MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 1, 2016

Ms. Anna Sheridan, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

Subject: Pleasant Manor Inc - IDR
CMS Certification Number (CCN): 24 5090
Project Number: S5090025

Dear Ms. Sheridan:

This is in response to your letter of November 20, 2015, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F314 issued pursuant to the survey event LM2411, completed on October 23, 2015.

The information presented with your letter, the CMS 2567 dated October 23, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F314 S/S – G 42 CFR § 483.25 (c) Pressure Sores
Based on comprehensive Assessment of a resident, the facility must ensure that—
(1) 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
(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Summary of the facility's reason for IDR of this tag:

The facility disputed the findings based on the fact the resident refused repositioning interventions attempted by the facility, assessed the resident to determine risk factors and interventions needed for pressure ulcer prevention and/ or healing of current pressure ulcers, and ensured the resident was reassessed by nursing, dietary, and occupational therapy.

Summary of findings:

The facility failed to reassess the resident's clinical condition and pressure ulcer risk factor(s) which included defining and implementing timely interventions which were consistent with the individual resident needs, monitoring the impact of the assessed interventions which were in place when multiple pressure ulcers developed, and reassessing and modifying the interventions as determined by an individual assessment when pressure ulcers developed and worsened.

The resident's initial Braden Scale completed on 11/18/14, identified the resident had no pressure ulcers upon admission, was at high risk for skin breakdown, and would be turned and repositioned every 2 hours and as needed, the facility completed no further Braden assessments since the resident's admission.

The resident's Turning and Repositioning Guidance completed on 11/19/14, identified the resident had a high risk Braden score, and directed staff to turn and reposition every 2 hours in bed, and off- load in chair every hour. The facility indicated this was an auto generated form, and when a resident was identified as being at high risk for pressure ulcer development according to the Braden score, the interventions for off-loading every one hour in the chair were automatically added to the assessment. However, the facility was unable to provide a corresponding assessment which determined how the every 2-3 hour repositioning was determined to be adequate for the resident. The facility completed no further Turning and Repositioning Guidance since the resident's admission.

The Pressure Ulcer Comprehensive Clinical Risk assessment completed on 11/18/14, indicated the resident was at high risk for pressure ulcers, had no current pressure ulcers, and directed to offload heels with pillows/ protective boots, reposition in bed and chair every 2 hours, and have pressure relief for heels. The facility had no further Pressure Ulcer Comprehensive Clinical Risk assessment since the resident's admission.

Left Lower back of Leg- The wound assessment detail report dated 3/12/15, indicated the area was trauma/ abrasion first identified on 3/2/15, and measured 4.6 cm x 4.4 cm x .10 cm (L x W x D) with an area of 20.24 cm. The facility continued to monitor, complete dressing changes, and document the measurements of the wound, which continued to get worse. On 6/9/15, the area was identified as 5.3 cm x 5 cm x unknown depth, with an area of 26.5. Although the pressure area on the left lower back of leg continued to worsen, the facility completed no further assessment to ensure the resident did not require further interventions to promote healing, and did not obtain a physician order for an OT evaluation of the resident's wheelchair positioning until 8/3/15, per request of the resident's son. The OT Therapist Progress and Updated Plan of care note dated 9/3/15, indicated the resident had left ankle and heal wounds, and weight/ pressure of legs on the calf pads from elevating leg rests on the wheelchair had been contributing to the worsening of calf and heal wounds. OT obtained a different wheelchair and leg rests.

Left heel- The wound assessment detail report dated 5/19/15, indicated the pressure ulcer was first identified on 5/19/15, and measured 1.4 cm x 1.9 cm x unknown depth, with a area of 2.66 cm. On 6/26/15, the pressure ulcer was identified as 3.4 cm x 4.8 cm x unknown depth, with an area of 16.32.

On 8/5/15, the pressure ulcer was identified as 8.4 cm x 6.4 cm x unknown depth, with an area of 53.76, and was noted the tendon was exposed on the left ankle, as the heel and calf pressure ulcers began to combine into one larger area. Although the pressure ulcer on the heel continued to worsen, the facility completed no further assessment to ensure the resident did not require further interventions to promote healing, and did not implement floating the resident heels as assessed on the Pressure Ulcer Comprehensive Clinical Risk assessment completed on 11/18/14, until 7/21/15, when a heel wedge was implemented. The resident's wheelchair was not evaluated by OT to ensure pressure was relieved from the heel when up in the wheelchair until 9/3/15.

Coccyx- The wound assessment detail report dated 6/3/15, indicated the pressure ulcer was first identified on 6/3/15, as a stage II, 1.1 cm x 1.6 cm x unknown depth, with an area of 1.76 cm. The current plan of care/ comments on the assessment indicated it was a new area, and the facility would reposition the resident "frequently," however, there was no corresponding assessment which changed the repositioning schedule that was put into place on admission. On 6/29/15, the wound assessment detail report indicated the pressure ulcer was 4.3 cm x 2.5 cm x 0, with an area of 10.75 cm. The current plan of care/ comments indicated upper and lower coccyx areas had combined. There was no corresponding assessment to determine if the current repositioning schedule was effective to promote healing of the pressure ulcer, nor were the current interventions in place reviewed. The OT assessment dated 8/12/15, indicated the resident was having pain in the buttocks, and the OT removed the hoyer sling and the patient reported immediate increased comfort. OT indicated she had educated the nurse manager, however, there was no direction to staff on the care plan to ensure the hoyer sling was removed from under the resident. The nursing assistant care sheet dated 10/23/15, did instruct staff to remove the hoyer sheet after the resident was seated in the wheelchair, although the resident was observed sitting on the hoyer sheet while on survey.

The resident's care plan dated 12/4/14, directed staff to reposition the resident every two to three hours and PRN. The repositioning schedule had not been reassessed since the initial assessment despite the multiple, worsening pressure ulcers. The Nursing Assistant Care sheet dated 10/23/15, directed staff to turn and reposition every one hour in the wheelchair, and every two hours in bed. During multiple observations identified on the 2567, the resident was observed to not be repositioned, nor did staff offer to reposition, during one observation for 2 hours and 53 minutes while in bed, and 2 hours and 15 minutes while in the wheelchair. In addition, the 2567 identified observations of pressure directly on the resident's pressure ulcers on the left calf, left heel, and coccyx.

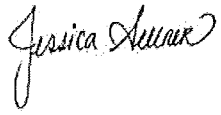
Although the facility indicated the resident refused repositioning, there was no corresponding documentation or assessments completed to determine what other interventions could be attempted to ensure pressure was relieved.

This is a valid deficiency at F314 and at the correct scope and severity (S/S) of G.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Jessica Sellner, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 320-223-7343 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Gayle Lanto, Metro D Unit Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LM24

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00568

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245090**
2.STATE VENDOR OR MEDICAID NO.
(L2) **270543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PLEASANT MANOR INC**
(L4) **27 BRAND AVENUE**
(L5) **FARIBAULT, MN** (L6) **55021**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/22/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)
13.Total Certified Beds **65** (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
	65			
(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 :
Jane Teipel, HFE NEII 01/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/21/1967
(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
12/11/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245090

January 27, 2016

Ms. Anna Sheridan, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, MN 55021

Dear Ms. Sheridan:

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 December 2, 2015 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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 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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 27, 2016

Ms. Anna Sheridan, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

RE: Project Number S5090025

Dear Ms. Sheridan:

On November 12, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 2, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 23, 2015, effective December 2, 2015 and therefore remedies outlined in our letter to you dated November 12, 2015, 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
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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
245090 Y1	A. Building B. Wing Y2	12/22/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	27 BRAND AVENUE FARIBAULT, MN 55021

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 F0176	Correction	ID Prefix F0274	Correction	ID Prefix F0278	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(g) - (j)	Completed
LSC	12/02/2015	LSC	12/02/2015	LSC	12/02/2015
ID Prefix F0279	Correction	ID Prefix F0281	Correction	ID Prefix F0282	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	12/02/2015	LSC	12/02/2015	LSC	12/02/2015
ID Prefix F0309	Correction	ID Prefix F0312	Correction	ID Prefix F0314	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed
LSC	12/02/2015	LSC	12/02/2015	LSC	12/02/2015
ID Prefix F0356	Correction	ID Prefix F0371	Correction	ID Prefix F0412	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.55(b)	Completed
LSC	12/02/2015	LSC	12/02/2015	LSC	12/02/2015
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	12/02/2015	LSC	12/02/2015	LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	GL/mm	01/27/2016	28230	12/22/2015
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/23/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LM24

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00568

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245090**
2.STATE VENDOR OR MEDICAID NO.
(L2) **270543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PLEASANT MANOR INC**
(L4) **27 BRAND AVENUE**
(L5) **FARIBAULT, MN** (L6) **55021**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/23/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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 :
Jane Teipel, HFE NEII — 12/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/21/1967
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 12, 2015

Ms. Anna Sheridan, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, MN 55021

RE: Project Number S5090025

Dear Ms. Sheridan:

On October 23, 2015, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

<u>Informal Dispute Resolution</u> - 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Gayle.Lantto@state.mn.us
Telephone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 2, 2015, 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 December 2, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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 January 23, 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 April 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution

policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the safe practice of self-administration of medications for 1 of 1 resident (R130) who was observed self-administering a nebulizer treatment. Findings include: R130's nebulizer (used to administer medication into the lungs) medication treatment was set up on 10/20/15, at 5:35 p.m. by a licensed practical nurse (LPN)-A. LPN-A gave R130 the hand-held device, instructed her to take deep breathes,	F 176	F 176 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:	12/2/15

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

Electronically Signed | 11/20/2015

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F 176	Continued From page 1 turned the nebulizer machine on and left the room. R130 was lethargic at the time, and was not holding device to mouth, however, the machine continued to run. At 5:40 p.m. R130 was observed lying sideways across her bed with the nebulizer treatment held to her side, and her hand was resting on the bed. R130 then attempted to take her first two inhalations from the nebulizer machine. LPN-A returned to the room from the hallway at 5:42 p.m. out of the sight of R130, to administer oral anti-anxiety medication. LPN-A again left the room. R130 then put the device on her abdomen while it continued to run without benefit. The nurse returned to R130's room at 5:45 p.m. and instructed the resident to take a "few more puffs." At 5:47 p.m. the nurse turned the machine off. On 10/22/15, at 8:10 a.m. R130 was again observed in her room, self-administering her nebulizer medication via the hand held device. Staff was not within sight of the resident. At 8:12 a.m. a registered nurse (RN)-B stated she usually stood in the hallway where she could visualize R130 while she was utilizing the nebulizer machine, "so I can make sure she is using it correctly." She verified she was not, however, in sight of R130 when she administered the medication that day. At 8:15 a.m. R130 continued using the hand held device independently. Staff was not in her room nor in the hallway adjacent to R130's room. The Admission Record for R130 indicated she was admitted to the facility on 10/16/15 with diagnoses including chronic obstructive pulmonary disease (COPD), and muscle weakness. R130's medication administration record verified she was prescribed DuoNeb	F 176	a. R130 a self administration of nebulizer was completed on 10/22/15.Care plan updated to reflect ability to self administer nebulizer on 10/22/15. Resident discharged from facility to hospital on 10/22/15. b. All residents requiring self administration of medication, including nebulizer, will be assessed for their individual needs upon admission, quarterly, with a significant change and as needed. Care plans and MAR will be revised for individualized needs. c. All licensed staff/ TMA will be re-educated by 12-1-2015 on appropriate procedure of completion of self administration of medication/nebulizer. d. DNS/Designee will audit, self administration of medication/nebulizer, 2 resident□s record per week for 4 weeks and then 1 resident□s record for 8 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. e. DNS or designee is responsible f. Completion date 12-2-15	

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F 176	Continued From page 2 Solution 0.5-2.5 milligrams/3 milliliters 1 vial inhale orally four times a day for COPD with a start date 10/16/15. R130 would have had 23 opportunities for nebulizer treatments since her admission to the facility. A Self Administration of Nebulizer's Evaluation was conducted for R130 on 10/22/15, at 9:03 a.m. The comment on the evaluation read, "Resident is able to administer nebulizer with nurse set up." The 2014 Standards Guideline Subject: Self Administration of Medication read that residents who required nebulizer treatments "will be assessed to determine if it is appropriate to leave alone during the nebulizer treatment. Evaluation and approval will be based on the Medication Self Administration Safety Screen. The Medication safety screen will be completed prior to the resident initiating self administration of medications...The IDT [interdisciplinary team] will review the summary of the Medication Self Administration Safety Screen to determine the appropriateness of self administration of medication." During an interview on 10/22/15, at 10:17 a.m. the director of nursing reported she expected staff to complete an assessment to determine appropriateness prior to self-administration of medications.	F 176		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined,	F 274		12/2/15

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F 274	Continued From page 3 that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a significant change in status Minimum Data Set (MDS) for 1 of 1 resident (R86) who developed pressure ulcers and experienced a decline in activities of daily living (ADL's). Findings include: R86 was admitted to the facility in 11/14. Nursing progress notes revealed the resident developed a stage III pressure ulcer to the left calf and an unstageable pressure ulcer to the left heel and left Achilles area. Stage III pressure ulcer is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. Unstageable ulcer is full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and the wound bed...the true depth, and therefore stage, cannot be determined.	F 274	F 274 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a .R86 has had a comprehensive assessment completed. Care plan has been revised to reflect current levels of care. b. All residents with a change in condition will be evaluated for a Significant Change in Condition MDS. Changes in resident conditions are reviewed by IDT team. c. RN responsible for completion of MDS has received re-education regarding significant change MDS requirements.	

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F 274	Continued From page 4 The quarterly Minimum Data Set (MDS) for R86 dated 2/24/15, identified the resident as having severely impaired cognition and required extensive assistance with transferring, locomotion and toilet use. No pressure ulcers present. The quarterly MDS dated 5/26/15, identified the presence of an unstageable ulcer and required total assistance with transferring, locomotion and toileting. During an interview on 10/22/15, at 1:45 p.m. the MDS nurse verified no significant change assessment had been completed. The MDS nurse explained the need for changes in assessments was discussed at morning meetings, however, "I guess that one didn't get discussed." In an interview on 10/23/15, at 11:07 a.m. the director of nursing verified a significant change assessment should have been completed for R86 due to the development of the pressure ulcers and decline in ADL's.	F 274	d. Nursing staff will receive re-education on significant change in abilities by 12/1/15. e. DNS/ Designee will audit 2 resident medical records weekly for 4 weeks then 1x weekly for 4 weeks for significant change. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. f. DNS or designee is responsible g. Completion date 12-2-15	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278		12/2/15

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F 278	Continued From page 5 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure annual and significant change Minimum Data Set (MDS) assessments were correct for 1 of 1 residents (R28) who was reviewed for oral/dental concerns. Findings include: R28 was observed on 10/20/15, at 1:59 p.m. and was missing upper teeth and the bottom were broken, with only stumps of teeth left. R28 was not able to interview. An Oral/Dental Assessment Form dated 6/22/15, completed by a licensed practical nurse (LPN) indicated R28 had no dentures, no loose teeth and no obvious or likely cavity. The form indicated R28 had her own teeth, had broken missing teeth.	F 278	F 278 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R28 an Oral/ Dental Assessment was completed on 11/13/15. Care plan and Nursing Assistant assignment sheet updated to reflect current cares. On 11/4/15 family declined dental services.	

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F 278	Continued From page 6 R28's annual MDS dated 6/23/15, indicated R28 was cognitively severely impaired and required total dependence assist of oral care needs. R28's oral status indicated there were obvious cavities or broken teeth. The corresponding Care Area Assessment (CAA) indicated R28 had some missing teeth and some broken and resident received a pureed diet. The CAA indicated R28 was dependent on staff for all activities of daily living (ADLs). R28's Oral/Dental Assessment Form dated 8/13/15, completed by a licensed practical nurse (LPN) indicated R28 had no dentures, had own teeth, had no broken, no missing, no loose teeth and no obvious or likely cavity. A significant change MDS dated 8/17/15, indicated R28 was cognitively severely impaired and required total dependence assist of oral care needs. R28's oral status however, indicated there were no natural teeth or tooth fragment(s)/edentulous. The corresponding CAA indicated that R28's oral cares are completed twice daily and as needed. The CAA indicated R28 refuses to wear dentures and signs and symptoms of pain are monitored daily. A nursing assistant (NA)-C was interviewed on 10/21/15, at 1:20 p.m. stated R28 had some stumps to the bottom gums, but did not have any other teeth. NA-C reported she had never seen R28 with dentures before and said, "I don't think she came with dentures." A registered nurse (RN)-E was interviewed on 10/22/15, at 8:15 a.m. RN-E stated she took information from the assessments and used it to	F 278	b. Nursing staff will receive re-education on completion of Oral/Dental assessment by 12/1/15. c. All residents will to be assessed for their individual dental and oral needs upon admission, quarterly, with a significant change and as needed. Care plans will reviewed for individualized dental/ oral needs. d. RN responsible for completion of the MDS has been re-educated regarding accuracy of the MDS. e. All nursing staff will receive re-education regarding oral cares. f. DNS/designee will audit, oral/dental assessment, 2 residents per week for 4 weeks, then 1 resident per week x 8 weeks for oral/dental needs by observation and medical record review. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. g. DNS or designee is responsible h. Completion date 12-2-15	

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F 278	Continued From page 7 code the MDS assessments. She noted that she did not physically assess a resident, but if she had any questions she asked the nurse manager. RN-E verified the assessment and MDS coding were inconsistent. RN-E stated, "I think the coding is wrong but I have to go back and look at the two MDS's and compare." A 8/15, Completion of the RAI [Resident Assessment Information] Process directed that, "Staff will complete the MDS sections assigned to them by utilizing resident assessments (UDA's), resident interview, staff interview, and observation of the resident while performing routine activities during the assessment reference period."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		12/2/15

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F 279	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for 1 of 3 residents (R34) who was reviewed for bruising. Based on interview and document review, the facility failed to develop a compressive individualized plan of care related to oral/dental care for 1 of 1 residents (R28) in the sample identified with oral/dental concerns. Findings Include: Findings include: R34 was observed on 10/19/15, at 1:29 p.m. The following skin issues were present: a skin tear to the left outer elbow, very darkened skin on arms and appeared bruised from the top of the hands past the elbows and onto the upper arms, a dark purple bruise approximately two centimeters (cm) in width to the right hand base of thumb (different than on the arms) extending from the knuckle of the thumb back to the wrist. R34 explained he bumped it when he fell last week. R34 stated he had very thin skin, and if he bumped into anything he sustained a skin tear or bruise. R34's medical record revealed he returned from the hospital 10/8/15. The nursing admission screening/history dated 10/8/15, identified multiple area of discoloration to both arms. Nursing progress notes identified R34 fell in his room 10/16/15, resulting in a skin tear to the left elbow. Skilled charting from 10/19/15 to 10/22/15 lacked information related to the bruise on R34's	F 279	F279 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to resident R28 care plan was updated to include oral care on 10/25/15. b. All residents will be assessed for their individual dental and oral needs upon admission, quarterly, with a significant change and as needed. Care plans will revised for individualized dental/ oral needs when appropriate. c. R34 daily bruise/skin monitoring was initiated on 10-25-15. Resident was discharged from the facility on 11-12-15 d. All residents receive a comprehensive skin assessment on admission, quarterly and with a significant change. Skin conditions observed daily with cares. IDT review of all alterations in skin. e. All nursing staff will receive re-education by 12-1-15 regarding documentation of impaired skin, revision of care plan, notification of family and MD. f. The DNS/Designee will audit 2	

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F 279	Continued From page 9 right hand. The nursing assistant care sheets identified R34 was at risk for bruising. The care plan dated updated 10/19/15, directed staff to report any change in skin such as redness, bruising, cuts to the nurse, weekly skin inspection by nursing and report any skin breakdown or open areas to nursing. A Medicare 5-day Minimum Data Set (MDS) dated 10/15/15, noted the resident was cognitively intact. In an interview with a registered nurse A (RN)-A on 10/22/15, at 8:38 p.m. it was verified the care plan had not been followed related to reporting skin conditions to the nurse. R28's care plan dated 9/23/25, identified activities of daily living (ADL) self care performance /mobility deficit related to end stage Alzheimer's type dementia, contracture in joints to multiple sites. Goal, "will be neat and clean and needs will be met daily through the review date." Among the interventions include, "Eating: See NA assignment sheet. Dressing, grooming, personal hygiene, oral care: See NA assignment sheet." Another intervention identified on the care plan was "coordination of care with hospice services." However, document review revealed that R28 was discharged from hospice on 8/11/15. Nursing assistant (NA) care sheet updated 10/20/15, identified R28 has needing assist of one in the dining. NA care sheet also Indicated that R28 did not have dentures and at the same time that R28 refuses to wear dentures. R28's care plan and NA care sheet does not address how oral/dental cares are supposed to be carried out. R28's annual Minimum Data Set (MDS) dated	F 279	resident medical records per week for 4 weeks and then 1 weekly for 4 weeks to ensure interventions for impaired skin and oral/ dental interventions are present. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. g. DNS or designee is responsible h. Completion date 12-2-15	

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	245090	A. BUILDING _____ B. WING _____	10/23/2015

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F 279	Continued From page 10	F 279		

6/23/15, indicated R28 was cognitively severely impaired and required total dependence assist of oral care needs. R28's oral status indicated there were obvious cavities or broken teeth. The corresponding Care Area Assessment (CAA) indicated that R28 had some missing teeth and some broken and resident was on pureed diet. The CAA indicated R28 was dependent on staff for all activities of daily living (ADLs)

R28's Oral/Dental Assessment Form dated 6/22/15, completed by a licensed practical nurse (LPN) indicated R28 had no dentures, no loose teeth and no obvious or likely cavity. Form indicated R28 had her own teeth, had broken teeth and had missing teeth.

Nursing assistant (NA)-C was interviewed on 10/21/15, at 1:20 p.m. stated that R28 had some stumps to the bottom but does not have any other teeth. NA-C stated that she uses the "pink swabs" toothettes to do R28's oral care. When asked how she knows what to use, NA-C stated, "we just do it".

Licensed practical nurse (LPN)-B was interviewed on 10/21/15, at 1:29 p.m. stated that R28 did not have any teeth. Stated that NAs uses a "soft brush" to do R28's oral care. When asked who determines what to be used, LPN-B stated that, "It's up to nursing assistants" discretion. When asked how the NAs know what to do, LPN-B stated that, "they have care sheets with information."

Registered nurse (RN)-A was interviewed on 10/21/15, at 1:36 p.m. stated that she's the one responsible with updating the NA care sheets and that she does it everyday. RN-A stated that R28

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F 279	Continued From page 11 does not have any dentures. RN-A verified that the NA care sheet was not up to date and that R28's care plan does not address oral care routine. A facility's undated Care Plan Policy and Procedure directed that, "Plans and interventions are what staff do to help the resident reach his/her goals. Plans and interventions should be specific, saying what we plan to do, when we plan to do it and the frequency. Plans and interventions should be realistic. If we say we will bathe a resident twice weekly, we must bathe them at least twice weekly or be sure to document this is not being done."	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication was not administered together via the tube unless determined the best practice for the individual for 1 of 1 resident (R2) observed for medications administered through at gastric feeding tube. Findings include: R2's medications administration was observed on 10/22/15, at approximately 8:00 a.m. by a registered nurse (RN)-B. RN-B set up R2's medication by placing 11 of 12 morning medications into a four-ounce drinking cup after	F 281	F 281 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. R2 a. new order was obtained on	12/2/15

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F 281	Continued From page 12 crushing. Next she measured two milliliters (ml) of liquid Neurontin (for seizures or neuropathic pain) and added it to the cup. RN-B then filled the cup with 60 ml of water and proceeded to R2's room. After explaining the procedure to R2 and checking for placement of g-tube, she poured the contents of the cup into a 30 ml syringe and allowed the medication to go into the g-tube via gravity. She flushed the tube with 30 ml of tap water. When the surveyor inquired as to whether R2 had physician order to administer the medications together RN-B responded ,"Probably not, but I will get one today." She explained she always administered the medication in the manner observed. RN-B verified R2 did not have a current order to cocktail (administer all medications together) R2's medications. A 2007, Administration of Medication via Tube Feeding Guidelines noted "There must an order from the physician for cocktailing of medications. Medications given individually would normally would be flushed with 10 cc water after each medication and after the last medication a 30 cc flush would be given. (Verify with physician.) If there is an order to cocktail medications, this would be followed by a 30 cc flush of water. (Verify with physician)." During an interview on 10/22/15, at 10:17 a.m. the director of nursing stated she expected the staff to obtain a physician order indicating the practice of administering multiple medications via g-tube was appropriate for R2 versus according to standards of practice.	F 281	10/22/15 to cocktail medications and administer via G tube. Care plan updated to reflect current orders b. All licensed staff will be re-educated by 12-1-15 regarding assessment and MD order to cocktail medications via G-Tube. c. Residents receiving medications via G-Tube will be assessed for ability to cocktail medications upon admission, quarterly, significant change and initiation of a new medication. e. DNS/Designee will audit 1 medical record per week for Tube feeding medication administration for 12 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits f. DNS or designee is responsible g. Completion date 12-2-15	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		12/2/15

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F 282	Continued From page 13 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for 1 of 3 residents (R34) reviewed for bruising. Findings include: R34 was observed on 10/19/15, at 1:29 p.m. The following skin issues were present: a skin tear to the left outer elbow, very darkened skin on arms and appeared bruised from the top of the hands past the elbows and onto the upper arms, a dark purple bruise approximately two centimeters (cm) in width to the right hand base of thumb (different than on the arms) extending from the knuckle of the thumb back to the wrist. R34 explained he bumped it when he fell last week. R34 stated he had very thin skin, and if he bumped into anything he sustained a skin tear or bruise. R34's medical record revealed he returned from the hospital 10/8/15. The nursing admission screening/history dated 10/8/15, identified multiple area of discoloration to both arms. Nursing progress notes identified R34 fell in his room 10/16/15, resulting in a skin tear to the left elbow. Skilled charting from 10/19/15 to 10/22/15 lacked information related to the bruise on R34's right hand. The nursing assistant care sheets identified R34 was at risk for bruising. The care plan dated updated 10/19/15, directed staff to report any change in skin such as redness,	F 282	F 282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. R34 daily bruise/skin monitoring was initiated on 10-25-15. Resident was discharged from the facility on 11-12-15 b. All residents receive a comprehensive skin assessment on admission, quarterly and with a significant change. Skin conditions observed daily with cares. IDT review of all alterations in skin c. All nursing staff will receive re-education by 12-1-15 regarding documentation of impaired skin, revision of care plan, notification of family and MD. d. The DNS/Designee will audit 2 resident medical records per week for 4 weeks and then 1 weekly for 8 weeks to ensure interventions for impaired skin and oral/ dental interventions are present. The data collected will be reviewed/discussed at the	

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F 282	Continued From page 14 bruising, cuts to the nurse, weekly skin inspection by nursing and report any skin breakdown or open areas to nursing. A Medicare 5-day Minimum Data Set (MDS) dated 10/15/15, noted the resident was cognitively intact. In an interview with a registered nurse A (RN)-A on 10/22/15, at 8:38 p.m. it was verified the care plan had not been followed related to reporting skin conditions to the nurse.	F 282	monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. e. DNS or designee is responsible f. Completion date 12-2-15	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services related to monitoring of bruises for 2 of 3 residents (R34, R128) in the sample identified as having skin conditions. Findings include: R128 was observed and interviewed on 10/20/15, at 5:04 p.m. and the following bruises were identified, all described as dark purple: left hand, left lower and left outer upper arm, right hand, right lower and upper arm. R128 explained the bruising was the result of intravenous (IV) access	F 309	F 309 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. R128, daily bruise/skin monitoring	12/2/15

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F 309	Continued From page 15 at the hospital. When asked about the bruising to the left outer upper arm, R128 stated that it occurred at the hospital, "but I don't know how it happened." R128's husband who was present during the interview stated R128 experienced a fall at the hospital, resulting in the bruise to her upper arm. R128's annual Minimum Data Set (MDS) dated 10/15, indicated R128 required extensive physical assistance from two persons with bed mobility, transferring, locomotion, dressing, toilet use and personal hygiene. R128's admission nursing screening history identified bruising to right iliac crest and left thigh. No skin issues were identified on R128's Individual Temporary Care Plan dated 10/8/15. Progress Notes indicated R128 had a bath on 10/14/15, at 9:44 p.m. The note identified that R128 had a slight redness to top of buttock and swelling to ankles. "No other skin issues or complaints of pain." A Weekly Skin Inspection dated 10/14/15, identified redness to R128's buttock area. None of the documentation revealed R128's bruising on her hands and arms. A registered nurse (RN)-B was interviewed on 10/21/15, at 3:06 p.m. and explained that when a resident was admitted with bruises, they were measured, charted in the progress notes and noted in the treatment administration record (TAR) for monitoring. RN-B acknowledged that although she had seen R128's bruises, she did was unaware staff was not monitoring for healing. RN-B stated, "I should expect to see documentation in the chart about bruises if a resident has one."	F 309	started on 10/25/15.Resident discharged from facility on 10/29/15 to home. b. R34, daily bruise/skin monitoring form started on 10/25/15. Resident was discharged from facility on 11/12/15. c. All residents receive a comprehensive skin assessment on admission, quarterly and with a significant change. Skin conditions observed daily with cares. IDT review of all alterations in skin d. All nursing staff will receive re-education by 12-1-15 regarding documentation of impaired skin, revision of care plan, notification of family and MD. e. The DNS/Designee will audit 2 resident medical records per week for 4 weeks and then 1 weekly for 4 weeks to ensure interventions for impaired skin and oral/ dental interventions are present. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. f. DNS or designee is responsible g. Completion date 12-2-15	

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F 309	Continued From page 16	F 309		

RN-C was working with R128 was interviewed on 10/23/15, at 8:31 a.m. RN-C stated that when a resident was admitted with bruises, they were supposed to be measured, charted in progress notes and monitored until healed.

Later that morning, at 8:38 a.m. RN-C verified there was no documentation of R128's bruising to bilateral hands and arms in the chart. RN-C stated, "I'm not usually her nurse, but I have seen the bruises. I didn't know there was no monitoring being done." RN-C indicated at 8:47 a.m that she had started a monitoring sheet in R128's TAR.

RN-D was interviewed on 10/23/15, at 9:01 a.m. and stated R128's bruises should have been measured and documented during the admission assessment and then monitored afterward. "That's the policy on how we do it." RN-D verified there was no documentation or monitoring in place and stated, "We measure bruises, note them on the progress notes and then monitor them in the treatment record for progress." RN-D admitted she had seen the bruises but had not checked to see they were being documented.

A Daily Wound Monitoring Form Guidelines dated 9/10, directed that "Daily monitoring of pressure and non pressure wounds promotes the early recognition of problems with wound healing, a dressing failure or unrelieved pain associated with the wound or the dressing change."

R34 was observed on 10/19/15, at 1:29 p.m. The following skin issues were present: a skin tear to the left outer elbow, very darkened skin on arms and appeared bruised from the top of the hands past the elbows and onto the upper arms, a dark purple bruise approximately two centimeters (cm)

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F 309	Continued From page 17 in width to the right hand base of thumb (different than on the arms) extending from the knuckle of the thumb back to the wrist. R34 explained he bumped it when he fell last week. R34 stated he had very thin skin, and if he bumped into anything he sustained a skin tear or bruise. R34's medical record revealed he returned from the hospital 10/8/15. The nursing admission screening/history dated 10/8/15, identified multiple area of discoloration to both arms. Nursing progress notes identified R34 fell in his room 10/16/15, resulting in a skin tear to the left elbow. Skilled charting from 10/19/15 to 10/22/15 lacked information related to the bruise on R34's right hand. The nursing assistant care sheets identified R34 was at risk for bruising. The care plan dated updated 10/19/15, directed staff to report any change in skin such as redness, bruising, cuts to the nurse, weekly skin inspection by nursing and report any skin breakdown or open areas to nursing. A Medicare 5-day Minimum Data Set (MDS) dated 10/15/15, noted the resident was cognitively intact. In an interview with a registered nurse A (RN)-A on 10/22/15, at 8:38 p.m. she verified the bruising to R34's right hand had not been reported and was not being monitored. She stated R34 experienced a fall on "Friday" and had very fragile skin. She stated the bruising should have been noted on the treatment or medication administration record and been monitored daily until the bruising resolved.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		12/2/15

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F 312	Continued From page 18 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 ensure a resident received grooming assistance for nail care for 1 of 1 residents (R80) reviewed for activities of daily living (ADLs). Findings include: R80 was observed on 10/20/15, at 6:22 p.m. His fingernails, unclean and were unclipped and somewhat jagged. R80 reported it had been three weeks since his nails had been clipped. He proceeded to show his nails to the surveyor stating, "As you can see, they are too long for any male." On 10/21/15, at 2:55 p.m. R80 was observed attending a resident council meeting, and on 10/22/15, at 7:05 a.m. was wheeling himself in the hallway. During both observations, the resident's nails were again noted to be unclean and unclipped/jagged. Later that morning, at 9:33 a.m. R80 stated his weekly bath day was Saturday and staff had always clipped his nails on his bath day, "up until three weeks ago." He explained that two weeks ago at bath time he requested his nails be trimmed by the nursing assistant (NA). The NA told R80 she would come to his room to complete the task, but "she never came." R80 then explained that, "Last week when I asked, they just ignored me. It bothers me because I don't think a	F 312	F312 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. R80, nail care was completed on 10/22/15. Resident discharged from facility on 11/9/15. b. All residents will be provided nail care weekly and as needed. c. All nursing staff will receive re-education on 12-1-15 regarding nail care. d. DNS/Designee will audit nail care, 2 residents per week for 4 weeks then 1 per week for 8 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. e. DNS or designee is responsible f. Completion date 12-2-15	

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F 312	Continued From page 19	F 312		

male should have long fingernails like that."

Weekly Skin Inspection Sheets signed as completed by a NA and a registered nurse (RN) on 10/17/15. On 10/10/15, nail care was "not completed" as signed by a NA and nurse (signature illegible). On 10/3/15, nail care was not provided and noted fingernails were "ok," and was signed by a NA and trained medication aide (TMA) and then was signed as verified by a RN.

Progress Notes noted nail care was provided on 7/4/15, however, on R80's bath days on 7/11/15, 7/18/15, 7/25/15, 8/1/15, 8/8/15, and 8/16/15 indicated nail care was not provided.

A Care Area Assessment (CAA) dated 12/19/14, noted R80 required extensive assistance of staff 1-2 with all ADLs. A Brief Interview for Mental Status assessment dated 9/8/15, noted R80 was cognitively intact.

RN-A stated on 10/22/15, at 1:47 p.m. she expected NAs to complete nail care on bath days for residents who did not have diabetes. Nail care was documented on weekly bath sheets by the NAs. RN-A stated R80 preferred his nails "longer." RN-A then observed R80's nails with the surveyor and verified his nails were too long and said, "It looks like they haven't been cut in two to three weeks."

During an interview on 10/23/15, at 8:59 a.m. the director of nursing (DON) explained the NAs were directed to complete nail care on a resident's bath day as noted on the Weekly Skin Inspection Sheets. Her expectation was that staff carried through with providing residents with nail care each week. The DON stated the facility did not

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F 312	Continued From page 20 have a policy regarding nail care because it was considered a standard of practice.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to minimize the risk for pressure ulcer development, and to promote healing, for 1 of 3 residents (R86) reviewed for pressure ulcers. This resulted in actual harm for R86 who acquired a stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) to the left heel, a stage III (full thickness tissue loss ulcer to the lower left leg without exposed bone, tendon or muscle) and a stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer) to the coccyx area while in the facility. Findings include: R86 was observed on 10/21/15, at 8:45 a.m. as she was brought back to her room from breakfast and assisted to lie down. R86 was positioned on	F 314	F314 The facility does not agree with various facts and conclusions in the statement of deficiencies and licensing violations and is seeking an appeal at this time. The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. R86 left lower leg wound is identified as vascular in origin and not pressure related. Interventions in place include	12/2/15

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	245090	A. BUILDING _____ B. WING _____	10/23/2015

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F 314	Continued From page 21 her back with feet elevated on a pillow (heels floating at edge of pillow) where she remained until 9:52 a.m. when a licensed practical nurse (LPN)-B entered the room to complete a wound treatment. A very foul odor was noted from the wound with green tinged bloody drainage. At 10:24 a.m. the treatment was completed, the resident was left in the same position. At 10:45 a.m. the resident remained on her back with the end of bed wedge under legs. R86's calf rested on the wedge and her heels floating off the end. At 11:00 a.m. R86 remained in the same position. At 11:19 a.m. R86 was up in a wheelchair seated in the lobby area. Her wheel chair leg rests were in place, but were not elevated. R86's feet did not appear to fit properly into boots attached to the wheelchair leg extenders, and the ball of her foot was resting on the foot pedal. At 12:47 p.m. R86 was still sitting up in wheel chair in her room, and at 12:57 p.m. staff assisted the resident to bed. At 1:08 p.m. R86's heels were observed to be resting on the bed. The end of bed wedge was under her calf area. At 2:13 p.m. R86 remained in bed in the same position with her right foot crossed over left at the ankle and her calves were resting on the wedge. At 2:48, 2:59, 3:27, and 3:53 p.m. R86 remained in the same position with her feet crossed, right foot resting on top of left foot. Throughout the observations, R86 was not repositioned even though she had been assisted to bed at 12:57 p.m. On 10/22/15 at 6:50 a.m. R86 was up in a wheelchair in her room. A dressing on left foot was hanging down and a foul odor was detected in the room from the dressing. Both feet were resting on the foot pedals. At 7:20 a.m. the resident's position was unchanged.	F 314	pressure redistribution cushion, alternating air mattress replacement, dietary supplements, occupational therapy for w/c positioning, and repositioning schedule. Wound treatment and monitoring was initiated with the discovery of pressure areas and venous ulcer. b. All residents receive a comprehensive skin assessment on admission, quarterly and with a significant change. Skin conditions observed daily with cares. IDT review of all alterations in skin. c. All nursing staff will receive re-education by 12-1-15 regarding care plan intervention, repositioning and skin observations. d. DNS/designee will audit 3 residents per week for 4 weeks then 2 residents per week for 8 weeks for repositioning. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. e. DNS or designee is responsible f. Completion date 12-2-15	

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On 10/22/15, a nursing assistant (NA)-A explained at 7:20 a.m. that the resident had been assisted out of bed at 6:30 a.m. At 7:45, 8:15, and 8:30 a.m. R86's position was unchanged. At 9:05 a.m. she was assisted to bed and was positioned lying on her back with her calves and feet resting on the wedge with the pressure ulcer areas pressing on the edge of the wedge. At 9:20, 9:27, 9:50, and 10:08 a.m. R86's position was unchanged. At 10:15 a.m. R86 requested to go to the toilet and the bedpan was provided as she declined the use of a commode. At 10:45 a.m. R86 was observed again to be laying on her back in bed.

On 10/22/15 from 11:13 to 11:50 a.m. LPN-C and a registered nurse (RN)-A were observed to complete care for one of R86's wounds. A stage II pressure ulcer was observed on the resident's coccyx. Following the treatment, the resident was observed at noon and 1:00 p.m., to be sitting up in the wheelchair. At 1:33 p.m. R86 was observed seated in the wheelchair at an activity. At 1:55 p.m., NA-A stated R86 had refused to lie down. Throughout these observations, the resident had a Hoyer lift sheet underneath her in her wheelchair. The resident was observed to remain in the wheelchair at 2:08 p.m. During all observations of the resident, at no time was she observed to be offered repositioning to her side, or stood, in order to relieve pressure to the coccyx area.

R86's quarterly Minimum Data Set (MDS) dated 2/24/15, indicated R86 was at risk for pressure ulcers, had no unhealed pressure ulcer, required extensive assist of two staff for bed mobility, transfers and toilet use, and was severely cognitively impaired. The MDS also noted the

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presence of moisture associated skin damage and the use of a pressure reducing device for chair and bed, but no turning and repositioning program.

R86's admission pressure ulcer risk assessment dated 11/18/14, indicated that although she had no existing or known history of pressure ulcers, R86 was at a high risk for developing pressure ulcers. The assessment also identified R86 should be turned and repositioned every two hours and as needed (PRN), her incontinent product would be checked every two hours, and peri care provided PRN. The assessment further indicated R86 had an indwelling Foley catheter with rare incontinence of bowel. Care plan information regarding the Braden Assessment (for predicting pressure ulcer risk), and turning and repositioning guidance interventions both dated 11/18/14, noted the resident was at high risk for pressure ulcer development. The Braden assessment summary noted the resident would be turned and repositioned every two hours and PRN. Interventions included pressure redistribution cushion, mattress replacement system, turn and reposition every two hours, attempt to position off the affected area, and off load in chair every hour. A body audit dated 11/19/14, did not indicated the presence of pressure ulcers to R86's body at that time.

Progress of the wounds was recorded in the Progress Notes:

1) 11/23/14, redness noted on both buttocks;
2) 12/30/14, continued with red spots on front and back of legs and feet;
3) 1/4/15, red area on right buttock, cream was applied;

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F 314	Continued From page 24 4) 1/10/15, skin alterations present including a moisture associated skin damage rash; 5) 1/13/15, staff continued to apply protective creams to open area on buttock; 6) 1/18/15, staff were to continue monitoring open area on buttocks; 7) 1/24/15, ointments/creams/medication were applied to moisture associated skin damage; 8) 1/27/15, scabbed area behind the left lower leg; 9) 2/3/15 scabbed areas back of lower left leg 10) 2/18/15, large black scab on posterior side of left calf. A non stick dressing covered with an ABD pad (a type of surgical dressing) and Kerlix (dressings) applied. 11) 2/20/15 identified non-surgical dressing changes but did not specify the location of the dressing. 12) 2/24/15 large black scabbed area behind left leg, area cleansed and dressing applied. Soiled dressing that was removed had a very small amount of yellowish drainage. 13) 3/2/15, open area on posterior left calf. A moderate amount of brown dried drainage mixed with red serosanguinous drainage was noted on the old dressing. 14) 6/7/15 identified the area to left heel was open and draining clear drainage. A nurse practitioner note dated 3/9/15, indicated the wound to the back of the left calf was now oozing, had previously been a scabbed lesion. The notes indicated the area was open and painful when touched. The area was documented as a 4 cm (centimeter) open ulcer left calf with 100% yellow slough, no odor. "Unsure origin of this wound. Left calf skin ulcer wound."	F 314		

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A body audit on 5/25/15, noted a small right buttock open area, left buttock dressing intact and one open area on the coccyx, as well as a dark spot to the left inner heel described as discoloration and hard.

Wound Assessment Detail reports were as follows:
1) 3/12/15 wound type identified as trauma, facility acquired and clinical stage was identified as partial thickness. The area measured 4.6 cm x 4.4 cm x .10 cm with area 20.24 cm with 10% pink/red tissue, 50% loose slough and 40% white fibrinous slough.
2) 5/19/15, for the left heel first identified the wound type as pressure, facility acquired and the clinical stage was identified as a suspected deep tissue injury. The heel area was measured at 1.4 cm x 1.9 cm x unknown with 100% purple ecchymosis (bruising).
3) 6/3/15, stage II pressure ulcers to the lower coccyx, facility acquired. The size of the ulcers measured 1.10 cm x 1.60 cm x unknown (length x width x depth). The same wounds measured on 10/22/15, was 1.40 cm x .20 cm x 0 and the area was identified as a stage II pressure ulcer.
4) 10/22/15 3.5 cm x 4 cm x unknown with total area of 14 cm partial thickness 70% non granulating 30% bright beefy red tissue--suspected deep tissue injury measuring 10.8 x 3.9 x unknown, total area of 42.12 cm, with tissue identified as 20% pink/red, 70% white fibrinous slough and 10% hard, firm adherent necrotic.

R86's care plan revised 9/23/15, identified interventions including the use of an air mattress system to bed (implemented 7/21/15), turn and reposition every two to three hours or more often

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as needed or requested, elevate feet/heels on end of bed wedge (implemented 7/21/15), treatments as ordered. Left leg compression per therapy recommendations (10/5/15). Pressure relieving support surfaces in bed and chair. The corresponding NA care sheet included: remove sling when up in wheelchair, reposition every hour in wheelchair and every two hours in bed, air mattress system, and end of bed wedge.

An occupational therapy (OT) care plan, therapist progress and discharge summary dated 8/5/15, indicated R86 had been referred for OT due to multiple wounds. The notes indicated nursing had been treating the wounds with repositioning, medication, and bandaging however, new sores still developed. The OT notes indicated R86 required skilled OT in order to improve posture/position in bed/wheelchair and to improve skin integrity. "Patient is currently in an 18" [inch] wide x 16" depth x 17 1/2" height standard wheelchair with elevating leg rest with calf pads and pillow under legs. Has a 2 1/2" thick KEEN level seat cushion. Leg rests are preventing patient from being positioned closer to dining room table causing patient to have a further and more difficult reach." The occupational therapist registered (OTR) documented analysis of functional outcome/clinical impression to include: "Pt [patient] also has multiple B (bilateral) LE (lower extremity) wounds - most significant wound is L ankle/heel. Weight/pressure of legs on calf pads from elevating leg rests have been contributing to worsening of calf and heel wounds." The notes further indicated R86 had complained of buttock pain while in OT, and that the therapist had removed the Hoyer (mechanical lift) sling from the resident's chair and the resident had expressed immediate relief.

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Although pressure ulcers were first noted on 5/19/15, a physician order was received to float heels at all times on 9/23/15. A physician's note dated 10/14/15, identified left lower leg wound present for seven months was "slowly improving. Diagnoses included pressure ulcer (unlikely location) vs vascular ulcer, left heel pressure ulcer stage 4 necrotic, though seems to be improving. "

NA-B was interviewed on 10/21/15, at 2:15 p.m. and stated R86 was supposed to be repositioned side to side when in bed every two hours and the time she spent in the chair was to be limited.

OTR-A was interviewed on 10/22/15, at 1:06 p.m. She stated R86 had been referred for OT due to the development of pressure areas, being red all over, and a wound from the calf pad on the wheel chair. OTR-A said she thought the ulcer on the back of the resident's lower left calf was more than likely caused by pressure from a calf rest previously utilized on the elevated leg rests of R86's wheelchair. She also stated that R86 previously had a two inch standard cushion (not pressure relieving) in the wheel chair which she had replaced with a four inch cushion. OTR-A said she had removed the elevated leg rests and placed the resident in a standard wheelchair that fit her better, and had removed the Hoyer sheet from her wheel chair and attached boots to the stationary leg rests of the wheel chair in an effort to protect her heels. OTR-A said R86 should be turned side to side and a pillow used between her legs in bed.

RN-A was interviewed on 10/21/15, at 10:13 a.m. RN-A said R86's heel was first noted as a deep

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tissue injury (DTI--purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.) She stated the area had become a hard scab and had spread toward the back of the resident's heel. RN-A stated the end of bed wedge had been implemented (start date 7/14/15) in an effort to float R86's heels however, within days of the bed wedge implementation, the compromised area was noticed to extend to the back of the heel. RN-A stated the areas "slowly combined and joined each other". She stated the air mattress had been placed on the bed at the end of July or early August, and that OT had been consulted and had worked with R86 for wheel chair positioning and compression to the leg. RN-A said repositioning was encouraged every one to two hours but that R86 did refuse at times, and also refused to lie down at times. RN-A verified the facility had not discussed the risk verses (vs) benefits of lying down for R86, and/or her family, nor had they explained risks of R86 not allowing them to provide repositioning. She also described the area on the lower calf as having begun as a rash, turned into a pimple, then became a scab. RN-A said the scab kept getting larger and ultimately opened up on 3/2/15. She said she was unsure about the suggestion that the leg rests may have caused or worsened the area, and that staff had not looked at the calf rests as a pressure point. However, she verified no interventions had been initiated the area to R86's calf opened up and stated, "we just monitored it." Finally, RN-A stated the stage II pressure ulcer to R86's coccyx began on 6/3/15.

The director of nursing stated on 10/23/15, at 9:52 a.m. all the areas should have been evaluated when they first opened up and

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F 314	Continued From page 29 interventions put in place immediately to prevent the areas from becoming worse. In addition, R86 should have been repositioned every one to two hours and positioned on her side if possible. The DON said if the resident refused, a negotiated risk vs benefit should have been initiated. The facility's Guidelines for Pressure Ulcer Prevention dated 9/2010 identified: 1. Comprehensive evaluation of the resident's clinical condition sand pressure ulcer risk factors at admission and as required throughout the resident's stay. 2. Recognition of any risk factors identified on the comprehensive assessment 3. Evaluation of the individual risk factors and determination, based on clinical judgement, selection of interventions to stabilize, reduce or remove the underlying risk factors identified on the assessment(s) 4. Monitor the effects of the interventions and modify the interventions when indicated 5. Re-assessment of the individual's pressure ulcer risk factors as required 6. Education program includes pressure ulcer prevention, the assessment and treatment of pressure ulcers, lower extremity ulcers and other skin conditions 7. Quality Assurance program: * Monitors the effectiveness of the pressure ulcer prevention program to reduce the development and progression of pressure ulcers * Monitors the incidence and prevalence of pressure ulcers within the facility and * Monitors adherence to policies and procedures for consistency in application and conformance with the current standards of practice.	F 314		

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure required posted nursing staffing information was current. This had the potential to affect the 63 residents residing in	F 356	F 356 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	12/2/15

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F 356	Continued From page 31 the facility and visitors. Findings include: On 10/19/15, at 9:15 a.m. the daily staff information sheet was observed in the hallway near the nursing station at the entrance of the facility. The date on the posting read 10/17/15. Behind the posting was another posting dated 10/18/15. The director of nursing (DON) verified the date was two days prior, and that the hours had not been posted on 10/18 or 10/19/15 as required. On 10/22/15, at 12:22 p.m. the DON stated she expected the nurse staffing information was posted at the beginning of the morning shift. She stated, "We are now having the night shift post the staffing information. It will be their responsibility." An undated, Nurse Staffing Information Guidelines directed staff to post information on a daily basis with the current date.	F 356	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. Facility procedure for updating staffing hours has been revised. b. Licensed staff will receive re-education on 12-1-15 regarding the procedure of updating posted staffing hours. c. Executive director/ Designee will audit posted staffing hours 3 times weekly for 4 weeks then 2 times weekly for 8 weeks to ensure the proper staffing hours are posted. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. d. Executive director or designee responsible. e. Completion date 12-2-15	
F 371 SS=D	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 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		12/2/15

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F 371	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain sanitation in the kitchen and serving areas related to mixer, cooks cooler, convection oven and stove/griddle potentially affecting 63 residents who were served food from the kitchen. Findings include: A kitchen tour was conducted on 10/19/15, at 9:30 a.m. with the director of food service (DFS). 1) A commercial Kitchen Aid mixer had dried food splatters throughout the base, top of the bowl, and where the beater was attached. The mixer had areas of chipped paint. The DFS stated she had attempted to clean the mixer but could not get it clean, and had to spray the dried food, but then the paint chipped. The table where the mixer was stored was also soiled with dried food splatters and had chipped paint. 2) The motor on the back and the top of the convection oven were greasy and dusty. Above the vent on the stove/griddle as well as the shelf directly above the stove/griddle was also greasy and dusty. The DFS climbed on a stool and ran her finger across the area and verified the build-up was grease and dust that had not been cleaned. A pipe beside the stove was greasy and had dust hanging. Dust was also hanging from the top of the cook's cooler. Although the DFS stated they utilized a weekly cleaning scheduled, she verified the above areas had not been	F 371	F371 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. Mixer was cleaned upon discovery of unclean condition. b. Motor on top of oven, vent above stove and pipe beside stove were cleaned upon discovery of unclean condition. c. Dietary staff will receive re-education on cleaning schedule by 12/1/15 d. Dietary Manager/ designee will audit cleaning of kitchen area 2 times weekly for 12 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. e. Dietary Manager or designee is responsible. f. Completion date 12-2-15..	

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F 371	Continued From page 33 thoroughly cleaned. On 10/22/15, at 8:27 a.m. the DFS stated she did not maintain copies of the weekly cleaning lists. She stated she needed to have both weekly and monthly cleaning schedules. The DFS also stated they needed to purchase a new mixer, as the last time they just painted over it.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental care was provided for 1 of 1 resident (R28) identified in need of dental care. Findings include: R28 was observed on 10/20/15, at 1:59 p.m. and was missing upper teeth and the bottom were broken, with only part of the tooth remaining. R28 was unable to be interviewed due to cognitive impairment.	F 412	F412 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:	12/2/15

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F 412	Continued From page 34 R28's annual Minimum Data Set (MDS) dated 6/23/15, indicated R28 was severely cognitively impaired and required total dependence assist of oral care needs. R28's oral status indicated there were obvious cavities or broken teeth. The corresponding Care Area Assessment (CAA) indicated that R28 had some missing teeth and some broken and resident received a pureed diet. The CAA indicated R28 was dependent on staff for all activities of daily living (ADLs). R28's significant change MDS dated 8/17/15, indicated R28 was cognitively severely impaired and required total dependence assist of oral care needs. R28's oral status however, indicated there were no natural teeth or tooth fragment(s) edentulous. The corresponding CAA indicated that R28's oral cares were completed twice daily and as needed. The CAA noted R28 refused to wear dentures and signs and symptoms of pain were monitored daily. R28's Oral/Dental Assessment Form dated 8/13/15, completed by a licensed practical nurse (LPN) indicated R28 had no dentures, had own teeth, had no broken, no missing, no loose teeth and no obvious or likely cavity. R28's Oral/Dental Assessment Form dated 6/22/15, completed by a licensed practical nurse (LPN) indicated R28 had no dentures, no loose teeth and no obvious or likely cavity. Form indicated R28 had her own teeth, had broken teeth and had missing teeth. R28's medical record lacked information showing R28 had seen or been offered to see a dentist since her admission in 2007.	F 412	a. With respect to R28 an Oral/ Dental Assessment was completed on 11/13/15. Care plan and Nursing Assistant assignment sheet updated to reflect current cares. On 11/4/15 family declined dental services. b. All residents will to be assessed for their individual dental and oral needs upon admission, quarterly, with a significant change and as needed. Care plans will reviewed for individualized dental/ oral needs. c. RN responsible for completion of the MDS has been re-educated regarding accuracy of the MDS. d. All nursing staff will receive re-education regarding oral cares by 12/1/15. e. DNS/designee will audit, oral/dental assessment, 2 residents per week for 4 weeks, then 1 resident per week for 8 weeks for oral/dental needs by observation and medical record review. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. f. DNS or designee is responsible g. Completion date 12-2-15	

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F 412	Continued From page 35	F 412		

R28's care plan dated 9/23/25, identified activities of daily living (ADL) self-care performance deficit related to end stage Alzheimer's type dementia. Goal, "will be neat and clean and needs will be met daily through the review date." Interventions included, "Eating: See NA [nursing assistant] assignment sheet...oral care: See NA assignment sheet." The 10/20/15, NA assignment sheet noted the resident needed the assist of one in dining, and noted the resident did not have and refused to wear dentures.

NA-C was interviewed on 10/21/15, at 1:20 p.m. stated R28 had some teeth on the lower bottom gums that were broken off, and otherwise did not have any other teeth. NA-C stated she had never seen R28 wearing dentures and added, "I don't think she came with dentures."

A licensed practical nurse (LPN)-B was interviewed on 10/21/15, at 1:29 p.m. stated R28 did not have any teeth. When asked about the broken off teeth she stated, "I don't remember seeing the teeth stumps before." LPN-C stated that staff is supposed to complete an oral assessment on bath days. LPN-C also stated that it was up to the family to make dental appointments and arrangements if there were any dental problems.

A registered nurse (RN)-A was interviewed on 10/21/15, at 1:36 p.m. stated that R28 did not have dentures, and she had never personally completed an oral assessment for R28. RN-A stated, "They usually do that quarterly." Usually family members were asked during care conferences if they wanted the resident to have a dental appointment. When asked if they R28's family was offered dental services for R28, RN-A

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F 412	Continued From page 36 stated, "I can't remember. If we did, it should be on care conference notes." On 10/21/15, at 2:05 p.m. a phone interview was conducted with R28's family member (FM)-A. FM-A stated that he attended all care conferences and that dental services "has never been discussed." FM-A stated did not remember dental services having been offered for R28. FM-A stated he actually wanted R28 to have a dental check up, but had always been worried how she could be transported to the dental clinic because of her physical limitations. R28's care conference notes from 1/1/15 to 10/21/15 were reviewed, and it was verified FM-A consistently attended the conferences. There was no documentation in the notes to indicate dental services had been discussed during the conference. A Care Conference Summary Sheet dated 4/14/15, indicated that R28 had no dentures/partial, and the last dental visit was noted as "unknown." A facility's Oral/Dental Assessment Guidelines dated 10/14, indicated "Oral dental health is a critical part of an individual's overall health and well being. Oral and dental problems may lead to infection, weight loss, pain or other disease complications." It further directed that, "The Oral/Dental Assessment is completed upon admission, re-admission and quarterly in conjunction with the MDS 3.0 and Nutritional Assessment. The oral/dental assessment may be completed at any time there is a change in a resident's oral/dental health."	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		12/2/15

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F 431	Continued From page 37 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications	F 431	F431 The preparation of the following plan of	

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F 431	Continued From page 38 labels were accurate for 1 of 7 residents (R2) observed for medication review. Findings include: R2's medication label did not reflect the current physician orders. On 10/22/15, at approximately 8:00 a.m. a registered nurse (RN)-B administered medication to R2. Although RN-B stated R2 has a physician's order stating R2 was not to receive any nutrition, fluid or medication by oral route (NPO) and further explained R2 received her medications through a gastric tube (g-tube). Upon review of the medication labels, n 9 of the 12 medications scheduled for R2 to receive at this time directed staff to give via oral route (PO). RN-B verified the labels were incorrect on the nine medications stating she believed there was an error when R2 returned from a hospitalization on 9/25/15. RN-B then verified the discharge orders from the hospital dated 9/25/15 directed staff to give these medication orally. She then explained the orders should have been clarified upon R2's readmission and "change of direction" labels should have been put on each medication label. R2's Admission Record sheet listed dysphagia (difficulty or discomfort in swallowing) as a current diagnosis. Mayo Clinic Hospital discharge orders dated 9/25/15 indicated 16 of 18 medications were to be administered orally, 1 medication by intravenous (IV) route and 1 medication through the g-tube. R2's diet order was tube feedings, nothing by mouth. Home tube feedings continued. Follow up swallow evaluation completed 9/24/2015 and revealed diffusely weak swallow mechanism.	F 431	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. R2 medication label, direction change labels were initiated on 10-22-15. b. All licensed staff will be re-educated by 12-1-15 regarding proper procedure for medication direction change labels. c. DNS/Designee will audit 2 medical records per week for 4 weeks then 1 time per week for 8 for weeks for proper procedure for medication direction change label. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. d. DNS or designee is responsible e. Completion date 12-2-15	

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F 431	Continued From page 39	F 431		

Recommended to keep NPO and therapeutic feeds only.

The Pleasant Manor Order Summary Report dated 9/25/15 directed staff to administer all 17 medications for R2 via the gastric tube.

Medication Administration Record dated October 2015 indicated staff is administering all of R2's medications via the g-tube.

The Care Area Assessment (CAA) dated 9/14/15 verify R2 had gastric ulcers, gastric bleeding or other stomach disorder. It also verified she aspirated on blood while in the hospital and had a emesis/regurgitation following placement of a gastric tube. She is NPO for all nutrition, fluids and medications\

The current care plan dated 9/16/15 directed staff to administer medications compatible with tube feeding by this means.

An interview with the director of nursing (DON) on 10/22/15, at 10:17 a.m. revealed she was aware the discharge orders dated 9/25/15 had the incorrect route for administering medications to R2 and placed and call to the medical doctor for clarification. The nurse at the hospital verified R2 was NPO and medications were to be given by g-tube. The DON stated she did not get a clarification order and did not ensure "change of direction" stickers were put on the labels because "all the nurses were aware". She further stated the stickers should have been applied immediately.

On 10/22/15, at 11:43 a.m. the administration stated it was ultimately the duty of the DON to

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F 431	Continued From page 40 ensure residents have the correct orders in place and she should have "carried it through." She further explained she expected the labels to be correct and the "change of direction" labels should have been applied even if nurses were aware of the situation. A new nurse could have potentially given the medication by the wrong route. A policy was requested but not provided.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		12/2/15

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F 441	Continued From page 41 (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 implement procedures to minimize the spread of infection during dining for 4 of 4 residents (R22, R28, R45, R47) who were observed being assisted at mealtime. Findings include: During initial dining observations on 10/19/15, at 12:21 p.m. the following was observed: R22, R28, R45 and R47 were seated around the same table and nursing assistant (NA)-A and NA-B were assisting them with their meals. NA-A was assisting R28 and R45 and NA-B was assisting R22 and R47. NA-A and NA-B were observed using same hand while assisting two residents with their meals. NA-A and NA-B were also observed touching, wiping and repositioning one resident, and using same hand to help the other resident without washing or sanitizing their hands. During a follow-up dining observation on 10/21/15, at 8:27 a.m. R22, R28, R45, and R47 were again observed seated on the same table. A nursing assistant (NA)-A assisted R22 and R45	F 441	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. In respect to R22, R28, R45, and R47, staff educated immediately on 10/22/15 regarding infection prevention during meals. b. All staff will receive re- education by 12-1-15 regarding prevention of infection during meals/cross contamination. c. DNS/Designee will audit 3 meals per week for 4 weeks and then 2 meals per week for 8 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing	

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F 441	Continued From page 42 while NA-B assisted R22 and R47. NA-B touched R22's clothing, wiped her mouth and then with the same hand, picked up a piece of bread and handed it to R47 without cleaning hands. NA-A touched R28's hair and used same hand to assist R47 with her meal without cleaning hands. NA-B used a napkin to wipe R22's mouth, put the napkin on the table, took another napkin and wiped R47's mouth with same hand, and then continued to assist the residents with eating. R22's care plan dated 9/23/25, identified activities of daily living (ADL) self-care performance/mobility/bathing deficit related to a stroke with upper extremity weakness. The goal was, "Resident will continue to assist as much as she is able with all of her ADL needs through the next review date." Interventions included, "Eating: requires extensive assist and encouragement." R28's care plan dated 9/23/25, identified (activities of daily living) ADL self-care performance /mobility deficit related to end stage Alzheimer's type dementia, contracture in joints to multiple sites. Goal, "will be neat and clean and needs will be met daily through the review date." Among the interventions include, "Eating: See NA assignment sheet." The NA care sheet identified R28 needed assist of one in the dining. R45's care dated 9/1/15, identified ADL self-care performance/limited mobility deficit related to severe dementia. The goal was, "will not develop complications of immobility through review date." Interventions included, "Eating: requires one staff assistance to eat." R47's care dated 7/29/15, identified ADL self-care performance deficit related to stroke with left	F 441	audits. d. DNS or designee is responsible e. Completion date 12-2-15	

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F 441	Continued From page 43	F 441		

hemiplegia (paralysis on one side of the body), limited range of motion (ROM) in lower extremities, limited mobility, confusion and impaired balance. The goal was, "will continue to participate in ADL's through next review." Interventions included, "Eating: requires one staff, cue as able, assist to eat."

NA-A was interviewed on 10/21/15, at 8:40 a.m. and verified that she had used same hand to assist with two different residents to eat. NA-A stated, "I'm suppose to use one hand for each resident but I know I used one hand for both." NA-A said staff was instructed to sanitize between residents if they used same hand, "but I didn't do it."

NA-B was interviewed on 10/21/15, at 8:44 a.m. and verified that she had used same hand to assist with two different residents to eat. NA-B acknowledged that she had touched the residents and then used same hand to assist with meals without sanitizing. NA-B stated that, "We are supposed to sanitize between residents if we use same hand. I guess I didn't do that." When asked if they carried hand sanitizers with them, NA-B replied, "No."

The director of nursing (DON) was interviewed on 10/22/15, at 10:33 a.m. and stated that she did not expect staff to touch a resident while assisting them with meals. However, if they did, her expectation was that they must sanitize in between the residents. When asked if the facility provided hand sanitizers to staff, the DON stated, "We can buy that if the staff asks for it."

A facility's undated Handwashing Policy and Procedure indicated the purpose was "To prevent

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F 441	Continued From page 44 the transmission of infectious organisms through careful cleaning of hands."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/20/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Pleasant Manor Nursing Home was found 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. Pleasant Manor Nursing Home is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1978, addition was constructed to the Northwest Wing that was determined to be of Type II(111) construction. In 1996, another addition was added to the Southeast Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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
	245090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/20/2015**

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K 000	Continued From page 1 MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		