13 required assistance every two hours with repositioning. R13's care plan dated 12/19/14, indicated R13 was at risk for skin breakdown related to incontinence. The plan directed the staff to assist R13 with repositioning every three hours. On 8/24/16, at 7:45 a.m. until 11:50 a.m. R13 was observed continuously. At 7:45 a.m. NA-C and NA-B were observed to assist R13 to transfer from the bed to a wheelchair via a full body mechanical lift. At 8:00 a.m. R13 was wheeled from her room to the dining room. R13 was observed to receive total assistance with her meal. At 8:37 a.m. R13 was wheeled from the dining room to the activity room. At 9:35 a.m. R13 was wheeled into the Garden Terrace day room. At 10:30 a.m. R13 was wheeled into the dining room for brunch. At 11:50 a.m. R13 was wheeled from the dining room back to her room. At 11:55 a.m. NA-A and NA-B transferred R13 from the wheelchair back to bed. R13's wheelchair was observed to be equipped with a pressure redistribution cushion. R13's buttocks was observed to be reddened, with multiple areas of scare tissue over her coccyx and left hip area.	F 314		

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R13's buttocks was observed to be intact. At 12:00 a.m. NA-B verified R13 had been last assisted with repositioning at 7:45 a.m. a total of four hours earlier.

On 8/25/16, at 12:00 p.m. the director of nursing (DON) verified R13 was to receive assistance with repositioning every three hours as directed by the care plan.

R22 did not receive assistance with repositioning for 3 hours and 20 minutes on 8/24/16.

R22's quarterly MDS dated 7/26/16, indicated R22 had severe cognitive impairments, depression, dementia and urinary incontinence. The assessment indicated R22 required extensive assistance with activities of daily living, and was frequently incontinent of bladder and at risk for the development of pressure ulcers.

R22's General Nurse's Observation note dated 2/24/16, indicated R22 had recently stopped walking and attempting to self transfer. R22 was at low risk for pressure ulcers, yet had a history of healed ulcers. R22 was frequently incontinent of bowels and bladder.

R22's Tissue Tolerance/ Repositioning Observation tool dated 10/4/15, indicated R22 required an every two hour repositioning scheduled while in bed and while seated.

R22's care plan dated 11/4/15, indicated R22 had a history of impaired skin integrity related to venous ulcers. The plan directed the staff to cue R22 to reposition herself at least every two hours.

On 8/24/16, at 8:40 a.m. NA-A was observed to

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F 314	Continued From page 33 assist R22 with morning cares. R22 was observed to sit on the edge of the bed. R22 had good sitting balance and was able to follow directions from NA-A. At 8:46 a.m. NA-A called for assistance and trained medication assistant (TMA)-A responded. NA-A and TMA-A cued R22 to stand while holding onto a front wheeled walker. At 8:50 a.m. R22 stood near her bed while NA-A removed a soiled incontinence brief and performed perineal cares. At 8:55 a.m. R22 to was seated in a wheelchair. At 9:00 a.m. R22 was wheeled to the dining room. At 9:01 a.m. R22 was wheeled to the activity room. At 9:40 a.m. R22 was assisted into the Garden Terrace day room. At 9:45 a.m. R22 propelled her own wheelchair into the DON's office. At 10:30 a.m. R22 was assisted to the Garden Terrace dining room. R22 remained in the dining room until 12:07 p.m. At no time was R22 cued to reposition herself or observed to receive assistance from the staff members to stand. On 8/24/16, at 12:00 p.m. NA-A stated R22 had last been assisted off of her bottom at 8:40 a.m. a total of 3 hours and 20 minutes earlier. On 8/24/16, at 12:07 p.m. NA-C and TMA-A assisted R22 to walk from her bed to the bathroom. R22's buttocks was observed to be pink and intact. R22's wheelchair was observed to be equipped with a pressure redistribution cushion. On 8/25/16, at 10:40 a.m. the DON confirmed R22 had not received assistance with repositioning according to the care plan. The Repositioning Policy dated 4/29/16, directed the staff to reposition the residents according to	F 314		

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their individualized assessment.

The Skin Ulcer Protocol dated 11/1/15, directed the staff to assist with repositioning at regular intervals which must be individually based on tissue tolerance. The policy also indicated the residents were to receive "Off Loading" for a full minutes for pressure relief.

R44 did not receive assistance with repositioning for 3 hours on 8/24/16.

R44 had a recently healed stage 3 pressure ulcer (a pressure ulcer with full thickness loss of tissue. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed) on her coccyx and was not repositioned for 3 hours on the afternoon of 8/24/16.

R44's Disease Diagnosis and Allergies report printed 8/25/16, indicated R44's diagnoses as heart failure and chronic pain.

R44's quarterly MDS dated 6/6/16, indicated R44 had severe cognitive impairment and required assistance with bed mobility, transferring, and toileting. The MDS indicated R44 was frequently incontinent of bladder and had a stage 3 pressure ulcer. Pressure ulcer treatment included a pressure reducing device in chair and bed, turning/repositioning program and pressure ulcer care.

R44's Care Area Assessment (CAA) for pressure ulcers dated 6/8/16, indicated R44 was at low risk for pressure ulcer development. However, R44 currently had an open pressure ulcer on her coccyx which was present upon admission. R44

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was on an every two hour turning and repositioning schedule as R44 could only make small adjustments independently. R44 was frequently incontinent of urine. R44 had daily wound care, was on a nutritional supplement, and had a pressure reducing mattress and cushion in R44's wheelchair.

R44's Braden Scale (tool used to assess a resident's level of risk for development of a pressure ulcer) dated 6/12/16, indicated R44 was at a low risk for the development of a pressure ulcer.

R44's Tissue Tolerance /Reposition Observation (assessment utilized to determine the ability of the skin and supporting tissue structure to endure the effects of pressure without adverse events) dated 9/22/15, indicated R44 should be turned and repositioned every two hours while lying or seated.

R44's Wound Care Instructions dated 6/20/16, indicated R44 should be encouraged to turn from side to side (NOT on back) every two hours.

R44's care plan dated 5/12/16, directed staff to turn and reposition R44 every two hours. R44's NAR Assignment Sheet (an extension of R44's care plan) directed the nursing assistant staff to reposition R44 every two hours from side to side.

On 8/24/16, during continuous observation from 12:07 p.m. until 3:08 p.m. (3 hours and 1 minute) R44 remained lying in bed positioned directly on R44's back. The following was observed:

- At 12:07 p.m. R44 was lying in bed, directly on R44's back. The head of the bed was elevated

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F 314	Continued From page 36 slightly and the lower portion of the bed was bent at the knees. R44 had oxygen on via nasal cannula. R44's eyes were closed and R44 appeared comfortable. - At 12:30 p.m. R44 remained in the same position, lying directly on her back. - At 1:47 p.m. R44 remained lying in bed, directly on R44's back. R44 woke up and turned on the television using the remote which had been positioned beside R44. R44 made no attempt to adjust her position in bed and remained directly on her back. - At 2:50 p.m. NA-H entered R44's room and gathered R44's water picture off of R44's bedside table. NA-H lacked offering R44 to be toileted or repositioned. - At 3:01 p.m. NA-I briefly entered R44's room, and directly exited without offering R44 to be toileted or repositioned. - At 3:03 p.m. surveyor intervened and interviewed NA-H. - At 3:08 p.m. (3 hours and one 1 minute since R44 had been repositioned) NA-H and NA-I entered R44's room. NA-H and NA-I gathered supplies and checked R44's brief. NA-H and NA-I acknowledged R44 had been incontinent and R44's brief needed to be changed. NA-H and NA-I proceeded to change R44's brief. Upon removal of R44's brief, R44's bottom was observed to be very reddened and moist around the coccyx area. No open areas were observed. NA-I confirmed R44's bottom was reddened, with no visual open areas. NA-I stated R44's bottom was probably so reddened because R44 had been laying too long. NA-I and NA-H finished changing R44's brief, completed peri-care, and applied a new brief. NA-I and NA-H boosted R44 up in bed and positioned R44 on her right side.	F 314		

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F 314	Continued From page 37 R44's weekly skin condition notes reviewed from 5/25/16 - 8/25/16, indicated the following: - Note dated 5/26/16, Stage 4 pressure ulcer measured 4.5 centimeters (cm) in length, 4.5 cm in width, and 4.1 cm in depth on coccyx area. - Note dated 6/7/16, Stage 3 pressure ulcer measured 1.5 cm x 1.5 cm x 0.7 cm on coccyx area. No change noted in treatment plan with pressure reducing devices in place, turning and repositioning program implemented, toileting schedule per care plan. - Note dated 6/13/16, coccyx wound measurements were 0.5 cm x 0.9 cm x 0.3 cm. - Note dated 6/18/16, pressure reducing devices in place and turning and repositioning program implemented. - Note dated 6/20/16, coccyx wound measured 1.0 cm x 1.0 cm x 0.3 cm. Pressure reducing devices in place and turning and repositioning program implemented. - Note dated 7/18/16, coccyx wound measured 0.5 cm x 0.4 x 0.1 cm. Pressure reducing devices in place and turning and repositioning program implemented. - Note dated 7/25/16, coccyx wound measured 0.3 cm x 0.3 cm x 0.0 cm. Pressure reducing devices in place and turning and repositioning program implemented. - Note dated 8/8/16, site healing very well. Only a small pin hole was left. - Note dated 8/9/16, coccyx wound was not open and a new dressing had been applied for protection. - Note dated 8/13/16, no open areas noted and coccyx area was pink. - Note dated 8/23/16, coccyx wound site was healed. Pressure reducing devices remained in place which included the turning and repositioning program.	F 314		

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On 8/24/16, at 3:03 p.m. NA-H confirmed R44 was to be turned from side to side every two hours. NA-H stated she had just started her shift and had been told that R44 had been repositioned after lunch, however NA-H was unaware of the exact time R44 had been repositioned. NA-H stated R44 was occasionally incontinent of urine.

On 8/24/16, NA-H and NA-I confirmed R44 had been positioned directly on her back when they had went in to change R44. NA-H and NA-I stated R44 should be kept off of her back and should have been positioned on to a side.

On 8/24/16, at 3:17 p.m. licensed practical nurse (LPN)-A confirmed R44's care plan directed staff to reposition R44 every two hours from side to side. LPN-A verified R44 was at risk for pressure ulcer development and that three hours was too long for R44 to go without being repositioned and R44 should not have been positioned on her back.

On 8/25/16, at 9:39 a.m. the DON confirmed R44 had been admitted with a pressure ulcer which had recently healed. The DON confirmed R44's should be turned from side to side every two hours according to the interventions which had been implemented to prevent R44 from obtaining another pressure ulcer. The DON confirmed three hours exceeded R44's turning and repositioning interventions and that was not acceptable.

Repositioning Policy [undated] indicated residents would be repositioned per their individualized assessment. In addition, at shift change the nursing assistants should communicate the

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actual time a resident had last been repositioned to the oncoming shift so a seamless transition would occur and the resident's repositioning scheduled continued.

Skin Ulcer Protocol dated 11/1/15, indicated residents would not develop pressure ulcers unless clinically unavoidable and appropriate care and services would be provided to prevent, treat, and monitor progress of all healed ulcers.

R48 did not receive assistance with repositioning on 8/24/16.

R48's Face Sheet printed 8/25/16, indicated R48's diagnoses included dementia with behavioral disturbance, congestive heart failure, edema (fluid in the tissues of the extremities), and hypothyroidism (thyroid imbalance).

R48's quarterly MDS dated 7/6/16, indicated R48 had a severe cognitive deficit and decision-making skills. R48's MDS indicated R48 required extensive staff assistance with bed mobility, transfers and toilet use. R48's MDS further indicated R48 was at risk for pressure ulcers and was always incontinent of bladder and bowel.

R48's care plan dated 4/12/16, directed nursing staff to encourage and assist R48 to turn and reposition every 2 hours and as needed for comfort.

The NAR (nursing assistant-registered) Assignment Sheet dated 8/24/16, lacked direction for R48's repositioning needs. The NAR

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Assignment Sheet directed staff to use two staff to transfer R48 and for bed mobility.

R48's Braden Scale for Predicting Pressure Sore Risk dated 6/29/16 indicated R48 was at moderate risk for pressure ulcers with a score of 14 out of 23. The Braden Scale indicated R48 was completely immobile, friction and Shearing was a problem, and probably had inadequate nutrition. The Braden Scale indicated R48 was rarely moist which contradicted the MDS, which indicated R48 was always incontinent of bladder and bowel.

On 8/24/16, at 9:10 a.m. R48 was in his room with the door closed and staff in the room. R48 had been assisted out of bed and was up in his wheelchair before 9:41 a.m. During continuous observations from 9:41 a.m. through 12:43 p.m. R48 had not been off-loaded (total pressure relieved) from a sitting position in his wheelchair. At 12:16 p.m. R48 began shifting and stirring in his wheelchair. At 12:43, R48 was taken to his room by two staff, NA-C and NA-J, and R48 was asked if he would like to lay down for a little bit. R48 was assisted by two staff and a stand assist lift to the bed. R48 was checked for incontinence and was cleaned of a small incontinence of bowel. R48 had reddish purple areas on the ischial tuberosities (bones of the buttocks that receive pressure while sitting) that were blanchable (had blood flow).

On 8/24/16, at 12:37 p.m. NA-C stated if the assignment sheet did not direct a repositioning time, they would reposition the resident every 2 hours. NA-C verified R48 did not have a repositioning time on the assignment sheet. NA-C stated she did not know R48 well, but thought he

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F 314	Continued From page 41 should be repositioned every 2 hours. On 8/25/16, at 2:59 p.m. the DON stated they typically determine the repositioning time based on the tissue tolerance, though there are other factors to consider, such as a history of pressure ulcers and the Braden score. DON stated the NAs would know how frequently to reposition a resident by their assignment sheet and then verified the NAR assignment sheet lacked a repositioning timeframe for R48. The DON stated R48's tissue tolerance assessment indicated he was able to sit or lay 2-3 hours, but residents who are immobile or have impaired mobility should be repositioned every 2 hours. DON verified she would expect R48 to be repositioned every 2 hours.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that 3 of 5 residents (R3, R22, R44) who required assistance with toileting received timely	F 315	Resident #3,#22 and #44 plans of care were reviewed and revised as needed. Staff caring for Resident #3,#22, and #44	9/27/16

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F 315	Continued From page 42 assistance with toileting based on the comprehensive assessment. Findings include: R3 did not receive assistance with incontinence cares for 4 hours and 45 minutes on 8/24/16. R3's annual Minimum Data Set (MDS) dated 5/12/16, indicated R3 had diagnoses including dementia, anxiety and depression. The assessment revealed R3 was totally dependent upon staff for all activities of daily living and was not able to ambulate. R3 was totally incontinent of bowel and bladder. R3's Bowel and Bladder Risk Assessment dated 5/1/16, indicated R3 had minimal restorative potential. The assessment indicated R3's cognitive state was such that she could not participate in a bladder or bowel restorative program. R3's General Nurse's Observation noted dated 8/10/16, indicated R3 was 100% incontinent and due to her severe cognitive deficit, she was unable to express her needs, communicate effectively or participate in a bowel or bladder program. R3 did not use the toilet and was on a check and change program. R3's care plan dated 12/09/14, indicated R3 was incontinent of bowel and bladder and was on an every three hour and as needed changing program. On 8/24/16, from 7:00 a.m. to 11:40 a.m. R3 was continuously observed to be seated in a wheelchair. At 7:00 a.m. R3 was in the Garden	F 315	were re-educated on their plan of care as it relates to toileting. Residents with urinary incontinence that require assistance have the potential to be affected by a deficient practice in this area. All residents have plans of care that must be followed by staff caring for the residents. Care plans remain readily available for all staff providing direct care/services to residents in a manner compliant with HIPAA requirements. Staff were re-educated on the availability of the plan of care and the need to follow residents plan of care. Staff were re-educated on urinary incontinence as it relates to their role/responsibility. DON or designee will complete random audits to ensure incontinence care is being provided per the resident's POC. 3 audits will be completed weekly for 2 weeks, then 2 audits weekly for 2 weeks then weekly for 2 weeks then monthly thereafter to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendation.	

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Terrace dining room. At 7:40 a.m. R3 was assisted to eat her breakfast meal. At 8:25 a.m. R3 was wheeled into the Garden Terrace lounge/day room. At 8:50 a.m. R3 was wheeled into the activity room for morning exercises and church. At 9:35 a.m. R3 was wheeled back into the Garden Terrace day room. At 10:30 a.m. R3 was wheeled back to the dining room for the brunch meal. At 11:15 a.m. R3 had finished her lunch meal in the dining room. At no time during the observation, was R3 observed to receive assistance with incontinence cares.

On 8/24/16, at 11:15 a.m. nursing assistant (NA)-A and NA-B stated R3 had been assisted with morning cares and transferred into the wheelchair at 6:45 a.m. NA-A and NA-B confirmed R3 had not been assisted out of her wheelchair since 6:45 a.m.

On 8/24/16, at 11:30 a.m. R3 was assisted from the wheelchair to bed via a full body mechanical lift (Hoyer lift) by NA-A and NA-B. R3 was observed to be incontinent of urine. NA-A and NA-B verified R3 had last been assisted with incontinence cares at 6:45 a.m. a total of 4 hours and 45 minutes earlier.

On 8/24/16, at 12:35 a.m. the DON stated R3 was to assisted with incontinence cares every three hours as directed by the care plan.

The Bowel and Bladder Audit Policy dated 1/23/14, indicated the resident's comprehensive audit will ensure that each resident with bowel or bladder incontinence will received appropriate treatment and services to restore as much bowel and bladder function as possible.

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R22 did not receive assistance with toileting care for 3 hours and 20 minutes on 8/24/16.

R22's quarterly MDS dated 7/26/16, indicated R22 had severe cognitive impairments, depression, dementia and urinary incontinence. The assessment indicated R22 required extensive assistance with activities of daily living, and was frequently incontinent of bladder.

R22's Bowel and Bladder Risk Assessment dated 5/1/16, indicated R22 had a low restorative potential.

R22's General Nurse's Observation note dated 2/24/16, indicated R22 had a history of incontinence due to dementia and required a scheduled toileting plan. The care plan directed staff to assist R22 to the toilet upon arising. They were to offer R22 to use the toilet at 10:00 a.m., 1:00 p.m., 4:00 p.m., 8:00 p.m. and at bedtime to assist with continence.

R22's care plan dated 11/4/15, identified R22 as being frequently incontinent of bowel and bladder. The care plan directed the staff to take R22 to the bathroom upon arising, prompt to toilet prior to meals and to assist R22 to find the bathroom.

On 8/24/16, at 8:40 a.m. NA-A was observed to assist R22 with morning cares. R22 was observed to sit on the edge of the bed. R22 had good sitting balance and was able to follow directions from NA-A. At 8:46 a.m. NA-A called for assistance and trained medication assistant (TMA)-A responded. NA-A and TMA-A cued R22 to stand while holding onto a front wheeled walker. At 8:50 a.m. R22 stood near her bed while NA-A removed a soiled incontinence brief

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and performed perineal cares. At 8:55 a.m. R22 to was seated in a wheelchair. At no time was R22 offered to use the toilet.

At 9:00 a.m. R22 was wheeled to the dining room. At 9:01 a.m. R22 was wheeled to the activity room. At 9:40 a.m. R22 was assisted into the Garden Terrace day room. At 9:45 a.m. R22 propelled her own wheelchair into the DON's office. At 10:30 a.m. R22 was assisted to the Garden Terrace dining room.

On 8/24/16, at 12:00 p.m. NA-A stated R22 was to receive assistance to sit on the toilet throughout the day. NA-A stated she did not assist R22 to the toilet during morning cares because R22 was already wet. NA-A verified R22 had not been assisted to the toilet and she had last been assisted with incontinence cares at 8:40 a.m. a total of 3 hours and 20 minutes earlier.

R22 remained in the dining room until 12:07 a.m. at which time NA- C and TMA-A assisted R22 to walk from her bed to the bathroom. R22 was observed to be continent of bladder and was able to void on the toilet.

On 8/25/16, at 10:40 a.m. the director of nursing (DON) stated R22 was to be assisted to the toilet upon rising and was to be given prompts to sit on the toilet after meals and at bedtime. The DON stated R22 was to be offered the toilet every 2-3 hours while awake. The DON verified R22 had not received assistance with toileting according to her care plan.

The undated Toileting Resident policy directed the staff to assist resident to the toilet on a routine basis in a timely manner according to their

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F 315	Continued From page 46 individualized plan of care. R44 was not toileted at 12:30 p.m. on 8/24/16, as directed by R44's toileting schedule and care plan. R44 was found to be incontinent of urine when checked on 8/24/16, at 3:08 p.m. R44's Disease Diagnosis and Allergies report printed 8/25/16, indicated R44's diagnoses as heart failure and chronic pain. R44's quarterly MDS dated 6/6/16, indicated R44 had severe cognitive impairment and required assistance with bed mobility, transferring, and toileting. The MDS indicated R44 was frequently incontinent of bladder. R44's care plan dated 5/12/16, indicated R44 was frequently incontinent of bladder and directed staff to prompt resident to toilet each day at 9:00 a.m., 12:30 p.m., 5:00 p.m. and 9:00 p.m. R44's NAR assignment sheet (an extension of the care plan) indicated R44 required assistance of one to toilet and should be prompted each day at the times noted above. R44's Care Area Assessment (CAA) dated 6/6/16, indicated R44 was frequently incontinent of bladder. R44 occasionally required staff assistance for toileting. R44 had not had a history of urinary tract infections, but was at risk related to frequent urinary incontinence, inadequate fluid intake and the need for assistance with peri-cares. No changes were made to the care plan at this time. R44's Bowel and Bladder Risk Assessment dated 6/12/16, indicated R44 had severe cognitive impairment, required extensive assist with mobility and was frequently incontinent of urine.	F 315		

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On 8/24/16, during continuous observation from 12:07 p.m. until 3:08 p.m. (3 hours and 1 minute) R44 remained lying in bed positioned directly on her back. The following was observed:

- At 12:07 p.m. R44 was lying in bed, directly on her back. The head of the bed was elevated slightly and the lower portion of the bed was bent at the knees. R44 had oxygen on via nasal cannula. R44's eyes were closed and she appeared comfortable.
- At 12:30 p.m. R44 remained in the same position, lying directly on her back.
- At 2:50 p.m. NA-H entered R44's room and gathered R44's water picture off of R44's bedside table. NA-H lacked offering R44 to be toileted.
- At 3:01 p.m. NA-I briefly entered R44's room, and directly exited without offering R44 to be toileted.
- At 3:03 p.m. surveyor intervened and interviewed NA-H.
- At 3:08 p.m. NA-H and NA-I entered R44's room. NA-H and NA-I gathered supplies and checked R44's brief. NA-H and NA-I acknowledged R44 had been incontinent and R44's brief needed to be changed. NA-H and NA-I proceeded to change R44's brief. Upon removal of R44's brief, R44's bottom was observed to be very reddened and moist around the coccyx area. NA-I and NA-H finished changing R44's brief, completed peri-care, and applied a new incontinent brief.

On 8/24/16, at 3:03 p.m. NA-H stated R44 was occasionally incontinent of urine and wore an incontinent brief.

On 8/25/16, at 8:22 a.m. licensed practical nurse

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F 315	Continued From page 48 (LPN)-A verified R44 required the assistance of one staff with toileting and that R44 should be prompted to utilize the toilet at 9:00 a.m., 12:30 p.m., 5:00 p.m. and 9:00 p.m. LPN-A stated R44 was mostly incontinent during the night time and that this toileting scheduled had been determined based on the times which R44 had most frequently asked to be toileted. On 8/25/16, at 9:39 a.m. the DON confirmed R44 was frequently incontinent of urine and that R44's toileting plan was for staff to prompt R44 to utilize the toilet at 9:00 a.m., 12:30 p.m., 5:00 p.m., and 9:00 p.m. The DON stated it was her expectation that staff offer R44 assistance with toileting at these times as directed by R44's care plan. The facility Bowel and Bladder Audit Policy dated 1/23/14, indicated the facility would ensure that each resident with bladder incontinence received appropriate treatment and services to restore as much bowel and bladder functioning as possible. The resident's care plan would be developed to address appropriate interventions for an elimination program.	F 315		
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.	F 325		9/27/16

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to consistently implement interventions to prevent weight loss for 1 of 3 residents (R48) reviewed for nutrition.

Findings include:

R48's Face Sheet printed 8/25/16, indicated R48's diagnoses included dementia with behavioral disturbance, congestive heart failure, edema (fluid in the tissues of the extremities), and hypothyroidism (thyroid imbalance).

R48's quarterly Minimum Data Set (MDS) dated 7/6/16, indicated R48 had severe cognitive deficit and decision-making skills, sometimes understood others, and sometimes was understood by others. R48's MDS indicated R48 had physical behavior and rejected care one to three days during the assessment period and required extensive staff assistance with eating. R48's MDS further indicated R48 had no swallowing problems, required a mechanically altered diet, had no significant weight change, and weighed 148 pounds. R48's comprehensive admission MDS dated 4/5/16, indicated R48's weight was 156 pounds.

R48's meals and weights record indicated on 8/20/16, R48 weighed 128.6 pounds.

R48's care plan dated 4/12/16, identified R48 as having the potential for weight loss related to his diagnoses, inadequate intakes, mechanically

R# 48 nutritional status was re-assessed and nutritional interventions were developed based upon the results of the assessment.

Staff caring for R#48 were re-educated on the plan of care.

All residents that have significant weight loss and require assistance with meals can be affected by a deficient practice in this area.

Staff were re-educated on the need to cue at meals, offering food alternatives and alternatives to supplements, and proper documentation of meal intake.

Resident Choice Meal Plan policy and procedure was reviewed and revised as needed.

Dietary Manager or designee will conduct random audits. 3 audits will be completed weekly for 2 weeks, then 2 times per week for 2 weeks, then weekly for 2 weeks, then monthly thereafter to ensure ongoing compliance.

Audit results will be brought to the QAPI committee for review and further recommendation.

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altered diet, and difficulty swallowing. The care plan directed staff to monitor fluid intake, meal and snack intake, provide a mechanical soft diet, and weigh weekly. R48's care plan further directed staff to allow R48 to eat independently if able, provide supervision or assistance if he was not eating independently, and prompt him to continue eating. R48's care plan further directed staff to offer fluid and snacks between meals and offer substitute for dislikes when not eating. The care plan indicated R48 was unable to communicate his needs, and had difficulty in daily decision-making.

The NAR (nursing assistant-registered) Assignment Sheet dated 8/24/16, indicated R48 was independent with eating.

R48's Braden Scale for Predicting Pressure Sore Risk dated 6/29/16 indicated R48 was at moderate risk for pressure ulcers with a score of 14 out of 23. The Braden Scale indicated R48 probably had inadequate nutrition.

R48's Dietary Risk Assessment dated 6/23/16, indicated R48 was nutritionally at high risk. R48's comprehensive admission MDS dated 4/5/16, indicated R48's weight was 156. R48's Meals & Weight record indicated R48's weight was 128.6 on 8/20/16.

R48's General Nurse's Observation documentation dated 6/29/16, indicated R48 ate with supervision and frequent assist, and his intakes at meals ranged from 50-75% with an average of 53%. The documentation indicated R48 had a 4.3% weight loss in 30 days and 180 days and was below the goal weight of 155 pounds +/- 5 pounds. R48 had been on a diuretic

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F 325	Continued From page 51 and also had an elevated thyroid lab, so his thyroid medication (Synthroid) had been increased. R48's Progress Notes by the registered dietician dated 8/24/16, indicated R48 had a weight loss with diagnoses that included dementia, dysphagia (swallowing difficulty), and a history of edema. The progress note indicated R48 received a diuretic with fluid fluctuations, and noted his current thyroid level was normal. R48's intake was noted to be poor at 25%. Special dietary programs included puree diet with ground meat, nectar thick liquids with thin water, and assist as he allows. R48 is offered mighty shakes three times daily between meals, though does decline cares and food and shakes at times. Supplements were increased on 8/8/16, though he does not always take them. R48's Meals & Weights record from 8/10/16 to 8/25/16, indicated: - R48's dinner intake and evening snack were not recorded on 8/13/16, indicating he had no food intake between lunch, of which he ate 25%, until breakfast on 8/14/16. -R48's dinner intake and evening snack were not recorded on 8/14/16, indicating he had no food intake between lunch and breakfast on 8/15/16. -R48 did not receive an evening snack on 8/17/16, because he was asleep and did not receive breakfast on 8/18/16 because he was asleep and there is no indication he had a morning snack. -R48's dinner and evening snack were not recorded on 8/18/16, indicating he had no food intake from lunch until breakfast on 8/19/16. -R48 did not receive an evening snack because he was asleep on 8/19/16, and did not receive	F 325		

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F 325	Continued From page 52 breakfast on 8/20/16, because he was asleep and there was no record of intake until lunch of which he ate 25%. -R48's intake at lunch on 8/23/16, was indicated to be 25% and at dinner his intake was 0%. The evening snack was not recorded and on 8/24/16, R48 did not receive breakfast because he was sleeping and there was no indication of food offered until lunch, of which he ate 25%. R48's electronic Medication Administration Record (eMAR) for 8/16, indicated R48 did not receive the mighty shake nutritional supplement on 8/11/16, and 8/20/16, during the 8:00 a.m. administration, on 8/10, 8/19, 8/23, and 8/24/16, during the 12:00 p.m. administration, and on 8/22 and 8/25/16, during the 6:00 p.m. administration. The eMAR did not indicate how much of the supplement R48 drank during each administration. On 8/24/16, at 10:28 a.m. R48 was taken to the dining room for brunch, where he was seated at the table in his wheelchair. He was served nectar thickened liquids and thin water at 10:33 a.m. He began to drink them independently. At 10:45 a.m. he was served his food with pureed sauerkraut and beans, and ground meat. He ate independently and by 10:53 a.m. he had eaten all his sauerkraut. Staff asked him how he was doing, turned the plate for him to reach his other food, and cued him to eat, and he did start eating the ribs and mashed potatoes. At 11:02 a.m. R48 put down his spoon and stopped eating. R48 had eaten 1/4 of his meat and bites of his potatoes, drank 7/8th's of his juice and 1/4 of his water. At 11:08 a.m. R48's table mate was cued to eat more, but R48 was not. At 11:16 a.m. R48's intake was marked down without encouraging	F 325		

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Continued From page 53
more intake or offering alternatives. A nursing assistant noted the pink meal ticket that R48 had indicated he was nutritionally at risk.

On 8/25/16, at 8:22 a.m. R48 was sitting at the dining room table with his breakfast of hot cereal and a brown pudding consistency substance and juice. R48 had eaten only bites of his cereal, and had drank most of the juice. No staff were in the dining room. At 8:25 a.m. a nursing assistant brought another resident in and asked R48 if he were done or if he would wanted more to eat. The nursing assistant offered the hot cereal, pureed roll, and the juice. R48 declined each one, and then was taken to activities. No alternatives were offered.

On 8/24/16, at 2:46 p.m. the registered dietician (RD) stated in the morning, R48 is doing OK with the supplement, at noon he took the supplement one day, but usually refused, and at night, he takes some of it about half the time. The RD stated R48 is sleeping most evenings when the snacks are offered. The RD verified R48's weight loss, identified that he is nutritionally at risk, and stated some of it was due to edema, his diuretic medication, and his thyroid levels and medication adjustments, along with his dementia and low intakes at meals. The RD stated he resists cares and intakes. The RD stated she reviews R48 monthly, and his supplement was increased 8/8/16. Food preferences are assessed when residents are admitted.

On 8/25/16, at 8:32 a.m. nursing assistant (NA)-A and licensed practical nurse (LPN)-B were interviewed. NA-A stated R48 seems to like sweets and ate all of his sauerkraut on 8/24/16. They indicated he varies and his intakes depend

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F 325	Continued From page 54 on his mood. LPN-B stated they have yogurts and applesauce, and other foods to offer for alternatives. LPN-B stated if he is awake, they get him up for breakfast and if he is sleeping, they let him sleep, which is about 50% of the time. LPN-B stated that he had taken all of his supplement that morning. On 8/25/16, at 2:35 p.m. registered nurse (RN)-B and LPN-B were interviewed. LPN-B stated R48 has more behaviors in the evening when he is tired, and may be more resistive. RN-B stated R48 gets a snack at night, but if he is sleeping, he does not get one. RN-B stated R48 gets a supplement in the evening. On 8/25/16, at 3:09 p.m. the director of nursing (DON) verified R48 is to receive a nutritional supplement three times daily and a snack, but the snack had not been documented. R48 stated the expectation is for R48 to be offered something to eat when he gets up in the morning, such as yogurt. The DON stated staff should offer food when residents are awake. The DON stated they review weight loss weekly at the interdisciplinary team meetings, and look for a root cause of the weight loss. The DON stated they look for swallowing difficulties, food preferences, update the physician with large weight loss of if it is a fluid retention or loss issue. The dietician follows and they try real food before supplements. If weighs are off, they are to re-weight the resident. The DON stated they talk with the family regarding what is more important to them; the resident's sleeping pattern or weight loss and food intake, if the resident is sleeping through meals. The facility policy and procedure for Resident	F 325		

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F 325	Continued From page 55 choice Meal Plan dated 4/16/08, indicated a continental breakfast would be served 7-9 a.m. and an afternoon snack would be served at 1:45 p.m. and the evening snack would be served at 6:45 p.m. The policy and procedure lacked information regarding recording of intakes, offering alternatives, and remaining meal times. A policy and procedure for nutrition was not provided.	F 325		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 353		9/27/16

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F 353	Continued From page 56 Based on observation, interview and document review, the facility failed to ensure that sufficient qualified nursing staff was available to meet the residents' needs for nursing care in a manner which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 38 residents residing in the facility. Findings include: Refer to F248: The facility failed to provide activities to meet the individual interests for 1 of 3 residents (R13) in the sample who were reviewed for activities. Refer to F282: The facility failed to ensure the care plan was followed for repositioning for 5 of 6 residents (R3, R22, R13, R44, R48) identified at risk for pressure ulcers, toilet use for 4 of 5 residents (R3, R22, R13, R44) identified with incontinence, and oral hygiene for 1 of 3 residents (R22) reviewed for activities of daily living. Refer to F309: The facility failed to ensure a resident identified at risk for pressure ulcers received the necessary care and treatment to prevent the development open areas for 1 of 1 resident (R3) in the sample who developed newly opened area. This practice resulted in actual harm for R3. Refer to F312: The facility failed to provide assistance with oral cares for 1 of 3 residents (R22) in the sample who were dependent on staff for oral hygiene. In addition, the facility failed to provide timely assistance with bowel incontinence for 1 of 1 resident (R13) observed to be	F 353	The facility staffer/designee will review staffing daily to ensure that there is sufficient nursing staff to provide appropriate resident care and services, adjusting with census, acuity and reallocating staff where appropriate. Call lights will be reviewed daily on normal business days and will be followed up on for outliers. Weekends and holidays will be followed up on the next business day. Staff efficiencies were reviewed, revised and additional equipment/modifications were evaluated and provided as necessary. All residents have the potential to be affected by a deficient practice in this area. Tissue tolerance testing was reviewed and revised to determine optimal repositioning. The system for toileting, turning and repositioning and communication of last toileting and turning and repositioning at change of shift report was reviewed and revised. Staff will be re-educated regarding communication, change of shift report, and the toileting and repositioning tool. Meal service is changing October 2 and staff will be educated on the new meal times and the process for documentation of meals and resident refusal of meals.	

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F 353	Continued From page 57 incontinent of bowels. Refer to F314: The facility failed to ensure residents identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 5 of 6 resident (R3, R13, R22, R44, R48) in the sample identified at risk for ulcers. Refer to F315: The facility failed to ensure that 3 of 5 residents (R3, R22, R44) in the sample who required assistance with toileting received timely assistance with toileting based on the comprehensive assessment. Refer to F368: The facility failed to ensure that breakfast was no later than 14 hours after the evening meal for 6 of 14 residents (R22, R14, R13, R3, R48, R21) reviewed residing on the Garden Terrace Neighborhood. On 8/22/16, at 7:30 p.m. family member (FM)-A stated she felt the staff members were working many shifts, her loved one was not able to attend activities as often as she felt she should and at times she felt the staff members were "frazzled" because they did not have enough help. On 8/23/16, at 8:26 a.m. R53, an alert and oriented resident, stated it may take up to 45 minutes for the call light to be answered. She stated if she were to ask for a pain medications, it could be to 45-60 minutes before she received the medication. She stated it sometimes took longer to get assistance, because it took two staff members to assist her and there were times that there was only one staff working the floor. On 8/23/16, at 8:50 a.m. R4, an alert and	F 353	Staffing patterns will be monitored the by the DON or designee, adjusting with census, acuity and reallocating staff where appropriate. Resident interviews are being conducted monthly to ensure resident needs are met. Nursing administration is randomly rounding 3 times weekly with staff to discuss efficiencies and task completion. Audit results will be brought to the QAPI committee for review and further recommendation.	

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orientated resident, stated she did not feel the facility had enough help.

On 8/23/16, at 9:00 a.m. R44, an alert and orientated resident, the facility did not have enough help. She stated she had to wait greater than 10 minutes for the staff to answer her light.

On 8/23/16, at 10:15 a.m. R18, an alert and orientated resident, stated the facility did not have enough help. She stated she had to wait up to a half and hour for her call light to be answered. R18 stated long call lights occurred approximately twice a week.

On 8/24/16, at 9:00 a.m. nursing assistant (NA)-A stated the facility has been working short for months. She stated the residents do not routinely get baths, they do not have time to care for the residents. She stated the facility did not have enough staff to ensure the residents were able to get to breakfast on time. She stated the weekends are worse because they did not have the extra help from the office.

On 8/24/16, at 10:20 a.m. nursing assistant (NA)-B stated the facility did not have enough staff to care for the residents. She stated the staff were not able to assist residents with their baths or to assist the residents up in time for breakfast. She stated many of the nurses do not assist with answering lights or assisting with resident care.

On 8/24/16, at 11:12 a.m. trained medication assistant (TMA)-A stated the facility did not have enough staff to care for the residents. She stated the staff did not consistently have time to get baths done and usually they were able to assist with breakfast, but not always. TMA-A stated the

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F 353	Continued From page 59 facility did not have enough staff to consistently assist with two person transfers. On 8/24/16, at 12:19 p.m. NA-C stated the facility did not have sufficient staff to assist the resident with off loading (repositioning), to assist the residents up and out of bed for breakfast, to feed the residents or to give them their baths. She stated the Town Square Neighborhood was worse than the Garden Terrace Neighborhood because the Town Square Neighborhood had more dependent resident which required two staff members for transfers. NA-C stated the staff members wore walkie talkies to communicate back and forth to each other, however; sometimes the staff did not respond to the requests. On 8/24/16, at 12:50 p.m. the activity director stated the residents frequently complained about the call lights not being answered timely. She stated the facility currently had residents that were able to voice their concerns and required more assistance. On 8/24/16, at 12:55 p.m. NA-D stated the facility did not have enough staff. She stated the facility had several residents that require assistance of two staff to provide care. She stated the staff try to get things done, but would like additional help to assist the residents. On 8/24/16, at 1:00 p.m. TMA-B stated the facility has has had to change the staffing pattern because of low census in the facility. TMA-B stated the facility has had to send staff home because the facility was not full enough to warrant additional staff members.	F 353		

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On 8/25/16, at 10:00 a.m. licensed practical nurse (LPN)-B stated the number of staff members needed in the facility depended upon the requests of the residents. LPN-B stated she felt the facility had enough staff members, but depending upon the resident requests, some days they nursing assistants were able to get their job done, other days they were not, it all depended upon the resident need.

On 8/24/16, at 2:05 p.m. the director of nurses (DON) stated she felt the facility was staffed adequately. The DON stated if the facility had a census of 44 the following staffing pattern would be used:

Day shift defined as 6:00 a.m. to 2:30 p.m. would consist of one charge nurse (LPN or registered nurse[RN]), two staff to pass medications (either two TMA, or one LPN and one TMA), 4 NA to provide cares, 1 restorative NA, and 1 bath aide. In addition, Monday - Friday, the Minimum Data Set (MDS) coordinator (RN) and herself were also in the facility. * Note that on some days, the day shift and night shift nurses may work 12 hours shifts but provided a total of 8 hours on each shift.

The afternoon shift defined as 2:00 p.m. to 10:30 p.m. consisted of two nurses (LPN or RN). The afternoon shift did not utilize TMA staff members. Four NAs who worked the full shift and one NA to work 6 p.m. to 10:00 p.m.

The night shift identified as 10:00 p.m. to 6:30 a.m. consisted of one RN and 2 NAs.

On 8/25/16, at 10:10 a.m. the administrator reviewed the staffing pattern with the survey staff.

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F 353	Continued From page 61 For the time period of 7/14/16 - 8/23/16, the facility was unable to maintain the identified staffing pattern on 33 of the 41 days. However; during that time facility had not been at full census. The administrator explained the facility staffing patter varied due to the number of residents in the facility. The census varied from 35 resident to 39 residents. She explained the facility had made adjustments to the staffing pattern depending upon the number of residents in the facility. If the facility had less than 40 residents, the ratio of NA to residents was to 1 NA for 10 residents. The ratio for nurses/TMA was to be 1 nurse/TMA for 19 residents. According to the staffing pattern adjustments completed the administrator, the facility was not short staffed during the identified time period. The administrator felt resident cares should able to be completed with the staff working in the facility. The administrator was informed of the residents who had been observed not to receive assistance with activities, oral cares, repositioning, toileting, and meals as identified in the aforementioned citations. The administrator was unaware the staff had not been able to complete cares timely for the residents. The Staffing Plan policy dated 10/23/15, indicated the facility was to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	F 353		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the	F 368		9/27/16

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F 368	Continued From page 62 community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that breakfast was no later than 14 hours after the evening meal for 6 of 14 residents (R22, R14, R13, R3, R48, R21) reviewed who resided on the Garden Terrace Neighborhood. Findings include: R22 did not receive breakfast for 18.5 hours after the evening meal on 8/23/16. R22's quarterly Minimum Data Set (MDS) dated 7/26/16, indicated R22 had severe cognitive impairments, depression, dementia and urinary incontinence. The assessment indicated R22 required extensive assistance with activities of daily living, and required supervision with eating. R22's Nutritional Assessment dated 2/24/16, indicated R22 was able to feed herself the meals	F 368	R# 22, #14, #13, #3, #48 and #21 will be reassessed to identify their nutrition risk and if at risk will be assessed to determine if it would be beneficial for them to be awakened and offered the continental breakfast. All other residents who are identified as nutritionally at risk will be reassessed and determined if it would be beneficial to be awakened and offered the continental breakfast. Dietary Manager and/or designee will develop measures to ensure this practice does not recur that include: Staff will document on the Snack Acceptance Sheet to alert day shift staff of those residents that did not participate in the evening meal and/or HS snack and who need to be awakened and offered	

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F 368	Continued From page 63 after set up. R22 had sustained a weight loss and had been started on nutritional supplements (mighty shakes) twice a day. R22's care plan dated 11/4/15, identified R22 at risk for weight loss related to impaired swallowing. The plan directed staff to monitor R22 during meals and provide nutritional supplements twice a day. On 8/24/16, at 8:40 a.m. R22 was observed to receive assistance with morning cares. At 9:00 a.m. nursing assistant (NA)-A wheeled R22 to the dining room. At 9:03 a.m. NA-A wheeled R22 to the activity room. NA-A stated R22 only wanted coffee for breakfast so she could drink coffee in the activity room. On 8/24/16, from 9:05 a.m. to 9:40 a.m. R22 was observed to be seated in the activity room. R22 was observed to be offered a glass of supplement from trained medication assistant (TMA)-A, however, R22 was not offered coffee or any other type of breakfast items. At 9:40 a.m. activity director (AD)-A informed TMA-A R22 had finished the nutritional supplement. At 11:00 a.m. R22 was served the noon meal in the Garden Terrace dining room. Review of R22's Meals and Weight record for 8/23/16-/8/24/16, revealed R22 had eaten 75% of the 4:30 p.m. evening meal on 8/23/16. The record did not indicated if R22 had received a bedtime snack. A total of 18.5 hours between the evening meal on 8/23/16 and the morning meal on 8/24/16. R14 did not receive breakfast for 18 hours after the evening meal on 8/23/16. R14's quarterly MDS dated 7/20/16, indicated R14 had diagnoses including dementia and depression. The MDS indicated R14 required	F 368	continental breakfast. Nursing/dietary staff will be educated on the form. Dietary Manager or designee will complete random audits to ensure they are receiving meals according to the Resident Choice Meal Plan. 3 observational audits will be completed weekly for 2 weeks, then 2 audits weekly for 2 weeks, then weekly for 2 weeks, then monthly thereafter to ensure compliance. Audit results will be brought to the QAPI committee for review and further recommendation	

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F 368	Continued From page 64 extensive assistance with dressing and limited assistance of one staff for meals. R14's Nutritional Assessment dated 5/6/16, indicated R14 had sustained an 11 pound weight loss in the last 180 days, and was to receive nutritional supplements twice a day. R14's care plan dated 9/7/14, indicated R14 received a mechanically altered diet and nutritional supplements. The plan directed staff to provide supervision and occasional assistance for eating. On 8/24/15, at 7:00 a.m. R14 was observed wheeling the hallway of the Garden Terrace neighborhood. At 7:15 a.m. R14 was observed to return to her room and transfer herself back to bed. At 9:11 a.m. the dietary aide (DA)-A was observed to remove the food from the Garden Terrace kitchenette. R14 had was not observed to receive breakfast. At 10:30 a.m. R14 was wheeled to the dining room for brunch. At 10:51 a.m. R14 received the brunch meal and began to eat on her own. R14's Meals and Weight record indicated on 8/23/16, R14 had eaten 50% of her supper (4:30 p.m.), she had not received an evening snack on 8/23/16, and did not eat breakfast on 8/24/16. A total of 18 hours between meals. R13 did not receive breakfast for 16 hours after the evening meal on 8/23/16. R13's quarterly MDS dated 7/26/16, indicated R13 had diagnosis including status post stroke, hemiplegia and dementia. The MDS indicated R13 displayed severe cognitive impairments, required total assistance with all activities of daily living including eating. R13's Nutritional Assessment dated 5/9/16, indicated R13 required a pureed diet with nectar	F 368		

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consistency liquids. The assessment indicated R13 had sustained a weight loss and was receiving nutritional supplements (mighty shakes) three times a day.

R13's care plan dated 7/8/14, indicated R13 was at risk for weight loss related to mechanically altered diet, impaired communication and dependent upon others for activities of daily living. The plan directed the staff to assist R13 with meals, offer double portions at brunch, monitor meal and snack intake offer nutritional supplements.

On 8/24/16, at 8:00 a.m. R13 was observed to be wheeled to the dining room. At 8:10 a.m. NA-B was observed to feed R13 her breakfast meal.

Review of R13's Meals and Weight record from 8/23/16, indicated R13 had eaten 50% of the 4:30 p.m. evening meal on 8/23/16. R13 had not received a bedtime snack. A total of 16 hours between supper and breakfast.
R3 did not receive breakfast for 15 hours after the evening meal on 8/23/16.
R3's annual MDS dated 5/12/16, indicated R3 had diagnoses including dementia, anxiety and depression. The assessment revealed R3 was totally dependent upon staff for all activities of daily living including eating.

R3's nutritional assessment dated 8/10/16, indicated R3 required nectar thick liquids and was totally dependent upon staff for foods and fluids. R3 had sustained a weight loss and had been started on nutritional supplements (mighty shakes) three times a day.

R3's care plan dated 9/7/14, indicated R3 was at

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risk for weight loss related to diagnoses, supplemental intake, mechanically altered diet and total dependent upon all activities of daily living. The plan directed to assist R3 with meals, snacks and supplements.

On 8/24/16, at 7:00 a.m. R3 was observed seated in the dining room. At 7:30 a.m. nursing assistant (NA)-A was observed to assist R3 with the breakfast meal. R3 was observed to eat 100% of the meal.

Review of the Meals and Weight documentation dated 8/24/16, indicated R3 had eaten 75% of the noon meal on 8/24/16. The evening meal and bedtime snack were blank.

On 8/24/16, at 9:10 a.m. dietary assistant (DA)-A stated the breakfast meal on Garden Terrace had been completed. DA-A was observed to remove the breakfast items from the steam table and place them onto a cart to return to the main kitchen. When queried on how she would know if the residents in the neighborhood had received their breakfast meal, she stated the facility did not have a system to ensure all of the residents had received their meal. She stated if the staff members required additional food, they would have to ask her before she left the neighborhood.

On 8/24/16, at 9:00 a.m. nursing assistant (NA)-A stated the facility did not have enough staff to ensure the residents were able to get to breakfast on time.
On 8/24/16, at 10:13 a.m. NA-B stated there were 14 residents residing on the Garden Terrace neighborhood and two nursing assistants and one trained medication assistant (TMA). She stated several of the residents had not received

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breakfast. NA-B stated R22, R14, R1, R48, R25 and R17 had not been offered breakfast. NA-B stated some of the residents eat on the Garden Terrace neighborhood and some of the eat in the Town Square neighborhood. NA-B stated R21 was waiting for a bath so she had not made it to the dining room for breakfast on time. NA-B stated the staff members were able to keep track of which residents had received breakfast or not by looking at the menu cards in the kitchenette. She then went to the kitchenette and indicated she could not find the slips. NA-B stated she did not have a way of knowing which residents had eaten breakfast and which ones had not.
On 8/24/16, at 2:14 p.m. the certified dietary manager (CDM) stated the facility utilized the five meal plan. The residents were offered a continental breakfast from 7 a.m. to 9:00 a.m. Brunch was served at 11:00 a.m., supper was served at 4:30 p.m. and an evening snack was severed between 6-7 p.m. The CDM stated if the residents were sleeping in the morning, the staff were not required to wake them to offer breakfast.

On 8/24/16, at 2:20 p.m. the director of nursing (DON) reviewed the meals and weight records for R22, R13, and R3. The DON verified none of the record included recordings of the a.m., p.m. or bedtime snacks. She verified the evening meal on Garden Terrace is served at 4:30 p.m. and lunch was not served until 10:30-11:00 a.m. The DON also verified this was greater than 14 hours between meals. The DON stated the five meal plan was not working well for the facility; they had identified concerns with the meal plan but had not made changes to the system.
On 8/25/16, at 9:45 a.m. the CDM stated the facility had been working with the five meal plan

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F 368	Continued From page 68 since 2008. The CDM verified if the residents did not offered and/or receive the bedtime snack, the resident would go grater than 14 hours between meals. The Resident Choice Meal plan Policy dated 4/16/08, indicated residents in the facility would be offered two large meals at brunch (10:30-11:00 a.m.) and supper (4:30 p.m.). In addition, the residents were to be offered a continental breakfast between 7 a.m. to 9 a.m., a mid-afternoon snack at 1:45 p.m. and an evening snack at 6:45 p.m. R48 did not receive a meal since being offered supper on 8/23/16, until the brunch meal on 8/24/16. R48 had not eaten a meal since the brunch meal on 8/23/16, which was 24 hours prior. R48's Face Sheet printed 8/25/16, indicated R48's diagnoses included dementia with behavioral disturbance, congestive heart failure, edema (fluid in the tissues of the extremities), and hypothyroidism (thyroid imbalance). R48's quarterly Minimum Data Set (MDS) assessment dated 7/6/16, indicated R48 had a severe cognitive deficit and decision-making skills, sometimes understood others, and sometimes was understood by others. R48's MDS indicated R48 had physical behavior and rejected care one to three days during the assessment period and required extensive staff assistance with eating. R48's MDS further indicated R48 had no swallowing problems, required a mechanically altered diet, had no significant weight change, and weighed 148 pounds. R48's comprehensive admission MDS dated 4/5/16, indicated R48's weight was 156	F 368		

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R48's meals and weights record indicated on 8/20/16, R48 weighed 128.6 pounds.

R48's care plan dated 4/12/16, identified R48 as having the potential for weight loss related to his diagnoses, inadequate intakes, mechanically altered diet, and difficulty swallowing. The care plan directed staff to monitor fluid intake, meal and snack intake, provide a mechanical soft diet, and weigh weekly. R48's care plan further directed staff to allow R48 to eat independently if able, provide supervision or assistance if he was not eating independently, and prompt him to continue eating. R48's care plan further directed staff to offer fluid and snacks between meals and offer substitute for dislikes when not eating. The care plan indicated R48 was unable to communicate his needs, and had difficulty in daily decision-making.

The NAR (nursing assistant-registered) Assignment Sheet dated 8/24/16, indicated R48 was independent with eating.

R48's Dietary Risk Assessment dated 6/23/16, indicated R48 was nutritionally at high risk. R48's comprehensive admission MDS dated 4/5/16, indicated R48's weight was 156. R48's Meals & Weight record indicated R48's weight was 128.6 on 8/20/16.

R48's General Nurse's Observation documentation dated 6/29/16, indicated R48 ate with supervision and frequent assist, and his intakes at meals ranged from 50-75% with an average of 53%. The documentation indicated R48 had a 4.3% weight loss in 30 days and 180

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days and was below the goal weight of 155 pounds +/- 5 pounds. R48 had been on a diuretic and also had an elevated thyroid lab, so his thyroid medication (Synthroid) had been increased.

R48's Progress Notes by the registered dietician dated 8/24/16, indicated R48 had a weight loss with diagnoses that included dementia, dysphagia (swallowing difficulty), and a history of edema. The progress note indicated R48 received a diuretic with fluid fluctuations, and noted his current thyroid level was normal. R48's intake was noted to be poor at 25%. Special dietary programs included puree diet with ground meat, nectar thick liquids with thin water, and assist as he allows. R48 is offered nutritional supplements (mighty shakes) daily between meals, though does decline cares and food and shakes at times. Supplements were increased on 8/8/16, though he does not always take them.

R48's Meals & Weights record from 8/10/16, to 8/25/16, indicated:
- R48's dinner intake and evening snack were not recorded on 8/13/16, indicating he had no food intake between lunch, of which he ate 25%, until breakfast on 8/14/16.
-R48's dinner intake and evening snack were not recorded on 8/14/16, indicating he had no food intake between lunch and breakfast on 8/15/16.
-R48 did not receive an evening snack on 8/17/16, because he was asleep and did not receive breakfast on 8/18/16, because he was asleep and there is no indication he had a morning snack.
-R48's dinner and evening snack were not recorded on 8/18/16, indicating he had no food intake from lunch 8/18/16, until breakfast on

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8/19/16.
-R48 did not receive an evening snack because he was asleep on 8/19/16, and did not receive breakfast on 8/20/16, because he was asleep and there was no record of intake until lunch of which he ate 25%.
-R48's intake at lunch on 8/23/16, was indicated to be 25% and at dinner his intake was 0%. The evening snack was not recorded and on 8/24/16, R48 did not receive breakfast because he was sleeping and there was no indication of food offered until lunch, of which he ate 25%.

On 8/24/16, at 10:28 a.m. R48 was taken to the dining room for brunch, where he was seated at the table in his wheelchair. He was served nectar thickened liquids and thin water at 10:33 a.m. He began to drink them independently. At 10:45 a.m. he was served his food with pureed sauerkraut and beans, and ground meat. He ate independently and by 10:53 a.m. he had eaten all his sauerkraut. Staff asked him how he was doing, turned the plate for him to reach his other food, and cued him to eat, and he did start eating the ribs and mashed potatoes. At 11:02 a.m. R48 put down his spoon and stopped eating. he had eaten 1/4 of his meat and bites of his potatoes, drank 7/8th's of his juice and 1/4 of his water. At 11:08 a.m. R48's table mate was cued to eat more, but he was not. At 11:16 a.m. R48's intake was marked down without encouraging more intake or offering alternatives. A nursing assistant noted the pink meal ticket that R48 had indicated he was nutritionally at risk.

On 8/25/16, at 8:22 a.m. R48 was sitting at the dining room table with his breakfast of hot cereal and a brown pudding consistency substance and juice. He had eaten only bites of his cereal. He

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had most of the juice. No staff were in the dining room. At 8:25 a.m. a nursing assistant brought another resident in and asked R48 if he were done or if he would wanted more to eat. The nursing assistant offered the hot cereal, pureed roll, and the juice. R48 declined each one, and then was taken to activities. No alternatives were offered.

On 8/24/16, at 2:46 p.m. the registered dietician (RD) stated R48 is sleeping most evenings when the snacks are offered. The RD verified R48's weight loss, identified that he is nutritionally at risk, and stated some of it was due to edema, his diuretic medication, and his thyroid levels and medication adjustments, along with his dementia and low intakes at meals. The RD stated he resists cares and intakes. She stated she reviews R48 monthly. His supplement was increased 8/8/16. Food preferences are assessed when residents are admitted.

On 8/25/16, at 3:09 p.m. the DON verified R48 is to receive a supplement three times daily and a snack, but the snack had not been documented. R48 stated the expectation is for R48 to be offered something to eat when he gets up in the morning, such as yogurt. The DON stated staff should offer food when residents are awake. The DON stated they talk with the family regarding what is more important to them; the resident's sleeping pattern or weight loss and food intake, if the resident is sleeping through meals.

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R21 did not receive breakfast for 18 hours after the evening meal on 8/23/16.

R21's face sheet printed on 8/25/16, indicated mild cognitive impairment, legal blindness, hearing loss, chronic kidney disease and chronic pain.

R21's significant change MDS dated 6/8/16, indicated R21 required extensive assistance with all activities of daily living (ADLs), including eating, and had had weight loss.

R21's Physician Orders dated 5/11/14, indicated Prosource (a nutritional supplement) twice a day. Review of R21's electronic Medication Administration Review (eMAR) for August, 2016, indicated R21 consumed 100% of this supplement most days during August. However, the Prosource was not available 7 times in August as recorded "out of stock."

R21's Nutritional Assessment dated 6/8/16, indicated R21 had been requiring increased assistance with meals, and at times R21 would eat with supervision and cuing and at other times R21 required assistance. R21's current weight was 85 pounds with a 5% weight loss in 30 days. The assessment indicated R21 was to continue on Prosource and was started on Mighty Shake (a nutritional supplement). No documentation was

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F 368	Continued From page 74 provided as to R21's consumption of the Mighty Shake. The assessment indicated R21 had less than six months to live. R21's care plan dated 8/12/14, indicated R21 was at risk for weight loss related to diagnoses, sub-optimal intakes, low BMI (body mass index), pain, medications and impaired vision and hearing. The plan directed the staff to monitor all fluid intake, monitor meal and snack intakes, and offer snacks (vanilla pudding or milkshakes) between meals. Review of R21's Meals and Weights from 8/1/16 to 8/25 16 revealed no a.m. or p.m. snacks recorded. HS (bedtime) snacks were recorded as "asleep"13 times, blank 9 times, and "refused" 3 times, for no recorded HS snacks. Review of R21's Meals and Weight record from 8/23/16, indicated R21 had eaten 25% of the 4:30 p.m. evening meal on 8/23/16. R13 had not received a bedtime snack and was "asleep" during breakfast and the a.m. snack was not recorded. R21 ate 50% of the lunchtime meal. A total of 18 hours were between R21's supper and brunch. On 8/24/16, at 9:08 a.m. R21 was observed in bed. At 10:29 a.m. R21 was observed in the dining room waiting for the brunch meal. R21 received her meal at 10:37 a.m.	F 368		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		9/27/16

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F 371	Continued From page 75 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the dishwasher in the kitchen was maintained in a sanitary manner. This had the potential to affect all 38 residents who received meals from the kitchen or utilized the kitchenettes. Findings include: On 8/22/16, at 2:51 p.m. during the initial tour of the kitchen with the dietary manager (DM) it was noted the top of the dishwasher had a thick coat of grime and dust with crumbles of white/gray lime deposits adhered to the layer of grime. The temperature dials for the wash and rinse cycle were also covered with a layer of grime and dust. The freezers numbered two and three were observed to have large crumbs of food debris, and dried white and pink colored stains on the bottom freezer shelves. The DM confirmed the kitchen staff were responsible for cleaning the freezers every six months. On 8/24/16, at 9:16 a.m. on the follow up tour of the kitchen, DM confirmed there was a layer of dust and lime deposit on the top of the dishwasher. The DM picked up a white cloth towel located by the dishwasher; wetted it down and proceeded, in a rubbing motion, to clean the top of the dishwasher. When DM lifted the white wet towel from the top of the dishwasher the white towel was stained black. In addition, the	F 371	The dish machine and dish machine hood was cleaned. Freezers #2 and #3 were cleaned. The copper piping behind the dish machine was cleaned. The tiled wall behind the freezers was cleaned. All residents have the potential to be impacted by unsanitary conditions in the kitchen. Policies and procedures regarding cleaning/sanitizing food storage and food preparation areas were reviewed and revised as needed. Dietary Staff and Maintenance were re-educated on the cleaning schedules/process. The Director of Dietary Services will perform random audits to ensure sanitary conditions in the kitchen. 3 audits will be completed weekly for 2 weeks, then 2 times per week for 2 weeks, then weekly	

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F 371	Continued From page 76 copper piping between the back of the dishwasher and the tiled wall was covered with a collection of clumps of dust. The clumps of dust had also accumulated and adhered to the white tiles on the wall behind the dishwasher. The hood above the dishwasher was observed to have a thick layer of grime and clumps of dust had adhered to and which dangled down from the lip of the dishwasher hood. The DM stated the dishwasher was scheduled to be cleaned and wiped down once a month. The DM was unable to confirm the last time the dishwasher had been cleaned. The DM verified there was a high likely hood of the dust particles from the hood to fall and land on the recently cleaned dishes. The DM also confirmed there were crumbs, dust and dried liquid stains on the bottom shelves of the freezers. DM stated that some of the dried liquid may have been dried "chicken juice." In addition, the DM confirmed there were dust particles adhered to a layer of grime on the outside front vents of the freezers, on the outside walls of the freezers and the tiled walls behind the freezers. DM stated the maintenance department was responsible for vacuuming the freezer vents. DM stated she thought this was scheduled to be done once every other month. DM confirmed the tops of the freezers had a layer of dust and overall the kitchen was in need of a dusting. On 8/24/16, at 12:14 p.m. the environmental services director (ESD) confirmed the maintenance department had not cleaned the dishwashers, freezers, or other kitchen equipment on a routine basis. ESD stated the maintenance department worked off of a work order system, and upon request of the kitchen staff would clean or repair equipment on an as needed basis. Cleaning of Dish Machine in the Kitchen policy	F 371	for 2 weeks, then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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F 371	Continued From page 77 dated 10/3/15, indicated dietary personnel would be responsible for monitoring the condition of the dishwasher. Environmental services department would be responsible for deep cleaning the dishwasher on an as needed basis. When the machinery became dusty or dirty, beyond what would be considered daily cleaning, dietary personnel would fill out a work order for maintenance personnel. The Monthly Cleaning checklist for 7/2016, was incomplete with just initials indicating the shelving in the walk-in refrigerator had been wiped down and the juice machine cleaned. The Cleaning Schedule check list for the week of 8/15/16, was completely blank indicating no cleaning had occurred in the kitchen area. The Storage policy for the Dietary department dated 7/7/08, indicated the dietary department would provide clean storage for all food and supplies. The frozen food storage areas would be cleaned by the food service staff on a monthly basis.	F 371		
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	F 441		9/27/16

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F 441	Continued From page 78 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow contact precautions during personal meals for 1 of 1 resident (R15) who was observed to receive assistance with meals while in contact precautions. In addition, the facility failed to establish a system in which personal laundry was cared for in a manner to prevent the spread of infections. Findings include: R15's face sheet printed 8/25/16, indicated	F 441	R#15 Contact Precautions were lifted on 9/2/16. A system was established for cleaning the washing machines between loads. All residents requiring contact precautions have the potential to be affected by a deficient practice in this area. The linen handling policy/procedure was reviewed and revised. Laundry staff were re-educated on the procedure for cleaning	

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F 441	Continued From page 79 diagnoses that included chronic systolic heart failure, edema, and type 2 diabetes. R15's physician's progress note dated 8/25/16, at 8:15 a.m. indicated R15 had impetigo (a contagious bacterial skin infection) on her upper lip where her oxygen tubing rests. R15 was prescribed Bactroban (an antibacterial cream). R15's quarterly Minimum Data Set (MDS) dated 5/19/16, indicated R15 was totally dependent for bed mobility, transfers and toileting. The MDS further stated R15 was incontinent of bladder but continent of bowel. On 8/23/16 at 4:16 p.m. a sign was observed on R15's door advising visitors to check with the nurse before entering the room. An isolation cart was outside the room with gowns and gloves. On 8/24/16, at 12:14 p.m. registered nurse (RN)-F was observed in R15's room, assisting her with her meal. RN-F did not have gloves on or a gown. Using a fork in her right hand, RN-F's left hand was leaning on an incontinent pad on R15's bed. RN-F's hip was leaning against the bed. On 8/24/16, at approximately 1:00 p.m. RN-F stated she had just wanted in to say "hi" and noticed that R15 needed assistance eating. RN-F confirmed she should have left the room to don gloves and a gown before providing feeding assistance to R15. On 8/25/16, at 2:11 p.m. the director of nursing (DON) stated her expectation would be that staff providing care or having contact with R15, or with anything in the room, including a remote or helping someone to eat, would put on a gown and gloves.	F 441	the washing machine between loads. All staff were re-educated on contact precautions as it relates to their role/responsibility. Maintenance director/designee will conduct random observational audits to ensure washing machine cleaning procedures are being followed. 3 audits will be completed weekly for 2 weeks, then 2 times weekly for 2 weeks, then weekly for 2 weeks and then monthly thereafter. Random observational audits for contact precautions during personal meals will be completed at the time of implementation of contact precautions. 2 random audits will be completed weekly for 2 weeks, then weekly for 2 weeks then monthly thereafter if/when contact precautions are implemented. Audit results will be brought to the QAPI committee for review and further recommendation.	

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The facility policy Isolation Precautions-Transmission Based dated 7/13, directed staff to wear gloves while caring for residents. The policy also directed staff to wear a gown for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment.

On 8/25/16, at 3:23 p.m. RN consultant and RN-A explained the facility linen handling practices. RN-A stated the facility laundry such as towels, blankets, sheets, etc. were washed by a contracted services facility. However, the resident's personal clothing was washed by the facility staff members. When questioned if the facility staff members had a system to ensure the cleanliness of the washing machines between loads, both RN's were unable to stated how the laundry was processed.

On 8/25/16, at 3:30 p.m. the laundry room was observed with RN-A, RN consultant, and laundry assistant (LA)-A. LA-A stated the personal laundry was washed in standard washing machines. LA-A explained that any contaminated laundry would be washed in the same machines as the standard laundry. When queried if the machines were cleaned in between loads, LA-A stated the machines were wiped down daily with a cleansing wipe. LA-A then pointed to a container of "Wet Tasks Wipes." She confirmed she did not wipe of the machines between adding dirty/contaminated laundry into the machine and removing the clean laundry from the machines.

Review of the Wet Tasks Wipe container indicated the bucket contained alcohol wipes and

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directed the consumer to add a cleaning agent to the container to ensure the wipes were wet. LA-A stated she did not know what type of cleaning agent was added to the wipes. The Wet Tasks container did not indicate what type of microorganisms it could eliminate.

On 8/25/16, at 4:17 p.m. the maintenance director stated the housekeeping staff members added the same solution they used to clean the bathrooms to the Wet Tasks containers.

The Material Safety Data Sheet (MSDS) dated 3/16/10, indicated the chemical used by the housekeeper for the bathrooms was a "non- acid restroom disinfectant/cleaner." The activities ingredient in the chemical was noted to be ammonium chloride.

The MSDS sheet for Kimtech Alcohol Antibacterial Wipe (Wet Tasks wipes) dated 12/2011, indicated the the active ingredient in the wipes was isopropanol (rubbing alcohol).

On 8/25/16, at 4:20 p.m. RN consultant confirmed rubbing alcohol and ammonia are not active chemicals which have the ability to eliminate common infectious diseases in nursing facilities such as clostridium difficile (c-diff), Methicillin resistant staph aureus (MRSA), vancomycin resistant enterococcus (VRE), or other common potentially infectious diseases.

The Linen Handling Policy dated 10/14/15, directed the staff to wipe the outside of the washing machine down with Kimtech wipes (surface sanitizing wipes) after each load of clothing.

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F 465	Continued From page 82	F 465		
F 465 SS=F	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 the freezers in 2 of 2 kitchenettes (kitchenettes in Town Square unit and the Activity Room) were maintained in a sanitary manner. This had the potential to affect all 38 residents who had the potential to receive food from the the kitchenettes. Findings include: On 8/24/16, at 9:40 a.m. on tour of the kitchenette in the Town Square unit DM confirmed the following: - The refrigerator had a large tan colored, hardened, liquid stain on the bottom shelf. - The oven had a large dark brown coating/stain covering ¾'s of the bottom of the oven. DM stated it appeared the bottom shelf of the oven also had dried burnt pizza cheese debris. DM confirmed it looked like the oven "could be wiped out a bit." - The microwave oven had dried splashed red sauce on the inside panels. DM stated the activity staff were responsible for cleaning the refrigerators, ovens and microwaves in the kitchenettes. However, the DM was responsible for overseeing that the activity department cleaned the kitchenette equipment. On 8/24/16, at 9:48 p.m. on tour of the kitchenette in the Activity Room the DM and	F 465	The refrigerators and freezers in Towns Square unit was cleaned. The refrigerator and freezer in the activity room was cleaned. The oven and microwave in Town Square was cleaned. The microwave in the activity room was cleaned and the toaster oven was removed. All resident have the potential to be affected by a deficient practice. Policies and procedures were reviewed and revised as needed. Activity staff were re-educated on the cleaning schedule. Activity director or designee will conduct random observational audits. 3 audits will be conducted weekly for 2 weeks then 2 times per week for 2 weeks, then weekly for 2 weeks, then monthly thereafter.	9/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 83 activity coordinator (AC) confirmed the following: - The microwave had dried food particles adhered to all inside panels of the microwave, including the glass on the front door of the microwave. - The upper freezer compartment needed to be cleaned. The floor of the freezer compartment and side door of the freezer had food debris crumbs and stained ice cream spills. - The toaster oven was dirty with dried burnt food debris, crumbs, and a layer of grime on the bottom and sides of the inside panels of the toaster oven. AC confirmed the toaster oven and microwave should be cleaned after each use. AC verified the last time the microwave had been cleaned was about a month ago. AD and DM confirmed they did not have a cleaning schedule for the kitchenettes' microwave, refrigerator, freezer, toaster oven, and oven. The Storage policy for the Dietary department dated 7/7/08, indicated the dietary department would provide clean storage for all food and supplies. The frozen food storage areas would be cleaned by the food service staff on a monthly basis.	F 465	Audit results will be brought to the QAPI committee for review and further recommendation.	

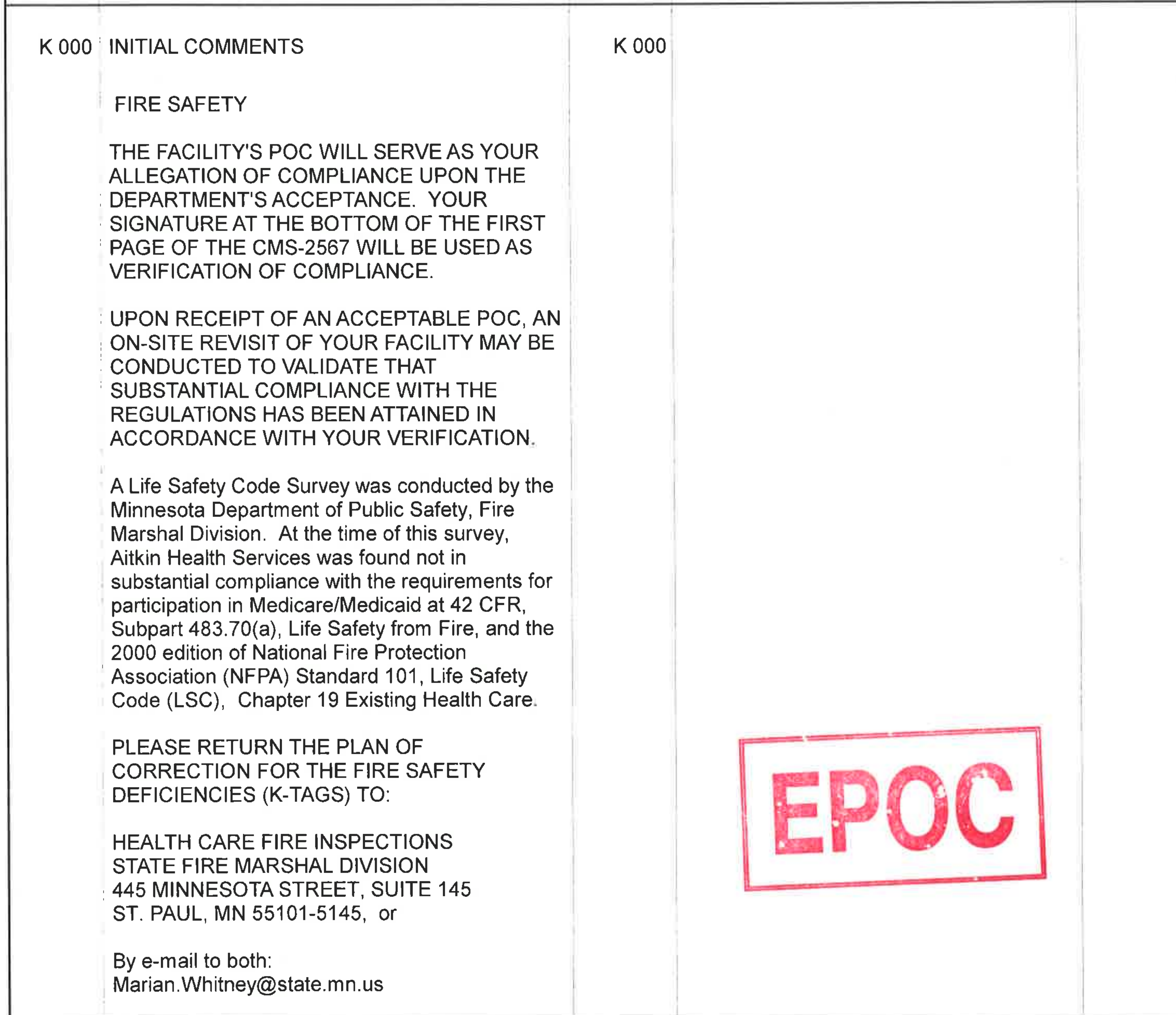
F5119025

PRINTED: 09/22/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/23/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH** **AITKIN, MN 56431**



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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Aitkin Health Services 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 STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/23/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH** **AITKIN, MN 56431**

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K 000	Continued From page 1 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. Aitkin Health Services is a one story building with a full basement. The original building was constructed in 1955 with additions in 1962, and a dining room main entry was added in 2002. Both the existing building and the addition are type II(111) construction. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 48 beds and had a census of 37 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 011	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		9/27/16

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	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/23/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH** **AITKIN, MN 56431**

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K 011 SS=E	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 12 of 48 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, observations revealed that there is a 2.5 inch by 2.5 inch square opening located in the 2 hour fire barrier located in resident room 131 above the ceiling tile. This deficient condition was verified by a Maintenance Supervisor.	K 011	Room 131 fire-rated sheetrock and fire-rated caulking were used to close the opening. The Director of Environmental Services inspected the 5 firewalls and smoke barriers in the facility. Two additional openings were identified and closed. When new construction takes place within the walls, the Director of Environmental Services will inspect to ensure there are no openings and if any arise they will be closed.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded	K 018		9/27/16

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K 018	Continued From page 3 core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 2 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.6.3.2. This deficient practice could affect 20 of 48 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, observations revealed that the following deficient conditions were found affecting corridor doors: 1. a brick was found propping resident room 131 door open - the brick was removed at the time of the discovery 2. Resident rooms 113,115,123,and 124 have corridor doors that did not fully close and latch into the door frames	K 018	On 08/23/2016 Room 131 brick was removed. All other doors in the facility were evaluated and no bricks were found propping any door. Rooms 113, 115, 123 and 124 were be modified by a general contractor to ensure doors fully close and latch. Four additional doors were identified and modifications made. Staff were re-educated not to prop doors open. Director of Environmental Services or designee will conduct random audits. Monthly audits will be completed to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendation.	

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K 018	Continued From page 4 This deficient condition was verified by a Maintenance Supervisor.	K 018		
K 022 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 1 of several non-required doors leading to the exterior that do not lead to the public way in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 7.10.1.7 and 7.10.8.1. These deficient practices could negatively affect residents, as well as an undetermined number of staff, and visitors by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, observations revealed that In the lower level cafe dining room there is a door that is not a required exit that leads to an enclosed courtyard that does not directly lead to the public way. This door is not part of the facility's required exits and is not labeled with a sign that reads as follows: "NO EXIT". The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO".	K 022	Lower level café dining room door had "NO EXIT" sign placed on 8/23/2016. Director of Environmental Services identified two additional doors in the facility that do not lead to the public way. "NO EXIT signs were placed on these two doors on 9/20/2016.	9/27/16

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K 022	Continued From page 5 This deficient condition was verified by a Maintenance Supervisor.	K 022		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 48 of 48 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, the following deficient conditions were found affecting the facility's fire alarm system: 1. A review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 1 of 12 monthly tests of the digital alarm communicator transmitter	K 052	Director of Environmental Services will document on a monthly base the testing of the digital alarm communicator transmitter. The opening in the Mechanical Room on Town Square will be closed with fire-rated bags. The damaged area of the ceiling was plastered on 9/16/2016. Director of Environmental Services inspected the facility to ensure no openings or any of the ceilings are damaged surrounding the smoke detectors.	9/27/16

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	245119	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/23/2016

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K 052	Continued From page 6 (DACT). 2. There is a smoke detector in the mechanical room located by resident room 138 that has been installed on the ceiling between a cable try with an approximate 3 by 9 opening in the ceiling and an area of ceiling that is damaged and is missing plaster. This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility faille to ensure that the automatic sprinkler system is installed in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 1999 edition sections 5-4 and 5-5. This deficient condition id causing a decrease in the fire protection system capability in the event of an emergency that could affect residents, as well as an undetermined number of staff, and visitors.	K 056	The two quick response sprinkler heads in the lower kitchen area were replaced by a contractor with standard response heads on 9/12/2016. Director of Environmental Services did not identify any mixed sprinkler heads in the same compartment throughout the facility.	9/27/16

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K 056	Continued From page 7 Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, observation and staff interviews revealed that there are 2 quick response fire sprinkler heads mixed with standard response heads in the same compartment that are located in the lower level kitchen exit area. This deficient condition was verified by a Maintenance Supervisor.	K 056		
K 154 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 48 of 48 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, during a records review and an interview with the Maintenance Supervisor, the	K 154	Director of Environmental Services revised System out of Service policy to include State Fire Marshal's contact information on 8/25/2016. The policy will be updated as needed with the appropriate contact information when there are changes.	9/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/23/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 154	Continued From page 8 facility did not have an acceptable fire sprinkler system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated. This deficient condition was verified by a Maintenance Supervisor.	K 154		
K 155 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 48 of 48 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current State Fire Marshal's contact information in	K 155	Director of Environmental Services revised System out of Service policy to include State Fire Marshal's contact information on 8/25/2016. The policy will be updated as needed with the appropriate contact information when there are changes.	9/27/16

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	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/23/2016**

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K 155	Continued From page 9 the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor.	K 155		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING 02 - AITKIN HEALTH SERVICES B. WING ______	08/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Aitkin Health Services Bldg 02 2009-2010 Addition 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 STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to both:

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/2016

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING **02 - AITKIN HEALTH SERVICES** B. WING _______	**08/23/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH** **AITKIN, MN 56431**

(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	K 000		

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.

Aitkin Health Services Bldg 02 - 2009-2010 addition, is one story building with a full basement that was determined to be of Type II(111) Constructions that is separated from the rest of the facility by 2 hour fire rated construction.

The building is fully sprinkler protected. The facility has a fire alarm system, with full corridor smoke detection and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that are interconnect with each other and is transmit to the nurses station.

The facility has a licensed capacity of 48 beds and had a census of 37 at the time of the survey.

The requirement at 42 CFR Subpart 483.70(a) is

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K 000	Continued From page 2 NOT MET.	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4., 18.3.6.3.2, 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 48 of 48 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, observations and a review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 1 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by a Maintenance Supervisor.	K 052	Director of Environmental Services will document on a monthly base the testing of the digital alarm communicator transmitter.	9/27/16

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K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly maintain the automatic sprinkler system in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.3.5.1, and "The Standard for the Installation of Sprinkler Systems" 1999 edition section 3-2.7.2, 3-2.6.3, 5-5.6, and 6-1.1.5. This deficient practice does not ensure that the fire sprinkler system will function properly and is fully operational in the event of a fire and could negatively affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, observation revealed that there is a sprinkler head located in the southwest exit stairwell that has been inadvertently painted from over spray during a recent painting operation. This deficient condition was verified by a Maintenance Supervisor.	K 062	The sprinkler head located in the southwest exit stairwell was replaced on 9/12/2016. Director of Environmental Services inspected all sprinkler heads in the facility, no others were identified as being painted or in need of replacement.	9/27/16
K 154 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the	K 154		9/27/16

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K 154	Continued From page 4 sprinkler system has been returned to service. 9.7.6.1. This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 48 of 48 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated. This deficient condition was verified by a Maintenance Supervisor.	K 154	Director of Environmental Services revised System out of Service policy to include State Fire Marshal's contact information on 8/25/2016. The policy will be updated as needed with the appropriate contact information when there are changes.	
K 155 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	K 155		9/27/16

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K 155	Continued From page 5 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 48 of 48 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:00 AM to 2:00 PM on 08/23/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor.	K 155	Director of Environmental Services revised System out of Service policy to include State Fire Marshal's contact information on 8/25/2016. The policy will be updated as needed with the appropriate contact information when there are changes.	