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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LRZ7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **254908000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN VALLEY REHABILITATION AND CARE CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

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

6. DATE OF SURVEY **04/27/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **164** (L18)

13.Total Certified Beds **164** (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
	164			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Michelle Koch, HFE NE II — 04/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/26/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245186
May 12, 2016

Ms. Lynn Hickey, Administrator
Golden Valley Rehabilitation & Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

Dear Ms. Hickey:

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 April 12, 2016 the above facility is certified for or recommended for:

164 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 164 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 12, 2016

Ms. Lynn Hickey, Administrator
Golden Valley Rehabilitation & Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

RE: Project Number S5186030

Dear Ms. Hickey:

On March 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2016. 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 April 27, 2016, 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 March 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2016, effective April 12, 2016 and therefore remedies outlined in our letter to you dated March 21, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245186 Y1	A. Building B. Wing Y2	4/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0311	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix F0315	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(d)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0329	Correction	ID Prefix F0332	Correction	ID Prefix F0353	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.25(m)(1)	Completed	Reg. # 483.30(a)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0364	Correction	ID Prefix F0371	Correction	ID Prefix F0412	Correction
Reg. # 483.35(d)(1)-(2)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.55(b)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0425	Correction	ID Prefix F0428	Correction	ID Prefix F0431	Correction
Reg. # 483.60(a),(b)	Completed	Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	JS/KJ	05/12/2016	35575	04/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245186 Y1	A. Building B. Wing Y2	4/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0465	Correction				
Reg. # 483.70(h)	Completed				
LSC	04/12/2016				

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) JS/KJ	DATE 05/12/2016	SIGNATURE OF SURVEYOR 35575	DATE 04/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/3/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LRZ7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **254908000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN VALLEY REHABILITATION AND CARE CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

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

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

6. DATE OF SURVEY **03/03/2016** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **164** (L18)

13.Total Certified Beds **164** (L17)

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	164			
(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 :
Mardelle Trettel, HFE NE II 04/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 04/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS
Posted 04/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 21, 2016

Ms. Lynn Hickey, Administrator
Golden Valley Rehabilitation & Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

RE: Project Number S5186030

Dear Ms. Hickey:

On March 3, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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. In addition, at the time of the March 3, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5186212 that was found to be unsubstantiated.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 12, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 12, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 June 3, 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 September 3, 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(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. A complaint investigation was also completed at the time of the standard survey, complaint H5186212, and was unsubstantiated.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the plan of care was implemented and followed for 2 of 3 residents (R89, R115, R5) reviewed for pressure ulcers, and 1 of 3 residents (R5) dependent upon staff for repositioning. Findings include: R89's plan of care dated 6/15, noted R89 was to	F 282	1.R89,R5,R60's skin assessments, plan of care, and nursing assistant care guides have been reviewed and updated as appropriate. R115 is not longer a resident at the facility. 2.All residents with pressure ulcers will be assessed and plan of care and nursing assistant care guides reviewed and updated as indicated. 3.Nurses will be educated on	4/12/16

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

Electronically Signed | 04/01/2016

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F 282	Continued From page 1 have both heels floated. In addition, the care plan noted R89 was to have the "bootie" on the right foot when in bed. The undated and untitled NA assignment sheet did not specify R89 was to have the heels floated nor did the sheet indicate R89 was to wear a foam boot on the right foot. The section under skin noted staff were to "Q [every] shift skin checks. Assist resident with back scratcher PRN [as needed]." R89 was observed on 3/2/16, at 6:20 a.m. through 7:29 a.m. continuously. R89 was noted to be sleeping on his back and both heels were lying directly on the mattress. The right heel had a blue foam boot on it. At 7:29 a.m. nursing assistant (NA)-A was interviewed and verified R89 did not have the heels floated. When asked if the heels should have been floated NA-A indicated, "No." Registered nurse consultant (RNC)-A was interviewed at 8:00 a.m. and verified R89 did not have the heels floated. RNC-A indicated R89 had a newly formed blister on the right foot and it was intact. She indicated there was no treatment to the right heel as the blister was intact. RN-A verified the NA sheet lacked direction of the blue foam boot and to float the heels. The health unit coordinator (HUC)-A was observed on 3/2/16, at 8:10 a.m. to look at the computerized NA sheet. HUC-A acknowledged the information of the blue boot and floating the heels was not on the computerized NA sheet. R89 did not receive the care and services that promoted healthy skin. Facility policy titled Care Plans dated 7/15,	F 282	implementing and following wound care protocol for residents with pressure ulcers, including completing and documenting treatments. Nursing staff will be educated on following interventions for pressure ulcer prevention and residents with pressure ulcers, including turning/repositioning and using pressure relieving devices or techniques. 4.DON or designee will complete random weekly audits to ensure staff follows the plan of care for residents at risk for skin altercation, including toileting and repositioning, for 4 weeks. Results of audits will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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identified a well developed care plan develops and implements an interdisciplinary care plan based on the assessment information gathered.
Pressure Ulcer Treatment Not Completed per Physician Orders

On 3/2/16, at 8:41 a.m. with the nurse practitioner R115 pressure ulcers were observed. The coccyx had two ulcers one above the other wound bed was beefy red, without drainage, odor and showed no signs of infection. The nurse practitioner stated the ulcers were healing nicely.

R115's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 1/16, indicated R115 had a pressure ulcer to midline sacrum and a pressure ulcer to the coccyx and directed staff to provide treatment per MD order.

Physician's wound care orders dated 2/3/16, directed staff to once daily apply Santyl, apply skin prep and cover with foam dressing to Stage III pressure wound to midline sacrum and right medial buttock following surgical debridement of the wounds.

The February 2016 treatment record for the daily treatment to cleanse wound apply Santyl apply skin prep and cover with adhesive foam was reviewed. 7 days in February the treatment was left blank and 4 days were marked refused.

When interviewed on 3/3/16, at 3:43 p.m. RN-G stated R115 is supposed to have a daily dressing change to the sacrum with Santyl and Allyven and the wound physician sees R115 every Wednesday. RN-G further stated the wound care is not always done as ordered because R115 refuses treatments at times. RN-G stated that the

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treatment sheets indicated resident refusals and if not marked the treatments were not completed.

R60's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 1/16, indicated a pressure ulcer to the right ischium and directed staff to provide treatment per MD order.

Physician's orders dated 1/27/16, directed staff to once daily apply Santyl, apply skin prep and cover with foam dressing to Stage III pressure wound to the right ischium.

On 3/3/16, at 9:27 a.m. R60 refused surveyor observation of pressure ulcer.

The January 2016 treatment record for the daily treatment to cleanse wound apply Santyl and cover with non adhesive foam was reviewed. Three out of five days the treatment was not documented as completed and was blank and one out of five days marked as refused.

The February 2016 treatment record for the daily treatment to cleanse and treat with Santyl and cover with adhesive foam was reviewed. Nine out of 28 days the treatment was not documented as completed and was blank. Seven out of 28 days the initials are circled without any follow up documentation and one out of 28 days were documented as refused.

When interviewed on 3/3/16, at 3:12 p.m. R60 stated that the nurses put cream on my bottom every day but the dressing does not get changed everyday. R60 further stated that she had never refused her dressing to be changed by the nurses.

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F 282	Continued From page 4 When interviewed on 3/3/16, at 3:38 p.m. RN- stated that R60 had wound care ordered daily to her coccyx and it does not get done everyday as ordered because the facility is short staffed. RN- further stated she reports off to the next shift that the dressing was not completed. When interviewed on 3/3/16, at 3:50 p.m. RN- expected the wound care be completed as ordered. RN- further stated she has been told by nurses that at times that the wound care did not get done on the shift. RN- stated she tells the nurses to pass it on to the next shift. RN- further stated that at times staffing is not adequate to get everything done. When interviewed on 3/3/16, at 5:43 p.m. RNC-A stated she expects all treatments to be done according to physician orders. R5's quarterly Minimum Data Set (MDS) dated 1/6/16, indicated the resident had severe cognitive impairment, and was dependent on staff for all activities of daily living (ADL's). The MDS also identified diagnoses of quadriplegia, hypertension, peripheral vascular disease, and neuromuscular dysfunction of the bladder.	F 282		

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Review of R5's care plan updated 1/15/16 identifies a risk of skin breakdown with impaired mobility and bowel incontinence. Staff were directed to turn, reposition, check and change for incontinence every 2 hours. Review of the NA undated work list directs the staff to turn and position R5 every two hours, was incontinent of stool and was to be checked and changed every two hours.

On 3/2/16, R5 was observed continuously from at 6:21 a.m. to 8:28. At 6:21 a.m. R5 was lying on his back in bed with pillow on the right side. At 7:06 a.m., respiratory therapist (RT)-A entered room to perform respiratory cares. At 7:35 a.m., continued to remain in the same position on his back, RT-A completed the respiratory cares and exited the room. R5 remained on his back, and was not repositioned nor was peri care performed during this time. At 8:18:a.m. R5 remained in the same backlying position. At 8:28 a.m. nursing assistant (NA)- B entered the room, and informed the surveyor that routine personal morning cares were provided by the night shift staff before 6:00 a.m., more than 2 hours and 28 minutes earlier. The day shift staff were responsible to provide R5 assistance with incontinence care prior to getting him up for breakfast. NA-B provided pericare, R5 was incontinent of a soft stool during this time. R5's skin had two large areas on his right and left buttocks, near rectum that was macerated, (an area of soft, white, deteriorating skin), which was covered with white barrier cream with areas of pink underlying tissue exposed. There was also an area of maceration under the right gluteal fold that measured approximately 2 cm in length and 1 cm in width which had a build up of sloughed tissue to the side of the maceration, with bright

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F 282	Continued From page 6 pink underlying tissue present (skin was intact). NA-B stated this area (right gluteal fold) was new and she would let the nurses know. R5 was observed in his room, on 3/3/16, at 9:44 a.m. seated in his wheelchair (w/c). At 10:11 a.m. he continued to be in the same position. At 10:16 a.m. NA-B and NA-A were assisting R5 into bed with the mechanical lift. NA-B stated that (R5) was last provided with pericare this morning at "about 7:45 a.m.", 2 hours and 31 minutes earlier. NA-A and NA-B provided pericare to R5, who was incontinent of soft stool. During interview on 3/3/16 at 5:10 p.m., NA-J, stated that she works with R5 routinely on different shifts and was aware to turn and reposition him every 2 hours, so he was off his buttocks and to check for bowel incontinence every two hours.	F 282		
F 309 SS=G	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 implement interventions to reduce skin irritation and breakdown for 2 of 2 residents (R5, R23)	F 309	1.R5 and R23 skin assessments, plan of care, and nursing assistant care guides have been reviewed and updated. R86 is no longer a resident at the facility.	4/12/16

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F 309	Continued From page 7 reviewed for non-pressure related skin conditions. This resulted in actual harm for R5 whose moisture associated skin damage became worse when interventions were not implemented. In addition, the facility failed to collaborate care with an outside dialysis agency for 1 of 1 residents (R86) reviewed for dialysis. Findings include: NON PRESSURE SKIN R5's quarterly Minimum Data Set (MDS) dated 1/6/16, indicated the resident had severe cognitive impairment, had an indwelling urinary catheter, was always incontinent of bowel, and dependent on staff for all activities of daily living (ADL's). The MDS also identified diagnoses of quadriplegia, hypertension, peripheral vascular disease, and neuromuscular dysfunction of the bladder. During interview on 3/1/16, at 12:08 p.m. registered nurse (RN)-B stated R5 had two areas of moisture associated skin breakdown, one on the left buttocks measuring 7 cm (centimenters) x 4.5 cm, and one on the right buttock measuring 7 cm x 5 centimeters (cm) on the right buttocks. On 3/2/16, R5 was observed continuously from at 6:21 a.m. to 8:28 a.m.. At 6:21 a.m. R5 was lying on his back in bed with a pillow on the right side. At 7:06 a.m., respiratory therapist (RT)-A entered room to perform respiratory cares. At 7:35 a.m., R5 continued to remain in the same position on his back, RT-A completed the respiratory cares and exited the room. R5 remained on his back, and was not repositioned nor was peri care performed during this time. At 8:18 a.m. R5	F 309	2.All residents with non pressure related skin alterations will be assessed, plan of care and nursing assistant care guides reviewed and updated. All residents receiving dialysis services will be reviewed to ensure collaboration/communication between dialysis and SNF. 3.Nurses will be educated on proper policies/procedures for residents with skin alterations including assessing & documentation, implementing interventions, and monitoring residents with skin alterations. They will also be educated on dialysis collaboration/communication. Nursing staff will be educated on following interventions for preventing skin alterations including repositioning and incontinence care. 4.DON or designee will complete random weekly audits to ensure interventions are being implemented for residents with non pressure related skin breakdown for 4 weeks. DON or Designee will audit communication between SNF and dialysis center weekly is being completed for 4 weeks. All audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to trending identified.	

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F 309	Continued From page 8 remained in the same backlying position. At 8:28 a.m. nursing assistant (NA)- B entered the room, and informed the surveyor that routine personal morning cares were provided by the night shift staff before 6:00 a.m., more than 2 hours and 28 minutes earlier. The day shift staff were responsible to provide R5 assistance with incontinence care prior to getting him up for breakfast. NA-B provided pericare and R5 was incontinent of a soft stool during this time. R5's skin had two large areas on his right and left buttocks, near rectum, that was macerated (an area of soft, white, deteriorating skin), which was covered with white barrier cream and areas of pink underlying tissue exposed. There was also an area of maceration under the right gluteal fold that measured approximately 2 cm in length and 1 cm in width which had a build up of slough (a mass of dead tissue) to the side of the maceration, with bright pink underlying tissue present (skin was intact). NA-B stated this area (right gluteal fold) was new and she would let the nurses know. On 3/2/16, at 12:58 p.m. R5 was seen by the wound care medical doctor (MD)-A and RN-B to evaluate the macerated areas on his buttocks with the surveyor present. MD-A assessed the area on R5's buttocks and stated the macerated areas were "incontinence associated dermatitis with excoriations." The area on the right gluteal fold was an "old healed ulcer over the ischial tuberosity" that was becoming macerated. RN-B stated that she was not aware of the new area of maceration on the gluteal fold until now. MD-A recommended to RN-B to provide "careful and meticulous hygiene" combined with barrier protection to these areas.	F 309		

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During a subsequent interview at 1:34 p.m., MD-A stated R5's skin has an acid mantle of about 4.5 to 6 and that incontinence, especially stool, is alkaline and can easily excoriate the skin. MD-A stated that treatment recommendations for incontinence associated dermatitis included provision of pericare, application of a barrier cream, and monitoring of the area.

On 3/3/16, at 9:44 a.m. R5 was observed in his room seated in his wheelchair (w/c). At 10:11 a.m. he continued to be in the same position. At 10:16 a.m. NA-B and NA-A were assisting R5 into bed with the mechanical lift. NA-B stated that (R5) was last provided with pericare this morning at "about 7:45 a.m." (2 hours and 31 minutes earlier). NA-A and NA-B provided pericare to R5, who was incontinent of soft stool. RN-B, who was in the room at the time, obtained measurements of the three macerated areas. The right buttock measured 8 cm x 6 cm, left buttocks 9 cm x 6 cm and right gluteal fold 2.5 cm x 2 cm.. RN-B stated all three areas of macerations had increased in size from previous measurements taken on 2/21/16.

Review of progress notes 2/21/16 identified that R5 had an open area on bilateral buttocks with the right buttocks measuring 7 x 5 cm and left buttocks 7 x 4.5 cm.. The note indicated that "open does not look new, but there is no order for dressing changes." Review of subsequent progress notes did not identify any monitoring, measurements, or a comprehsive assessment of R5's macerated skin areas.

Review of the physician progress note dated 2/24/16, R5's primary physician (MD-B) indicated that R5 had "increased skin breakdown

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peri-rectal area recently, mild peri-rectal skin inflammation, need better pericare, discussed with nursing staff." A review of MD-A's (wound care physician) progress notes of 3/2/16, identified the the diagnosis of incontinence associated dermatitis and the need for "meticulous hygiene combined with barrier protection."

Review of R5's care plan updated on 1/15/16, identified a risk of skin breakdown with impaired mobility and bowel incontinence. Staff were directed to turn, reposition, check and change for incontinence every 2 hours. The care plan also directed staff to apply barrier cream to peri area daily, monitor the wound weekly and as needed, and to update the physician within two weeks if there was no evidence of healing.

Review of the undated NA Work List directed the staff to turn and position R5 every two hours, was incontinent of stool and was to be checked and changed every two hours. Although the physician progress notes of both 2/24/16 and 3/2/16, identified the need for "better" and "meticulous pericare" and barrier protection, neither the care plan, nor the work list were updated to reflect this.

During interview on 3/3/16, at 11:11 a.m. RN-B stated she had not completed physician rounds on 2/24/16, with MD-B, and was unaware of the recommendation to provide "better pericare" and barrier protection for R5. RN-B stated there were some interventions in place, but acknowledged that new diagnosis of increased skin breakdown from 2/24/16, the incontinence related dermatitis from 3/2/16, and the interventions of "better" and "meticulous" pericare were not added to R5's care plan, even though the area was first

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F 309	Continued From page 11 identified in the medical record on 2/21/16, 11 days earlier. During interview on 3/3/16, at 5:10 p.m. NA-J stated that she works with R5 routinely on different shifts and was aware to turn and reposition him every 2 hours so he was off his buttocks and to check for bowel incontinence every two hours. NA-J indicated she was not directed to provide pericare more frequently because of R5's skin concerns, or to use a different skin barrier. NA-J stated, "We get report at the beginning of each shift, and no one has directed the staff to do anything different for [R5's] skin concern." Even though R5 was dependent on staff for activities of daily living, and was frequently incontinent of bowel and had two existing areas of skin maceration. Both the primary physician (MD-B) and the wound care medical doctor (MD-A) identified the need for better peri-care and barrier protection. Theses interventions were not implemented and the existing skin maceration had increased in size, with an additional area developing in the peri gluteal fold which resulted in actual harm for R5. A procedure, titled: Wound Prevention and Management, effective July 2015, outlines the Turning and Repositioning Program for residents who are unable to turn and reposition independently. This is to occur between 15 minutes before or 15 minutes after the predetermined times. "Communicate the individualized turning and repositioning schedule using: Skin Integrity Assessment; prevention and Treatment Care Plan, Care Deliver Guide/Nursing Assistant Assignment Sheet. "	F 309		

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R23's admission record dated 9/30/15, included diagnosis of heart failure, chronic kidney disease, edema, and identified R23 was receiving hospice care. R23's annual MDS dated 10/12/15, identified R23 had severe cognitive impairment, and the quarterly MDS, dated 1/13/16, identified R23 required extensive assistance for activities of daily living, and had no venous or arterial ulcers present.

During an observation on 3/2/16, at 1:32 p.m. R23 was sitting in his wheelchair in the hallway near the nurse's station with wraps noted to both lower extremities.

Review of R23's Skin Grid-Pressure/Venous Insufficiency Ulcer/Other forms,completed for each leg and dated 10/2/15, identified the wounds were present on admission, identified as "excoriation," and had large amounts of purulent, red, foul odor drainage. The right lower extremity wound was 30 cm (centimeters) in length and 43 cm in width, and the left lower extremity wound was 45 cm in length and 43 cm in width. There were no additional Skin Grid-Pressure/Venous Insufficiency Ulcer/Other forms completed by the facility regarding these areas. Even though the form directed staff to complete weekly assessments, and to include the date, length, width, depth, color of drainage, color, odor, tunneling/undermining with depth, both forms were blank.

Review of the facility EHSI Skin Assessment form for R23 dated 11/25/15, identified a picture of the front and back side of a body with hand drawn

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lines and arrows to both lower legs, with "weeping wounds, weeping legs" written beside the picture. An Admission Skin Assessment dated 1/7/16, included hand drawn marks on both lower legs with, "cellulitis" written beside the picture. There were no further skin assessment forms identified for R23's bilateral lower extremities.

Review of R23's Comprehensive Care Plan Review Summary, dated 10/20/15, 1/7/16 and 1/19/16, under Skin/Wound, included, "No skin/wound issues since last review." However the record review indicated R23 had ongoing treatments to his bilateral "weepy" legs. R23's Skin Integrity Assessment: Prevention and Treatment Care Plan, dated 1/7/16, included, "Lymphedema BLE [bilateral lower extremity] edema [with] weeping."

Review of progress notes from 11/3/15 through 2/21/16, identified R23's legs were clean, dressed and treatment applied. There was no mention of size, location, color, drainage, or odor of R23's bilateral lower legs until the 2/22/16, progress notes. The 2/22/16, progress note identified, "Res [resident] legs are continually getting worse...Legs have musky smell, and pants & socks were so soaked [with] LE [lower extremity] drainage they were dripping on the floor." There were no additional notes that identified the appearance of R23 bilateral lower extremities from 2/23/16 until 3/3/16, even though the 2/22/16, notes identified his legs had a "musky smell" and socks and pants were soaked with drainage.

R23's physician's orders dated 2/16, included, "Bilateral lower ext [extremity] wash with no rinse soap and water, pat dry, apply Atractain lotion to

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both legs and feet, cover with edema wear (large, red stripe) tubular compression stocking from toes to 1 inch below knee." R23's Medication Administration Record dated 2/16, directed staff to complete this treatment twice daily.

During an interview on 3/3/16, at 10:11 a.m. RN-H stated she was unsure how long R23's legs have been "weeping", she has only been at the facility since December 2015. She also indicated the assessment and monitoring of R23's lower extremity "weeping area" should be monitored in the nursing progress notes, and/or Treatment Administration Record (TAR) at least weekly. The location, size, drainage, color, odor, and description of the area should be monitored. RN-H stated, "They [staff] should be documenting what we are assessing, that would be my expectation."

Review of R23's TAR's dated 11/15, 12/15, 1/16, and 2/16, lacked documentation of assessment or monitoring of R23's bilateral lower extremities to determine if they were improving or not.

During interview on 03/03/16, at 11:22 a.m. RN-M stated R23's legs are soaked twice a day, cleaned, dried and Bacitracin ointment is placed on the areas. They use ABD pads (thick absorbent dressing that soaks up large volume of fluid), because there is so much drainage, and then wrap the area with kerlix from his knee to ankles.

Although R23 currently had "weeping" bilateral lower extremities are soaked and washed twice a day, and being treated with different ointments, Bacitracin and Atractain. The facility has not consistently monitored R23's "weeping" legs, and

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F 309	Continued From page 15 skin condition for location, size, drainage, periwound condition, wound edges, signs and symptoms of infection, pain or odor to determine if R23's legs were healing and if the current treatment was effective for R23. Review of the facility's procedure: Lower Extremity Ulcer Intervention and Treatment, dated 7/15, directed staff to document the progression of wound healing by measuring length, width, and depth of the wound, and documentation should include drainage/exudate, color, odor, tunneling/undermining, periwound condition, wound edges, anatomical location, pain, signs and symptoms of infection, and wound base tissue. Also included, "Regardless of who is doing the wound treatment, Nursing Services will do the weekly assessment." DIALYSIS R86's significant change Minimum Data Set (MDS) dated 2/10/16, identified R86 had intact cognition and received dialysis services. During interview on 3/2/16, at 8:18 a.m. R86 stated she just started dialysis when she had been hospitalized recently, and currently had a port in her chest the dialysis center was managing for her. When interviewed on 3/2/16, at 12:51 p.m. registered nurse (RN)-E stated R86 started dialysis when she was recently hospitalized, and used a port on her right chest wall for access. RN-E stated the facility used a binder (a communication book) to help manage R86's care with her dialysis, and they send the binder with R86 to her dialysis treatments.	F 309		

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Review of R86's Hemodialysis Treatment record dated 2/23/16, identified R86 had received a total of eight dialysis treatments at the off-site dialysis clinic.

An undated blank Dialysis Center Communication Record, a tool used to ensure collaboration of care with the off-site dialysis clinic, was reviewed. The form used three spaces for the facility and dialysis center to document pertinent results and notes for R86's care including vital signs, nutrition, and medications. R86's records were reviewed and identified the following:

On 2/5/16, the facility nurses completed R86's pre/post dialysis documentation, however the dialysis nurse did not record any information on R86's treatment, including any completed lab work, if any access complications, of changes in condition, or how she tolerated her dialysis treatment even though R86 was a new dialysis patient. The spaces to record these items were left blank.

On 2/8/16, the facility nurse completed R86's pre-dialysis documentation, however the dialysis nurse and returning facility nurse did not record any information on record of how R86 tolerated the treatment since she was new to dialysis. The spaces to record the completed vital signs, treatment complications, and any completed lab work was left blank.

On 2/10/16, the facility nurses completed R86's pre and post dialysis documentation, however the dialysis nurse did not record any information on R86's treatment, including any completed lab work, if any access complications, or changes in

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F 309	Continued From page 17 condition even though R86 was new to dialysis. The spaces to record these items were left blank. On 2/29/16, the facility nurse completed R86's pre-dialysis documentation, and the dialysis nurse complete their documentation. However, the returning facility nurse did not complete any documentation including identifying if any signs or symptoms of bleeding, low blood volume, or pain were present even though R86 was a new dialysis patient. The spaces to record these items was left blank. There were no treatment records identified on 2/12/16, 2/15/16, 2/17/16, 2/19/16, or 2/22/16 although R86's Hemodialysis Treatment record identified she received services on these dates. When interviewed on 3/3/16, at 9:24 a.m. RN-E stated staff are instructed to, "Send the binder with [R86]" to her dialysis treatments, and everything pertaining to her dialysis records, "Stays in the binder." RN-E reviewed R86's dialysis communication records identified above and stated, "people haven't been filling it out." RN-E stated the entire record should of been completed because it was, "Supposed to be our communication tool" with the off-site dialysis clinic." This was their form of communication, and they not communicate through telephone, about R86 even though she was a new dialysis patient. During interview on 3/3/16, at 9:33 a.m. the dialysis nurse (DN) stated the clinic did not complete the record consistently because there was, "Just not enough room" on the record to do so. Further, DN stated she was unaware if the communication record was something the facility was to be completing or not.	F 309		

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F 309	Continued From page 18 When interviewed on 3/3/16, at 1:09 p.m. RN-B stated R86's dialysis communication book (binder) was used for communication between the facility and off-site dialysis clinic and it was, "Supposed to be completed" adding it was, "A communication tool between the center and us [facility]." Although R86 was new to dialysis treatments and had received eight treatments, there was no coordination of care completed with the dialysis center and facility to ensure R86 tolerated her dialysis runs which started February 8, 2016. A facility policy on dialysis care was requested, but none was provided.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with eating was provided for 1 of 3 residents (R90) reviewed for activities of daily living (ADLs). Findings include: R90's annual Minimum Data Set (MDS) dated 1/10/16, identified R90 had severe decision making ability, long and short term memory	F 311	1.R90 ADL care plan in regarding to dining services has been reviewed and updated 2.All residents requiring assistance with dining services have been assessed and plan of care reviewed and updated as indicated 3.Facility staff will be educated on policy regarding residents requiring assistance with eating. 4.DON or designee will complete random	4/12/16

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F 311	Continued From page 19 impairments, and required supervision with set-up from staff for eating. R90's nutrition risk care plan dated 10/2014, identified R90 was at nutritional risk and directed staff to, "Assist with meals as needed," further identifying R90 required, "Extensive Assist to complete [her] meal." During observation of meal service on 3/1/16, at 8:08 a.m. R90 was seated at a table with three other residents and had been served a plate of food consisting corned beef hash, toast, oatmeal, and a banana. R90 had a fork in her left hand and was trying to pick up various food items from her plate using the fork backwards, holding onto the fork using the tines before placing it back on the table. R90 then lowered her head onto her chest and closed her eyes. At 8:11 a.m. licensed practical nurse (LPN)-B came over to R90's table, gave R90's tablemate some toast and left without offering assistance to R90. At 8:15 a.m. R90 opened her eyes and moved the fork around on her plate of food, staring at her tablemates and watching them eat until 8:17 a.m. when LPN-B again came to R90's table and woke up R90's tablemate who had fallen asleep. LPN-B left the table at 8:19 a.m. without offering any assistance or encouragement to R90 for eating. At 8:20 a.m. R90 picked up a single piece of toast from her plate and took several small bites before placing the piece of toast on a folded up towel on the table. At 8:29 a.m. nursing assistant (NA)-D came to R90's table and stirred R90's tablemates food and offered the table mate assistance, however, no help or encouragement was offered to R90. NA-D left the table at 8:30 a.m. without offering any encouragement or assistance to R90 to eat her meal. R90 closed her eyes again, and	F 311	weekly audits on residents requiring assistance with eating for 4 weeks. All audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to trending identified.	

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lowered her head onto her chest. At 8:37 a.m. R90 opened her eyes and looked around the table at her tablemates and the food on her plate, before lowering her head back onto her chest and closing her eyes again. At 8:49 a.m. (41 minutes since observation of meal service began) NA-E pulled up a chair to the right side of R90 and offered her assistance, "Shall we have some of this?" NA-E helped R90 pick up and hold a full glass of apple juice, peeled the banana, and provided assistance to eat; R90 stated, "That's good." NA-E provided R90 assistance with eating until 9:10 a.m. when NA-E stood up and left the table to help other residents. R90 had consumed all of her banana, and nearly all of her toast and juices after being provided assistance with eating from staff.

When interviewed on 3/1/16, at 1:38 p.m. family member (FM)-F stated she did not feel there was enough staff to help R90 and the other residents eat, "I wish there was more help at meal times." FM-F had visited R90 before during meal times and noticed R90 didnt eat well unless someone sat and cued her to do so, and FM-F stated R90 would often play with her silverware or use it incorrectly to eat.

During interview on 3/2/16, at 9:23 a.m. NA-F stated R90 would at times refuse assistance with eating, but staff were supposed to attempt to assist her with all meals. NA-F stated R90 had to wait for assistance because their was not enough staff in the dining room to help all the residents eat at the same time, and stated, "We need more help."

When interviewed on 3/2/16, at 11:29 a.m. registered nurse (RN)-C stated staff should be

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F 311	Continued From page 21 offering assistance and cues to R90 for eating if they notice she is not eating on her own, "[Staff are] supposed to assist her, or try to." A facility policy on eating assistance was requested, but none was provided.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative ambulation services as ordered to improve and / or maintain the resident's ambulation ability for 1 of 1 residents (R84) reviewed for ambulation. Findings include: R84's quarterly Minimum Data Set (MDS) dated 1/7/16, identified R84 had severe cognitive impairment, required extensive assist with transfers, physical assistance with walking, and was on a restorative nursing program. R84's Therapy Recommendations for a Restorative Program dated 10/23/15, identified staff were to ambulate with the resident three times per day using a wheeled walker from his room to the dining room.	F 312	1.R84 has been re-assessed for restorative ambulation and plan of care and nursing assistant care guides have been updated. 2.All residents with recommended restorative ambulation plans have been reviewed to ensure their program is careplanned and communicated on the nursing assistant care guide. 3.Nursing staff will be educated on careplanning restorative ambulation programs, communicating restorative ambulation programs on the nursing assistant care sheet, and ensuring programs are being followed. 4.DON or designee will complete random weekly audits to include restorative ambulation programs being careplanned and communicated on the nursing assistant care sheet and programs being	4/12/16

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F 312	Continued From page 22 R84's care plan dated 10/15, identified staff were to provide assistance to and from the dining room, and R84 required a cane, walker, or wheelchair for mobility. However, it did not identify staff were to assist with ambulation to meals. No restorative flow sheets were available for ambulation for R84. When interviewed on 3/2/16, at 11:43 a.m. trained medication aid (TMA)-A stated R84 does not self-propel the wheelchair, and staff push him in the wheelchair to the dining room. When interviewed on 3/3/16, at 2:42 p.m. physical therapist (PT)-A stated R84 was last seen in therapy from 9/29/15 - 10/27/15. At this time, it was unsafe for R84 to ambulate independently, and PT recommended a restorative nursing program to be implemented for R84 to participate in an ambulation program. PT-A stated once the recommendation was forwarded to nursing, PT was no longer involved unless nursing notify's PT of a change in resident condition, or if there is a physician referral for further services. PT-A stated they had not received any referrals or nursing communication regarding R84 after 10/27/15. During interview on 3/3/16, at 4:16 p.m. nursing assistant (NA)-K stated nursing staff was in charge of ordering the ambulation program, and nursing assistants provide the assistance with ambulation. NA-K stated R84 had never ambulated that she was aware of, and if an ambulation program was ordered and provided, it was documented on the computer program. NA-K was unable to find any order for R84 to	F 312	completed x 4 weeks. All audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to trending identified.	

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F 312	Continued From page 23 ambulate. When interviewed on 3/3/16, at 4:27 p.m. Corporate registered nurse (RNC)-A stated recommendations from therapy are transferred to the care plan, into care tracker, and onto the nursing assistant care sheets. RNC-A stated staff were provided education on providing the ambulation program, and the registered nurse would assess monthly the effectiveness of the program and adapt as needed. During an observation on 3/3/16, at 4:55 p.m. PT-A assisted R84 to ambulate, with the use of a wheeled walker and transfer belt. PT-A stated a wheeled walker was provided from therapy at this time, as no walker was available in R84's room. PT-A stated R84 ambulated with a shuffled gate, and no change was noted to R84's ambulation since he was discharged from therapy. PT-A stated she was not aware R84 was not provided ambulation assistance as recommended. Facility policy on restorative nursing was requested, but not provide.	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.	F 314		4/12/16

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F 314	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 4 residents (R89, R115, R60) received care and services to promote healing and prevent the development of pressure ulcers. This resulted in actual harm for R89 whose stage II pressure ulcer became worse when interventions were not implemented. This resulted in actual harm for R89. Findings include: R89 was re-admitted to the hospital on 1/21/16, for fever, shortness of breathe, and was discharged back to the facility on 1/25/16, per the Hospital Discharge Summary dated 1/25/16. The discharge summary also noted R89 had a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or serosanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising) pressure ulcer on the coccyx and "had another open wound on the LE [lower extremity]." The Admission Skin Assessment dated 1/25/16, indicated R89 had a stage I ulcer (nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators) on the coccyx and the heels were void of any ulcers.	F 314	1.R89 and R60 skin assessments and plan of care have been reviewed and updated as appropriate. R115 is no longer a resident at the facility. 2. All residents with pressure ulcers will be assessed and plan of care reviewed and updated as indicated. 3. Nurses will be re-educated on implementing and following wound care protocol for residents with pressure ulcers including proper assessment and documentation, implementing interventions, and monitoring of pressure ulcers. Nursing staff will be educated on following interventions for pressure ulcer prevention and residents with pressure ulcers, including turning/repositioning and using pressure relieving devices or techniques. 4. DON or designee will complete random weekly audits to ensure staff follows the plan of care for residents at risk for skin altercation, including toileting and repositioning, for 4 weeks. Results of audits will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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R89's progress note dated 1/26/16, indicated no signs and symptoms of the coccyx being open and there was no mention of the LE wound. The note commented the staff would use the barrier cream to the resident's "bottom." However, the medical lacked any evidence of skin monitoring of the heel.

R89's quarterly Minimum Data Set (MDS) dated 12/4/15, indicated the resident had severe cognitive impairment, required extensive assistance with all activities of daily living (ADL) except for eating, was at risk for pressure ulcer development, but had no current pressure ulcers.

R89's quarterly MDS dated 2/10/16, indicated the resident remained at risk for pressure ulcers, but had no current pressure ulcers. The quarterly MDS did not identify the stage I ulcer noted upon re-admission on 1/26/16.

R89's Skin Integrity Assessment: Prevention and Treatment Plan of Care dated 2/25/16, was revised and indicated the resident had a stage II pressure ulcer on the right heel, and directed staff to float (relieve pressure) the heels, and apply a "bootie" onto the right foot. The plan of care did not indicate how often R89 was to be turned and repositioned. The plan of care indicated the wound was to be monitored weekly and staff were directed to document on the Skin Grid.

R89's Skin Grid - Pressure/Venous Insufficiency Ulcer/Other form dated 2/25/16, noted R89 had a stage II ulcer on the bottom of the right heel.

R89's progress notes dated 2/25/16, at 6:00 p.m. indicated, "New blister found to R [right] heel. Serous filled 5 cm x 5 cm [centimeter]." The note

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further indicated staff would float heels and add the bootie. The Progress Notes lacked evidence of daily wound monitoring.

R89's progress note dated 2/25/16, at 8:30 p.m. indicated the primary physician was notified of R89's pressure ulcer on the right heel, and orders were given to elevate legs, apply a soft boot, and continue to monitor.

R89's progress note dated 3/1/16, indicated a dressing change was done to the resident's right heel pressure ulcer, and there was a scant amount of bleeding, and, "only complains of pain when heel touched."

The undated and untitled NA assignment sheet did not specify R89 was to have the heels floated, nor were staff directed that R89 was to wear a foam boot on the right foot. The section under skin noted staff were to complete, "Q [every] shift skin checks. Assist resident with back scratcher PRN [as needed]."

R89 was continuously observed on 3/2/16, from 6:20 a.m. to 7:29 a.m. in bed. R89 was sleeping on his back, and both heels were lying directly on the mattress. The right heel had a blue foam boot on that was to float R89's heel. At 7:29 a.m. nursing assistant (NA)-A was interviewed and stated R89 did not have the heels floated, and NA-A stated she did not believe staff were supposed to be floating the resident's heels.

On 3/2/16, at 11:30 a.m. registered nurse (RN)-B was interviewed and was asked if R89 was going to see the wound MD today. The wound list was reviewed and noted R89's name was not on the list and was added by RN-B.

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F 314	Continued From page 27 On 3/2/16, at 1:13 p.m. physician (MD)-A was observed to assess R89 during wound rounds. MD-A assessed the pressure ulcer on the right heel and stated, "That's going to mature to a big time ulcer. That is 4 cm by 6 cm deep tissue injury [an injury to a patients underlying tissue below the skin's surface that results from prolonged pressure in an area] of right heel. Anticipate that will turn to eschar [a slough or piece of dead tissue that is cast off from the surface of the skin] in the next week or two." MD-A also stated the orders were for pressure relief to the heels with a boot and to float the heels. During interview on 3/3/16, at 8:00 a.m. corporate registered nurse (RNC)-A stated R89 was observed not to have the heels floated. RNC-A remarked R89 had a newly formed blister on the right foot and it was intact. There was no treatment to the right heel as the blister was intact. RNC-A verified the NA sheet lacked direction of the blue foam boot and the floating the heels. RNC-A indicated the skin assessment was the plan of care. The health unit coordinator (HUC)-A was observed on 3/2/16, at 8:10 a.m. to look at the computerized NA sheet. HUC-A acknowledged the information of the blue boot and floating the heels was not on the computerized NA sheet. During observations on 3/3/16, at 8:17 a.m. and 8:27 a.m. R84 was sitting in his wheelchair in the dining room, with the right foot pedal pushed off to the side, and R84's foot was in a blue boot placed directly on the floor. R89 was observed leaning forward in the wheelchair and was putting	F 314		

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pressure onto his right foot. At 8:57 a.m. NA-B moved the right foot pedal in front of R89, and placed R89's right foot on the pedal, and brought R89 to his room. There was no pressure relieving device placed on the foot pedals.

During interview on 3/3/16, at 9:08 a.m. NA-A stated both of the foot pedals for R89's wheelchair were missing until yesterday, however, staff provided foot pedals when R89 left the facility on 3/2/16, for an outing. NA-A stated R89's feet would be resting on the floor when in the wheelchair if no foot pedals were used.

During interview on 3/3/16, at 9:10 a.m. NA-B stated R89's feet were to be elevated, and he should be wearing the protective boot on the right foot.

During interview on 3/3/16, at 11:13 a.m. RN-B stated the first time she had seen the pressure ulcer was 3/2/16, during wound rounds with MD-A. RN-B stated R89 returned to the facility on 1/25/16, from the hospital with a pressure ulcer, but was not sure if R89 was added to the wound round list at that time. RN-B stated R89's heels were to be floated, and foot rests were to be used when he was in the wheelchair. RN-B stated she was aware R89 did not have foot pedals on his wheelchair from 2/25/16 to 3/2/16. R89's Skin Grid - Pressure/Venous Insufficiency Ulcer/Other form dated 2/25/16, was reviewed with RN-B. The Skin Grid Sheets had been changed from a stage II to a stage III pressure ulcer (Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without

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undermining of adjacent tissue). RN-B indicated she did alter the documentation because MD-A stated the pressure ulcer was a stage III pressure ulcer during his rounds on 3/2/16, however, MD-A indicated R89 had a deep tissue injury.

During interview on 3/3/16, at 1:02 p.m. RNC-A stated education would be provided to the nurses on staging a pressure ulcer. RNC-A stated she had done the wound rounds on 2/25/16, with RN-B and informed her how to fill out the assessment form, and the pressure ulcer was a stage II pressure ulcer at that time (that statement contraindicated what RN-B stated on 3/3/16, at 11:13 a.m.). RNC-A stated she was not aware the documentation was changed by RN-B to a stage III, and stated, "She [RN-B] can't do that; This is very serious."

On 3/3/16, at 1:13 p.m. R89 was observed lying in bed with his heels directly touching a pillow which was placed underneath, and the heels were not floated. R89 was wearing the blue boot on the right foot. At 1:16 p.m. licensed practical nurse (LPN)-D observed R89 in bed and stated R89's heel was directly on the pillow and not floating to relieve pressure as ordered. LPN-D assessed R89's heel in the boot, and stated the pressure ulcer on the right heel was directly on the foam inside the Rooke Breeze Boot, touching the sheep wool lining, which was not relieving the pressure to the pressure ulcer on the right heel.

The Wound Prevention and Treatment policy effective July 2015, directed staff to review assessments and identify interventions using the Skin Integrity Assessment: Prevention and Treatment Care Plan. Staff were to manage the pressure of a resident by utilizing support

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surfaces on bed or wheelchair, use turning and repositioning and off load heel pressure. R89 did not receive the care and services to promote the healing of the right heel blister. The heel blister went from a stage II to a deep tissue injury and that caused R89 harm.

R115's admission MDS dated 1/20/16, indicated R115 had moderate cognitive impairment, needed extensive assistance with bed mobility, was totally dependent on staff for transfers, was at risk for pressure ulcers, and had an unhealed stage II pressure ulcer on admission. The MDS identified R115 had a pressure reduction device for the bed and chair, was on a turning/repositioning program with nutrition interventions to promote pressure ulcer healing, and hydration management interventions in place to manage skin problems. The MDS indicated the resident had diagnoses including peripheral vascular disease and diabetes mellitus.

R115's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 1/16, indicated R115 had a pressure ulcer to midline sacrum, and a pressure ulcer to the coccyx, and directed staff to provide treatment per MD order.

Physician's wound care orders dated 2/3/16, directed staff to apply Santyl, apply skin prep, and cover with foam dressing once daily to the Stage III pressure wound to midline sacrum, and right medial buttock following a surgical debridement of the pressure ulcer(s).

On 3/2/16, at 8:41 a.m. with nurse practitioner (NP)-A R115 pressure ulcers were observed. R115's had two ulcers one to the coccyx and one above it at the midline sacrum. Both wound beds

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were beefy red, without drainage, odor, with edges intact and showed no signs of infection. NP-A stated the pressure ulcers appeared as they were healing.

R115's February 2016, treatment record directed staff to do a daily treatment to the pressure ulcers including cleanse the wound, apply Santyl, apply skin prep, and cover with adhesive foam. 7 days in February the treatment was left blank, and 4 days were marked as refused.

When interviewed on 3/3/16, at 3:43 p.m. RN-G stated R115 was to have a daily dressing change to the sacrum pressure ulcers using Santyl and Allyven, and the wound physician sees R115 every Wednesday. RN-G stated R115's pressure ulcer treatment is not always completed because R115 refused treatments at times. RN-G stated the treatment sheets indicated resident refusals, and if the treatment sheets were blank and not marked as refused, it indicated the pressure ulcer treatments were not completed.

R60's admission MDS dated 12/16/15, indicated R60 was cognitively intact and required extensive assistance with bed mobility, transfers, was at risk for developing pressure ulcers, did not have current pressure ulcers, and had a pressure reduction device for the bed and chair. The MDS identified R60 had diagnoses including paraplegia and wound infection.

R60's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 1/16, indicated the resident had a pressure ulcer to the right ischium, and directed staff to provide treatment per MD

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order.

R60's Physician's orders dated 1/27/16, directed staff to apply Santyl, apply skin prep, and cover with foam dressing once daily to the Stage III pressure ulcer to the right ischium.

On 3/3/16, at 9:27 a.m. R60 refused surveyor observation of pressure ulcer.

The January 2016, treatment record directed staff to cleanse the pressure ulcer, apply Santyl, and cover it with non adhesive foam. Three out of five days the treatment was not documented as completed with no indication as to why the treatment was not completed, and one out of five days was marked as refused.

The February 2016, treatment record directed staff to cleanse the pressure ulcer, apply Santyl, and cover it with non adhesive foam. Nine out of 28 days the treatment was not documented as completed and was blank with no indication as to why the treatment was not completed, and seven out of 28 days there were staff initials which were circled (which indicate treatment was not completed), and one out of 28 days were documented as refused.

When interviewed on 3/3/16, at 3:12 p.m. R60 stated the nurses put cream on her "bottom" every day, however, staff did not change the dressing on a daily basis. R60 stated she was not aware why staff did not change the pressure ulcer dressing every day, and stated she had not ever refused to allow nursing to complete the treatment for the pressure ulcer(s).

During interview on 3/3/16, at 3:38 p.m. RN-I

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stated R60 had pressure ulcer treatment ordered to be completed daily to her coccyx,however, staff is not able to complete this everyday because of lack of staffing. RN-I stated if she is not able to complete the pressure ulcer treatment, it is reported off to the next shift so they can complete it.

When interviewed on 3/3/16, at 3:50 p.m. RN-H stated pressure ulcer treatments should be completed as ordered by the physician, and she had been told by nurses at times that the pressure ulcer treatment(s) could not be completed due to lack of staffing. RN-H stated nurses are directed to pass it on to the next shift to ensure the treatment is done as ordered.

When interviewed on 3/3/16, at 5:43 p.m. RNC-A stated she expects all treatments to be done according to physician orders.

The facility policy/procedure Wound Prevention and Treatment dated 7/15, "recognizes even the most vigilant nursing care may not prevent the development and or worsening of pressure ulcers in some residents. In most cases, intensive efforts will be directed at the following: managing risk factors, providing preventative interventions and providing treatment."

The facility procedure Pressure Ulcer Prevention/ Treatment dated 7/15, directs staff to Assess all residents upon admission, review assessments and identify individualized interventions... by managing pressure, moisture, nutrition, friction and friction and sheer. The procedure also indicated that interventions will be communicated to staff and training would be provided as needed.

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a suprapubic catheter was inserted using sterile technique and according to the physician orders for 1 of 1 residents, (R5), reviewed with a suprapubic catheter. Findings include: R5's quarterly Minimum Data Set (MDS) dated 1/6/16, indicated he had severe cognitive impairment, required complete staff assistance for activities of daily living (dressing, grooming, bathing, eating, and mobility), and had an indwelling Foley catheter related to neuromuscular dysfunction of the bladder. R5's physicians orders dated February 2016, identified the resident was to have his S/P (suprapubic) catheter changed every month, and as needed if pulled or plugged, and was to use a	F 315	1.R5 suprapubic catheter plan of care was reviewed and updated as appropriate. 2.All residents with urinary catheters have been reviewed and plan of care updated as appropriate. 3.Nursing staff will be educated on proper procedure for working with suprapubic catheters. 4.DON or Designee will complete random audits regarding catheter reinsertion techniques monthly for 3 months. Audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	4/12/16

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F 315	Continued From page 35 22 or 24 FR (french)/5 cc's(cubic centimeters) (a liquid unit of measurement). R5's diagnosis included neurogenic bladder and recurrent UTI's (urinary tract infections). R5's care plan, most recently reviewed 1/15/16, indicated the resident had a suprapubic catheter related to neurogenic bladder with urine retention and recurrent UTI's . The care plan identified the resident was to have a 22 or 24 FR suprapubic catheter, and staff were directed to, "Follow sterile technique for supra-pubic catheter reinsertion." During observation of cares for R5 on 3/3/16, at 10:22 a.m. R5's suprapubic catheter was not in place, and Registered nurse (RN)-B indicated it would need to be replaced. RN-B proceeded to prepare to insert the S/P catheter, and it was observed RN-B had a gastrostomy tube instead of a S/P catheter. RN-B indicated she had the wrong equipment, and obtained a S/P catheter. RN-B proceeded to obtain a 26 FR S/P catheter, placed on non-sterile gloves, requested nursing assistant (NA)-A's assistance and had her apply non-sterile gloves, and applied sterile lubricant to the end of the S/P catheter and was prepared to insert the S/P catheter. Before RN-B continued with insertion, the surveyor questioned RN-B regarding sterile technique and the supplies she had been using. RN-B stated the S/P catheter she was going to use was a 26 FR, and not the 22 or 24 FR as directed by the physician. NA-A left R5's room to seek additional assistance and to obtain the correct supplies. At 10:31 a.m., licensed practical nurse (LPN)-D arrived with supplies, including a 22 FR S/P catheter and sterile gloves, and the S/P catheter was inserted under sterile technique.	F 315		

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F 315	Continued From page 36 A policy regarding urinary catheter insertion was requested but not provided.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure orthostatic blood pressures were monitored for administered anti-hypertensive medication for 1 of 5 residents	F 329	1.R84 treatment record has been reviewed and updated to reflect necessary orthostatic blood pressure monitoring. The MD has been updated on results obtained	4/12/16

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F 329	Continued From page 37 (R84) and effectiveness of as needed narcotic pain medication was evaluated using adeqaute parameters for 1 of 5 residents (R66) reviewed for unneccessary medication use. Findings include: R84's quarterly MDS dated 1/7/16, identified diagnoses including heart failure, hypertension (high blood pressure), and dementia. The MDS identified R84 had severe cognitive impairment, required extensive assistance with transfers, and was not steady without human assistance. R84's signed physician orders dated 2/3/16, identified orders for amlodipine besylate (medication to treat high blood pressure) 5 milligrams (mg) twice daily by mouth (po), and carvedilol (medication to treat high blood pressure) 25 mg po twice daily which had been initiated on 5/2/15. The physician orders directed to check orthostatic blood pressure once a week and vital signs to be checked weekly. Review of R84's medication administration record (MAR) for March 2016, identified staff were to monitor for side effects of medications which included dizziness, fatigue, hypertension, and orthostatic hypotension. Review of R84's treatment administration record (TAR) identified an order dated 5/2/15, to monitor orthostatic blood pressures weekly on Friday, identified the following for completion of the orthostatic blood pressure: - February 2016 0 of 4 opportunities - January 2016 0 of 5 opportunities - December 2015 1 of 4 opportunities	F 329	and reviewed resident plan of care accordingly. R66 physician orders for pain medication has been clarified by the physician and updated to reflect changes accordingly. 2.All residents on hypertensive medications were reviewed and MARS updated as necessary for appropriate monitoring. All residents on narcotic pain medication were reviewed and orders clarified for clear parameters as necessary. 3.Nurses will be educated regarding documentation requirements for drug monitoring to evaluate effectiveness of medications, potential side effects, or unnecessary medications. 4.Pharmacist or Designee will complete monthly random audits to ensure adequate drug monitoring and documentation is being completed. DON or designee will complete random weekly audits for 4 weeks to ensure documentation of side effect monitoring and PRN Analgesic Record/ Pain Flow Sheet is being completed Audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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F 329	Continued From page 38 - November 2015 1 of 4 opportunities - October 2015 1 of 5 opportunities - September 2015 0 of 4 opportunities Review of R84's Vital Sign-Individual Resident Flowsheet from 12/12/15 to 2/28/16 revealed documentation R84's blood pressure had been checked on 12/12/15, 12/27/15, 1/9/16, 2/7/16, 2/14/16 and 2/28/16. The form listed the single blood pressure checks, however, did not included orthostatic blood pressure monitoring for R84. When interviewed on 3/2/16, at 12:45 p.m. corporate registered nurse (RNC)-A stated orthostatic blood pressures had not been completed for R84 as ordered, and it was her expectation that the orthostatic blood pressures were to be completed. LACK OF MONITORING FOR NARCOTICS: R66's annual Minimum Data Set (MDS) dated 2/18/16, identified R66 had intact cognition, frequent episodes of pain, and received scheduled and as needed (PRN) pain medications. R66's signed physician orders dated 2/3/16, identified orders for the following narcotics: > "Fentanyl C2 [controlled drug] 25 mcg/hr [micrograms per hour] ... Apply 1 patch and change every 72 hours," and	F 329		

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F 329	Continued From page 39 > "Fentanyl C2 100 mcg/hr ... Apply 1 patch and change every 72 hours," and > "Methadone HCL C2 10 mg [milligrams] ... 3 tabs [tablets] [30 mg] by mouth every bedtime," and > "Oxycodone [a narcotic pain medication] 5 mg Tablet ... 1-2 tabs[tablets] [5-10mg] by mouth every bedtime as needed." Review of R66's Medication Administration Record (MAR) for 1/16 and 2/16 identified the following: -MAR dated 1/2016, identified R66 received 20 doses of the as-needed narcotic pain medication during the month. However, there was no documentation to determine if R66 received the ordered 5 mg dose or 10 mg dose of the as needed narcotic medication. R66's PRN (as-needed) Analgesic Record / Pain Flow Sheet (tool used to monitor pain and medication effectiveness of administered medication) dated 1/1/16 to 1/31/16, identified spacing to record the date and time of administration, pain description and numerical rating, the medication provided, and follow-up to the provided medication. However, all of these fields were left blank on R66's records. -MAR dated 2/2016, identified R66 received 19 doses of the as-needed narcotic medication, before the order was discontinued. A new order was transcribed which identified, "Oxycodone 5 mg i-ii [1-2 tablets] PO [by mouth] Q 4 HRS [every four hours] PRN" and R66 received 14 additional doses of the as-needed narcotic medication. However, there was no documentation to determine if R66 received the ordered 5 mg dose or 10 mg dose of the as needed narcotic	F 329		

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medication. PRN (as-needed) Analgesic Record / Pain Flow Sheet dated 2/1/16 to 2/29/16, identified spacing to record the date and time of administration, pain description and numerical rating, the medication provided, and follow-up to the provided medication. However, all of these fields were left blank on the record.

R66's progress notes dated 1/1/2016 through 2/28/16, were reviewed but lacked documentation identifying what dose of the as needed medication had been administered, why R66 had been provided the as needed narcotic medication, or any follow up on if the provided medication had been effective.

When interviewed on 3/3/16, at 10:48 a.m. registered nurse (RN)-E stated R66 had chronic complaints of pain and, "is on a couple of meds [medications] to help with that," including scheduled narcotics in addition to as needed narcotic medication. R66 had orders for one to two tablets of as-needed oxycodone for pain, and RN-E stated she used a pain scale to identify how many tablets of the as needed narcotic medication to provide to R66. RN-E stated the nursing staff should be recording the dose provided and it's effectiveness on the PRN Analgesic Record each time a as-needed pain medication was administered. RN-E stated she was not aware of any other location the staff would be documenting their non-pharmacological interventions, monitoring or follow-up of the as-needed narcotic medication than on the PRN Analgesic Record, "not that I'm aware of." RN-E reviewed the January and February analgesic records and stated there was no monitoring of the effectiveness completed for R66's as needed narcotic medication use, "It should have been

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F 329	Continued From page 41 written here," and staff, "Need to be re-taught to use it each time." Further, RN-E stated she was unable to determine how many tablets of the as needed narcotic medication had been given each time R66 received the as needed narcotic. During interview on 3/3/16, at 12:56 p.m. the assistant director of nursing (ADON) stated staff were expected to use the PRN analgesic records to document a resident's pain, and the effectiveness monitoring for it, "[They're] supposed to use that sheet." Further, RN-B stated she did not think physicians should be writing range orders (i.e. one to two tabs) anymore, "I thought that was banned a long time ago," and staff should have clarified the order. Although R66 had orders for as needed narcotic medication, the facility failed to ensure staff identified the administered dose, and then monitored the administered medication to ensure it was effective and necessary in managing R66's pain. A facility Pain Management policy dated 7/2015, identified, "Record an administered scheduled and/or PRN analgesic. Include data regarding resident pain intensity, intervention and effectiveness of intervention to manage pain on the [MAR]." A facility Medication Administration policy dated 7/2015, directed staff to, "Indicate reason for administration and effectiveness of PRN medication in the nursing progress notes or on the back of the [MAR]."	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		4/12/16

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F 332	Continued From page 42 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all medications were administered in a timely fashion in accordance with physician orders and facility practice for 1 of 7 residents (R101) observed to receive medication during the survey. This resulted in a medication error rate of 8.3% (percent). Findings include: During an observation of medication administration on 3/2/16, at 9:28 a.m., licensed practical nurse (LPN)-D was observed to administer R101's medications. LPN-E administered Baclofen 20 mg tablet, Morphine Sulfate ER 15 mg tablet and Lorazepam 2 mg tablet with various other medications to R101 at that time. LPN-H stated she was aware that R101's Morphine Sulfate was scheduled for 7:00 a.m., and Baclofen and Lorazepam were scheduled for 8:00 a.m.. She indicated R101 had an appointment today and wanted to be up between 8:30 and 9:00 a.m., but stated, "It's just been busy this morning." R101's admission record, dated 12/3/15, included diagnoses of paraplegia, post traumatic stress disorder, and chronic pain. R101's admission Minimum Data Set (MDS), dated 12/16/15, identified R101 had intact cognition and had pain	F 332	1.R101 is no longer a resident at this facility. The facility will provide medications in a safe, professional manner to include right drug, right reason, right dose and preparation, right patient, right time, right route and right documentation with oversight to ensure a medication delivery system that meets professional standards. Medication Administration Records have been audited to ensure residents are receiving medications in a safe professional manner. 2.All nurses will receive education regarding the policy of medication administration and seeking out assistance if having difficulty completing medication administration timely. 3.DON or Designee will complete random weekly medication administration audits for 4 weeks to ensure timeliness of medication administration. All audits will be reviewed at QAPI meeting for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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almost constantly, had difficulty sleeping due to pain at night, and had limited day to day activities due to pain.

During an interview on 2/29/16, at 6:20 p.m., R101 stated he had constant pain in his chest, abdomen, back, hand and lower arm, and spasms in his legs and bladder, and indicated his medications, especially pain medications, were often given late or not at all, when he requested them. R101 indicated he needed Morphine Sulfate and Baclofen right away in the morning to help with his pain and stiffness before getting up for the day, and stated it was difficult to manage his pain on the days that his medications were late.

R101's physician orders, dated 2/3/16, included, "Morphine Sulfate [medication used to treat pain] ER [extended release] 15 mg [milligrams] tablet...1 tab by mouth every 8 hours," for pain, "Baclofen [medication used to treat muscle spasms, pain and stiffness] 20 mg tablet, 1 tab by mouth four times daily," for muscle spasms, and, "Lorazepam [medication used to treat anxiety] 2 mg tablet, 1 tab by mouth three times daily," for anxiety.

R101's medication administration record (MAR), dated 3/16, indicated Morphine Sulfate was to be administered at 7:00 a.m., 3:00 p.m., and 11:00 p.m., Baclofen was to be administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 2:00 a.m., and Lorazepam was to be administered at 8:00 a.m., 12:00 p.m., and 8:00 p.m.

During an interview on 3/3/16, at 1:06 p.m., RN-H stated, when giving scheduled medications, "We have an hour before and an hour after [the

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F 332	Continued From page 44 scheduled time] to give them," and indicated if medications were given outside of that time frame, it would be a considered a medication error. Review of the facility's procedure, Medication Administration, dated 7/15, included, "The licensed nurse and/or medication assistant will check the following to administer medication: Right medication, Right dose, Right dosage form, Right route, Right resident, and Right time."	F 332		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 353		4/12/16

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F 353	Continued From page 45 by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed resident needs for 1 of 3 residents (R90) reviewed for activities of daily living, and for 1 of 2 residents (R66) who complained about cold food. In addition, for 9 of 9 residents (R39, R158, R68, R66, R110, R127, R88, R137, R77), 2 of 3 family members (FM-E, FM-F), and 7 of 7 staff members (NA-H, CDM-A, RD-A, NA-F, LPN-A, SM-A, SM-B) who identified concerns with the lack of adequate staff in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: See F311 as the facility failed to ensure timely assistance with eating was provided for 1 of 3 residents (R90) reviewed for activities of daily living (ADLs). See F364 as the facility failed to ensure food was served hot and palatable for 1 of 2 residents (R66) who complained about cold food. RESIDENT CONCERNS WITH LACK OF ADEQUATE STAFFING: R39's quarterly Minimum Data Set (MDS) dated 12/12/15, identified R39 had intact cognition and required extensive assistance with his activities of daily living (ADLs). During interview on 2/29/15, at 5:22 p.m. R39 stated he did not feel there was enough staff available in the facility to help residents, "I think	F 353	1.Facility has reviewed staffing levels to ensure facility has sufficient staffing levels to meet resident needs. This is done through daily evaluation of resident census and acuity levels by the DON or designee. Also Refer to F282, F311, F312, F314, F332, F364 plan of correction. 2.Residents in the facility will receive care by skilled/experienced staff that are supervised to ensure care needs are being met. Administrator/DON or designee will review scheduled staffing daily to ensure adequate staffing levels and to ensure appropriate quantity, quality, and composition of staff. 3.Staff will receive education regarding sufficient staffing levels and providing nursing and nursing related services accordingly. 4.Executive Director will complete random weekly audits x 4 weeks to ensure adequate staffing levels are provided to include interviews with staff. Caring Partners will complete weekly audits regarding customer service and resident satisfaction with cares. Audits will be reviewed at QAPI meeting and QAPI team will adjust audit schedule appropriately based on findings.	

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they need more staff." R39 stated he will request to go to bed and staff will tell him they have other things to do before they can help him, and it, "Will be awhile" before he received help, "They will come, [it] just takes awhile."

R158's admission MDS dated 12/24/15, identified R158 had intact cognition and required extensive assistance with his activities of daily living (ADLs). During interview on 2/29/16, at 6:49 p.m. R158 stated he did not feel the facility had enough staff. R158 stated the staff had too much to do, and not enough time to complete it and spend adequate time with the residents.

R68's quarterly MDS dated 2/9/16, identified R68 had intact cognition and required extensive assistance with her (ADLs).
During interview on 2/29/16, at 6:52 p.m. R68 stated she did not feel the facility had adequate staff to ensure she received care in a timely manner. R68 required two staff to assist her with cares, and at times during the night, there is only one staff member working so she had to wait and doesn't get her incontinence product changed as a result. R68 reported staff always tell her they do not have time to help her when asked, and sometimes it takes up to 45 minutes to get her call light answered.

R66's annual MDS dated 2/18/16, identified R66 had intact cognition and required extensive assistance to complete her ADLs.
During interview on 2/29/16, at 6:58 p.m. R66 stated there was not enough staff to help residents at the facility, "They are so short staff[ed]." R66 stated she frequently received her medication late from the nursing staff and this was concerning to her, "Its become a real

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hazard." R66 indicated call lights were not answered timely, sometimes having to wait, "Up to two hours" for someone to answer it and assist her, "The care is so bad."

R110's quarterly MDS dated 1/7/16, identified R110 had intact cognition and required extensive assistance to complete his ADLs.
During interview on 3/1/16, at 8:50 a.m. R110 stated he did not think there was enough staff at the facility to help residents get the care they need. Staff often tell him to wait and then do not return to help him. R110 reported often times having to sit in stool waiting to get help after having a bowel movement which made him feel uncomfortable.

R127's quarterly MDS dated 1/6/16, identified R127 had intact cognition.
During interview on 3/1/16, at 9:59 a.m. R127 stated there was not enough staff at the facility. R127 stated he often has to wait for long periods to receive his medications and meals, and it upsets him.

R88's annual MDS dated 1/15/16, identified R88 had intact cognition and required extensive assistance to complete her ADLs.
During interview on 3/1/16, at 10:19 a.m. R88 stated she did not feel there was enough staff at the facility because she was not being assisted with toileting or incontinence care every two hours as she needed. R88 stated she didn't receive her scheduled bathing or morning cares on a consistent basis which often made her late to activities.

R137's quarterly MDS dated 11/26/15, identified R137 had intact cognition.

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During interview on 3/1/16, at 11:20 a.m. R137 stated she did not feel there was enough staff in the facility to help her and the other residents get the care they need. R137 stated the overnight hours were the worst, and one night she had significant pain and there was no staff to help her so she called another resident on a different floor in the building to have them send help up to her, "It's like no one up here at all." Further, R137 stated it had taken, "40 minutes, sometimes longer" to get her call light answered and receive help.

R77's quarterly MDS dated 12/2/15, identified R77 had intact cognition and required extensive assistance to complete his ADLs.
During interview on 3/1/16, at 11:31 a.m. R77 stated he did not feel there was enough staff to help deliver meals or medications to the residents in the facility because he receives his food and pain medications late often times.

FAMILY CONCERNS WITH LACK OF ADEQUATE STAFFING:

When interviewed on 3/1/16, at 11:21 a.m. family member (FM)-E stated he did not feel there was enough staff at the facility to make sure residents received the care they needed adding his wife often received her medications late as a result. Further, FM-E stated he often ends up doing most of his wife's care because there is not enough staff to help her.

During interview on 3/1/16, at 1:38 p.m. FM-F stated there was not enough staff at the facility. FM-F had noticed concerns with residents not getting assistance to eat at meal times, "I wish there was more help at meal times."

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F 353	Continued From page 49 STAFF CONCERNS WITH BEING UNABLE TO COMPLETE CARE DUE TO LACK OF STAFFING: During interview on 3/2/16, at 6:08 a.m. nursing assistant (NA)-H stated staff often felt like they don't have "quite enough time" to get all of the assigned cares completed, especially before meal times. NA-H stated the weekend staffing is hardest, and the staff are often short NAs which makes it, "really stressful" for the residents and staff. On 3/2/16, at 8:59 a.m. the certified dietary manager (CDM)-A and registered dietician (RD)-A were interviewed. CDM-A stated the lack of nursing staff to help pass meals and room trays was an "ongoing problem" which affected the dietary departments ability to serve palatable food. RD-A stated the lack of nursing staff to assist with meal times was, "affecting my department and the residents point blank." When interviewed on 3/2/16, at 9:23 a.m. NA-F stated some residents often have to wait for assistance to eat because there is not enough staff to help everyone eat at the same time, "we need more help." NA-F stated he/she had reported the concerns to the assistant director of nursing and a floor nurse in the past. During interview on 3/2/16, at 1:31 p.m. licensed practical nurse (LPN)-A stated she felt there needed to be more staff on the floor to help care for the residents. Several of the residents required, "total care" and the lack of adequate staffing did not allow the floor staff enough time to complete it, "[It would] be nice to have one more	F 353		

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F 353	Continued From page 50	F 353		

on the floor."

On 3/2/16, during an anonymous interview, SM-B stated the facility needed more staff to ensure care was being completed. SM-B stated at times orders from the physician don't get transcribed timely, and treatments are being missed or not completed at all because there was no time for the staff to do them. SM-B stated residents were neglected, and the staffing at the facility was getting worse lately with the director of nursing (DON) changing several times and no staff being held accountable for errors and not completing their assigned tasks. Further, SM-B stated the lack of staff was so detrimental to the residents, the facility should close down.

On 3/3/16 during an anonymous interview, staff member (SM)-A stated the staffing at the facility was, "bad someday's" and, "we [staff] need more help up here." SM-A stated residents get upset because they have to wait for cares, and added the lack of staff contributes to increased behaviors because the residents get upset. SM-A stated the nurses and social workers only help out, "when State is here" and when the staff voiced concerns to administration it was perceived as complaining. Further, SM-A stated the facility needed more staff so they, "could give the residents more time."

On 3/3/16, at 2:02 p.m. registered nurse consultant (RNC)-A and the assistant executive director (AED) were interviewed. The facility used a "minimum standard" of staffing, and changed it based on the acuity of the residents by monitoring the 24 hour boards (communication tool used between the staff) for concerns and comments. The facility had started using pool

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F 353	Continued From page 51 staff from an outside agency several months ago. The RNC-A stated the facility had not been aware of staff concerns about inabiity to complete resident cares. Although resident, families and staff had stated call lights do not get answered timely, meals were not served timely and they had to wait for assistance with activities of daily living. The facility had not identified there was a staffing concerns despite multiple resident, family and staff complaints. A facility policy and procedure on staff was requested, but none was provided.	F 353		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served hot and palatable for 1 of 2 residents (R66) who complained about cold food. Findings include: R66's annual Minimum Data Set (MDS) dated 2/18/16, identified R66 had intact cognition, and was independent with eating after set up by staff.	F 364	1. R66 is receiving palatable meals at the proper temperature. 2. All residents will receive palatable meals at the proper temperature. 3. Cooks were re-educated on taking food temperatures and reheating when food is not at the proper temperature prior to food leaving the kitchen. Nursing staff have been re-educated on the dining process for resident who receive trays. 4. Dietary Manager or designee will	4/12/16

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F 364	Continued From page 52 During interview on 2/29/16, at 6:49 p.m. R66 stated she received meal trays in her room because she didn't like eating with other residents in the dining room, and stated her food was, "Generally always cold" when served to her. During observation of the breakfast meal on 3/2/16, at 7:00 a.m. cook (CK)-A prepared french toast, sausage links, and oatmeal in the facility kitchen. CK-A checked the food temperatures using the facility thermometer and identified the french toast was 140 degrees (Fahrenheit, F), the sausage links were 170 degrees, and the oatmeal was 158 degrees. The food was placed in metal serving pans, and placed in a steam table being brought to the fourth floor dining room. CK-A stated room trays were served throughout the meal services, and certified dietary manager (CDM)-A stated two residents, including R66, were served their trays first before the dining room was served to help maintain the heat of the food. At 7:22 a.m. the steam table with the food was brought up to the fourth floor, and at 7:34 a.m. dietary aide (DA)-A began to serve breakfast meals to the residents seated in the dining room. A mobile cart was placed next to the steam table with trays and silverware set-up for room tray delivery, however, no food was put on to plates or deliver to any residents in their rooms. At 7:49 a.m. nearly all of the residents in the dining room had been served their breakfast meal, and no room trays had been delivered. CDM-A was present during the meal service and left the dining room to retrieve the room tray orders. At 8:04 a.m. (42 minutes after the steam table arrived on fourth floor), CDM-A started to prepare room trays for residents, including R66. The surveyor requested a sample tray, and nursing assistant (NA)-G took R66's covered meal tray,	F 364	conduct random weekly food temping in the kitchen prior to meal service. If found that food is not at the proper temperature, food will be reheated to the proper temperature to ensure that it is served hot and palatable. In addition, Dietary Manager or designee will conduct random weekly test trays to ensure that food is served hot and palatable x 4 weeks. Results of audits will be reviewed at QAPI for tracking and trending and QAPI team will then adjust audit schedule accordingly.	

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F 364	Continued From page 53	F 364		

prepared at the same time the sample tray was requested, to R66 in her room. DA-A temped the served food on the sample tray, and stated the oatmeal was 98 degrees (F), the french toast was 54 degrees, and the sausage was 95 degrees, and the food on the tray felt cold to the touch. At 8:11 a.m. R66 had been served her meal tray which had been prepared along with the requested sample tray, and R66 stated her french toast, "Isn't warm" and her food was cold. NA-H arrived in the room and observed R66's room tray. NA-G stated the french toast was, "Ice cold" and she would, "Go grab another tray" for R66.

When interviewed on 3/2/16, at 8:27 a.m. NA-G stated the nursing staff were responsible to serve the room trays, and two residents, including R66, should be served first to make sure their food remains warm. NA-G stated the staff were, "Very busy today" and unable to serve them first however, adding it, "Happens sometimes." NA-G stated he was unsure how hot R66's food was when he served it to her because, "That is the kitchen['s] responsibility."

During interview on 3/2/16, at 8:59 a.m. CDM-A and registered dietician (RD)-A stated R66 should have been served at the beginning of the meal, "To help hold temperatures," because of past complaints from her about food being served cold. The nursing staff was responsible to serve the meals to residents in their rooms, but that, "Didn't happen" as it was supposed to, and R66 should have been served at the beginning of the meal service. Further, CDM-A stated this was an, "On-going problem", and the lack of nursing staff and their support was affecting the meal service.

A facility Room Service policy dated 7/2015,

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F 364	Continued From page 54 identified the facility, "Strives to provide all residents a pleasurable dining experience by offering nutritious, attractive meals served in the resident room when required." The policy directed staff to serve room trays covered, but did not identify when room trays were to be served during the meal service to maintain heat and palatability or direct staff to check the temperature before serving the prepared food.	F 364		
F 371 SS=E	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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure left-over fish based product was discarded in a timely manner to reduce the risk of food borne illness. This had potential to affect 15 of 15 residents identified by the facility as who could have potentially consumed the food. Findings include: An initial tour of the facility kitchen was completed on 2/29/16, at 12:55 p.m. with certified dietary manager (CDM)-A and registered dietician	F 371	1.Left-over fish product was immediately discarded and coolers were inspected to determine there were no other food products that needed to be discarded. 2.Facility staff were re-educated on policy for discarding leftover refrigerated items. 3.Dietary Manager or designee will conduct weekly audits of coolers for proper discarding of leftover items x 4 weeks. Audits will be reviewed at QAPI meeting and QAPI team will adjust audit schedule appropriately based on findings.	4/12/16

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F 371	Continued From page 55 (RD)-A. During the tour, a cooler was reviewed underneath a metallic serving table which RD-A stated was a, "Nourishment area" used to prepare foods for residents in between meal hours. A one gallon plastic container of light brown colored food was in the cooler which was labeled, "Tuna Salad," with a date written, "02-23-16" (six days prior) in black marker. The container was approximately 1/2 full and covered with saran wrapping. RD-A stated the foods in the cooler, including the tuna salad, were available for resident consumption and the tuna salad should have been removed after,"Three days." On 3/1/16, at 2:20 p.m. CDM-A, RD-A and culinary manager (CM)-A were interviewed. The tuna salad had been made on 2/23/16 for, "Whoever wanted it" and would have been used if any residents had requested tuna salad. CDM-A stated the facility policy was to discard left-over food after three days, and leaving the tuna salad in the cooler was an oversight by the cook. RD-A stated the left-over tuna salad was a, "Higher risk food" and could cause potential food poisoning if it was consumed after three days of being made. Further, CDM-A stated the amount remaining in the one gallon container was enough tuna salad to make, "About 15 [sandwiches]", and again stated it should have been discarded after three days. A facility Refrigerator Storage policy dated 7/2015, identified all leftover items should be labeled with the item name and date of storage, then "Discard refrigerated leftovers after 3 days."	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	F 412		4/12/16

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F 412	Continued From page 56 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 interview and document review, the facility failed to coordinate dental care and services for 1 of 3 residents (R110) reviewed for dental hygiene and care. Findings include: R110's quarterly Minimum Data Set (MDS) dated 1/7/16, identified the resident was cognitively intact, required extensive assistance to complete activities of daily living (ADL's) including dressing, grooming, bathing, and toileting, and was independent with eating once he was set up. An undated nursing assistant worklist directs the staff to provide assist with activities of daily living. During interview on 3/1/16, at 8:55 a.m. R110 stated he had problems with cavities and his, "teeth are all busted up." R110 stated he had requested to see a dentist, however, he has not seen the dentist. During an interview on 3/1/16 at 8:46 a.m., NA-B stated the resident some times does not want to	F 412	1.R110 was evaluated by nursing and is scheduled for non-emergency dental visit on 4/7/16. 2.All residents have been reviewed for potential dental needs, and referrals have been completed as indicated. 3.All staff will received education regarding the policy for routine and emergency dental services. 4.Social Services will continue to offer dental services with admissions, and review on a quarterly basis for routine services. Caring Partners will conduct weekly audits with residents regarding dental service requests. Results of these audits will be reviewed at QAPI for tracking and trending.	

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F 412	Continued From page 57 brush his teeth. During a subsequent interview on 3/3/16 at 12:16 p.m., NA-B stated (R110) required assistance with activities of daily living but does brushes his teeth independently. Review of the Associated Clinic of Psychology (ACP) of 7/31/15, identified (R110) stated that " food doesn't taste right, kinda like its spoiled". The ACP note from 9/21/15 also identified the resident expressed that food tasted poorly, "as though it has gone bad, or having a bad taste." The progress notes of 1/18/16 indicated social service (SS)-B indicated R110 was "put on list to be seen...dental." During interview on 3/3/16, at 10:12 a.m. with health unit coordinator (HUC)-A stated R110 had not seen the dentist even though he was referred in January 2016. She stated he was last seen by the dentist in 7/2014, over 1/1/2 years ago. During interview on 3/3/16 at 4:49 p.m. , SS-B stated that she had reviewed dental status with R110 during care conference and had scheduled an appointment in follow up. Resident dental schedules were reviewed for 2/16, 3/16, and 4/16 with SS-B and HUC-A during this time. R110 had not been on schedule for a dental exam. SS-B stated that social services was responsible to schedule ancillary services during care conference and as needed, but this was missed.	F 412		
F 425 SS=B	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425		4/12/16

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F 425	Continued From page 58 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure tuberculin solution available for resident and staff use was not expired. This had potential to affect 4 of 4 residents or staff who could have received the expired solution. Findings include: On 3/3/16, at 12:16 p.m. the third floor medication storage room was observed with licensed practical nurse (LPN)-B. A refrigerator inside the room contained an opened package of Tuberculin Purified Protein Derivative (a medication used to test for exposure to Tuberculosis) which had a date written on the box in black marker of, "1-13-16." LPN-B stated the tuberculin solution was available for resident and staff. LPN-B	F 425	1.Facility has destroyed the tuberculin solution labelled 1/13/16. 2.All opened tuberculin solutions have been audited and are currently within manufacturer guidelines for usage. 3.Nurses will be educated on following policy for medication storage recommendations. 4.DON or Designee will complete random weekly audits to ensure proper medication storage x 4 weeks. Results of audits will be reviewed at QAPI meeting for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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F 425	Continued From page 59 stated the remaining solution was enough for approximately four doses to be administered, and it should have been discarded after 30 days from being opened on 1/13/16. Further, LPN-B stated all of the staff were responsible to check the refrigerator for expired medications and solutions, however, she was unaware if the facility had a specific system to ensure expired medications were identified. During interview on 3/3/16, at 3:44 p.m. registered nurse consultant (RNC)-A stated the tuberculin solution should have been discarded after being opened for thirty days because the medication effectiveness could be decreased. A facility undated Injectable Medications flowsheet identifying, "Storage Recommendations," identified tuberculin solution should be, "Date[ed] when opened and discard unused portion after 30 days [underlined]." The facility consulting pharmacist was contacted on several occasions during the survey, but was unable to be reached for interview.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		4/12/16

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F 428	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist identified irregularities with dosing and monitoring for effectiveness of as needed pain medication for 1 of 5 residents (R66) reviewed for unnecessary medication use. Findings include: R66's annual Minimum Data Set (MDS) dated 2/18/16, identified R66 had intact cognition, frequent episodes of pain, and received scheduled and as needed (PRN) pain medications. R66's signed physician orders dated 2/3/16, identified orders for the following narcotics: > "Fentanyl C2 [controlled drug] 25 mcg/hr [micrograms per hour] ... Apply 1 patch and change every 72 hours," and > "Fentanyl C2 100 mcg/hr ... Apply 1 patch and change every 72 hours," and > "Methadone HCL C2 10 mg [milligrams] ... 3 tabs [tablets] [30 mg] by mouth every bedtime," and > "Oxycodone [a narcotic pain medication] 5 mg Tablet ... 1-2 tabs[tablets] [5-10mg] by mouth every bedtime as needed." Review of R66's Medication Administration Record (MAR) for 1/16 and 2/16 identified the following: -MAR dated 1/2016, identified R66 received 20 doses of the as-needed narcotic pain medication	F 428	1.R66 drug regime has been reviewed and updated as indicated. 2.All residents with PRN pain medications have been reviewed to identify potential irregularities with dosing and monitoring for effectiveness. 3.Nurses have received education regarding documentation requirements for PRN Pain medication usage and monitoring for potential dosing irregularities. Pharmacy Consultant was included in education relating to noting lack of effectiveness and dosing of narcotics. 4.DON or designee will complete random weekly audits for documentation and clarification of potential irregularities with dosing and monitoring for effectiveness of prn pain meds x 4 weeks. Results of audits will be reviewed at QAPI meeting for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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F 428	Continued From page 61 during the month. However, there was no documentation to determine if R66 received the ordered 5 mg dose or 10 mg dose of the as needed narcotic medication. R66's PRN (as-needed) Analgesic Record / Pain Flow Sheet (tool used to monitor pain and medication effectiveness of administered medication) dated 1/1/16 to 1/31/16, identified spacing to record the date and time of administration, pain description and numerical rating, the medication provided, and follow-up to the provided medication. However, all of these fields were left blank on R66's records. -MAR dated 2/2016, identified R66 received 19 doses of the as-needed narcotic medication, before the order was discontinued. A new order was transcribed which identified, "Oxycodone 5 mg i-ii [1-2 tablets] PO [by mouth] Q 4 HRS [every four hours] PRN" and R66 received 14 additional doses of the as-needed narcotic medication. However, there was no documentation to determine if R66 received the ordered 5 mg dose or 10 mg dose of the as needed narcotic medication. PRN (as-needed) Analgesic Record / Pain Flow Sheet dated 2/1/16 to 2/29/16, identified spacing to record the date and time of administration, pain description and numerical rating, the medication provided, and follow-up to the provided medication. However, all of these fields were left blank on the record. R66's progress notes dated 1/1/2016 through 2/28/16, were reviewed but lacked documentation identifying what dose of the as needed medication had been administered, why R66 had been provided the as needed narcotic medication, or any follow up on if the provided medication had been effective.	F 428		

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F 428	Continued From page 62	F 428		

When interviewed on 3/3/16, at 10:48 a.m. registered nurse (RN)-E stated R66 had chronic complaints of pain and, "is on a couple of meds [medications] to help with that," including scheduled narcotics in addition to as needed narcotic medication. R66 had orders for one to two tablets of as-needed oxycodone for pain, and RN-E stated she used a pain scale to identify how many tablets of the as needed narcotic medication to provide to R66. RN-E stated the nursing staff should be recording the dose provided and it's effectiveness on the PRN Analgesic Record each time a as-needed pain medication was administered. RN-E stated she was not aware of any other location the staff would be documenting their non-pharmacological interventions, monitoring or follow-up of the as-needed narcotic medication than on the PRN Analgesic Record, "not that I'm aware of." RN-E reviewed the January and February analgesic records and stated there was no monitoring of the effectiveness completed for R66's as needed narcotic medication use, "It should have been written here," and staff, "Need to be re-taught to use it each time." Further, RN-E stated she was unable to determine how many tablets of the as needed narcotic medication had been given each time R66 received the as needed narcotic.

During interview on 3/3/16, at 12:56 p.m. the assistant director of nursing (ADON) stated staff were expected to use the PRN analgesic records to document a resident's pain, and the effectiveness monitoring for it, "[They're] supposed to use that sheet." Further, RN-B stated she did not think physicians should be writing range orders (i.e. one to two tabs) anymore, "I thought that was banned a long time

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F 428	Continued From page 63 ago," and staff should have clarified the order. On 7/16/15, no irregularities were identified. On 8/13/15, no irregularities were identified. On 9/7/15, no irregularities were identified. On 10/14/15, no irregularities were identified. On 11/14/15, no irregularities were identified. On 12/19/15, no irregularities were identified. On 1/22/16, the pharmacist noted R66 had been using the as-needed narcotic pain medication almost daily, however signed, "NI" for no irregularities were identified in the medication regimen. On 2/24/16, no irregularities were identified. Although R66 had orders for as needed narcotic medication, the facility failed to ensure staff identified the administered dose, and then monitored the administered medication to ensure it was effective and necessary in managing R66's pain and the consulting pharmacist failed to identify this irregularity. The consulting pharmacist was contacted on several occasions during the survey, but was unable to be reached for interview. A facility policy related to the consulting pharmacist was requested. The facility provided policy titled Consultants, which indicated "for Pharmacist consultant recommendations, refer to "Medication Regimen Review" procedure located in the Med Administration Program. However, this portion was not provided as requested.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		4/12/16

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F 431	Continued From page 64 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 interview and document review, the facility failed to ensure Fentanyl Patches (transdermal narcotic patches) were destroyed according to facility policies and procedures to	F 431	1.R66 medication administration record has been reviewed and updated to include documentation and adherence to transdermal narcotic patches destruction.	

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F 431	Continued From page 65 reduce the risk of diversion for 1 of 5 residents (R66) reviewed for unnecessary medication use. This had potential to affect 4 of 4 residents (R66, R147, R65, R111) residing in the facility who had current orders for Fentanyl patches. Findings include: A facility provided undated titled Fentanyl Patche(s) listing identified R66, R147, R65, and R111 had current orders for Fentanyl (a narcotic medication) transdermal patches. R66's signed physician orders dated 2/5/16, identified R66 had current orders for, "Fentanyl C2 [controlled substance] 25 mcg/hr [micrograms an hour] Patch ... Apply 1 patch and change every 72 hours," and, "Fentanyl C2 100 mcg/hr Patch ... Apply 1 patch and change every 72 hours." Further, R66's physician orders identified nursing staff was to, "Fold and flush patch down toilet following removal / Two nurses must witness." R66's medication administration record (MAR) dated 2/2016, identified spacing for an administering nurse to document applying a new Fentanyl patch by writing their initials, as well as a space to record when the staff removed and disposed of the old patches with "NURSE 1 INT [initials]", and "NURSE 2 INT" being provided for staff to have two nurses sign the witnessed destruction as directed by the physician orders. R66's MAR identified a total of ten Fentanyl patch changes occurred, however, only four of the ten times indicated two nurses signed the MAR to indicate the disposal was witnessed by 2 nurses. When interviewed on 3/3/16, at 11:00 a.m.	F 431	2.All residents receiving transdermal narcotic patches medication administration record has been reviewed and updated. 3.Nurses have received education on following policy for transdermal narcotic patch destruction. 4.DON or designee will complete random weekly audits for 4 weeks to ensure appropriate transdermal narcotic patch destruction. Results of audits will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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F 431	Continued From page 66 registered nurse (RN)-E stated two nurses should be signing off they witnessed the transdermal patch destruction, "Both [nurses] are supposed to mark you saw it." RN-E reviewed R66's February 2016 MAR and stated, "People aren't doing it," RN-E stated two nurses should be signing off on the destruction to ensure they are being disposed of correctly, and to ensure the narcotic medication isn't being diverted because the removed patches still, "Have partial [medication] dosage on it." During interview on 3/3/16, at 12:34 p.m. registered nurse consultant (RNC)-A stated the removed transdermal narcotic patches should have a second nurse sign off to make sure it was destroyed correctly because the removed patches, "Still could have some potential residue [of medication]." The consulting pharmacist was contacted for interview several times during the survey, but was unable to be reached. A facility Destruction of Controlled Drugs policy dated 7/2015, identified used transdermal patches should be destroyed following their removal, and "Two licensed nurses must sign for the destruction of the used patch on the resident's Medication Administration Record [MAR]."	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		4/12/16

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F 465	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a hazard-free outside patio area, used as a designated smoking area, which had the potential to affect 23 residents who smoked (R56, R88, R18, R138, R83, R115, R53, R169, R42, R170, R109, R114, R75, R9, R10, R26, R129, R134, R74, R39, R127, R95 and R25) as well as other residents, staff and visitors who utilized the outside patio. In addition, the facility failed to maintain a clean and sanitary wheel chair for 1 of 1 residents (R90) who utilized a wheel chair for locomotion. Findings include: UNEVEN SURFACE NEAR ENTRYWAY R88's annual Minimum Data Set (MDS), dated 1/15/2016, indicated R88 had intact cognition. R114's quarterly MDS, dated 12/21/2015, indicted R114 had intact cognition. R45's admission MDS, dated 2/5/2016, indicated R45 had intact cognition. During observation on 3/3/2016 at 1:22 p.m. outside on patio area near the 2nd floor entry to the building, there were residents, seated in their electric-powered or standard wheel chairs, who were smoking. The round-shaped patio area, approximately 10 feet in diameter, was located to the right of the exit for the facility. A sidewalk,	F 465	1.Areas of patio that is designated as smoking area has been repaired eliminating unevenness from concrete slab to slab. R90's wheelchair armrest has been replaced. 2.Public sidewalks have been inspected and repaired as necessary. All resident wheelchairs have been inspected for being in proper repair. Any noted in disrepair have been corrected. 3.Facility staff have been educated on notifying maintenance department of any issues with uneven patio areas/sidewalks and wheelchairs being in proper repair. 4.Maintenance Director or designee will conduct monthly audits of sidewalks to identify any potential hazards. Maintenance Director or designee will conduct random weekly audits of wheelchairs x 4 weeks. Results of audits will be reviewed through QAPI committee and QAPI team will adjust audit schedule as appropriate.	

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sloped slightly upward, led to the patio, and was marked with a worn, yellow-painted stripe, where the patio began. Another sidewalk, sloping downward from the patio led toward the parking area, was also marked with a faded, yellow painted stripe where it joined the patio. This section of concrete was 1 1/2" (inches) lower than the patio, and was as wide as walk leading away from the patio toward the parking area. The difference in the height of these concrete sections created a ridge on the patio area, identified as a resident smoking area.

During a subsequent observation at 4:19 p.m., there were again residents who were smoking, seated in their wheel chairs, or on a bench chair, with their walkers parked in front of them. R114 independently navigated the patio area with a regular walker, and was observed to lift the walker up slightly in order to go over the ridge to the entrance of the patio. R45 independently propelled a standard wheel chair, and upon reaching the patio area, R45 backed up slightly, required a couple of attempts to push the wheels of the wheelchair over the ridge of the walk where the surface was uneven. R88 was observed seated in an electric chair, as she maneuvered the chair over the ridge.

In an interview on 3/3/2016 at 3:20 p.m., R88 stated she "has not seen anyone fall," outside on the patio, but has seen "people stub their toes" on the uneven ridge. R88 also stated she had seen residents struggle to maneuver over the ridge with their individual wheel chairs. R88 also stated "I don't have an issue" with the my power chair, but there "is a potential for a problem because a lot of people shuffle."

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During an interview on 3/3/2016 at 3:55 p.m., R114 stated when smoking "I have to be supervised." R114 stated she usually did not go over the area that is a different height. R114 stated she had never fallen, nor seen anyone fall or trip on the pavement. R114 also stated she tries to "not go beyond the striped area when smoking."

In an interview on 3/3/2016 at 3:58 p.m., registered nurse (RN)-I stated the concrete area utilized by smokers did shift, but that in the spring it usually "levels back out." RN-I stated there were "all kinds of residents" who used the area, including those who propelled their own wheel chairs "four-wheeled walkers, regular walkers, and some who use no assist devices," and also non-smokers. RN-I stated residents were assessed to be able smoke, which included their ability to be outside the facility. RN-I also stated if residents required supervision, staff went with them during specific times. (RN)-I indicated there had been no falls because of the uneven surface of the smoking area.

A review of facility incident reports from 10/1/2015 to 3/3/2016 revealed there were no resident incidents which resulted in falls or accidents due to the uneven surface on the outside patio area.

During an interview on 3/3/2016 at 4:58 p.m., the maintenance personnel (MP)-A stated he was aware of the uneven concrete area, and indicated the concrete would rise when the ground come up in the spring. The MP stated he felt there would be a concern "if the ridge was higher on the slab away from the building," making it more difficult for wheel chairs to get over it. The MP stated if the slab did not go down after spring,

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F 465	Continued From page 70 "then I will be trimming it and leveling it" and he would also "re-marking the stripes." A facility policy regarding maintenance of property as it relates to resident safety was requested, but none was provided. BROKEN WHEELCHAIR: R90's annual Minimum Data Set (MDS) dated 1/16/16 identified R90 had severely impaired decision making skills, long and short term memory problems, and used a wheelchair for mobility. During observation on 2/29/16, at 2:42 p.m. R90 was in bed with her wheelchair against the wall. R90's wheelchair had visible white paper tape going around the right armrest which appeared visibly soiled with an unknown, dark-colored substance. On 2/29/16, at 6:41 p.m. R90 was seated in the wheelchair with the soiled taped arm rest in the dining room eating. During a subsequent observation on 3/1/16, at 8:08 a.m. R90 was seated at the dining room table, and her wheelchair continued to have the soiled paper tape on the right armrest. When interviewed on 3/2/16, at 1:37 p.m. nursing assistant (NA)-C observed R90's wheelchair and stated she was unaware how long the tape had been in place. NA-C removed the tape of the wheelchair exposing a hard plastic perimeter of the arm rest cushion which was cracked and broken. During interview on 3/2/16, at 1:39 p.m. licensed practical nurse (LPN)-A observed R90's wheelchair and stated the cracked perimeter was, "Sharp" and maintenance should have been notified to fix the chair.	F 465		

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F 465	Continued From page 71 During interview on 3/2/16, at 1:50 p.m. maintenance personnel (M)-A and (M)-B stated they had not been notified of R90's broken wheelchair, but would fix it immediately to ensure R90 was not cut by the broken plastic perimeter. A facility Wheelchair Safety Checks policy dated 7/2015, identified, "When clinical or non-clinical staff notices loose hardware of other possible safety issues with the operation of a wheelchair, the resident should be removed from the potentially unsafe wheelchair, the wheelchair taken out of operation, and the repair personnel should be contacted."	F 465		

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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. A complaint investigation was also completed at the time of the standard survey, complaint H5186212, and was unsubstantiated.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the plan of care was implemented and followed for 2 of 3 residents (R89, R115, R5) reviewed for pressure ulcers, and 1 of 3 residents (R5) dependent upon staff for repositioning. Findings include: R89's plan of care dated 6/15, noted R89 was to	F 282	1.R89,R5,R60's skin assessments, plan of care, and nursing assistant care guides have been reviewed and updated as appropriate. R115 is not longer a resident at the facility. 2.All residents with pressure ulcers will be assessed and plan of care and nursing assistant care guides reviewed and updated as indicated. 3.Nurses will be educated on	4/12/16

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

Electronically Signed | 04/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	C 03/03/2016

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GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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F 282	Continued From page 1 have both heels floated. In addition, the care plan noted R89 was to have the "bootie" on the right foot when in bed. The undated and untitled NA assignment sheet did not specify R89 was to have the heels floated nor did the sheet indicate R89 was to wear a foam boot on the right foot. The section under skin noted staff were to "Q [every] shift skin checks. Assist resident with back scratcher PRN [as needed]." R89 was observed on 3/2/16, at 6:20 a.m. through 7:29 a.m. continuously. R89 was noted to be sleeping on his back and both heels were lying directly on the mattress. The right heel had a blue foam boot on it. At 7:29 a.m. nursing assistant (NA)-A was interviewed and verified R89 did not have the heels floated. When asked if the heels should have been floated NA-A indicated, "No." Registered nurse consultant (RNC)-A was interviewed at 8:00 a.m. and verified R89 did not have the heels floated. RNC-A indicated R89 had a newly formed blister on the right foot and it was intact. She indicated there was no treatment to the right heel as the blister was intact. RN-A verified the NA sheet lacked direction of the blue foam boot and to float the heels. The health unit coordinator (HUC)-A was observed on 3/2/16, at 8:10 a.m. to look at the computerized NA sheet. HUC-A acknowledged the information of the blue boot and floating the heels was not on the computerized NA sheet. R89 did not receive the care and services that promoted healthy skin. Facility policy titled Care Plans dated 7/15,	F 282	implementing and following wound care protocol for residents with pressure ulcers, including completing and documenting treatments. Nursing staff will be educated on following interventions for pressure ulcer prevention and residents with pressure ulcers, including turning/repositioning and using pressure relieving devices or techniques. 4.DON or designee will complete random weekly audits to ensure staff follows the plan of care for residents at risk for skin altercation, including toileting and repositioning, for 4 weeks. Results of audits will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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identified a well developed care plan develops and implements an interdisciplinary care plan based on the assessment information gathered.
Pressure Ulcer Treatment Not Completed per Physician Orders

On 3/2/16, at 8:41 a.m. with the nurse practitioner R115 pressure ulcers were observed. The coccyx had two ulcers one above the other wound bed was beefy red, without drainage, odor and showed no signs of infection. The nurse practitioner stated the ulcers were healing nicely.

R115's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 1/16, indicated R115 had a pressure ulcer to midline sacrum and a pressure ulcer to the coccyx and directed staff to provide treatment per MD order.

Physician's wound care orders dated 2/3/16, directed staff to once daily apply Santyl, apply skin prep and cover with foam dressing to Stage III pressure wound to midline sacrum and right medial buttock following surgical debridement of the wounds.

The February 2016 treatment record for the daily treatment to cleanse wound apply Santyl apply skin prep and cover with adhesive foam was reviewed. 7 days in February the treatment was left blank and 4 days were marked refused.

When interviewed on 3/3/16, at 3:43 p.m. RN-G stated R115 is supposed to have a daily dressing change to the sacrum with Santyl and Allyven and the wound physician sees R115 every Wednesday. RN-G further stated the wound care is not always done as ordered because R115 refuses treatments at times. RN-G stated that the

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treatment sheets indicated resident refusals and if not marked the treatments were not completed.

R60's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 1/16, indicated a pressure ulcer to the right ischium and directed staff to provide treatment per MD order.

Physician's orders dated 1/27/16, directed staff to once daily apply Santyl, apply skin prep and cover with foam dressing to Stage III pressure wound to the right ischium.

On 3/3/16, at 9:27 a.m. R60 refused surveyor observation of pressure ulcer.

The January 2016 treatment record for the daily treatment to cleanse wound apply Santyl and cover with non adhesive foam was reviewed. Three out of five days the treatment was not documented as completed and was blank and one out of five days marked as refused.

The February 2016 treatment record for the daily treatment to cleanse and treat with Santyl and cover with adhesive foam was reviewed. Nine out of 28 days the treatment was not documented as completed and was blank. Seven out of 28 days the initials are circled without any follow up documentation and one out of 28 days were documented as refused.

When interviewed on 3/3/16, at 3:12 p.m. R60 stated that the nurses put cream on my bottom every day but the dressing does not get changed everyday. R60 further stated that she had never refused her dressing to be changed by the nurses.

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F 282	Continued From page 4 When interviewed on 3/3/16, at 3:38 p.m. RN- stated that R60 had wound care ordered daily to her coccyx and it does not get done everyday as ordered because the facility is short staffed. RN- further stated she reports off to the next shift that the dressing was not completed. When interviewed on 3/3/16, at 3:50 p.m. RN- expected the wound care be completed as ordered. RN- further stated she has been told by nurses that at times that the wound care did not get done on the shift. RN- stated she tells the nurses to pass it on to the next shift. RN- further stated that at times staffing is not adequate to get everything done. When interviewed on 3/3/16, at 5:43 p.m. RNC-A stated she expects all treatments to be done according to physician orders. R5's quarterly Minimum Data Set (MDS) dated 1/6/16, indicated the resident had severe cognitive impairment, and was dependent on staff for all activities of daily living (ADL's). The MDS also identified diagnoses of quadriplegia, hypertension, peripheral vascular disease, and neuromuscular dysfunction of the bladder.	F 282		

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Review of R5's care plan updated 1/15/16 identifies a risk of skin breakdown with impaired mobility and bowel incontinence. Staff were directed to turn, reposition, check and change for incontinence every 2 hours. Review of the NA undated work list directs the staff to turn and position R5 every two hours, was incontinent of stool and was to be checked and changed every two hours.

On 3/2/16, R5 was observed continuously from at 6:21 a.m. to 8:28. At 6:21 a.m. R5 was lying on his back in bed with pillow on the right side. At 7:06 a.m., respiratory therapist (RT)-A entered room to perform respiratory cares. At 7:35 a.m., continued to remain in the same position on his back, RT-A completed the respiratory cares and exited the room. R5 remained on his back, and was not repositioned nor was peri care performed during this time. At 8:18:a.m. R5 remained in the same backlying position. At 8:28 a.m. nursing assistant (NA)- B entered the room, and informed the surveyor that routine personal morning cares were provided by the night shift staff before 6:00 a.m., more than 2 hours and 28 minutes earlier. The day shift staff were responsible to provide R5 assistance with incontinence care prior to getting him up for breakfast. NA-B provided pericare, R5 was incontinent of a soft stool during this time. R5's skin had two large areas on his right and left buttocks, near rectum that was macerated, (an area of soft, white, deteriorating skin), which was covered with white barrier cream with areas of pink underlying tissue exposed. There was also an area of maceration under the right gluteal fold that measured approximately 2 cm in length and 1 cm in width which had a build up of sloughed tissue to the side of the maceration, with bright

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F 282	Continued From page 6 pink underlying tissue present (skin was intact). NA-B stated this area (right gluteal fold) was new and she would let the nurses know. R5 was observed in his room, on 3/3/16, at 9:44 a.m. seated in his wheelchair (w/c). At 10:11 a.m. he continued to be in the same position. At 10:16 a.m. NA-B and NA-A were assisting R5 into bed with the mechanical lift. NA-B stated that (R5) was last provided with pericare this morning at "about 7:45 a.m.", 2 hours and 31 minutes earlier. NA-A and NA-B provided pericare to R5, who was incontinent of soft stool. During interview on 3/3/16 at 5:10 p.m., NA-J, stated that she works with R5 routinely on different shifts and was aware to turn and reposition him every 2 hours, so he was off his buttocks and to check for bowel incontinence every two hours.	F 282		
F 309 SS=G	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 implement interventions to reduce skin irritation and breakdown for 2 of 2 residents (R5, R23)	F 309	1.R5 and R23 skin assessments, plan of care, and nursing assistant care guides have been reviewed and updated. R86 is no longer a resident at the facility.	4/12/16

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F 309	Continued From page 7 reviewed for non-pressure related skin conditions. This resulted in actual harm for R5 whose moisture associated skin damage became worse when interventions were not implemented. In addition, the facility failed to collaborate care with an outside dialysis agency for 1 of 1 residents (R86) reviewed for dialysis. Findings include: NON PRESSURE SKIN R5's quarterly Minimum Data Set (MDS) dated 1/6/16, indicated the resident had severe cognitive impairment, had an indwelling urinary catheter, was always incontinent of bowel, and dependent on staff for all activities of daily living (ADL's). The MDS also identified diagnoses of quadriplegia, hypertension, peripheral vascular disease, and neuromuscular dysfunction of the bladder. During interview on 3/1/16, at 12:08 p.m. registered nurse (RN)-B stated R5 had two areas of moisture associated skin breakdown, one on the left buttocks measuring 7 cm (centimenters) x 4.5 cm, and one on the right buttock measuring 7 cm x 5 centimeters (cm) on the right buttocks. On 3/2/16, R5 was observed continuously from at 6:21 a.m. to 8:28 a.m.. At 6:21 a.m. R5 was lying on his back in bed with a pillow on the right side. At 7:06 a.m., respiratory therapist (RT)-A entered room to perform respiratory cares. At 7:35 a.m., R5 continued to remain in the same position on his back, RT-A completed the respiratory cares and exited the room. R5 remained on his back, and was not repositioned nor was peri care performed during this time. At 8:18 a.m. R5	F 309	2.All residents with non pressure related skin alterations will be assessed, plan of care and nursing assistant care guides reviewed and updated. All residents receiving dialysis services will be reviewed to ensure collaboration/communication between dialysis and SNF. 3.Nurses will be educated on proper policies/procedures for residents with skin alterations including assessing & documentation, implementing interventions, and monitoring residents with skin alterations. They will also be educated on dialysis collaboration/communication. Nursing staff will be educated on following interventions for preventing skin alterations including repositioning and incontinence care. 4.DON or designee will complete random weekly audits to ensure interventions are being implemented for residents with non pressure related skin breakdown for 4 weeks. DON or Designee will audit communication between SNF and dialysis center weekly is being completed for 4 weeks. All audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to trending identified.	

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F 309	Continued From page 8 remained in the same backlying position. At 8:28 a.m. nursing assistant (NA)- B entered the room, and informed the surveyor that routine personal morning cares were provided by the night shift staff before 6:00 a.m., more than 2 hours and 28 minutes earlier. The day shift staff were responsible to provide R5 assistance with incontinence care prior to getting him up for breakfast. NA-B provided pericare and R5 was incontinent of a soft stool during this time. R5's skin had two large areas on his right and left buttocks, near rectum, that was macerated (an area of soft, white, deteriorating skin), which was covered with white barrier cream and areas of pink underlying tissue exposed. There was also an area of maceration under the right gluteal fold that measured approximately 2 cm in length and 1 cm in width which had a build up of slough (a mass of dead tissue) to the side of the maceration, with bright pink underlying tissue present (skin was intact). NA-B stated this area (right gluteal fold) was new and she would let the nurses know. On 3/2/16, at 12:58 p.m. R5 was seen by the wound care medical doctor (MD)-A and RN-B to evaluate the macerated areas on his buttocks with the surveyor present. MD-A assessed the area on R5's buttocks and stated the macerated areas were "incontinence associated dermatitis with excoriations." The area on the right gluteal fold was an "old healed ulcer over the ischial tuberosity" that was becoming macerated. RN-B stated that she was not aware of the new area of maceration on the gluteal fold until now. MD-A recommended to RN-B to provide "careful and meticulous hygiene" combined with barrier protection to these areas.	F 309		

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During a subsequent interview at 1:34 p.m., MD-A stated R5's skin has an acid mantle of about 4.5 to 6 and that incontinence, especially stool, is alkaline and can easily excoriate the skin. MD-A stated that treatment recommendations for incontinence associated dermatitis included provision of pericare, application of a barrier cream, and monitoring of the area.

On 3/3/16, at 9:44 a.m. R5 was observed in his room seated in his wheelchair (w/c). At 10:11 a.m. he continued to be in the same position. At 10:16 a.m. NA-B and NA-A were assisting R5 into bed with the mechanical lift. NA-B stated that (R5) was last provided with pericare this morning at "about 7:45 a.m." (2 hours and 31 minutes earlier). NA-A and NA-B provided pericare to R5, who was incontinent of soft stool. RN-B, who was in the room at the time, obtained measurements of the three macerated areas. The right buttock measured 8 cm x 6 cm, left buttocks 9 cm x 6 cm and right gluteal fold 2.5 cm x 2 cm.. RN-B stated all three areas of macerations had increased in size from previous measurements taken on 2/21/16.

Review of progress notes 2/21/16 identified that R5 had an open area on bilateral buttocks with the right buttocks measuring 7 x 5 cm and left buttocks 7 x 4.5 cm.. The note indicated that "open does not look new, but there is no order for dressing changes." Review of subsequent progress notes did not identify any monitoring, measurements, or a comprehsive assessment of R5's macerated skin areas.

Review of the physician progress note dated 2/24/16, R5's primary physician (MD-B) indicated that R5 had "increased skin breakdown

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peri-rectal area recently, mild peri-rectal skin inflammation, need better pericare, discussed with nursing staff." A review of MD-A's (wound care physician) progress notes of 3/2/16, identified the the diagnosis of incontinence associated dermatitis and the need for "meticulous hygiene combined with barrier protection."

Review of R5's care plan updated on 1/15/16, identified a risk of skin breakdown with impaired mobility and bowel incontinence. Staff were directed to turn, reposition, check and change for incontinence every 2 hours. The care plan also directed staff to apply barrier cream to peri area daily, monitor the wound weekly and as needed, and to update the physician within two weeks if there was no evidence of healing.

Review of the undated NA Work List directed the staff to turn and position R5 every two hours, was incontinent of stool and was to be checked and changed every two hours. Although the physician progress notes of both 2/24/16 and 3/2/16, identified the need for "better" and "meticulous pericare" and barrier protection, neither the care plan, nor the work list were updated to reflect this.

During interview on 3/3/16, at 11:11 a.m. RN-B stated she had not completed physician rounds on 2/24/16, with MD-B, and was unaware of the recommendation to provide "better pericare" and barrier protection for R5. RN-B stated there were some interventions in place, but acknowledged that new diagnosis of increased skin breakdown from 2/24/16, the incontinence related dermatitis from 3/2/16, and the interventions of "better" and "meticulous" pericare were not added to R5's care plan, even though the area was first

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identified in the medical record on 2/21/16, 11 days earlier.

During interview on 3/3/16, at 5:10 p.m. NA-J stated that she works with R5 routinely on different shifts and was aware to turn and reposition him every 2 hours so he was off his buttocks and to check for bowel incontinence every two hours. NA-J indicated she was not directed to provide pericare more frequently because of R5's skin concerns, or to use a different skin barrier. NA-J stated, "We get report at the beginning of each shift, and no one has directed the staff to do anything different for [R5's] skin concern."

Even though R5 was dependent on staff for activities of daily living, and was frequently incontinent of bowel and had two existing areas of skin maceration. Both the primary physician (MD-B) and the wound care medical doctor (MD-A) identified the need for better peri-care and barrier protection. Theses interventions were not implemented and the existing skin maceration had increased in size, with an additional area developing in the peri gluteal fold which resulted in actual harm for R5.

A procedure, titled: Wound Prevention and Management, effective July 2015, outlines the Turning and Repositioning Program for residents who are unable to turn and reposition independently. This is to occur between 15 minutes before or 15 minutes after the predetermined times. "Communicate the individualized turning and repositioning schedule using: Skin Integrity Assessment; prevention and Treatment Care Plan, Care Deliver Guide/Nursing Assistant Assignment Sheet. "

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R23's admission record dated 9/30/15, included diagnosis of heart failure, chronic kidney disease, edema, and identified R23 was receiving hospice care. R23's annual MDS dated 10/12/15, identified R23 had severe cognitive impairment, and the quarterly MDS, dated 1/13/16, identified R23 required extensive assistance for activities of daily living, and had no venous or arterial ulcers present.

During an observation on 3/2/16, at 1:32 p.m. R23 was sitting in his wheelchair in the hallway near the nurse's station with wraps noted to both lower extremities.

Review of R23's Skin Grid-Pressure/Venous Insufficiency Ulcer/Other forms,completed for each leg and dated 10/2/15, identified the wounds were present on admission, identified as "excoriation," and had large amounts of purulent, red, foul odor drainage. The right lower extremity wound was 30 cm (centimeters) in length and 43 cm in width, and the left lower extremity wound was 45 cm in length and 43 cm in width. There were no additional Skin Grid-Pressure/Venous Insufficiency Ulcer/Other forms completed by the facility regarding these areas. Even though the form directed staff to complete weekly assessments, and to include the date, length, width, depth, color of drainage, color, odor, tunneling/undermining with depth, both forms were blank.

Review of the facility EHSI Skin Assessment form for R23 dated 11/25/15, identified a picture of the front and back side of a body with hand drawn

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lines and arrows to both lower legs, with "weeping wounds, weeping legs" written beside the picture. An Admission Skin Assessment dated 1/7/16, included hand drawn marks on both lower legs with, "cellulitis" written beside the picture. There were no further skin assessment forms identified for R23's bilateral lower extremities.

Review of R23's Comprehensive Care Plan Review Summary, dated 10/20/15, 1/7/16 and 1/19/16, under Skin/Wound, included, "No skin/wound issues since last review." However the record review indicated R23 had ongoing treatments to his bilateral "weepy" legs. R23's Skin Integrity Assessment: Prevention and Treatment Care Plan, dated 1/7/16, included, "Lymphedema BLE [bilateral lower extremity] edema [with] weeping."

Review of progress notes from 11/3/15 through 2/21/16, identified R23's legs were clean, dressed and treatment applied. There was no mention of size, location, color, drainage, or odor of R23's bilateral lower legs until the 2/22/16, progress notes. The 2/22/16, progress note identified, "Res [resident] legs are continually getting worse...Legs have musky smell, and pants & socks were so soaked [with] LE [lower extremity] drainage they were dripping on the floor." There were no additional notes that identified the appearance of R23 bilateral lower extremities from 2/23/16 until 3/3/16, even though the 2/22/16, notes identified his legs had a "musky smell" and socks and pants were soaked with drainage.

R23's physician's orders dated 2/16, included, "Bilateral lower ext [extremity] wash with no rinse soap and water, pat dry, apply Atractain lotion to

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both legs and feet, cover with edema wear (large, red stripe) tubular compression stocking from toes to 1 inch below knee." R23's Medication Administration Record dated 2/16, directed staff to complete this treatment twice daily.

During an interview on 3/3/16, at 10:11 a.m. RN-H stated she was unsure how long R23's legs have been "weeping", she has only been at the facility since December 2015. She also indicated the assessment and monitoring of R23's lower extremity "weeping area" should be monitored in the nursing progress notes, and/or Treatment Administration Record (TAR) at least weekly. The location, size, drainage, color, odor, and description of the area should be monitored. RN-H stated, "They [staff] should be documenting what we are assessing, that would be my expectation."

Review of R23's TAR's dated 11/15, 12/15, 1/16, and 2/16, lacked documentation of assessment or monitoring of R23's bilateral lower extremities to determine if they were improving or not.

During interview on 03/03/16, at 11:22 a.m. RN-M stated R23's legs are soaked twice a day, cleaned, dried and Bacitracin ointment is placed on the areas. They use ABD pads (thick absorbent dressing that soaks up large volume of fluid), because there is so much drainage, and then wrap the area with kerlix from his knee to ankles.

Although R23 currently had "weeping" bilateral lower extremities are soaked and washed twice a day, and being treated with different ointments, Bacitracin and Atractain. The facility has not consistently monitored R23's "weeping" legs, and

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F 309	Continued From page 15 skin condition for location, size, drainage, periwound condition, wound edges, signs and symptoms of infection, pain or odor to determine if R23's legs were healing and if the current treatment was effective for R23. Review of the facility's procedure: Lower Extremity Ulcer Intervention and Treatment, dated 7/15, directed staff to document the progression of wound healing by measuring length, width, and depth of the wound, and documentation should include drainage/exudate, color, odor, tunneling/undermining, periwound condition, wound edges, anatomical location, pain, signs and symptoms of infection, and wound base tissue. Also included, "Regardless of who is doing the wound treatment, Nursing Services will do the weekly assessment." DIALYSIS R86's significant change Minimum Data Set (MDS) dated 2/10/16, identified R86 had intact cognition and received dialysis services. During interview on 3/2/16, at 8:18 a.m. R86 stated she just started dialysis when she had been hospitalized recently, and currently had a port in her chest the dialysis center was managing for her. When interviewed on 3/2/16, at 12:51 p.m. registered nurse (RN)-E stated R86 started dialysis when she was recently hospitalized, and used a port on her right chest wall for access. RN-E stated the facility used a binder (a communication book) to help manage R86's care with her dialysis, and they send the binder with R86 to her dialysis treatments.	F 309		

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Review of R86's Hemodialysis Treatment record dated 2/23/16, identified R86 had received a total of eight dialysis treatments at the off-site dialysis clinic.

An undated blank Dialysis Center Communication Record, a tool used to ensure collaboration of care with the off-site dialysis clinic, was reviewed. The form used three spaces for the facility and dialysis center to document pertinent results and notes for R86's care including vital signs, nutrition, and medications. R86's records were reviewed and identified the following:

On 2/5/16, the facility nurses completed R86's pre/post dialysis documentation, however the dialysis nurse did not record any information on R86's treatment, including any completed lab work, if any access complications, of changes in condition, or how she tolerated her dialysis treatment even though R86 was a new dialysis patient. The spaces to record these items were left blank.

On 2/8/16, the facility nurse completed R86's pre-dialysis documentation, however the dialysis nurse and returning facility nurse did not record any information on record of how R86 tolerated the treatment since she was new to dialysis. The spaces to record the completed vital signs, treatment complications, and any completed lab work was left blank.

On 2/10/16, the facility nurses completed R86's pre and post dialysis documentation, however the dialysis nurse did not record any information on R86's treatment, including any completed lab work, if any access complications, or changes in

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F 309	Continued From page 17 condition even though R86 was new to dialysis. The spaces to record these items were left blank. On 2/29/16, the facility nurse completed R86's pre-dialysis documentation, and the dialysis nurse complete their documentation. However, the returning facility nurse did not complete any documentation including identifying if any signs or symptoms of bleeding, low blood volume, or pain were present even though R86 was a new dialysis patient. The spaces to record these items was left blank. There were no treatment records identified on 2/12/16, 2/15/16, 2/17/16, 2/19/16, or 2/22/16 although R86's Hemodialysis Treatment record identified she received services on these dates. When interviewed on 3/3/16, at 9:24 a.m. RN-E stated staff are instructed to, "Send the binder with [R86]" to her dialysis treatments, and everything pertaining to her dialysis records, "Stays in the binder." RN-E reviewed R86's dialysis communication records identified above and stated, "people haven't been filling it out." RN-E stated the entire record should of been completed because it was, "Supposed to be our communication tool" with the off-site dialysis clinic." This was their form of communication, and they not communicate through telephone, about R86 even though she was a new dialysis patient. During interview on 3/3/16, at 9:33 a.m. the dialysis nurse (DN) stated the clinic did not complete the record consistently because there was, "Just not enough room" on the record to do so. Further, DN stated she was unaware if the communication record was something the facility was to be completing or not.	F 309		

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F 309	Continued From page 18 When interviewed on 3/3/16, at 1:09 p.m. RN-B stated R86's dialysis communication book (binder) was used for communication between the facility and off-site dialysis clinic and it was, "Supposed to be completed" adding it was, "A communication tool between the center and us [facility]." Although R86 was new to dialysis treatments and had received eight treatments, there was no coordination of care completed with the dialysis center and facility to ensure R86 tolerated her dialysis runs which started February 8, 2016. A facility policy on dialysis care was requested, but none was provided.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with eating was provided for 1 of 3 residents (R90) reviewed for activities of daily living (ADLs). Findings include: R90's annual Minimum Data Set (MDS) dated 1/10/16, identified R90 had severe decision making ability, long and short term memory	F 311	1.R90 ADL care plan in regarding to dining services has been reviewed and updated 2.All residents requiring assistance with dining services have been assessed and plan of care reviewed and updated as indicated 3.Facility staff will be educated on policy regarding residents requiring assistance with eating. 4.DON or designee will complete random	4/12/16

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F 311	Continued From page 19 impairments, and required supervision with set-up from staff for eating. R90's nutrition risk care plan dated 10/2014, identified R90 was at nutritional risk and directed staff to, "Assist with meals as needed," further identifying R90 required, "Extensive Assist to complete [her] meal." During observation of meal service on 3/1/16, at 8:08 a.m. R90 was seated at a table with three other residents and had been served a plate of food consisting corned beef hash, toast, oatmeal, and a banana. R90 had a fork in her left hand and was trying to pick up various food items from her plate using the fork backwards, holding onto the fork using the tines before placing it back on the table. R90 then lowered her head onto her chest and closed her eyes. At 8:11 a.m. licensed practical nurse (LPN)-B came over to R90's table, gave R90's tablemate some toast and left without offering assistance to R90. At 8:15 a.m. R90 opened her eyes and moved the fork around on her plate of food, staring at her tablemates and watching them eat until 8:17 a.m. when LPN-B again came to R90's table and woke up R90's tablemate who had fallen asleep. LPN-B left the table at 8:19 a.m. without offering any assistance or encouragement to R90 for eating. At 8:20 a.m. R90 picked up a single piece of toast from her plate and took several small bites before placing the piece of toast on a folded up towel on the table. At 8:29 a.m. nursing assistant (NA)-D came to R90's table and stirred R90's tablemates food and offered the table mate assistance, however, no help or encouragement was offered to R90. NA-D left the table at 8:30 a.m. without offering any encouragement or assistance to R90 to eat her meal. R90 closed her eyes again, and	F 311	weekly audits on residents requiring assistance with eating for 4 weeks. All audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to trending identified.	

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lowered her head onto her chest. At 8:37 a.m. R90 opened her eyes and looked around the table at her tablemates and the food on her plate, before lowering her head back onto her chest and closing her eyes again. At 8:49 a.m. (41 minutes since observation of meal service began) NA-E pulled up a chair to the right side of R90 and offered her assistance, "Shall we have some of this?" NA-E helped R90 pick up and hold a full glass of apple juice, peeled the banana, and provided assistance to eat; R90 stated, "That's good." NA-E provided R90 assistance with eating until 9:10 a.m. when NA-E stood up and left the table to help other residents. R90 had consumed all of her banana, and nearly all of her toast and juices after being provided assistance with eating from staff.

When interviewed on 3/1/16, at 1:38 p.m. family member (FM)-F stated she did not feel there was enough staff to help R90 and the other residents eat, "I wish there was more help at meal times." FM-F had visited R90 before during meal times and noticed R90 didnt eat well unless someone sat and cued her to do so, and FM-F stated R90 would often play with her silverware or use it incorrectly to eat.

During interview on 3/2/16, at 9:23 a.m. NA-F stated R90 would at times refuse assistance with eating, but staff were supposed to attempt to assist her with all meals. NA-F stated R90 had to wait for assistance because their was not enough staff in the dining room to help all the residents eat at the same time, and stated, "We need more help."

When interviewed on 3/2/16, at 11:29 a.m. registered nurse (RN)-C stated staff should be

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F 311	Continued From page 21 offering assistance and cues to R90 for eating if they notice she is not eating on her own, "[Staff are] supposed to assist her, or try to." A facility policy on eating assistance was requested, but none was provided.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative ambulation services as ordered to improve and / or maintain the resident's ambulation ability for 1 of 1 residents (R84) reviewed for ambulation. Findings include: R84's quarterly Minimum Data Set (MDS) dated 1/7/16, identified R84 had severe cognitive impairment, required extensive assist with transfers, physical assistance with walking, and was on a restorative nursing program. R84's Therapy Recommendations for a Restorative Program dated 10/23/15, identified staff were to ambulate with the resident three times per day using a wheeled walker from his room to the dining room.	F 312	1.R84 has been re-assessed for restorative ambulation and plan of care and nursing assistant care guides have been updated. 2.All residents with recommended restorative ambulation plans have been reviewed to ensure their program is careplanned and communicated on the nursing assistant care guide. 3.Nursing staff will be educated on careplanning restorative ambulation programs, communicating restorative ambulation programs on the nursing assistant care sheet, and ensuring programs are being followed. 4.DON or designee will complete random weekly audits to include restorative ambulation programs being careplanned and communicated on the nursing assistant care sheet and programs being	4/12/16

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F 312	Continued From page 22 R84's care plan dated 10/15, identified staff were to provide assistance to and from the dining room, and R84 required a cane, walker, or wheelchair for mobility. However, it did not identify staff were to assist with ambulation to meals. No restorative flow sheets were available for ambulation for R84. When interviewed on 3/2/16, at 11:43 a.m. trained medication aid (TMA)-A stated R84 does not self-propel the wheelchair, and staff push him in the wheelchair to the dining room. When interviewed on 3/3/16, at 2:42 p.m. physical therapist (PT)-A stated R84 was last seen in therapy from 9/29/15 - 10/27/15. At this time, it was unsafe for R84 to ambulate independently, and PT recommended a restorative nursing program to be implemented for R84 to participate in an ambulation program. PT-A stated once the recommendation was forwarded to nursing, PT was no longer involved unless nursing notify's PT of a change in resident condition, or if there is a physician referral for further services. PT-A stated they had not received any referrals or nursing communication regarding R84 after 10/27/15. During interview on 3/3/16, at 4:16 p.m. nursing assistant (NA)-K stated nursing staff was in charge of ordering the ambulation program, and nursing assistants provide the assistance with ambulation. NA-K stated R84 had never ambulated that she was aware of, and if an ambulation program was ordered and provided, it was documented on the computer program. NA-K was unable to find any order for R84 to	F 312	completed x 4 weeks. All audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to trending identified.	

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F 312	Continued From page 23 ambulate. When interviewed on 3/3/16, at 4:27 p.m. Corporate registered nurse (RNC)-A stated recommendations from therapy are transferred to the care plan, into care tracker, and onto the nursing assistant care sheets. RNC-A stated staff were provided education on providing the ambulation program, and the registered nurse would assess monthly the effectiveness of the program and adapt as needed. During an observation on 3/3/16, at 4:55 p.m. PT-A assisted R84 to ambulate, with the use of a wheeled walker and transfer belt. PT-A stated a wheeled walker was provided from therapy at this time, as no walker was available in R84's room. PT-A stated R84 ambulated with a shuffled gate, and no change was noted to R84's ambulation since he was discharged from therapy. PT-A stated she was not aware R84 was not provided ambulation assistance as recommended. Facility policy on restorative nursing was requested, but not provide.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		4/12/16

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F 315	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a suprapubic catheter was inserted using sterile technique and according to the physician orders for 1 of 1 residents, (R5), reviewed with a suprapubic catheter. Findings include: R5's quarterly Minimum Data Set (MDS) dated 1/6/16, indicated he had severe cognitive impairment, required complete staff assistance for activities of daily living (dressing, grooming, bathing, eating, and mobility), and had an indwelling Foley catheter related to neuromuscular dysfunction of the bladder. R5's physicians orders dated February 2016, identified the resident was to have his S/P (suprapubic) catheter changed every month, and as needed if pulled or plugged, and was to use a 22 or 24 FR (french)/5 cc's(cubic centimeters) (a liquid unit of measurement). R5's diagnosis included neurogenic bladder and recurrent UTI's (urinary tract infections). R5's care plan, most recently reviewed 1/15/16, indicated the resident had a suprapubic catheter related to neurogenic bladder with urine retention and recurrent UTI's . The care plan identified the resident was to have a 22 or 24 FR suprapubic catheter, and staff were directed to, "Follow sterile technique for supra-pubic catheter reinsertion."	F 315	1.R5 suprapubic catheter plan of care was reviewed and updated as appropriate. 2.All residents with urinary catheters have been reviewed and plan of care updated as appropriate. 3.Nursing staff will be educated on proper procedure for working with suprapubic catheters. 4.DON or Designee will complete random audits regarding catheter reinsertion techniques monthly for 3 months. Audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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F 315	Continued From page 25 During observation of cares for R5 on 3/3/16, at 10:22 a.m. R5's suprapubic catheter was not in place, and Registered nurse (RN)-B indicated it would need to be replaced. RN-B proceeded to prepare to insert the S/P catheter, and it was observed RN-B had a gastrostomy tube instead of a S/P catheter. RN-B indicated she had the wrong equipment, and obtained a S/P catheter. RN-B proceeded to obtain a 26 FR S/P catheter, placed on non-sterile gloves, requested nursing assistant (NA)-A's assistance and had her apply non-sterile gloves, and applied sterile lubricant to the end of the S/P catheter and was prepared to insert the S/P catheter. Before RN-B continued with insertion, the surveyor questioned RN-B regarding sterile technique and the supplies she had been using. RN-B stated the S/P catheter she was going to use was a 26 FR, and not the 22 or 24 FR as directed by the physician. NA-A left R5's room to seek additional assistance and to obtain the correct supplies. At 10:31 a.m., licensed practical nurse (LPN)-D arrived with supplies, including a 22 FR S/P catheter and sterile gloves, and the S/P catheter was inserted under sterile technique. A policy regarding urinary catheter insertion was requested but not provided.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		4/12/16

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F 329	Continued From page 26 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure orthostatic blood pressures were monitored for administered anti-hypertensive medication for 1 of 5 residents (R84) and effectiveness of as needed narcotic pain medication was evaluated using adeqaute parameters for 1 of 5 residents (R66) reviewed for unneccessary medication use. Findings include: R84's quarterly MDS dated 1/7/16, identified diagnoses including heart failure, hypertension (high blood pressure), and dementia. The MDS identified R84 had severe cognitive impairment, required extensive assistance with transfers, and was not steady without human assistance.	F 329	1.R84 treatment record has been reviewed and updated to reflect necessary orthostatic blood pressure monitoring. The MD has been updated on results obtained and reviewed resident plan of care accordingly. R66 physician orders for pain medication has been clarified by the physician and updated to reflect changes accordingly. 2.All residents on hypertensive medications were reviewed and MARS updated as necessary for appropriate monitoring. All residents on narcotic pain medication were reviewed and orders clarified for clear parameters as necessary. 3.Nurses will be educated regarding	

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F 329	Continued From page 27 R84's signed physician orders dated 2/3/16, identified orders for amlodipine besylate (medication to treat high blood pressure) 5 milligrams (mg) twice daily by mouth (po), and carvedilol (medication to treat high blood pressure) 25 mg po twice daily which had been initiated on 5/2/15. The physician orders directed to check orthostatic blood pressure once a week and vital signs to be checked weekly. Review of R84's medication administration record (MAR) for March 2016, identified staff were to monitor for side effects of medications which included dizziness, fatigue, hypertension, and orthostatic hypotension. Review of R84's treatment administration record (TAR) identified an order dated 5/2/15, to monitor orthostatic blood pressures weekly on Friday, identified the following for completion of the orthostatic blood pressure: - February 2016 0 of 4 opportunities - January 2016 0 of 5 opportunities - December 2015 1 of 4 opportunities - November 2015 1 of 4 opportunities - October 2015 1 of 5 opportunities - September 2015 0 of 4 opportunities Review of R84's Vital Sign-Individual Resident Flowsheet from 12/12/15 to 2/28/16 revealed documentation R84's blood pressure had been checked on 12/12/15, 12/27/15, 1/9/16, 2/7/16, 2/14/16 and 2/28/16. The form listed the single blood pressure checks, however, did not included orthostatic blood pressure monitoring for R84. When interviewed on 3/2/16, at 12:45 p.m.	F 329	documentation requirements for drug monitoring to evaluate effectiveness of medications, potential side effects, or unnecessary medications. 4.Pharmacist or Designee will complete monthly random audits to ensure adequate drug monitoring and documentation is being completed. DON or designee will complete random weekly audits for 4 weeks to ensure documentation of side effect monitoring and PRN Analgesic Record/ Pain Flow Sheet is being completed Audit results will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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F 329	Continued From page 28 corporate registered nurse (RNC)-A stated orthostatic blood pressures had not been completed for R84 as ordered, and it was her expectation that the orthostatic blood pressures were to be completed. LACK OF MONITORING FOR NARCOTICS: R66's annual Minimum Data Set (MDS) dated 2/18/16, identified R66 had intact cognition, frequent episodes of pain, and received scheduled and as needed (PRN) pain medications. R66's signed physician orders dated 2/3/16, identified orders for the following narcotics: > "Fentanyl C2 [controlled drug] 25 mcg/hr [micrograms per hour] ... Apply 1 patch and change every 72 hours," and > "Fentanyl C2 100 mcg/hr ... Apply 1 patch and change every 72 hours," and > "Methadone HCL C2 10 mg [milligrams] ... 3 tabs [tablets] [30 mg] by mouth every bedtime," and > "Oxycodone [a narcotic pain medication] 5 mg Tablet ... 1-2 tabs[tablets] [5-10mg] by mouth every bedtime as needed." Review of R66's Medication Administration Record (MAR) for 1/16 and 2/16 identified the following:	F 329		

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F 329	Continued From page 29 -MAR dated 1/2016, identified R66 received 20 doses of the as-needed narcotic pain medication during the month. However, there was no documentation to determine if R66 received the ordered 5 mg dose or 10 mg dose of the as needed narcotic medication. R66's PRN (as-needed) Analgesic Record / Pain Flow Sheet (tool used to monitor pain and medication effectiveness of administered medication) dated 1/1/16 to 1/31/16, identified spacing to record the date and time of administration, pain description and numerical rating, the medication provided, and follow-up to the provided medication. However, all of these fields were left blank on R66's records. -MAR dated 2/2016, identified R66 received 19 doses of the as-needed narcotic medication, before the order was discontinued. A new order was transcribed which identified, "Oxycodone 5 mg i-ii [1-2 tablets] PO [by mouth] Q 4 HRS [every four hours] PRN" and R66 received 14 additional doses of the as-needed narcotic medication. However, there was no documentation to determine if R66 received the ordered 5 mg dose or 10 mg dose of the as needed narcotic medication. PRN (as-needed) Analgesic Record / Pain Flow Sheet dated 2/1/16 to 2/29/16, identified spacing to record the date and time of administration, pain description and numerical rating, the medication provided, and follow-up to the provided medication. However, all of these fields were left blank on the record. R66's progress notes dated 1/1/2016 through 2/28/16, were reviewed but lacked documentation identifying what dose of the as needed medication had been administered, why R66 had been provided the as needed narcotic	F 329		

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F 329	Continued From page 30	F 329		

medication, or any follow up on if the provided medication had been effective.

When interviewed on 3/3/16, at 10:48 a.m. registered nurse (RN)-E stated R66 had chronic complaints of pain and, "is on a couple of meds [medications] to help with that," including scheduled narcotics in addition to as needed narcotic medication. R66 had orders for one to two tablets of as-needed oxycodone for pain, and RN-E stated she used a pain scale to identify how many tablets of the as needed narcotic medication to provide to R66. RN-E stated the nursing staff should be recording the dose provided and it's effectiveness on the PRN Analgesic Record each time a as-needed pain medication was administered. RN-E stated she was not aware of any other location the staff would be documenting their non-pharmacological interventions, monitoring or follow-up of the as-needed narcotic medication than on the PRN Analgesic Record, "not that I'm aware of." RN-E reviewed the January and February analgesic records and stated there was no monitoring of the effectiveness completed for R66's as needed narcotic medication use, "It should have been written here," and staff, "Need to be re-taught to use it each time." Further, RN-E stated she was unable to determine how many tablets of the as needed narcotic medication had been given each time R66 received the as needed narcotic.

During interview on 3/3/16, at 12:56 p.m. the assistant director of nursing (ADON) stated staff were expected to use the PRN analgesic records to document a resident's pain, and the effectiveness monitoring for it, "[They're] supposed to use that sheet." Further, RN-B stated she did not think physicians should be

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F 329	Continued From page 31 writing range orders (i.e. one to two tabs) anymore, "I thought that was banned a long time ago," and staff should have clarified the order. Although R66 had orders for as needed narcotic medication, the facility failed to ensure staff identified the administered dose, and then monitored the administered medication to ensure it was effective and necessary in managing R66's pain. A facility Pain Management policy dated 7/2015, identified, "Record an administered scheduled and/or PRN analgesic. Include data regarding resident pain intensity, intervention and effectiveness of intervention to manage pain on the [MAR]." A facility Medication Administration policy dated 7/2015, directed staff to, "Indicate reason for administration and effectiveness of PRN medication in the nursing progress notes or on the back of the [MAR]."	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all medications were administered in a timely fashion in accordance with physician orders and facility practice for 1 of 7 residents (R101) observed to	F 332	1.R101 is no longer a resident at this facility. The facility will provide medications in a safe, professional manner to include right drug, right reason, right dose and preparation, right patient,	4/12/16

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F 332	Continued From page 32 receive medication during the survey. This resulted in a medication error rate of 8.3% (percent). Findings include: During an observation of medication administration on 3/2/16, at 9:28 a.m., licensed practical nurse (LPN)-D was observed to administer R101's medications. LPN-E administered Baclofen 20 mg tablet, Morphine Sulfate ER 15 mg tablet and Lorazepam 2 mg tablet with various other medications to R101 at that time. LPN-H stated she was aware that R101's Morphine Sulfate was scheduled for 7:00 a.m., and Baclofen and Lorazepam were scheduled for 8:00 a.m.. She indicated R101 had an appointment today and wanted to be up between 8:30 and 9:00 a.m., but stated, "It's just been busy this morning." R101's admission record, dated 12/3/15, included diagnoses of paraplegia, post traumatic stress disorder, and chronic pain. R101's admission Minimum Data Set (MDS), dated 12/16/15, identified R101 had intact cognition and had pain almost constantly, had difficulty sleeping due to pain at night, and had limited day to day activities due to pain. During an interview on 2/29/16, at 6:20 p.m., R101 stated he had constant pain in his chest, abdomen, back, hand and lower arm, and spasms in his legs and bladder, and indicated his medications, especially pain medications, were often given late or not at all, when he requested them. R101 indicated he needed Morphine Sulfate and Baclofen right away in the morning to help with his pain and stiffness before getting up	F 332	right time, right route and right documentation with oversight to ensure a medication delivery system that meets professional standards. Medication Administration Records have been audited to ensure residents are receiving medications in a safe professional manner. 2.All nurses will receive education regarding the policy of medication administration and seeking out assistance if having difficulty completing medication administration timely. 3.DON or Designee will complete random weekly medication administration audits for 4 weeks to ensure timeliness of medication administration. All audits will be reviewed at QAPI meeting for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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F 332	Continued From page 33 for the day, and stated it was difficult to manage his pain on the days that his medications were late. R101's physician orders, dated 2/3/16, included, "Morphine Sulfate [medication used to treat pain] ER [extended release] 15 mg [milligrams] tablet...1 tab by mouth every 8 hours," for pain, "Baclofen [medication used to treat muscle spasms, pain and stiffness] 20 mg tablet, 1 tab by mouth four times daily," for muscle spasms, and, "Lorazepam [medication used to treat anxiety] 2 mg tablet, 1 tab by mouth three times daily," for anxiety. R101's medication administration record (MAR), dated 3/16, indicated Morphine Sulfate was to be administered at 7:00 a.m., 3:00 p.m., and 11:00 p.m., Baclofen was to be administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 2:00 a.m., and Lorazepam was to be administered at 8:00 a.m., 12:00 p.m., and 8:00 p.m. During an interview on 3/3/16, at 1:06 p.m., RN-H stated, when giving scheduled medications, "We have an hour before and an hour after [the scheduled time] to give them," and indicated if medications were given outside of that time frame, it would be a considered a medication error. Review of the facility's procedure, Medication Administration, dated 7/15, included, "The licensed nurse and/or medication assistant will check the following to administer medication: Right medication, Right dose, Right dosage form, Right route, Right resident, and Right time."	F 332		
F 353	483.30(a) SUFFICIENT 24-HR NURSING STAFF	F 353		4/12/16

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F 353 SS=E	Continued From page 34 PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed resident needs for 1 of 3 residents (R90) reviewed for activities of daily living, and for 1 of 2 residents (R66) who complained about cold food. In addition, for 9 of 9 residents (R39, R158, R68, R66, R110, R127, R88, R137, R77), 2 of 3 family members (FM-E, FM-F), and 7 of 7 staff members (NA-H, CDM-A, RD-A, NA-F, LPN-A, SM-A, SM-B) who identified concerns with the lack of adequate staff in the facility.	F 353	1.Facility has reviewed staffing levels to ensure facility has sufficient staffing levels to meet resident needs. This is done through daily evaluation of resident census and acuity levels by the DON or designee. Also Refer to F282, F311, F312, F314, F332, F364 plan of correction. 2.Residents in the facility will receive care by skilled/experienced staff that are supervised to ensure care needs are being met. Administrator/DON or	

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F 353	Continued From page 35 Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: See F311 as the facility failed to ensure timely assistance with eating was provided for 1 of 3 residents (R90) reviewed for activities of daily living (ADLs). See F364 as the facility failed to ensure food was served hot and palatable for 1 of 2 residents (R66) who complained about cold food. RESIDENT CONCERNS WITH LACK OF ADEQUATE STAFFING: R39's quarterly Minimum Data Set (MDS) dated 12/12/15, identified R39 had intact cognition and required extensive assistance with his activities of daily living (ADLs). During interview on 2/29/15, at 5:22 p.m. R39 stated he did not feel there was enough staff available in the facility to help residents, "I think they need more staff." R39 stated he will request to go to bed and staff will tell him they have other things to do before they can help him, and it, "Will be awhile" before he received help, "They will come, [it] just takes awhile." R158's admission MDS dated 12/24/15, identified R158 had intact cognition and required extensive assistance with his activities of daily living (ADLs). During interview on 2/29/16, at 6:49 p.m. R158 stated he did not feel the facility had enough staff. R158 stated the staff had too much to do, and not enough time to complete it and spend adequate	F 353	designee will review scheduled staffing daily to ensure adequate staffing levels and to ensure appropriate quantity, quality, and composition of staff. 3.Staff will receive education regarding sufficient staffing levels and providing nursing and nursing related services accordingly. 4.Executive Director will complete random weekly audits x 4 weeks to ensure adequate staffing levels are provided to include interviews with staff. Caring Partners will complete weekly audits regarding customer service and resident satisfaction with cares. Audits will be reviewed at QAPI meeting and QAPI team will adjust audit schedule appropriately based on findings.	

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F 353	Continued From page 36 time with the residents. R68's quarterly MDS dated 2/9/16, identified R68 had intact cognition and required extensive assistance with her (ADLs). During interview on 2/29/16, at 6:52 p.m. R68 stated she did not feel the facility had adequate staff to ensure she received care in a timely manner. R68 required two staff to assist her with cares, and at times during the night, there is only one staff member working so she had to wait and doesn't get her incontinence product changed as a result. R68 reported staff always tell her they do not have time to help her when asked, and sometimes it takes up to 45 minutes to get her call light answered. R66's annual MDS dated 2/18/16, identified R66 had intact cognition and required extensive assistance to complete her ADLs. During interview on 2/29/16, at 6:58 p.m. R66 stated there was not enough staff to help residents at the facility, "They are so short staff[ed]." R66 stated she frequently received her medication late from the nursing staff and this was concerning to her, "Its become a real hazard." R66 indicated call lights were not answered timely, sometimes having to wait, "Up to two hours" for someone to answer it and assist her, "The care is so bad." R110's quarterly MDS dated 1/7/16, identified R110 had intact cognition and required extensive assistance to complete his ADLs. During interview on 3/1/16, at 8:50 a.m. R110 stated he did not think there was enough staff at the facility to help residents get the care they need. Staff often tell him to wait and then do not return to help him. R110 reported often times	F 353		

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F 353	Continued From page 37	F 353		

having to sit in stool waiting to get help after having a bowel movement which made him feel uncomfortable.

R127's quarterly MDS dated 1/6/16, identified R127 had intact cognition.
During interview on 3/1/16, at 9:59 a.m. R127 stated there was not enough staff at the facility. R127 stated he often has to wait for long periods to receive his medications and meals, and it upsets him.

R88's annual MDS dated 1/15/16, identified R88 had intact cognition and required extensive assistance to complete her ADLs.
During interview on 3/1/16, at 10:19 a.m. R88 stated she did not feel there was enough staff at the facility because she was not being assisted with toileting or incontinence care every two hours as she needed. R88 stated she didn't receive her scheduled bathing or morning cares on a consistent basis which often made her late to activities.

R137's quarterly MDS dated 11/26/15, identified R137 had intact cognition.
During interview on 3/1/16, at 11:20 a.m. R137 stated she did not feel there was enough staff in the facility to help her and the other residents get the care they need. R137 stated the overnight hours were the worst, and one night she had significant pain and there was no staff to help her so she called another resident on a different floor in the building to have them send help up to her, "It's like no one up here at all." Further, R137 stated it had taken, "40 minutes, sometimes longer" to get her call light answered and receive help.

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R77's quarterly MDS dated 12/2/15, identified R77 had intact cognition and required extensive assistance to complete his ADLs.
During interview on 3/1/16, at 11:31 a.m. R77 stated he did not feel there was enough staff to help deliver meals or medications to the residents in the facility because he receives his food and pain medications late often times.

FAMILY CONCERNS WITH LACK OF ADEQUATE STAFFING:

When interviewed on 3/1/16, at 11:21 a.m. family member (FM)-E stated he did not feel there was enough staff at the facility to make sure residents received the care they needed adding his wife often received her medications late as a result. Further, FM-E stated he often ends up doing most of his wife's care because there is not enough staff to help her.

During interview on 3/1/16, at 1:38 p.m. FM-F stated there was not enough staff at the facility. FM-F had noticed concerns with residents not getting assistance to eat at meal times, "I wish there was more help at meal times."

STAFF CONCERNS WITH BEING UNABLE TO COMPLETE CARE DUE TO LACK OF STAFFING:

During interview on 3/2/16, at 6:08 a.m. nursing assistant (NA)-H stated staff often felt like they don't have "quite enough time" to get all of the assigned cares completed, especially before meal times. NA-H stated the weekend staffing is hardest, and the staff are often short NAs which makes it, "really stressful" for the residents and staff.

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F 353	Continued From page 39 On 3/2/16, at 8:59 a.m. the certified dietary manager (CDM)-A and registered dietician (RD)-A were interviewed. CDM-A stated the lack of nursing staff to help pass meals and room trays was an "ongoing problem" which affected the dietary departments ability to serve palatable food. RD-A stated the lack of nursing staff to assist with meal times was, "affecting my department and the residents point blank." When interviewed on 3/2/16, at 9:23 a.m. NA-F stated some residents often have to wait for assistance to eat because there is not enough staff to help everyone eat at the same time, "we need more help." NA-F stated he/she had reported the concerns to the assistant director of nursing and a floor nurse in the past. During interview on 3/2/16, at 1:31 p.m. licensed practical nurse (LPN)-A stated she felt there needed to be more staff on the floor to help care for the residents. Several of the residents required, "total care" and the lack of adequate staffing did not allow the floor staff enough time to complete it, "[It would] be nice to have one more on the floor." On 3/2/16, during an anonymous interview, SM-B stated the facility needed more staff to ensure care was being completed. SM-B stated at times orders from the physician don't get transcribed timely, and treatments are being missed or not completed at all because there was no time for the staff to do them. SM-B stated residents were neglected, and the staffing at the facility was getting worse lately with the director of nursing (DON) changing several times and no staff being held accountable for errors and not completing	F 353		

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their assigned tasks. Further, SM-B stated the lack of staff was so detrimental to the residents, the facility should close down.

On 3/3/16 during an anonymous interview, staff member (SM)-A stated the staffing at the facility was, "bad someday's" and, "we [staff] need more help up here." SM-A stated residents get upset because they have to wait for cares, and added the lack of staff contributes to increased behaviors because the residents get upset. SM-A stated the nurses and social workers only help out, "when State is here" and when the staff voiced concerns to administration it was perceived as complaining. Further, SM-A stated the facility needed more staff so they, "could give the residents more time."

On 3/3/16, at 2:02 p.m. registered nurse consultant (RNC)-A and the assistant executive director (AED) were interviewed. The facility used a "minimum standard" of staffing, and changed it based on the acuity of the residents by monitoring the 24 hour boards (communication tool used between the staff) for concerns and comments. The facility had started using pool staff from an outside agency several months ago. The RNC-A stated the facility had not been aware of staff concerns about inabiity to complete resident cares.

Although resident, families and staff had stated call lights do not get answered timely, meals were not served timely and they had to wait for assistance with activities of daily living. The facility had not identified there was a staffing concerns despite multiple resident, family and staff complaints.

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F 353	Continued From page 41 A facility policy and procedure on staff was requested, but none was provided.	F 353		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served hot and palatable for 1 of 2 residents (R66) who complained about cold food. Findings include: R66's annual Minimum Data Set (MDS) dated 2/18/16, identified R66 had intact cognition, and was independent with eating after set up by staff. During interview on 2/29/16, at 6:49 p.m. R66 stated she received meal trays in her room because she didn't like eating with other residents in the dining room, and stated her food was, "Generally always cold" when served to her. During observation of the breakfast meal on 3/2/16, at 7:00 a.m. cook (CK)-A prepared french toast, sausage links, and oatmeal in the facility kitchen. CK-A checked the food temperatures using the facility thermometer and identified the french toast was 140 degrees (Fahrenheit, F), the sausage links were 170 degrees, and the oatmeal	F 364	1. R66 is receiving palatable meals at the proper temperature. 2. All residents will receive palatable meals at the proper temperature. 3. Cooks were re-educated on taking food temperatures and reheating when food is not at the proper temperature prior to food leaving the kitchen. Nursing staff have been re-educated on the dining process for resident who receive trays. 4. Dietary Manager or designee will conduct random weekly food temping in the kitchen prior to meal service. If found that food is not at the proper temperature, food will be reheated to the proper temperature to ensure that it is served hot and palatable. In addition, Dietary Manager or designee will conduct random weekly test trays to ensure that food is served hot and palatable x 4 weeks. Results of audits will be reviewed at QAPI for tracking and trending and QAPI team will then adjust audit schedule accordingly.	4/12/16

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was 158 degrees. The food was placed in metal serving pans, and placed in a steam table being brought to the fourth floor dining room. CK-A stated room trays were served throughout the meal services, and certified dietary manager (CDM)-A stated two residents, including R66, were served their trays first before the dining room was served to help maintain the heat of the food. At 7:22 a.m. the steam table with the food was brought up to the fourth floor, and at 7:34 a.m. dietary aide (DA)-A began to serve breakfast meals to the residents seated in the dining room. A mobile cart was placed next to the steam table with trays and silverware set-up for room tray delivery, however, no food was put on to plates or deliver to any residents in their rooms. At 7:49 a.m. nearly all of the residents in the dining room had been served their breakfast meal, and no room trays had been delivered. CDM-A was present during the meal service and left the dining room to retrieve the room tray orders. At 8:04 a.m. (42 minutes after the steam table arrived on fourth floor), CDM-A started to prepare room trays for residents, including R66. The surveyor requested a sample tray, and nursing assistant (NA)-G took R66's covered meal tray, prepared at the same time the sample tray was requested, to R66 in her room. DA-A temped the served food on the sample tray, and stated the oatmeal was 98 degrees (F), the french toast was 54 degrees, and the sausage was 95 degrees, and the food on the tray felt cold to the touch. At 8:11 a.m. R66 had been served her meal tray which had been prepared along with the requested sample tray, and R66 stated her french toast, "Isn't warm" and her food was cold. NA-H arrived in the room and observed R66's room tray. NA-G stated the french toast was, "Ice cold" and she would, "Go grab another tray" for R66.

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F 364	Continued From page 43 When interviewed on 3/2/16, at 8:27 a.m. NA-G stated the nursing staff were responsible to serve the room trays, and two residents, including R66, should be served first to make sure their food remains warm. NA-G stated the staff were, "Very busy today" and unable to serve them first however, adding it, "Happens sometimes." NA-G stated he was unsure how hot R66's food was when he served it to her because, "That is the kitchen['s] responsibility." During interview on 3/2/16, at 8:59 a.m. CDM-A and registered dietician (RD)-A stated R66 should have been served at the beginning of the meal, "To help hold temperatures," because of past complaints from her about food being served cold. The nursing staff was responsible to serve the meals to residents in their rooms, but that, "Didn't happen" as it was supposed to, and R66 should have been served at the beginning of the meal service. Further, CDM-A stated this was an, "On-going problem", and the lack of nursing staff and their support was affecting the meal service. A facility Room Service policy dated 7/2015, identified the facility, "Strives to provide all residents a pleasurable dining experience by offering nutritious, attractive meals served in the resident room when required." The policy directed staff to serve room trays covered, but did not identify when room trays were to be served during the meal service to maintain heat and palatability or direct staff to check the temperature before serving the prepared food.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		4/12/16

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F 371	Continued From page 44 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure left-over fish based product was discarded in a timely manner to reduce the risk of food borne illness. This had potential to affect 15 of 15 residents identified by the facility as who could have potentially consumed the food. Findings include: An initial tour of the facility kitchen was completed on 2/29/16, at 12:55 p.m. with certified dietary manager (CDM)-A and registered dietician (RD)-A. During the tour, a cooler was reviewed underneath a metallic serving table which RD-A stated was a, "Nourishment area" used to prepare foods for residents in between meal hours. A one gallon plastic container of light brown colored food was in the cooler which was labeled, "Tuna Salad," with a date written, "02-23-16" (six days prior) in black marker. The container was approximately 1/2 full and covered with saran wrapping. RD-A stated the foods in the cooler, including the tuna salad, were available for resident consumption and the tuna salad should have been removed after,"Three	F 371	1.Left-over fish product was immediately discarded and coolers were inspected to determine there were no other food products that needed to be discarded. 2.Facility staff were re-educated on policy for discarding leftover refrigerated items. 3.Dietary Manager or designee will conduct weekly audits of coolers for proper discarding of leftover items x 4 weeks. Audits will be reviewed at QAPI meeting and QAPI team will adjust audit schedule appropriately based on findings.	

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F 371	Continued From page 45 days." On 3/1/16, at 2:20 p.m. CDM-A, RD-A and culinary manager (CM)-A were interviewed. The tuna salad had been made on 2/23/16 for, "Whoever wanted it" and would have been used if any residents had requested tuna salad. CDM-A stated the facility policy was to discard left-over food after three days, and leaving the tuna salad in the cooler was an oversight by the cook. RD-A stated the left-over tuna salad was a, "Higher risk food" and could cause potential food poisoning if it was consumed after three days of being made. Further, CDM-A stated the amount remaining in the one gallon container was enough tuna salad to make, "About 15 [sandwiches]", and again stated it should have been discarded after three days. A facility Refrigerator Storage policy dated 7/2015, identified all leftover items should be labeled with the item name and date of storage, then "Discard refrigerated leftovers after 3 days."	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.	F 412		4/12/16

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F 412	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate dental care and services for 1 of 3 residents (R110) reviewed for dental hygiene and care. Findings include: R110's quarterly Minimum Data Set (MDS) dated 1/7/16, identified the resident was cognitively intact, required extensive assistance to complete activities of daily living (ADL's) including dressing, grooming, bathing, and toileting, and was independent with eating once he was set up. An undated nursing assistant worklist directs the staff to provide assist with activities of daily living. During interview on 3/1/16, at 8:55 a.m. R110 stated he had problems with cavities and his, "teeth are all busted up." R110 stated he had requested to see a dentist, however, he has not seen the dentist. During an interview on 3/1/16 at 8:46 a.m., NA-B stated the resident some times does not want to brush his teeth. During a subsequent interview on 3/3/16 at 12:16 p.m., NA-B stated (R110) required assistance with activities of daily living but does brushes his teeth independently. Review of the Associated Clinic of Psychology (ACP) of 7/31/15, identified (R110) stated that " food doesn't taste right, kinda like its spoiled". The ACP note from 9/21/15 also identified the resident expressed that food tasted poorly, "as though it has gone bad, or having a bad taste." The progress notes of 1/18/16 indicated social	F 412	1.R110 was evaluated by nursing and is scheduled for non-emergency dental visit on 4/7/16. 2.All residents have been reviewed for potential dental needs, and referrals have been completed as indicated. 3.All staff will received education regarding the policy for routine and emergency dental services. 4.Social Services will continue to offer dental services with admissions, and review on a quarterly basis for routine services. Caring Partners will conduct weekly audits with residents regarding dental service requests. Results of these audits will be reviewed at QAPI for tracking and trending.	

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F 412	Continued From page 47 service (SS)-B indicated R110 was "put on list to be seen...dental." During interview on 3/3/16, at 10:12 a.m. with health unit coordinator (HUC)-A stated R110 had not seen the dentist even though he was referred in January 2016. She stated he was last seen by the dentist in 7/2014, over 1/1/2 years ago. During interview on 3/3/16 at 4:49 p.m. , SS-B stated that she had reviewed dental status with R110 during care conference and had scheduled an appointment in follow up. Resident dental schedules were reviewed for 2/16, 3/16, and 4/16 with SS-B and HUC-A during this time. R110 had not been on schedule for a dental exam. SS-B stated that social services was responsible to schedule ancillary services during care conference and as needed, but this was missed.	F 412		
F 425 SS=B	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425		4/12/16

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F 425	Continued From page 48 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure tuberculin solution available for resident and staff use was not expired. This had potential to affect 4 of 4 residents or staff who could have received the expired solution. Findings include: On 3/3/16, at 12:16 p.m. the third floor medication storage room was observed with licensed practical nurse (LPN)-B. A refrigerator inside the room contained an opened package of Tuberculin Purified Protein Derivative (a medication used to test for exposure to Tuberculosis) which had a date written on the box in black marker of, "1-13-16." LPN-B stated the tuberculin solution was available for resident and staff. LPN-B stated the remaining solution was enough for approximately four doses to be administered, and it should have been discarded after 30 days from being opened on 1/13/16. Further, LPN-B stated all of the staff were responsible to check the refrigerator for expired medications and solutions, however, she was unaware if the facility had a specific system to ensure expired medications were identified. During interview on 3/3/16, at 3:44 p.m. registered nurse consultant (RNC)-A stated the tuberculin solution should have been discarded	F 425	1.Facility has destroyed the tuberculin solution labelled 1/13/16. 2.All opened tuberculin solutions have been audited and are currently within manufacturer guidelines for usage. 3.Nurses will be educated on following policy for medication storage recommendations. 4.DON or Designee will complete random weekly audits to ensure proper medication storage x 4 weeks. Results of audits will be reviewed at QAPI meeting for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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F 425	Continued From page 49 after being opened for thirty days because the medication effectiveness could be decreased. A facility undated Injectable Medications flowsheet identifying, "Storage Recommendations," identified tuberculin solution should be, "Date[ed] when opened and discard unused portion after 30 days [underlined]." The facility consulting pharmacist was contacted on several occasions during the survey, but was unable to be reached for interview.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist identified irregularities with dosing and monitoring for effectiveness of as needed pain medication for 1 of 5 residents (R66) reviewed for unnecessary medication use. Findings include:	F 428	1.R66 drug regime has been reviewed and updated as indicated. 2.All residents with PRN pain medications have been reviewed to identify potential irregularities with dosing and monitoring for effectiveness. 3.Nurses have received education regarding documentation requirements for PRN Pain medication usage and	4/12/16

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F 428	Continued From page 50 R66's annual Minimum Data Set (MDS) dated 2/18/16, identified R66 had intact cognition, frequent episodes of pain, and received scheduled and as needed (PRN) pain medications. R66's signed physician orders dated 2/3/16, identified orders for the following narcotics: > "Fentanyl C2 [controlled drug] 25 mcg/hr [micrograms per hour] ... Apply 1 patch and change every 72 hours," and > "Fentanyl C2 100 mcg/hr ... Apply 1 patch and change every 72 hours," and > "Methadone HCL C2 10 mg [milligrams] ... 3 tabs [tablets] [30 mg] by mouth every bedtime," and > "Oxycodone [a narcotic pain medication] 5 mg Tablet ... 1-2 tabs[tablets] [5-10mg] by mouth every bedtime as needed." Review of R66's Medication Administration Record (MAR) for 1/16 and 2/16 identified the following: -MAR dated 1/2016, identified R66 received 20 doses of the as-needed narcotic pain medication during the month. However, there was no documentation to determine if R66 received the ordered 5 mg dose or 10 mg dose of the as needed narcotic medication. R66's PRN (as-needed) Analgesic Record / Pain Flow Sheet (tool used to monitor pain and medication effectiveness of administered medication) dated 1/1/16 to 1/31/16, identified spacing to record the date and time of administration, pain description and numerical rating, the medication provided, and follow-up to the provided medication. However, all of these fields were left blank on R66's records.	F 428	monitoring for potential dosing irregularities. Pharmacy Consultant was included in education relating to noting lack of effectiveness and dosing of narcotics. 4.DON or designee will complete random weekly audits for documentation and clarification of potential irregularities with dosing and monitoring for effectiveness of prn pain meds x 4 weeks. Results of audits will be reviewed at QAPI meeting for tracking and trending. QAPI team will then adjust audit schedule accordingly to the trending identified.	

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-MAR dated 2/2016, identified R66 received 19 doses of the as-needed narcotic medication, before the order was discontinued. A new order was transcribed which identified, "Oxycodone 5 mg i-ii [1-2 tablets] PO [by mouth] Q 4 HRS [every four hours] PRN" and R66 received 14 additional doses of the as-needed narcotic medication. However, there was no documentation to determine if R66 received the ordered 5 mg dose or 10 mg dose of the as needed narcotic medication. PRN (as-needed) Analgesic Record / Pain Flow Sheet dated 2/1/16 to 2/29/16, identified spacing to record the date and time of administration, pain description and numerical rating, the medication provided, and follow-up to the provided medication. However, all of these fields were left blank on the record.

R66's progress notes dated 1/1/2016 through 2/28/16, were reviewed but lacked documentation identifying what dose of the as needed medication had been administered, why R66 had been provided the as needed narcotic medication, or any follow up on if the provided medication had been effective.

When interviewed on 3/3/16, at 10:48 a.m. registered nurse (RN)-E stated R66 had chronic complaints of pain and, "is on a couple of meds [medications] to help with that," including scheduled narcotics in addition to as needed narcotic medication. R66 had orders for one to two tablets of as-needed oxycodone for pain, and RN-E stated she used a pain scale to identify how many tablets of the as needed narcotic medication to provide to R66. RN-E stated the nursing staff should be recording the dose provided and it's effectiveness on the PRN

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Analgesic Record each time a as-needed pain medication was administered. RN-E stated she was not aware of any other location the staff would be documenting their non-pharmacological interventions, monitoring or follow-up of the as-needed narcotic medication than on the PRN Analgesic Record, "not that I'm aware of." RN-E reviewed the January and February analgesic records and stated there was no monitoring of the effectiveness completed for R66's as needed narcotic medication use, "It should have been written here," and staff, "Need to be re-taught to use it each time." Further, RN-E stated she was unable to determine how many tablets of the as needed narcotic medication had been given each time R66 received the as needed narcotic.

During interview on 3/3/16, at 12:56 p.m. the assistant director of nursing (ADON) stated staff were expected to use the PRN analgesic records to document a resident's pain, and the effectiveness monitoring for it, "[They're] supposed to use that sheet." Further, RN-B stated she did not think physicians should be writing range orders (i.e. one to two tabs) anymore, "I thought that was banned a long time ago," and staff should have clarified the order.

On 7/16/15, no irregularities were identified. On 8/13/15, no irregularities were identified. On 9/7/15, no irregularities were identified. On 10/14/15, no irregularities were identified. On 11/14/15, no irregularities were identified. On 12/19/15, no irregularities were identified. On 1/22/16, the pharmacist noted R66 had been using the as-needed narcotic pain medication almost daily, however signed, "NI" for no irregularities were identified in the medication regimen. On 2/24/16, no irregularities were

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F 428	Continued From page 53 identified. Although R66 had orders for as needed narcotic medication, the facility failed to ensure staff identified the administered dose, and then monitored the administered medication to ensure it was effective and necessary in managing R66's pain and the consulting pharmacist failed to identify this irregularity. The consulting pharmacist was contacted on several occasions during the survey, but was unable to be reached for interview. A facility policy related to the consulting pharmacist was requested. The facility provided policy titled Consultants, which indicated "for Pharmacist consultant recommendations, refer to "Medication Regimen Review" procedure located in the Med Administration Program. However, this portion was not provided as requested.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		4/12/16

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F 431	Continued From page 54 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 interview and document review, the facility failed to ensure Fentanyl Patches (transdermal narcotic patches) were destroyed according to facility policies and procedures to reduce the risk of diversion for 1 of 5 residents (R66) reviewed for unnecessary medication use. This had potential to affect 4 of 4 residents (R66, R147, R65, R111) residing in the facility who had current orders for Fentanyl patches. Findings include: A facility provided undated titled Fentanyl Patche(s) listing identified R66, R147, R65, and R111 had current orders for Fentanyl (a narcotic medication) transdermal patches.	F 431	1.R66 medication administration record has been reviewed and updated to include documentation and adherence to transdermal narcotic patches destruction. 2.All residents receiving transdermal narcotic patches medication administration record has been reviewed and updated. 3.Nurses have received education on following policy for transdermal narcotic patch destruction. 4.DON or designee will complete random weekly audits for 4 weeks to ensure appropriate transdermal narcotic patch destruction. Results of audits will be reviewed at QAPI for tracking and trending. QAPI team will then adjust audit	

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F 431	Continued From page 55 R66's signed physician orders dated 2/5/16, identified R66 had current orders for, "Fentanyl C2 [controlled substance] 25 mcg/hr [micrograms an hour] Patch ... Apply 1 patch and change every 72 hours," and, "Fentanyl C2 100 mcg/hr Patch ... Apply 1 patch and change every 72 hours." Further, R66's physician orders identified nursing staff was to, "Fold and flush patch down toilet following removal / Two nurses must witness." R66's medication administration record (MAR) dated 2/2016, identified spacing for an administering nurse to document applying a new Fentanyl patch by writing their initials, as well as a space to record when the staff removed and disposed of the old patches with "NURSE 1 INT [initials]", and "NURSE 2 INT" being provided for staff to have two nurses sign the witnessed destruction as directed by the physician orders. R66's MAR identified a total of ten Fentanyl patch changes occurred, however, only four of the ten times indicated two nurses signed the MAR to indicate the disposal was witnessed by 2 nurses. When interviewed on 3/3/16, at 11:00 a.m. registered nurse (RN)-E stated two nurses should be signing off they witnessed the transdermal patch destruction, "Both [nurses] are supposed to mark you saw it." RN-E reviewed R66's February 2016 MAR and stated, "People aren't doing it," RN-E stated two nurses should be signing off on the destruction to ensure they are being disposed of correctly, and to ensure the narcotic medication isn't being diverted because the removed patches still, "Have partial [medication] dosage on it." During interview on 3/3/16, at 12:34 p.m.	F 431	schedule accordingly to the trending identified.	

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F 431	Continued From page 56 registered nurse consultant (RNC)-A stated the removed transdermal narcotic patches should have a second nurse sign off to make sure it was destroyed correctly because the removed patches, "Still could have some potential residue [of medication]." The consulting pharmacist was contacted for interview several times during the survey, but was unable to be reached. A facility Destruction of Controlled Drugs policy dated 7/2015, identified used transdermal patches should be destroyed following their removal, and "Two licensed nurses must sign for the destruction of the used patch on the resident's Medication Administration Record [MAR]."	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a hazard-free outside patio area, used as a designated smoking area, which had the potential to affect 23 residents who smoked (R56, R88, R18, R138, R83, R115, R53, R169, R42, R170, R109, R114, R75, R9, R10, R26, R129, R134, R74, R39, R127, R95 and R25) as well as other residents, staff and visitors who utilized the	F 465	1.Areas of patio that is designated as smoking area has been repaired eliminating unevenness from concrete slab to slab. R90's wheelchair armrest has been replaced. 2.Public sidewalks have been inspected and repaired as necessary. All resident wheelchairs have been inspected for being in proper repair. Any noted in	4/12/16

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F 465	Continued From page 57 outside patio. In addition, the facility failed to maintain a clean and sanitary wheel chair for 1 of 1 residents (R90) who utilized a wheel chair for locomotion. Findings include: UNEVEN SURFACE NEAR ENTRYWAY R88's annual Minimum Data Set (MDS), dated 1/15/2016, indicated R88 had intact cognition. R114's quarterly MDS, dated 12/21/2015, indicted R114 had intact cognition. R45's admission MDS, dated 2/5/2016, indicated R45 had intact cognition. During observation on 3/3/2016 at 1:22 p.m. outside on patio area near the 2nd floor entry to the building, there were residents, seated in their electric-powered or standard wheel chairs, who were smoking. The round-shaped patio area, approximately 10 feet in diameter, was located to the right of the exit for the facility. A sidewalk, sloped slightly upward, led to the patio, and was marked with a worn, yellow-painted stripe, where the patio began. Another sidewalk, sloping downward from the patio led toward the parking area, was also marked with a faded, yellow painted stripe where it joined the patio. This section of concrete was 1 1/2" (inches) lower than the patio, and was as wide as walk leading away from the patio toward the parking area. The difference in the height of these concrete sections created a ridge on the patio area, identified as a resident smoking area.	F 465	disrepair have been corrected. 3.Facility staff have been educated on notifying maintenance department of any issues with uneven patio areas/sidewalks and wheelchairs being in proper repair. 4.Maintenance Director or designee will conduct monthly audits of sidewalks to identify any potential hazards. Maintenance Director or designee will conduct random weekly audits of wheelchairs x 4 weeks. Results of audits will be reviewed through QAPI committee and QAPI team will adjust audit schedule as appropriate.	

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During a subsequent observation at 4:19 p.m., there were again residents who were smoking, seated in their wheel chairs, or on a bench chair, with their walkers parked in front of them. R114 independently navigated the patio area with a regular walker, and was observed to lift the walker up slightly in order to go over the ridge to the entrance of the patio. R45 independently propelled a standard wheel chair, and upon reaching the patio area, R45 backed up slightly, required a couple of attempts to push the wheels of the wheelchair over the ridge of the walk where the surface was uneven. R88 was observed seated in an electric chair, as she maneuvered the chair over the ridge.

In an interview on 3/3/2016 at 3:20 p.m., R88 stated she "has not seen anyone fall," outside on the patio, but has seen "people stub their toes" on the uneven ridge. R88 also stated she had seen residents struggle to maneuver over the ridge with their individual wheel chairs. R88 also stated "I don't have an issue" with the my power chair, but there "is a potential for a problem because a lot of people shuffle."

During an interview on 3/3/2016 at 3:55 p.m., R114 stated when smoking "I have to be supervised." R114 stated she usually did not go over the area that is a different height. R114 stated she had never fallen, nor seen anyone fall or trip on the pavement. R114 also stated she tries to "not go beyond the striped area when smoking."

In an interview on 3/3/2016 at 3:58 p.m., registered nurse (RN)-I stated the concrete area utilized by smokers did shift, but that in the spring it usually "levels back out." RN-I stated there

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were "all kinds of residents" who used the area, including those who propelled their own wheel chairs "four-wheeled walkers, regular walkers, and some who use no assist devices," and also non-smokers. RN-I stated residents were assessed to be able smoke, which included their ability to be outside the facility. RN-I also stated if residents required supervision, staff went with them during specific times. (RN)-I indicated there had been no falls because of the uneven surface of the smoking area.

A review of facility incident reports from 10/1/2015 to 3/3/2016 revealed there were no resident incidents which resulted in falls or accidents due to the uneven surface on the outside patio area.

During an interview on 3/3/2016 at 4:58 p.m., the maintenance personnel (MP)-A stated he was aware of the uneven concrete area, and indicated the concrete would rise when the ground come up in the spring. The MP stated he felt there would be a concern "if the ridge was higher on the slab away from the building," making it more difficult for wheel chairs to get over it. The MP stated if the slab did not go down after spring, "then I will be trimming it and leveling it" and he would also "re-marking the stripes."

A facility policy regarding maintenance of property as it relates to resident safety was requested, but none was provided.

BROKEN WHEELCHAIR:

R90's annual Minimum Data Set (MDS) dated 1/16/16 identified R90 had severely impaired decision making skills, long and short term memory problems, and used a wheelchair for

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mobility.

During observation on 2/29/16, at 2:42 p.m. R90 was in bed with her wheelchair against the wall. R90's wheelchair had visible white paper tape going around the right armrest which appeared visibly soiled with an unknown, dark-colored substance. On 2/29/16, at 6:41 p.m. R90 was seated in the wheelchair with the soiled taped arm rest in the dining room eating. During a subsequent observation on 3/1/16, at 8:08 a.m. R90 was seated at the dining room table, and her wheelchair continued to have the soiled paper tape on the right armrest.

When interviewed on 3/2/16, at 1:37 p.m. nursing assistant (NA)-C observed R90's wheelchair and stated she was unaware how long the tape had been in place. NA-C removed the tape of the wheelchair exposing a hard plastic perimeter of the arm rest cushion which was cracked and broken. During interview on 3/2/16, at 1:39 p.m. licensed practical nurse (LPN)-A observed R90's wheelchair and stated the cracked perimeter was, "Sharp" and maintenance should have been notified to fix the chair.

During interview on 3/2/16, at 1:50 p.m. maintenance personnel (M)-A and (M)-B stated they had not been notified of R90's broken wheelchair, but would fix it immediately to ensure R90 was not cut by the broken plastic perimeter.

A facility Wheelchair Safety Checks policy dated 7/2015, identified, "When clinical or non-clinical staff notices loose hardware of other possible safety issues with the operation of a wheelchair, the resident should be removed from the potentially unsafe wheelchair, the wheelchair

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F 465	Continued From page 61 taken out of operation, and the repair personnel should be contacted."	F 465		

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GOLDEN VALLEY REHABILITATION AND CAR	**7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427**

(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 on March 2, 2016. At the time of this survey, Golden Valley Rehab and CC 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. This 3-story building was constructed in 1972 and was determined to be of Type II (222) construction. It has partial basement and is automatic fire sprinkler protected throughout. The facility has fire alarm detection in resident rooms, corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 1 and had a census of 1 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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.