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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LSCM
Facility ID: 00730

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245299**

2.STATE VENDOR OR MEDICAID NO.
(L2) **972153000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FRAZEE CARE CENTER**
(L4) **219 WEST MAPLE AVENUE, PO BOX 96**
(L5) **FRAZEE, MN** (L6) **56544**

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) **11/01/2004**

6. DATE OF SURVEY **12/21/2016** (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)
09/30

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

12.Total Facility Beds **74** (L18)
13.Total Certified Beds **74** (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
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 12/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/17/2017 (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
11/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/15/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5299

On December 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 21, 2016 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 24, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of December 14, 2016. We have determined, based on our visit, that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2016, as of December 21, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 21, 2016.

In addition, the Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of November 10, 2016:

- Civil money penalty for the deficiency cited at F310, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F318, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2017, be rescinded. (42 CFR 488.417 (b))

Since the facility achieved compliance prior to the denial of payment for new admissions, the NATCEP prohibition would also be rescinded.

Refer to the CMS 2567b forms for health and life safety code.

Effective December 21, 2016, the facility is certified for 74 skilled nursing facility beds.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245299

February 14, 2017

Mr. Mike Anderson, Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, Minnesota 56544

Dear Mr. Anderson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 21, 2016 the above facility is certified for:

74 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 74 skilled nursing facility beds.

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

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

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

Sincerely,

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

An equal opportunity employer.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 27, 2016

Mr. Ben Prince, Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, Minnesota 56544

RE: Project Number S5299028

Dear Mr. Prince:

On November 10, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 15, 2016. (42 CFR 488.422)

In addition, on November 10 2016, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F318. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on October 24, 2016. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 21, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 24, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 14, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2016, as of December 21, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 21, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of November 10, 2016:

- Civil money penalty for the deficiency cited at F310, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F318, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2017, be rescinded. (42 CFR 488.417 (b))

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245299 Y1	A. Building B. Wing Y2	12/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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 F0201 Reg. # 483.12(a)(2) LSC	Correction Completed 12/21/2016	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 12/21/2016	ID Prefix F0242 Reg. # 483.15(b) LSC	Correction Completed 12/21/2016
ID Prefix F0244 Reg. # 483.15(c)(6) LSC	Correction Completed 12/21/2016	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 12/21/2016	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 12/21/2016
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 12/21/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/21/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 12/21/2016
ID Prefix F0310 Reg. # 483.25(a)(1) LSC	Correction Completed 12/21/2016	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 12/21/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 12/21/2016
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 12/21/2016	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 12/21/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 12/21/2016

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) LB/mm	DATE 12/27/2016	SIGNATURE OF SURVEYOR 31256	DATE 12/21/2016
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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245299	A. Building B. Wing	12/21/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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 F0334 Reg. # 483.25(n) LSC	Correction Completed 12/21/2016	ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 12/21/2016	ID Prefix F0412 Reg. # 483.55(b) LSC	Correction Completed 12/21/2016
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 12/21/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 12/21/2016	ID Prefix F0520 Reg. # 483.75(o)(1) LSC	Correction Completed 12/21/2016

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) LB/mm	DATE 12/27/2016	SIGNATURE OF SURVEYOR 31256	DATE 12/21/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/24/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245299 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	11/20/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 11/17/2016	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 11/17/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 11/17/2016
ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 11/17/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 12/27/2016	**SIGNATURE OF SURVEYOR** 36536	**DATE** 11/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 10/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 27, 2016

Mr. Ben Prince, Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, Minnesota 56544

Re: Reinspection Results - Project Number S5299028

Dear Mr. Prince:

On December 21, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 24, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00730 Y1	A. Building B. Wing Y2	12/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20255 Reg. # MN Rule 4658.0070 LSC	Correction Completed 12/21/2016	ID Prefix 20555 Reg. # MN Rule 4658.0405 Subp. 1 LSC	Correction Completed 12/21/2016	ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 12/21/2016
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 12/21/2016	ID Prefix 20690 Reg. # MN Rule 4658.0465 Subp. 3 LSC	Correction Completed 12/21/2016	ID Prefix 20800 Reg. # MN Rule 4658.0510 Subp. 1 LSC	Correction Completed 12/21/2016
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 12/21/2016	ID Prefix 20885 Reg. # MN Rule 4658.0525 Subp. 1 LSC	Correction Completed 12/21/2016	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 12/21/2016
ID Prefix 20915 Reg. # MN Rule 4658.0525 Subp. 6 A LSC	Correction Completed 12/21/2016	ID Prefix 20920 Reg. # MN Rule 4658.0525 Subp. 6 B LSC	Correction Completed 12/21/2016	ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 12/21/2016
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 12/21/2016	ID Prefix 21435 Reg. # MN Rule 4658.0900 Subp. 1 LSC	Correction Completed 12/21/2016	ID Prefix 21620 Reg. # MN Rule 4658.1345 LSC	Correction Completed 12/21/2016

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
X	LB/mm	12/27/2016	31256	12/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00730 Y1	A. Building B. Wing Y2	12/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21805 Reg. # MN St. Statute 144.651 Subd. 5 LSC	Correction Completed 12/21/2016	ID Prefix 21870 Reg. # MN St. Statute 144.651 Subd. 18 LSC	Correction Completed 12/21/2016		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	12/27/2016	31256	12/21/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/24/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LSCM
Facility ID: 00730

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245299**

2. STATE VENDOR OR MEDICAID NO. (L2) **972153000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FRAZEE CARE CENTER**
(L4) **219 WEST MAPLE AVENUE, PO BOX 96**
(L5) **FRAZEE, MN** (L6) **56544**

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) **11/01/2004**

6. DATE OF SURVEY **10/24/2016** (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) **09/30**

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

12.Total Facility Beds **74** (L18)

13.Total Certified Beds **74** (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
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sherri Softing, HFE NEII — 12/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 12/15/2016 (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 **11/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5299

On October 24, 2016, the Departments of Health and Public Safety completed a survey to verify the facility is in compliance with Federal participation requirements. The survey found the facility not in substantial compliance. The current survey found the most serius deficiencies in the facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level
G), whereby corrections are required. As of September 1, 2016, CMS policy required that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited at the current survey, and on any survey between the current survey and any survey within the last two calendar years. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on November 23, 2015.. Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following Category 1 remedy:

• State Monitoring effective November 15, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:
• Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F318. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid Admissions, effective January 24, 2017. (42 CFR 488.417 (b))

If Mandatory denial of payment for new Medicare and Medicaid Admissions, goes into effect. The facility would be subject to a two year loss of NATCEP, beginning January 24, 2016.

Refer to the CMS 2567 for both health and life safety code along with the facility's pllan of correction. Post Certification Revisit (PCR) to following.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 10, 2016

Mr. Brad Molgard, Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, Minnesota 56544

RE: Project Number S5299028

Dear Mr. Molgard:

On October 24, 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and
>
> Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited at the current survey, and on any survey between the current survey and any survey within the last two calendar years. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on November 23, 2015. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 15, 2016. (42 CFR 488.422)

The Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F318. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective January 24, 2017. (42 CFR 488.417 (b))

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by January 24, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 24, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245299	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 10/24/2016
NAME OF PROVIDER OR SUPPLIER **FRAZEE CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245299	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: **10/24/2016**
NAME OF PROVIDER OR SUPPLIER **FRAZEE CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 1 of 3 residents (R52) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, informing them of their rights to an appeal an expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services.

Findings include:

R52 was provided a Notice of Medicare Non Coverage on 6/22/16 which indicated her skilled coverage would end when she was discharged from therapy services on 6/23/16 due to therapy goals being met. Although R52 received the Notice of Non-Coverage, it was not provided 48 hours prior to discontinuation of skilled therapy. R52 was given the right to appeal the notice, and just below the signature of the responsible party, a note had been documented which indicated R52 would be discharging home on 6/24/16.

On 10/24/16 at 10:36 a.m., the assistant director of nursing (ADON) confirmed R52 had not received the required the Notice of Non Coverage 48 hours prior to discontinuation of skilled care. The ADON stated, " they (residents) are to have a 2 day notice." The ADON verified she could not find any other documentation that R52 would have continued therapy services up until her discharge on 6/24/16 and verified therapy services ended on the 6/23/16.

A policy was requested, but not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING ______ B. WING ______	10/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing	F 201		12/14/16

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

Electronically Signed — 11/30/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING ______ B. WING ______	10/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 201	Continued From page 1 facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents are not inappropriately discharged from the facility for 1 of 1 (R103) residents reviewed for discharge requirements. Findings include: R103's undated diagnoses list identified diagnoses which included, alcohol cirrhosis of the liver with ascites, hepatic encephalopathy, alcohol induced insomnia, uncontrolled diabetes and chronic obstructive pulmonary disease (COPD). R103's Admission Assessment form dated 10/20/16, identified R103 was alert, oriented and had clear speech. R103's assessment also revealed R103 was independent in mobility and was full weight bearing. R103's Individual Resident Care Plan dated 10/20/16, identified R103 was alert and oriented and was independent with activities of daily living (ADL's) including ambulation. Review of R103's nurses progress notes from 10/20/16 to 10/21/16 revealed the following: -10/20/16, at 2:00 p.m. R103 was admitted to the facility, was independent with ambulation, had been wandering in the facility and was forgetful at	F 201	F 201 Reason for transfer/discharge of a resident 1. Resident # 103 was discharged from the facility on 10-20-2016. 2. All residents have the potential to be affected in this area. By educating our staff and monitoring our systems, this will ensure compliance in this area. 3. Mandatory education provided to nursing staff on 11-16-2016 and 11-17-2016 on the procedure titled, Transferring a Resident to Another Facility or Hospital with a focus on the ensuring residents are not discharged from the facility without just cause and physician notification. The physician must document why the residents needs are not able to be met within the facility. The bed hold notice must be completed at the time of the transfer. The facility must use all resources available to avoid an acute ER visit/unexpected transfer/discharge from facility. 4. An audit has been developed to monitor the documentation on resident transfers to the hospital for appropriate transfer discharge. The audit will be completed by the DON or designee on all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING ______ B. WING ______	10/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 201

Continued From page 2

times.

-10/20/16, 5:45 p.m. R103 was alert, asked and answered questions appropriately and ate poorly at the evening meal.

- 10/21/16, at 6:00 a.m. R103 had only slept for short periods of time. R103 requested Tums for a stomach ache and Melatonin (supplement used for insomnia) and had been up to the bathroom 3 times during the night.

-10/21/16, at 8:30 a.m. nursing staff had attempted to reach R103's medical doctor, and had left a message with the MD's nurse. R103 had been wandering constantly and his mood had been fluctuating. R103 had yelled at a nurse consultant and had physically hit the door when the staff member attempted to assist him. R103 had verbally threatened to kill the nurse and had been sitting on a dining room table which was occupied by other residents, threatening others in the facility. The note identified at 8:40 a.m. the nurse spoke with R103's MD and an order was obtained to send R103 back to the hospital.

- 10/21/16, late entry at 10:00 a.m. R103 had been up wandering since 6:00 a.m. and had been redirected to return to his room to watch TV. R103 was observed lying in the hallway by his room, made the statement, "I gotta sleep somewhere." R103 got up off of the floor on his own and stated to the nurse he was sick. R103 took all of his a.m. medications, stated that was it and he was all done. R103 became threatening towards the nurse, stated he would kill her. R103 had reported to the nurse the day prior that all of the bruises on his arms were not from IV's but from the nurses hitting him. The note revealed

F 201

resident transfers to the hospital to monitor the documentation of a change of condition with an SBAR assessment, documentation from primary care physician on why the facility cannot meet the needs of the resident, notification to the POA/responsible party and the receipt of a signed bed hold. Audits will be completed weekly X 4 weeks, then monthly X 2 months. Audit findings will be reported monthly to the QA committee x 3 months with follow-up to Committee recommendations.

5. Deficient practice will be corrected by December 14, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING ______ B. WING ______	10/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 201	Continued From page 3	F 201		

the facility nurse had heard R103 yelling in his room to stop hitting him, though no person was in R103's room. R103's behavior continued to escalate and act erratically, the ambulance arrived at 9:00 a.m. and R103 was transported to the emergency room with his clothing, glasses and shoes sent with him.

Review of R103 social services notes from 10/20/16 to 10/21/16 revealed the following:

-10/20/16, R103 had been admitted to the facility following a 3 month hospital stay which was for an altered mental status. R103 had been living with various relatives in the last year and a half. R103 had orders for therapy and length of stay had not been determined at that time. R103 had declined to complete the admission paperwork as he requested to play bingo.

-10/21/16, at 3:30 p.m. R103 was transported to the emergency room following a 911 call due to R103 acting erratically and had been threatening staff and residents. R103 was issued a Notice of Immediate Discharge via fax to the hospital where R103 had been transported to. SW had notified R103's daughter of his discharge from the facility and the daughter had applied for a guardian several weeks prior with a case manager from White Earth Reservation where R103 was a member. The note also revealed SW contacted Hennepin County (where R103 had an open case) and White Earth regarding R103's admission and discharge.

Review of R103's physician orders, revealed a telephone order dated 10/21/16, to send R103 to the hospital by ambulance.

F 201 | F 201

Continued From page 4

R103's medical record did not have any futher documentation by R103's physician.

On 10/24/16, at approximately 3:00 p.m., during telephone interview with hospital social worker (HSW), she stated R103 had been transferred from the nursing home to the hospital on 10/21/16. The nursing home had sent his personal belongings with him and shortly after he arrived the facility had sent a Notice of Discharge via fax from the nursing home. The fax cover sheet had instructed to give the notice to R103. HSW stated R103 had been admitted because of acute complications from liver problems, presented to the ER "sedated" and with treatment was now alert, cooperative and ambulating himself without difficulty and was ready for discharge from the hospital. She indicated she had been in contact with the nursing home, most recently, 10/24/16, and was told the facility would not be accepting R103 back to the nursing home. HSW indicated she had been told the facility would not take him back due to R103 being a threat to himself and others. HSW stated R103 had told her he was looking forward to returning to the facility, and had told her he liked the staff in the facility and was looking forward to playing bingo.

Review of an untitled Frazee Care Center form, dated 10/21/16, revealed a Notice to Discharge Pursuant to Minnesota Statutes 144.651, subd. 29 and 42 U.S.C 1369 r. had been issued to R103 via fax from the facility. A letter head cover sheet timed 10:20 a.m., was attached to the notice requesting the hospital emergency room department to deliver the notice to R103. The notice revealed R103 had been immediately discharged from the facility due to the safety of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING ______ B. WING ______	10/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 201	Continued From page 5 individuals had been endangered and R103 had been threatening the life of other residents and caregivers in the facility. The notice also revealed the health of individuals in the facility would be endangered. The notice was signed by the facility administrator (FM.) Review of R103's facility discharge summary dated 10/21/16, revealed R103 was discharged to the hospital due to wandering, placing self on the floor and sitting on occupied dining room tables. The summary revealed R103 had been sent to the hospital by ambulance with all belongings sent with. Review of the hospital discharge planning assessment dated 10/24/16, revealed R103 had been admitted with a diagnosis of hepatic encephalopathy and had exhibited no behavioral disturbances since he had arrived at the hospital. The note revealed R103 had requested to return to the facility. The note revealed no information regarding R103's threatening behavior had been sent with R103 to the emergency room. The note further revealed R103 had not received a 30 day notice from the facility regarding an intent to discharge and the hospital social worker would consult the MN Office of Ombudsman for Long Term Care. On 10/24/16, at 3:52 p.m. the administrator stated he was aware of R103 being transferred to the hospital as well as being subsequently discharged from the facility. The administrator stated he had been told R103 was extremely uncooperative, lying on the floors and standing on the dining room tables. Administrator stated R103 had also threatened staff and other residents, and added he had spoken with the hospital social	F 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING ______ B. WING ______	10/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

(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 201	Continued From page 6 service worker at that time and had felt the facility was not the best place for R103 and wanted to make sure R103 was going to receive the best care. Administrator stated the regional director of operations was consulted on 10/21/16, the morning R103 was transferred to the emergency room and had made the decision to discharge R103 from the facility and not to re-admit R103 when his acute illness resolved. On 10/24/16, at 4:02 p.m. the social worker (SW) stated she had been with R103 when he was admitted on 10/20/16. SW stated R103 would not complete all of his admission paperwork as he wanted to attend bingo. SW stated she felt R103 was acting out of sorts but felt he settled in for the evening. SW stated when she arrived to the facility the am of 10/21/16, she had been met in the hallway by staff stating R103 was threatening staff and residents as well being uncooperative. SW stated it had taken several nurse managers to de-escalate R103 and get him off of the dining room tables. SW stated others residents had been fearful of R103 so she had spoken directly with the director of operations and a discharge note (due to violence) was sent to the hospital R103 was sent to, as well as 3 different counties in which R103 had resided and the local vulnerable adult reporting agency. SW stated she had spoken with R103's daughter and had been told R103's behavior had been escalating for 6 months and he had been acting strangely before his last hospitalization. SW stated she felt the previous hospital had dumped on them by sending R103 to the facility with orders for physical and occupational therapies as a guise as R103 was independent with all mobility. On 10/24/16, at 4:12 p.m. nurse manager (NM)-C	F 201		

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F 201	Continued From page 7 stated she had completed R103's admission paperwork and had worked with him. NM-C stated R103's cognition had fluctuated and his behavior would also fluctuate from appropriate to inappropriate. NM-C stated R103 did not sleep very well the night before he was sent to the hospital and the morning R103 was sent to the hospital he had become very threatening towards staff and residents. NM-C stated the director of operations told them to call 911 and apparently had made the decision to discharge R103.	F 201		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain dignity for 1 of 1 residents (R66) who was observed lying in soiled linens. Findings include: R66's quarterly Minimum Data Set (MDS), dated 7/13/16 identified R66 had severe cognitive impairment, and was totally dependent of staff for activities of daily living (ADLs), and required 2 or more staff to assist with bed mobility. The MDS further identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes.	F 241	F 241 Resident dignity 1. Resident # R66 has clean linen on her bed. 2. All incontinent residents have the potential to be affected in this area. A list of residents frequently incontinent of urine will be generated and used for facility auditing. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 to educate staff on the procedure titled Linens and Dignity with a focus on the need to change residents soiled	12/14/16

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F 241	Continued From page 8 On 10/19/16, at 10:05 a.m. R66 was observed in her bed, on her back and dressed in a hospital gown. Licensed practical nurse (LPN)-A and nursing assistant (NA)-E were present in her room for morning cares. LPN-A pulled away R66's white sheet and white cotton blanket from R66's body and set both off to R66's right side. NA-E was positioned on R66's right side and LPN-A was positioned on R66's left side of her bed. R66' bottom bed sheet was observed to have several dried brown streaks, and a large round, dried, yellow stain on her white cotton bed sheet which extended to the left edge of her bed sheet where LPN-A was positioned to perform cares on R66. The stains were next to R66's left arm and hand on the bed LPN-A leaned over R66's bed with her torso and scrub top resting on the multiple browns streaks and yellow stained areas on R66's sheet. LPN-A confirmed multiple brown streaks and large yellow stain were feces and urine, covered the multiple stained areas with R66's white cotton blanket and continued to perform R66's morning cares. On 10/19/16, at 1:03 p.m. NA-E stated the usual facility practice was for resident's sheets to be changed on resident bath days, and whenever linens became soiled. She stated R66 had received a bath on Monday, and her next bath was today. NA-E indicated she was not aware how long R66's bed linens had been soiled, and indicated she thought night shift had last repositioned R66 in bed. On 10/19/16, at 1:06 p.m. NA-D stated facility staff changed resident bed sheets on their bath day, or whenever they had an "accident."	F 241	linens with each incontinent episode. 4. An audit has been developed to monitor resident bed linens. The audit will be completed by the DON, or designee to monitor the cleanliness of resident bed linens on all three shifts. The audit will be completed 2-3 per week on all three shifts X 4 weeks, the weekly for 4 weeks, then monthly X 2 months. Audit findings will be reported to the QA committee x 3 months with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	

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F 241	Continued From page 9 On 10/19/16, at 1:16 p.m. LPN-A stated the usual facility practice was for resident's sheets to be changed whenever the linens became soiled, and on bath days. She stated R66's soiled sheets should have been changed right away when they became soiled. On 10/24/16, at 10:53 a.m. clinical manager (CM)-A stated resident bed sheets should be checked for cleanliness when staff provide resident care. She stated resident sheets should be changed whenever staff notice they are soiled, and routinely on their bath days. She stated it should have been very obvious to staff when R66's sheets became soiled, and she would expect staff to change the sheets right away. Review of facility policy, Linens-Handling dated 3/1/14, identified soiled linen was to be immediately removed from the resident's room and taken to the laundry room. The policy further identified dirty laundry should not be close to a person's body and hands were to be washed after handling dirty laundry and prior to handling clean laundry to prevent the spread of infection.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		12/14/16

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F 242	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure each resident's preference for bathing frequency was provided for 1 of 3 residents (R61) who was reviewed for bathing preference. Findings include: Review of R61's quarterly Minimum Data Set (MDS) dated 7/24/16, identified R61 was cognitively intact and had diagnoses which included, insulin dependent diabetes, congestive heart failure (CHF) and anxiety. The MDS identified R61 required extensive assistance from staff with dressing and bathing. Review of R61's current care plan revised 1/27/16, revealed R61 required assistance of one with bathing. Review of nursing assistant care sheet provided by the facility, dated 10/17/16, directed staff to assist R61 with a bath 3 times a week, Monday, Wednesday and Fridays. On 10/19/16, at 1:26 p.m. R61 stated she had not received her bath on Monday 10/17/16, due to not enough staff on the floor. R61 stated she had been told the staff would try to help her with bathing on 10/18/16, though due to not enough staff on the floor, she had not received assistance with a bath. R61 stated the nursing assistants (NA) do not have enough time during the day to give baths, so she had changed to before bed. R61 stated she was scheduled to have 3 baths a week, Monday, Wednesday and Fridays and was still not able to get 3 baths a week due to not	F 242	F 242 Right to make choices 1. Resident R61 is being offered a bath three times per week; R61 s care plan and bath schedule have been updated. 2. All cognitively intact residents have the potential to be affected in this area. A list of residents with a BIMS score of 12 or greater will be interviewed to determine their bathing preferences. Care plans will be updated to reflect resident choice in bathing preferences. The cognitively impaired residents bathing needs will be based on assessment and family input. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 to educate staff on the procedure titled, Resident Rights with a focus on the need to offer residents a choice in their bathing. 4. An audit has been developed to monitor resident satisfaction and compliance in resident bathing preference that includes bathing type, frequency and time of day. The audit will be completed by the DON, or designee. The audit will be weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided to the QA committee with follow-up to committee recommendations 5. Deficient practice will be corrected by December 14, 2016	

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F 242 — Continued From page 11 — F 242

enough staff on the floor. R61 stated it had been "months" since she had received 3 baths a week, and indicated she understood it was due to the lack of nursing staff.

On 10/20/16, at 1:52 a.m. NA-F stated she understood R61 was supposed to receive 2 baths a week in the evenings and was not sure if R61 received her baths routinely.

On 10/21/16, at 11:02 a.m. ADON indicated she had met with R61 on 10/20/16 and confirmed R61 had not been routinely receiving her 3 baths a week as care planned.

On 10/21/16, at 1:37 p.m. during a follow up interview, ADON stated she felt staff were unable to routinely complete the number of baths based on residents preference, such as R61, due to staffing shortages.

On 10/24/16, at 9:31 a.m. nurse manager (NM)-A stated she was unaware R61's baths were not getting done 3 times a week. She stated R61's care plan should be followed.

A facility policy titled Resident Rights, dated April 1, 2008, revealed a list of resident rights which included the right to receive services in the facility with reasonable accommodation of individual needs and preferences. The policy also revealed residents right to choose activities, schedules, and health care consistent with interests, assessments and plans of care.

F 244 SS=E — 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION — F 244 — 12/14/16

When a resident or family group exists, the facility

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Continued From page 12
must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure resident council concerns related to sufficient staffing and long call light response times were acted upon for 5 of 5 residents (R27, R1, R2, R5, R45) who voiced concerns at the resident council.

Findings include:

R27's annual Minimum Data Set (MDS), dated 8/17/16, identified R27 had intact cognition and required extensive assistance from staff for personal hygiene, dressing, transferring and toilet use.

On 10/24/16, at 3:31 p.m. R27 stated she routinely attended resident council meetings and she had reported at the resident council meetings she had waited frequently for at least 2 hours when she put her light on and needed help. R27 stated she was beginning to feel like she did something wrong and that was why staff didn't answer light for that long. She stated other residents had also complained of long call light responses from staff and short staff in the meetings and she felt the facility had not responded to the concerns.

R27 stated she had also brought up the lack of

Provider's plan of correction:

F 242 Right to make choices
1. Resident R61 is being offered a bath three times per week; R61 s care plan and bath schedule have been updated. Resident counsel members R27, R1, R2, and R45 are receiving their bathes according to their bathing preferences and care plans updated as needed.

2. All residents have the potential to be affected in this area including resident counsel members R27, R1, R2, R5, and R45). Resident counsel members will be asked monthly at resident counsel by the DNS or administrator on their grievances concerns and follow up on staffing and long call light response times. Care plans will be updated to reflect resident choice in bathing preferences. The cognitively impaired residents bathing needs will be based on assessment and family input.

3. Mandatory nursing staff education was provided on November 16 and 17, 2016 to educate staff on the procedure titled, Resident Rights with a focus on the need to offer residents a choice in their bathing and care plan accordingly. Staff informed of resident counsel compliant on sufficient staffing and long call light

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F 244	Continued From page 13 staff, and long call light waits during her care conferences. She stated the facility had always told her they will look into it, but they hadn't done anything about it. She stated she felt residents weren't getting the care they needed because they were short staffed. She stated the activities director (AD) was at every resident council meeting and she would tell residents she talked to the ones she should talk to, but evidently it was not doing any good. R27 stated she was aware of at least 4 residents who had brought up short staffing concerns and long call light wait times, and stated the facility had not given any explanation for why this concern continued. She stated the facility kept telling resident council they would look into it, and the residents continued to bring it up again, and again, and again. Review of the resident council meeting minutes from 7/27/16, 8/31/16, and 9/28/2016 identified: -7/27, residents were concerned about their needs to have their call lights answered sooner than 2 hours -8/31, residents were concerned it took staff too long to answer their call lights. The minutes further identified R27 had put on her light that morning at 8:00 a.m. and her light was not answered until 10:00 a.m. The minutes also indicated R27 stated she didn't like to wait that long because she wanted to get up to go to morning activities. The minutes identified other residents had the same concerns typically in the morning.	F 244	response times. 4. An audit has been developed to monitor resident satisfaction, included resident counsel members R27, R1, R2, and R45 and compliance in resident bathing preference that includes bathing type, frequency and time of day. The audit will be completed by the DON, or designee. The audit will be weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided to the QA committee with follow-up to committee recommendations 5. Deficient practice will be corrected by December 14, 2016	

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F 244	Continued From page 14 9/28, residents had a concern that their call lights weren't being answered and residents could wait up to an hour to get their lights answered at any time during the day. Review of the resident council concern follow-up forms from 7/27/16, 8/31/16, and 9/28/16 identified: -7/27, director of nursing (DON) identified the resident council concerns and indicated audits and monitoring had been done. DON also indicated they had room for improvement and all staff had been asked to assist in answering resident call lights. DON further indicated the concerns were posted in the nursing communication board and discussed at the morning meetings with administrator and department heads. DON identified she would continue to monitor call lights and address any further complaints as needed. -8/31, nurse consultant indicated she witnessed call light response times on 8/31/16, and communicated staffing plans with regional director, facility nurses and interim administrator. She indicated she communicated call light response times and resident concerns to nursing staff. The form lacked documentation of actions to be taken to correct or improve the staffing concerns and long call lights responses. -9/28, nurse consultant indicated indicated she reviewed resident call light response time concerns and staffing plan with regional director, scheduler, nursing staff, and interim administrator. She indicated she provided education on the importance of timely call light response. The form lacked further documentation	F 244		

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F 244	Continued From page 15	F 244		

of actions to be taken or monitoring to correct or improve the staffing concerns and long call lights responses.

On 10/24/16, at 4:08 p.m. the activities director (AD) stated she coordinated the facility's resident council meetings and typed the meeting minutes. She stated the usual practice was to review the minutes from the last resident council meeting, review any follow up or response to previous concerns, reviewed old business, new business, and inform residents of upcoming events in the facility. She stated at every meeting she went over all of the service areas individually and asked residents to speak up if they had any concerns with any departments.

AD stated R27 routinely attended resident council meetings and R27, R1, R2, R5, and R45 had all voiced concerns regarding the facility being short-staffed and long call light waits.
She stated almost every month residents complained about nursing and long call light waits, and not enough staff. She stated she knew the assistant director of nursing and the registered nurse consultant were aware of resident concerns regarding long call light waits and being short staffed.

AD stated she brought up resident concerns from resident council also verbally during morning meetings to all department heads, and resident concerns were always brought up at monthly quality assurance meetings. She stated sometimes she filled out a Resident Council Concern Follow-up form, and delivered it to nursing, or put the form in their mailboxes. She stated nursing completed and returned the form

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F 244	Continued From page 16 to her before the next scheduled resident council meeting. The AD confirmed resident council meetings minutes and follow up forms in July, August, and September. AD stated she didn't always feel like residents received a straight answer for why their call lights were not being answered, and what was going to be done to fix the problem. Review of facility policy Resident Council/Family Council dated 4/1/08, identified when a resident group exists, the facility must listen to their views and act upon their concerns and recommendations of residents concerning policy and operational decisions that affected resident care and quality of life.	F 244		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide meaningful activities identified in the comprehensive assessment for 1 of 3 residents (R66) who was dependent on staff to provide all leisure activities. Findings include: R66's admission Minimum Data Set (MDS), dated	F 248	F 248 Activities meet interests/needs of each resident 1. Resident R66 was reassessed for activities of interest on November 15, 2016; R66 s care plan was updated to reflect assessment findings. 2. All residents dependent on staff for participation in activities have the potential	12/14/16

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F 248	Continued From page 17 1/11/16 identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS identified R66 had severe cognitive impairment, and was totally dependent of staff for activities of daily living (ADLs), and required 2 staff to assist with transfers and locomotion off the unit. The MDS identified R66 enjoyed listening to music, being around animals such as pets, keeping up with the news, doing things with groups of people, participating in favorite activities and spending time outdoors. R66's Care Area Assessment (CAA), dated 1/11/16 identified R66 suffered from a traumatic brain injury, was unable to speak and make needs known and was dependent on staff for all her ADL. The CAA further identified R66 followed people with her eyes and blinked to answer yes or no questions and appeared to watch TV when it was on. R66's care plan dated 2/18/16 identified R66 was a big fan of duck Dynasty and Keeping up with the Kardashians. R66's care plan indicated she liked to browse through gossip magazines and enjoyed a good book at times. R66's care plan directed activity staff had posted a sign in her room to inform all staff that she enjoys Duck Dynasty and Keeping up with the Kardashians, activity staff were to complete 4 1:1 visits a week, and activity staff would provide gossip magazines (people, Us Weekly, Star) and would read to her during 1:1 visits and would see if she was up to enjoy story time. R66's care plan further directed R66 required a mechanical lift and 2 staff to get her up and into her wheelchair, and R66 would be wheeled to all of her destinations as desired and in a timely manner.	F 248	to be affected in this area. A list of residents dependent on staff for activities has been generated, sctivity assessment and care plans will be reviewed and updated as needed to ensure dependent residents are receiving adequate assistance in activities of interest. 3. Mandatory nursing and activity staff education was provided on November 16 and 17, 2016 on the procedure titled, Activities with a focus on the need for staff to provide 1:1 visits for residents dependent on staff for activities and providing activities according to resident interests. 4. Residents Therapeutic Recreation 1:1 logs will be audited to monitor activity participation and documentation of activities for residents dependent on staff for activities. Residents requiring assistance with activities assessments and care plans will be reviewed and updated as needed. The audit will be completed by the Activity director, or designee, weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided to the QA committee monthly x 3 months with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	

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R66's Recreation/Therapeutic Programs Assessment dated 1/4/16, identified activities staff indicated they would try to bring her to activities to let her observe and be around people, and indicated R66 was in bed a lot. The assessment further identified R66's past interests included cards and games and plan included large group programs and entertainment, small group activities such as manicures, 1:1 programing would be needed, and R66 also enjoyed watching the birds and TV.

Review of R66's activities quarterly progress note dated 7/26/16, identified R66's activity involvement was fair and participation was passive, R66 was unable to structure her time in a meaningful way. The note identified R66 watched TV on a daily basis, and sometimes watched movies. The note indicated R66 would sometimes watch the birds, but staff felt R66 would rather watch TV and R66 would have 4, 1:1 visits by staff each week. The note also indicated family visited once per week and took her outside.

Review of activities quarterly progress note dated 10/11/16, identified R66's activity involvement was fair, participation level remained passive and R66 was unable to structure her time in a meaningful way. The note indicated R66 loved TV also watches movies on her personal DVD player. The note further identified R66 would have 4, 1:1 visits by activity staff each week and they would sometimes read her a book. The note also indicated family visited once per week and wheeled her around or took her outside if the weather was nice. The progress note identified R66's activity plan was appropriate, had met her

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goal for the last 3 months, activity interventions were effective. and no changes were recommended for R66's activity program.

Review of the facility activity calendar for residents from 4/16 to 10/16 identified 4-5 activities per week which R66 had special interest in such as music, Bingo, movies, outside walks and manicures.

Review of R66's Resident Activity Attendance Chart forms from 4/1/16 to 10/17/16 revealed R66 consistently watched TV and family visited. However, the attendance charts did not include consistent 1:1 visits, and did not consistently include attendance at either large or small group acclivities. The monthly documentation as follows:

-4/16, 6 out of 16 opportunities of 1:1 visits from staff for the month, and 3 unable and 1 refused. No other documentation of large or small group activities or activities out of room

-5/16, 7 out of 18 opportunities for 1:1 visits from staff for the month, 1 in family lounge, 1 in activities room, 1 mail reading, and 2 cleaning glasses.

-6/16, 9 out of 16 opportunities of 1:1 visits from staff for the month, 1 mail reading,1 glider, and 4 unable.

-7/16, 5 of out 18 opportunities for 1:1 visits from staff for the month, 1 special event, 1 bird watching, 2 cleaning glasses, 2 outside, 1 glider and 3 unable

-8/16, 7 out of 18 opportunities for 1:1 visits for

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the month, 1 bird watching, 1 wheeling, 1 outside, 1 cleaning glasses, and 1 unable

-9/16, 7 out of 18 opportunities for 1:1 visits for the month, 1 outside, 1 cleaning glasses, and 1 unable

-10/1-10/24/16, 7 out of 13 opportunities for 1:1 visits, 1 sitting in family lounge, 2 cleaning glasses, 1 outside

On 10/19/16, during observation from 7:00 a.m. to 10:03 a.m. R66's room was dark and quiet, and her bedroom door was open. R66 was observed on her back in bed, dressed in a hospital gown. R66 remained in the same position with no meaningful activity for 3 hours and 3 minutes. R66 had a monthly activities calendar posted on her closet door across from the foot of her bed, and a hand written 8.5 X 11 sign was posted on the wall across from R66's recliner and identified:

-R66 was to be changed during check ups
-No more Kardashians'!
-Family Feud on channel 11:00 a.m.
-Wheel of fortune
-Jeopardy 5:00 p.m.
-Judge Judy 9:00 a.m. & 11:00 a.m.
-get movie going early in the am or at bedtime

On 10/19/16, at 10:35 a.m. LPN-A and NA-E were in R66's room after R66 was dressed and in her recliner. LPN-A asked R66, "What are you going to watch on TV today?, I know you like those Kardashian girls." LPN-A stated she gave R66 a hard time about the Kardashians' because you never now what their gonna do on the show.

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F 248	Continued From page 21 On 10/19/16, at 12:10 p.m. R66 was dressed and seated in her recliner, in front of the TV. A political type program was on TV and R66 eyes were turned away from the TV and out her bedroom window. On 10/20/16, at 9:42 a.m. R66 was in her bed dressed in a hospital gown. R66's TV was off, and her eyes were focused on the ceiling. On 10/18/16, at 12:17 p.m. family member (FM-A) stated no facility staff visits R66 and she felt no facility staff went into her room unless they had to. She stated she visited R66 about twice a week and a nurse used to come and visit R66 even when she wasn't working, but she was gone now. On 10/21/16, at 10:24 a.m. licensed practical nurse (LPN-A) stated R66 was totally dependent on staff for ADLs. She stated the usual routine was after R66 got up, she spent her day watching TV in her recliner. On 10/24/16, at 10:08 a.m. activities aide (AA-A) stated R66 spent her day watching TV and would get 1:1 visits. She stated during 1:1 visits they open curtains, and sit with her talk to her about the TV shows she liked, or put a movie on. She stated she didn't know how often R66 came out of her room, and stated sometimes they had her sit at the nurses desk. She stated R66 slept a lot, and missed 1:1 visits because she was in bed and asleep. She stated activity staff tried to provide 1:1 visits on an attempt basis. She stated it was hard to provide activities for R66 because R66 required so much care, and was difficult to get up. She stated she felt R66 was probably up in her chair when family visited, and staff had	F 248		

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tried to get her out to story time but it was too difficult.

On 10/24/16, at 10:53 a.m. clinical manager (CM-A) stated staff would get her up in her recliner and she watched the Kardashians' because they were on a lot, otherwise R66 was in bed or her Broda chair in her room the majority of the time. She confirmed R66's current care plan and stated she understood activities staff spent time with her in her room.

On 10/24/16, at 12:27 p.m. activities director (AD) stated activity staff had posted a sign in R66's room which told staff what TV shows R66 liked and stated R6 also had a portable DVD player in her room. AD indicated in the past activities staff had wanted to bring R66 to the Afternoon Adventure activity, which was scheduled daily during the week, but struggled to get R66 to attend because she was not in her chair. She stated R66 used to get her nails done but activity staff struggled with finding staff to get her up in her wheelchair to attend the activity. She stated she would like R66 to attend music programs but it was such a hassle to find staff to get her up in her wheelchair, and R66 was usually in her bed or recliner. AD confirmed R66's care plan and stated her care plan could be updated. She stated her care plan was TV focused and the portable DVD player also. AD confirmed R66's activity records and stated R66 mostly watched TV. She confirmed the sign posted in room and R66's care plan had not been updated with current information.

Review of facility policy, Activities, dated 4/1/08 identified the facility must provide an ongoing program for activities designed to meet the

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care which included a therapy recommended range of motion (ROM) program for 1 of 4 residents (R66) who had functional decline in her upper extremeties. Findings include:	F 279	F 279 Development of a comprehensive care plan 1. Resident R 66 was evaluated by therapy with recommendations for ROM and upper extremity splinting. R66s care plan was updated. 2. All residents with a functional decline	12/14/16

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R66's quarterly Minimum Data Set (MDS) dated 7/13/16, identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS identified R66 had severe cognitive impairment, and was totally dependent on staff for assistance with all activities of daily living (ADLs). R66's MDS identified R66 had functional limitations in range of motion on both sides, upper and lower extremities, and did not receive therapy services or restorative nursing services.

R66's annual MDS dated 1/11/16, identified R66 had severe cognitive impairment, and was totally dependent on staff for assistance with all ADLs. The MDS identified R66 had functional limitations on both sides, upper and lower extremities, and did not receive therapy services or restorative nursing services.

R66's Care Area Assessment (CAA) dated 1/11/16, identified R66 was dependent on staff for all ADLs related to traumatic brain injury over the last year, and had difficulty with mobility, communication and cognition.

R66's care plan dated 2/18/16, identified R66 was aphasic (non verbal) due to traumatic brain injury, and was unable to make her needs known. R66's care plan also identified R66 was to wear hand splints for 2 hours on and 2 hours off during the day, and was to wear the splints all night. R66's care plan failed to identify R66 had contractures, and did not identify a ROM or a restorative nursing program for R66 to prevent further decline.

Review of the Aide Care Plan, Group B dated

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in ROM will be referred to therapy for screening and recommendations. Follow up with physician/nursing orders or therapy recommendation for ROM and/or splints have the potential to be affected in this area. Care plans of residents with decline in ROM/splints or braces have been updated as needed.

3. Mandatory nursing staff education was provided on November 16 and 17, 2016 on the procedure titled, Restorative Program-ROM and Splinting with a focus on the need for staff to provide ROM before and following splinting; to avoid a decline in ROM.

4. An audit was developed to monitor participation and documentation of Restorative nursing interventions, including ROM programs and application of splints or braces. Care plans will be reviewed to ensure care planning for restorative nursing programs ROM and splints/braces. The audit will be completed by the DON, or designee, weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided to the QA committee monthly x 3 months with follow-up to committee recommendations.

5. Deficient practice will be corrected by December 14, 2016

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10/17/16, identified R66 required total assistance with cares and was to wear hand splints on and off every 2 hours during the day and leave them on all night. The Aide Care Plan did not identify R66 had contractures or that she required a ROM or restorative nursing program to prevent further decline.

R66's Admission Assessment form dated 12/31/15, indicated R66 was non verbal, was non-weight bearing, transferred with a mechanical lift, and had elbow contractures. R66's Admission Assessment form indicated R66's hand grasps had not been assessed.

Review of R66's Resident Referral Interdepartmental Communication form dated 1/12/16, identified directions for nursing to complete R66's passive range of motion (PROM) to both upper extremities, active range of motion (AROM) to left hand, and included instruction to have R66 open and close fingers and to have R66 squeeze staff's hand with her left hand daily to maintain strength.

Review of a second Resident Referral from therapy dated 2/18/16, identified R66's hand splint wearing schedule as for R66 to wear splints 2 hours on, 2 hours off throughout the day and on at night.

R66's progress notes reviewed from 1/3/16 to 10/17/16 identified:

-1/3/16, R66 reached over and grabbed the TV remote with her left hand and could hold her TV remote in her left hand.

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-1/21/16, R66 was changing TV channels with remote.

R66's progress notes lacked further documentation regarding communication skills or techniques and lacked any documentation of upper extremity motion, exercises, or decline in function.

Review of R66's physician progress notes from 2/9/16 to 10/16/16 identified:

-2/9/16, identified R66 suffered a traumatic brain injury in 12/14, had been in a former long term care facility, but family had requested a transfer closer to their home. R66's could not communicate verbally. Nursing had reported R66 did not communicate verbally but was able to push her call light button and could change the channel on her TV with her TV remote.

-3/17/16, identified R66 still had some movement which involved the left upper extremity, and the physician would make sure therapy had a maintenance regimen from a contracture and general limb standpoint for R66.

-10/6/16, identified R66 could squeeze his fingers with left hand.

On 10/19/16, observations from 7:00 a.m. to 9:47 a.m. were conducted:

-At 7:00 a.m., R66 was observed lying on her back in bed, with her eyes closed. Both R66's arms were bent at the elbow, her right hand was in a fist position on her chest, and her left hand

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was in a "C" shaped position with fingers bent and hand slightly tilted away from her body. Splint devices were not observed on either of R66's hands, and the splint devices were not observed in her room.

-7:49 a.m. licensed practical nurse (LPN)-A entered R66's room to provide her trachea (artificial opening at windpipe) site care. She confirmed R66 was not wearing hand splints and stated R66 had not been wearing them in the recent past because she thought the splints were uncomfortable for R66. LPN-A exited R66's room and did not apply R66's hand splints.

-8:03 a.m. the nurse consultant walked in R66's room and immediately walked down to the nurses station. R66 remained on her back in bed, with her hands and arms in the same positron, no splints observed.

-8:20 a.m. R66 remained lying in bed in the same position with R66's arms bent at her elbows and her hands rested on her chest in the same position. No hand splints were observed on R66's hands and splints were not observed in R66's room.

-9:47 a.m. R66 remained in the same position in bed, no hand splints were observed on R66 or present in R66's room.

On 10/19/16, at 10:03 a.m. LPN-A confirmed R66 had not worn hand splints and stated R66 did not wear the splints "at all." She stated she was not aware when R66 last had worn the splints and indicated she thought it had been in the distant past. LPN-A left room and did not apply hand splints to R66.

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On 10/19/16, at 10:33 am nursing assistant (NA)-E confirmed R66 did not routinely wear hand splints, and stated she could not remember the last time R66 had worn her splints. NA-E provided a copy of the a NA care sheet and confirmed the care sheet directed for R66 to wear hand splints. She stated she had not been aware R66 was to wear hand splints. NA-A and LPN-A exited R66's room and did not apply her hand splints.

On 10/19/16, at 10:40 a.m. NA-D stated she was not aware of how R66's care plan directed her to care for R66. She stated she was not aware if R66 had hand splints or if R66 was supposed to wear them.

On 10/19/16, at 12:10 p.m. R66 was seated in her recliner in her room with both hands resting on her chest, right hand in fist, left hand curled in a "C" shape. R66 did not have hand splints on either hand.

On 10/20/16, at 9:30 a.m., during follow up interview, NA-B stated R66 presently did not receive range of motion services or presently was not receiving a restorative nursing program.

On 10/20/2016, at 9:36 a.m., during follow up interview, NA-D stated R66 did not routinely use her hands and was not aware if R66's hand stiffness had gotten worse. She stated she was not aware if R66 was on a restorative program or received range of motion services. NA-D reviewed the therapy referral in the nursing assistant reference book at the nursing station and stated she felt R66's therapy screening was not current, and R66 did not need range of

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motion services and did not need to wear splints since the screen was old (February 2016) She stated she was sure R66 got enough range of motion when they dressed her.

On 10/20/16, at 9:45 a.m. assistant director of nursing stated she was not aware if R66's splints had been discontinued in the past and indicated she questioned if the splints bothered R66 and indicated she felt R66 was not anymore contracted than when she was admitted.

On 10/20/16, at 10:03 a.m. occupational therapist (OT)-A stated R66 had worn hand splints at the time of admission, and indicated she was not aware if R66 had contractures on admission. She confirmed R66's therapy screens on 1/12/16 and 2/18/16, and indicated the therapy screen on 2/18/16, was completed after the facility changed the style of splint for R66 per family request. She stated a comprehensive assessment of R66's contractures had not been completed because the facility did not have a physician order for a consult. She stated she was not aware of R66's baseline for her contractures as the screen did not include measurements of limitations and stated the ROM and hand splints were recommended for R66 to prevent further contracture and discomfort in the future for R66.

OT-A stated the facility NAs were responsible for providing ROM services, restorative program and applying R66's splints and indicated the facility had a book of recommendations for residents' programs at the nurses desk. She confirmed R66 was unable to move both hands or her fingers independently. She stated she felt R66's left fingers were tighter, and flexion and extension was slightly limited, and stated she felt R66's

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limitations were within normal limits. She stated she felt R66's hands weren't contracted but had high tone. She confirmed the ROM and the splints were recommended treatments for R66's high tone. She stated she would expect R66 to wear the splints all night and alternating on and off every 2 hours throughout the day since 12/31/15, and should have received ROM services since 1/12/16.

At approximately 10:10 a.m., NA-B entered R66's room and OT-A asked her to locate R66's hand splints. NA-B looked in R66's bedroom in various locations and found them on R66's wheelchair underneath blankets and equipment. OT-A stated R66 should have been wearing her hand splints according to the schedule to prevent further functional decline. NA-B stated R66 had not worn the hand splints in awhile, and stated she was not sure why R66 had not been wearing them.

On 10/20/16, at 10:35 a.m. LPN-A stated she felt R66's care plan did not include a restorative program or ROM that she knew of. She confirmed R66's care plan and stated that ROM services were not on R66's care plan. She stated R66 had never used hand splints, and she felt R66's ROM, "Was about the same."

On 10/20/16, at 10:37 a.m. certified occupational therapy assistant (COTA)
stated their usual process for implementing a ROM program for residents was to complete a therapy screen and give a copy of the recommended ROM program to the clinical manager (CM.) She stated once the CM received the plan she was expected to implement the program with NAs and set up the "Maintenance ADL Worksheet," in the NA Book for documenting

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ROM provided. She confirmed there was no documentation that ROM services were provided for R66 in her medical record or in the NA Book. She confirmed R66 should have received ROM services since 1/12/16, and stated she could not explain why she never received ROM services.

On 10/20/16, at 10:40 a.m. NA-B stated she felt R66's stiffness had gotten worse and her arms were more stiff now. She stated she noticed R66 was more stiff when they dressed her, and stated they really had to manipulate her arms when they put her shirts on.

On 10/20/16, at 11:45 a.m. OT evaluated R66's elbow ROM while R66 was awake in her bed. OT physically picked up R66's right arm and after she manipulated both arms, she confirmed R66's right elbow lacked 25% extension. She confirmed R66 was a little tight with initial right side movements, and confirmed R66 grimaced in pain with movement. She confirmed R66 also had pain and grimaced with movement of her left arm, and R66's left elbow lacked about 10% for extension.

On 10/20/2016 at 12:00 p.m. NA-D stated sometimes R66 was a little more stiff in her upper extremities, and staff had to manipulate her arms more depending on the shirt they were putting on her.

On 10/21/16, at 10:14 a.m. NA-A stated R66 was totally dependent on staff for all of her cares. She stated she was unsure if R66 was on a ROM program , but stated she felt R66 should be. She stated she knew R66's right arm was more stiff than her left arm. She stated R66 just started wearing hand splints to both hands today and

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stated she had never seen R66 wear see hand splints until today.

On 10/21/16, at 2:16 p.m. R66 was observed on her back in bed with both arms resting on chest, right hand in a fist, left hand in a "C" shape. No splints were observed on either of R66's hands. A 8.5 X 11" white piece of paper with both typed instructions and hand-written notes, dated 8/3/16, was observed posted on R66's bedroom wall across from her recliner and identified R66's TV show preferences.

On 10/21/16, at 2:55 p.m. speech language pathologist (SLP) stated she had been working with R66 on communication techniques and assessed her ability to use her hands and elbows in the past. SLP repeated her functional assessment of R66. R66 was reclined in bed and SLP held "Yes and No" flash cards above R66's chest. SLP instructed R66 to point at the card that answered her questions. R66 unable to point or motion hand toward cards. SLP instructed R66 to use her eyes to look at either card to answer her questions. R66 was unable to participate in the assessment at all. R66 began crying and SLP ended assessment. SLP confirmed R66 had 0% success today, where R66 responded correctly to 60% of her questions during a past assessment.

On 10/24/16, at 9:50 a.m. NA-B stated at present, she was not aware if R66 could use her call light , and stated she did not know if R66 could hold a TV remote or use it.

On 10/24/16, at 10:14 a.m. NA-D stated R66 might be able to use her call light or TV remote if you put them in her hand, but wasn't sure.

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On 10/24/16, at 10:38 a.m. registered nurse (RN-A) stated R66 had severe cognitive impairment and was totally dependent on staff for all cares. She stated she was unaware if R66 was on a ROM program, wore her arm splints before today, or had declined in ROM to her upper extremities. She stated R66 should have received ROM and wore her arm splints according to the therapy recommendations and confirmed ROM was not on R66's care plan.

On 10/24/16, at 10:53 a.m. clinical manager (CM)-A stated R66 had severe cognitive impairment, and was dependent on staff for cares. She indicated she thought R66 had contractures on admission, but stated she did not remember where the contractures were, or which side of R66's body was affected. CM-A stated she remembered talking to the physician in the distant past about R66's contractures after admission and stated she told him she saw R66 use her TV remote in her room.

CM-A stated R66 was supposed to get ROM since 1/12/16, and was to wear hand splints on and off during the day, and keep on all night. She stated she expected R66 to wear her hand splints according to the schedule and receive ROM services from the NA's. She confirmed there was no documentation in R66's medical record or in the NA book that R66 had ever received ROM services since admission. She confirmed ROM services were not on R66's care plan.

On 10/24/16, at 12:00 p.m. COTA evaluated R66 while she was awake and sat in her recliner. COTA picked up R66's right arm by her elbow and put her call light in between R66's finger and adjusted her fingers to hold call light. R66's

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F 279	Continued From page 34 fingers were very weak and her fingers and hand didn't move and the call light fell on her lap. COTA picked up R66's left arm by the elbow, placed her call light between R66's fingers. R66's left hand and fingers did not move. R66 hand and fingers were very weak and call light just sat loose in her hand and R66 could not grasp or activate her call light. COTA also evaluated R66 for holding her TV remote. COTA attempted to place R66's TV remote in R66's right hand while she supported R66's arm by her elbow. R66 was unable to hold the TV remote at all with her right hand or fingers. COTA lifted R66's left arm up by the elbow and put the remote between R66's left fingers. The TV remote slipped in R66's hand and pointed up to the ceiling. R66 was unable to hold the remote towards her TV or activate the remote with her left hand and fingers. She stated she was sure R66 declined in her upper extreme ROM. On 10/24/16, at 12:27 p.m. Activities Director (AD) confirmed activity staff had posted a paper in R66's room at the time of admission, which listed TV shows R66 like to watch. AD indicated at the time the sign was originally posted, R66 could hold and use the remote, and liked to channel surf on the TV and would stop on the shows she liked to watch. On 10/24/16, at 1:45 p.m. nurse practitioner (NP) stated she felt if R66 was unable to use her remote or call light now, and could on admission, it was evidence of a functional decline. She stated the failure to provide ROM services was not a new concern for her and stated she had brought her concerns to administration in the past, but continued to be a long standing problem in the facility.	F 279		

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F 279	Continued From page 35 On 10/25/16, at 5:05 p.m. family member (FM)-A stated when R66 first got to the facility she could use her TV remote, change the channels, use her call light, and write her name and the word Mom. She stated when R66 was first admitted to the facility R66 could also pull her covers up, put her arms in the arm holes of her night gown. FM-A stated R66 could no longer do any of those things and indicated she felt R66 was sad and frequently cried. She stated R66's right side was most affected by her brain injury. She stated she had visited R66 over the previous weekend and noticed staff were now putting the hand splints on both hands. and stated she felt the facility should of been using the hand splints for R66 " the whole time." FM-A stated she had never seen staff do any exercises with R66 for her hands and arms, and stated she didn't know if they ever had. She stated R66 received ROM all the time before admission to this facility. She stated she had asked facility staff why R66 did not get ROM exercises and stated she had been told by staff they felt her brain was not working enough for them to do that. Review of facility policy, Restorative Program, dated 4/1/08 identified residents would be assessed on admission for a restorative program such as ROM. If a ROM program was an identified need, a plan would be individualized to meet resident needs and goals. The policy further identified residents would be supported and their highest level of functioning maintained.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		12/14/16

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F 280	Continued From page 36 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to revise the plan of care for 1 of 3 residents(R66) who was dependent on staff to provide all leisure activities. In addition, the facility failed to revise the care plan for ambulation for 3 of 4 residents (R29, R46, R38) reviewed for ambulation services. Findings include: R66's admission Minimum Data Set (MDS), dated 1/11/16 identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS identified R66 had severe cognitive impairment, and was totally dependent of staff for activities of daily living (ADLs), and required 2 staff to assist with	F 280	F 280 1. R66 s care plan was updated to include focus on R66 s activities of interest, and 1:1 visits. R29 is on a restorative nursing ambulation program and is being walked by staff. R 46 is on a restorative nursing ambulation program and is being walked by staff. R 38 was evaluated by Physical Therapy on 10-31-16 and is currently being treated by Physical Therapy. 2. All residents dependent of staff for activities participation and need assistance from staff with ambulation	

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F 280	Continued From page 37 transfers and locomotion off the unit. The MDS identified R66 enjoyed listening to music, being around animals such as pets, keeping up with the news, doing things with groups of people, participating in favorite activities and spending time outdoors. R66's Care Area Assessment (CAA), dated 1/11/16 identified R66 suffered from a traumatic brain injury, was unable to speak and make needs known and was dependent on staff for all her ADL. The CAA further identified R66 followed people with her eyes and blinked to answer yes or no questions and appeared to watch TV when it was on. R66's care plan dated 2/18/16 identified R66 was a big fan of duck Dynasty and Keeping up with the Kardashians. R66's care plan indicated she liked to browse through gossip magazines and enjoyed a good book at times. R66's care plan directed activity staff had posted a sign in her room to inform all staff that she enjoys Duck Dynasty and Keeping up with the Kardashians, activity staff were to complete 4 1:1 visits a week, and activity staff would provide gossip magazines (people, Us Weekly, Star) and would read to her during 1:1 visits and would see if she was up to enjoy story time. R66's care plan further directed R66 required a mechanical lift and 2 staff to get her up and into her wheelchair, and R66 would be wheeled to all of her destinations as desired and in a timely manner. R66's Recreation/Therapeutic Programs Assessment dated 1/4/16, identified activities staff indicated they would try to bring her to activities to let her observe and be around people, and indicated R66 was in bed a lot. The	F 280	have the potential to be affected in this area. Care plans reviewed and updated as needed. 3. Mandatory education provided to staff who develop comprehensive care planning was provided on November 16 and 17, 2016 providing education on the procedure titled, Care Plans-Comprehensive with a focus on care planning for residents dependent on staff for activities and need for a restorative nursing ambulation program. A licensed nurse to monitor restorative nursing program progress through a monthly review of residents receiving restorative care, ADL score, and decline in ADL score, and from Casper reports. 4. An audit was developed to monitor activities and restorative nursing care planning including the monitoring of resident participation and resident progress in nursing restorative ROM and splint programs. The audit will be completed by the DON or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided to the QA committee monthly x 3 months with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	

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F 280	Continued From page 38 assessment further identified R66's past interests included cards and games and plan included large group programs and entertainment, small group activities such as manicures, 1:1 programing would be needed, and R66 also enjoyed watching the birds and TV. Review of R66's activities quarterly progress note dated 7/26/16, identified R66's activity involvement was fair and participation was passive, R66 was unable to structure her time in a meaningful way. The note identified R66 watched TV on a daily basis, and sometimes watched movies. The note indicated R66 would sometimes watch the birds, but staff felt R66 would rather watch TV and R66 would have 4, 1:1 visits by staff each week. The note also indicated family visited once per week and took her outside. Review of activities quarterly progress note dated 10/11/16, identified R66's activity involvement was fair, participation level remained passive and R66 was unable to structure her time in a meaningful way. The note indicated R66 loved TV also watches movies on her personal DVD player. The note further identified R66 would have 4, 1:1 visits by activity staff each week and they would sometimes read her a book. The note also indicated family visited once per week and wheeled her around or took her outside if the weather was nice. The progress note identified R66's activity plan was appropriate, had met her goal for the last 3 months, activity interventions were effective. and no changes were recommended for R66's activity program. Review of the facility activity calendar for residents from 4/16 to 10/16 identified 4-5	F 280		

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F 280	Continued From page 39 activities per week which R66 had special interest in such as music, Bingo, movies, outside walks and manicures. Review of R66's Resident Activity Attendance Chart forms from 4/1/16 to 10/17/16 revealed R66 consistently watched TV and family visited. However, the attendance charts did not include consistent 1:1 visits, and did not consistently include attendance at either large or small group acclivities. The monthly documentation as follows: -4/16, 6 out of 16 opportunities of 1:1 visits from staff for the month, and 3 unable and 1 refused. No other documentation of large or small group activities or activities out of room -5/16, 7 out of 18 opportunities for 1:1 visits from staff for the month, 1 in family lounge, 1 in activities room, 1 mail reading, and 2 cleaning glasses. -6/16, 9 out of 16 opportunities of 1:1 visits from staff for the month, 1 mail reading,1 glider, and 4 unable. -7/16, 5 of out 18 opportunities for 1:1 visits from staff for the month, 1 special event, 1 bird watching, 2 cleaning glasses, 2 outside, 1 glider and 3 unable -8/16, 7 out of 18 opportunities for 1:1 visits for the month, 1 bird watching, 1 wheeling, 1 outside, 1 cleaning glasses, and 1 unable -9/16, 7 out of 18 opportunities for 1:1 visits for the month, 1 outside, 1 cleaning glasses, and 1 unable	F 280		

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-10/1-10/24/16, 7 out of 13 opportunities for 1:1 visits, 1 sitting in family lounge, 2 cleaning glasses, 1 outside

On 10/19/16, during observation from 7:00 a.m. to 10:03 a.m. R66's room was dark and quiet, and her bedroom door was open. R66 was observed on her back in bed, dressed in a hospital gown. R66 remained in the same position with no meaningful activity for 3 hours and 3 minutes. R66 had a monthly activities calendar posted on her closet door across from the foot of her bed, and a hand written 8.5 X 11 sign was posted on the wall across from R66's recliner and identified:

-R66 was to be changed during check ups
-No more Kardashians'!
-Family Feud on channel 11:00 a.m.
-Wheel of fortune
-Jeopardy 5:00 p.m.
-Judge Judy 9:00 a.m. & 11:00 a.m.
-get movie going early in the am or at bedtime

On 10/19/16, at 10:35 a.m. LPN-A and NA-E were in R66's room after R66 was dressed and in her recliner. LPN-A asked R66, "What are you going to watch on TV today?, I know you like those Kardashian girls." LPN-A stated she gave R66 a hard time about the Kardashians' because you never now what their gonna do on the show.

On 10/19/16, at 12:10 p.m. R66 was dressed and seated in her recliner, in front of the TV. A political type program was on TV and R66 eyes were turned away from the TV and out her bedroom window.

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On 10/20/16, at 9:42 a.m. R66 was in her bed dressed in a hospital gown. R66's TV was off, and her eyes were focused on the ceiling.

On 10/21/16, at 10:24 a.m. licensed practical nurse (LPN-A) stated R66 was totally dependent on staff for ADLs. She stated the usual routine was after R66 got up, she spent her day watching TV in her recliner.

On 10/24/16, at 10:08 a.m. activities aide (AA-A) stated R66 spent her day watching TV and would get 1:1 visits. She stated during 1:1 visits they open curtains, and sit with her talk to her about the TV shows she liked, or put a movie on. She stated she didn't know how often R66 came out of her room, and stated sometimes they had her sit at the nurses desk. She stated R66 slept a lot, and missed 1:1 visits because she was in bed and asleep. She stated activity staff tried to provide 1:1 visits on an attempt basis. She stated it was hard to provide activities for R66 because R66 required so much care, and was difficult to get up. She stated she felt R66 was probably up in her chair when family visited, and staff had tried to get her out to story time but it was too difficult.

On 10/24/16, at 10:53 a.m. clinical manager (CM-A) stated staff would get her up in her recliner and she watched the Kardashians' because they were on a lot, otherwise R66 was in bed or her Broda chair in her room the majority of the time. She confirmed R66's current care plan and stated she understood activities staff spent time with her in her room.

On 10/24/16, at 12:27 p.m. activities director (AD) stated activity staff had posted a sign in R66's

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F 280	Continued From page 42 room which told staff what TV shows R66 liked and stated R6 also had a portable DVD player in her room. AD indicated in the past activities staff had wanted to bring R66 to the Afternoon Adventure activity, which was scheduled daily during the week, but struggled to get R66 to attend because she was not in her chair. She stated R66 used to get her nails done but activity staff struggled with finding staff to get her up in her wheelchair to attend the activity. She stated she would like R66 to attend music programs but it was such a hassle to find staff to get her up in her wheelchair, and R66 was usually in her bed or recliner. AD confirmed R66's care plan and stated her care plan could be updated. She stated her care plan was TV focused and the portable DVD player also. AD confirmed R66's activity records and stated R66 mostly watched TV. She confirmed the sign posted in room and R66's care plan had not been updated with current information. R29 R29's Order Summary form dated 9/16/16, identified R29 had diagnoses which included muscle weakness, malaise, and psychosis.	F 280		

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F 280	Continued From page 43 R29's admission Minimum Data Set (MDS) dated 7/14/16, identified R29 had severe cognitive impairment, and required extensive assistance for bed mobility, transfer, locomotion on and off of the unit, dressing and hygiene. The MDS identified ambulation did not occur for R29 during the assessment period. R29's admission CAA dated 7/14/16, identified R29 had dementia, both short term and long term memory problems, and had poor balance which appeared related to decreased weight bearing status related to fall prior to admission. R29's current care plan revised 10/14/16, revealed R29 had an unsteady gait, used a walker with assist of one and assist with ambulation, toileting, and mobility as needed. R29's care plan directed assist of one with front wheeled walker and wheelchair for ambulation. On 10/19/2016, at 8:46 a.m. R29 was seated in her wheelchair, at a table in the dining room. R29 propelled herself with her feet, from the dining room towards her room. On 10/19/2016, at 9:02 a.m. R29 self propelled her wheelchair with her feet in the hall. R29 asked staff directions to her room and then continued to self propel down the hall. On 10/19/2016, at 10:30 a.m. licensed practical nurse (LPN)-C ambulated R29 past the nurses desk with a front wheeled walker and a gait belt around R29's waist. On 10/24/2016, at 9:57 a.m. R29 propelled her wheelchair in the hall with her feet. The facility form titled Resident Referral, Interdepartmental Communication dated 8/4/16,	F 280		

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to nursing from physical therapy directed R29 receive the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (contact guard assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps."

R29's progress notes were reviewed 6/30/16, through 10/23/16, the notes identified R29 had received therapy for strengthening; however did not note that resident had received the referral for nursing staff to ambulate resident two times a day, nor was there documentation that R29 had received ambulation services with floor staff.

R29 did not have a ambulation program sheet in the nursing assistant maintenance book.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had serious concerns with residents ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis. PTA stated residents such as R29 did not routinely receive their ambulation programs.
On 10/24/2016, at 10:14 a.m. NA-I indicated R29 was not on a walking program. NA-I indicated R29 would self transfer and staff would walk with her in her room to the bathroom.

On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program.

On 10/24/2016, at 10:32 a.m. physical therapy assistant (PTA)-G indicated residnets who had

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reached their goal in therapy were discontinued from therapy services and then continue with a ambulation or lower extremity exercise program to be completed by the nursing assistants in order to maintain the progress which was made in therapy. PTA-G verified R29 was discharged from therapy in August of 2016, and should be currently walking two times a day up to 150 feet. PTA-G indicated ambulation into the bathroom would not be enough steps to be considered a walking program.

On 10/24/16, at 10:52 a.m. the clinical manager (CM)-B indicated R29 had an ambulation program for one staff to walk the full length of the hallway with use of a gait belt and a walker. CM-B was unaware how often R29 ambulated. CM-B verified R29's Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (care giver assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps." CM-B verified R29 did not have a form which directed the ambulation program in the NA maintenance book. CM-B verified the NA group sheet was part of R29's current care plan and the group sheet did indicate R29 was to receive assistance with ambulation two times a day with CGA of one and a FWW. CM-B indicated without documentation or observations of R29's ambulation with staff , she was unaware if R29 had received the referred ambulation program two times a day up to 150 feet.

R46

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On 10/24/2016, at 11:00 p.m. R46 was laying on top of her bed on her right side, covered with two small blankets, the call light was secured to the grab bar attached to the side of the bed, and a wheel chair was approximately 3 feet from the bed in which R46 lay.

R46's physicians orders dated 9/20/16, identified diagnoses included muscle weakness, syncope and collapse.

R46's quarterly Minimum Data Set (MDS) dated 8/11/16, identified R46 had intact cognition, and required extensive assistance for transfer, locomotion on and off of the unit, dressing and toilet use, limited assistance for bed mobility and personal hygiene. The MDS identified ambulation did not occur for R46 during the assessment period.

R46's Care Area Assessment (CAAS) dated 11/9/15, included: Cognitive Patterns- intact. Functional status: Activities of daily living status- limited assistance of one staff for transfers, limited assistance of staff to ambulate in room, ambulation in corridor did not occur.

The facility form titled Resident Referral, Interdepartmental Communication dated 11/6/15, to nursing from physical therapy directed R46 receive the following: "Please ambulate Pt (patient) with RW (regular walker), transfer belt, and 1 A (assist) 2 X (times) daily. Pt. amb. (ambulate) up to 200' any ? (questions) call."

R46's current care plan revised 8/22/16, revieled R46 had an unsteady gait and weakness, SBA (stand by assist) of one for transfer and with

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walker.

R46's progress notes were reviewed 4/3/16, through 10/1/16, did not note that R46 had received ambulation services with floor staff.

R46 did not have a ambulation program sheet in the nursing assistant maintenance book.

On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program. NA-E stated R29 could pivot transfer and take a couple steps but not walk any distance.

On 10/24/2016, at 10:32 a.m. physical therapy assistant (PTA)-G indicated residnets who had reached their goal in therapy were discontinued from therapy services and then continued with a ambulation or lower extremity exercise program to be completed by the nursing assistants in order to maintain the progress which was made in therapy. PTA-G verified R46 had been discharged from therapy and should be currently walking two times a day up to 200 feet or as far as R46 tolerated. PTA-G indicated she would expect staff to be walking with R46 in the hall and the program should continue unless the resident had a decline, hospitalization or pain. PTA-G indicated if a decline were to occur the resident should then be re-screened. PTA-G indicated ambulation into the bathroom would not be enough steps to be considered a walking program.

On 10/24/16, at 10:52 a.m. the clinical manager (CM)-B indicated she had never seen R46 ambulate. CM-B indicated when a referral from therapy was received for an ambulation program or other exercise program it would be written on a

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form for the nursing assistants(NA) in the NA maintenance book. CM-B verified R46's Resident Referral, Interdepartmental Communication dated 11/6/15, to nursing from physical therapy directed the following: "Please ambulate Pt (patient) with RW (regular walker), transfer belt, and 1 A (assist) 2 X (times) daily. Pt. amb. (ambulate) up to 200' any ? (questions) call." CM-B verified R46 did not have a form which directed the ambulation program in the NA maintenance book. With review of R46's chart, CM-B verified the ambulation program had been in place for the months of December 2015, April, May, June and July 2016, but no further ambulation program documentation was found. The CM-B verified R46's ambulation program was not currently being performed.

On 10/24/16, at 11:11 a.m. R46 verified the nursing staff did not walk with her in the hall and had not asked her to walk with them. While walking with the use of a walker, gait belt and PTA-G, R46 stated," I can feel I have not walked in a while, I can feel it in my arms." R46 walked approximately 8 feet, stopped and requested to stop a while to rest her arms. After resting a few minutes, R46 continued to walk with PTA-G back to her room. R46 was breathing heavily when she reached her room.

On 10/24/16, at 11:24 a.m. a follow up interview with R46 identified she was aware she should walk more; however, believed the facility staff were very busy and she required a lot of assistance and took a lot of the staffs time.

On 10/24/16, at 2:00 p.m. physician assistant (PA)-A indicated she would expect facility staff to follow resident care plans and to initiate

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F 280	Continued From page 49 recommended walking or exercise programs to prevent resident functional decline and a decline in the residnets quality of life. PA-A stated, " Sadly not providing recommended restorative exercises is not uncommon here." R38's significant change Minimum Data Set (MDS) 9/26/16, identified R38 had moderate cognitive impairment and had diagnoses which included degenerative joint disease, weakness and back pain. The MDS identified R38 was independent in bed mobility, transfers and used a wheelchair independently for locomotion. Further, the MDS identified activity did not occur for turning around and facing opposite direction while walking and R38 did not walk. R38's ADL Care Area Assessment (CAA) dated 9/26/16, indicated R38 had improved ADL performance and would be addressed on care plan. The CAA did not address R38's ambulation. R38's admission MDS dated 5/24/16, identified R38 was not steady, only able to stabilize with human assistance for walking and turning around and facing opposite direction while walking. The identified R38 had ambulated with limited	F 280		

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F 280	Continued From page 50 assistance from staff. R38's ADL CAA dated 5/24/16, identified R38 required assistance from staff to safely ambulate and transfer. The CAA revealed R38 was receiving therapies and her goal was to return to independence in hopes of returning home. R38's Behavioral CAA dated 5/24/16, identified R38's goal was to cooperative with therapies in order to return home. R38's current care plan updated 6/10/16, indicated she was fully ambulatory with a walker and contact guard assistance. R38's care plan also indicated R38 was receiving therapy and assist to transfer with one and gait belt, and R38 wheeled self independently in wheelchair. R38's care plan did not identify any updates past 6/10/16. Review of the Aide Care Plan Group C form, dated 10/17/16, listed various interventions which included R38 was assist of one for transfers, toileting and ADL's, and listed R38 received therapy for walking. The form did not list any other interventions for R38's ambulation. On 10/18/16, at 1:36 p.m. R38 was observed in the facility hallway, seated in a wheelchair, propelling herself to the activity room with both feet. R38 propelled herself up to a squared table, opened the daily newspaper and began to read the paper. On 10/20/16, at 1:38 p.m. R38 indicated she had wheeled herself into the bathroom and slid herself	F 280		

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to the toilet seat to use the toilet. She stated she was able to complete most cares for herself and liked to be as independent as possible. R38 proceeded to propel herself out of her room, utilizing both feet to the activity room to attend an activity. At 3:08 p.m. R38 was seated in her wheelchair in the activity room actively participating in Bingo. R38 was not observed to ambulate at any time during observations.

On 10/20/16, at 1:57 p.m. nursing assistant (NA)-F stated R38 used a wheelchair for mobility and was able to propel herself to and from destinations. NA-F stated R38 was independent with all of her personal cares and liked to maintain her independence. NA-F stated she did not think R38 was able to walk and had never assisted R38 to ambulate. NA-F stated the nursing assistants were responsible to ambulate residents who were on an ambulation program and stated she did not think R38 was on an ambulation program in the facility.

On 10/20/16, at 2:30 p.m. NA-B stated she had not assisted R38 with ambulation at any time in the past. NA-B stated the NA on the individual units were responsible for residents walking programs, after the program had been determined by occupational (OT) and physical therapies (PT). NA-B stated R38 had received both PT and OT upon admission for a few months and indicated she was unsure if R38 had been placed on the ambulation program. NA-B stated she felt R38 was unable to fully stand nor could R38 ambulate. NA-B stated the NA on the unit often times could not assist residents with their ambulation programs due to not enough NAs on the floor.

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On 10/20/16, at 3:18 p.m. licensed practical nurse (LPN)-B stated the NAs on the units were responsible to ambulate with residents who had ambulation programs in the facility. LPN-B stated she was unsure if R38 was on an ambulation program at present and after review of R38's clinical record, confirmed R38 had a referral from PT and OT dated 7/8/16, which directed R38 was to be assisted with ambulation twice daily with a walker and one-person assistance up to 40 feet. LPN-B stated she did not think R38 had been assisted to ambulate since therapy ended.

On 10/21/16, at 10:35 a.m. registered nurse (RN)-A stated she was unaware if R38 was on an ambulation program and indicated she had not seen R38 ambulate with staff in the past.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated R38 had received both physical and occupational therapy upon admission to the facility in May of 2016. PTA stated R38 was discontinued from both therapies in July 2016, with a referral to nursing for R38 to be placed on an ambulation program with nursing staff. PTA stated R38 was able to ambulate with one assist and a front wheeled walker up to 40 feet consistently, when PT and OT were stopped. PTA stated she had serious concerns with residents' ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis.

On 10/21/16, at 11:30 a.m. R38 stated she was no longer able to walk and used a wheelchair to move about the facility. R38 stated she had been walking when she was admitted to the facility and

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had worked with therapy for her walking. R38 stated nursing staff had not assisted with her ambulation since therapy had stopped several months ago. R38 stated she had bad knees which affected her ability to walk, but felt if she had some "treatments" she would be able to walk again with help.

On 10/21/16, at 11:36 a.m. PTA entered R38's room, and looked in her closet and various locations in her room for her walker. PTA stated R38 no longer had a walker in her room and stated she would expect R38 to have a walker available so nursing staff could assist her to walk. PTA left R38's room briefly, returned with a front wheeled walker and placed the walker in front of R38. PTA applied a transfer belt around R38's torso and cued R38 to stand from her wheelchair up to the walker while PTA pulled upwards on the gait belt. R38 was only able to lift her buttocks from the wheelchair seat approximately 7 inches. R38's knees remained bent at approximately an 80 degree angle, was unable to stand fully erect or straighten her knees. PTA attempted to stand R38 twice more and R38 continued to not able to stand erect or straighten her knees. R38 stated she could not stand up all of the way and had not stood up for a long time. R38 stated she could not remember the last time she had used a walker. PTA asked R38 when the last time she had walked and R38 responded, "with you." PTA confirmed the last time she had worked with R38 was in July, 2016. PTA confirmed R38 had lost the ability to fully stand and to ambulate.

On 10/21/16, at 11:44 a.m. during a follow up interview, PTA stated when R38 was discharged from therapy, R38 had been ambulating about 40-60 feet daily with minimal assist of one and a

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front wheeled walker. PTA stated R38 was referred to an ambulation maintenance program and she would have expected R38 to receive assistance with walking with nursing staff twice daily. PTA stated she felt the facility had a huge problem with the facility's ambulation/maintenance program due to staffing concerns and stated she felt there were not enough NAs to complete resident ambulation/maintenance programs.

Review of R38's hospital discharge summary dated 5/17/16, identified R38 had been treated for weakness and falls at home. The summary revealed R38 was having difficulty standing and walking. The summary further revealed R38 was sent to the facility for acute rehab due to lower extremity weakness.

Review of R38's physician progress note dated 8/2/16, revealed R38's primary medical doctor (MD) had seen her at the clinic. The note also revealed R38 had plateau in therapy, however, was ambulating using a walker. The note further revealed R38's daughter had concerns that R38 had exhibited regression after therapy was ended.

Review of R38's physician progress note dated 10/6/16, revealed R38 had established care with another practitioner. The note revealed R38 used a wheelchair for long distances, had received PT and OT during the spring and summer, and at that time due to increased care needs R38 was determined to be a long term patient.

Review of a facility form titled, Resident Referral Interdepartmental Communication dated 7/8/16, revealed therapy had referred R38 to nursing for

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a ambulation program to include ambulation twice daily with front walker and one assistance up to 40 feet. The form also identified R38 has complained of left knee pain and if nursing had any questions to call.

Review of R38's medical record revealed the record lacked further documentation of R38's ambulation status or progress and lacked documentation of facility forms maintenance ADL worksheets.

Nursing progress notes were reviewed from 5/17/16, to 10/18/16, revealed the following:

On 5/17/16, R38 was full weight bearing and required one assistance with ADL's.

On 6/10/16, the note indicated R38 was working with therapy.

On 6/11/16, R38 questioned nursing staff on when she would be able to return home.

On 8/4/16, R38 required one assist with ADL's.

R38's nursing progress notes lacked any documentation of R38's ambulation and decline in R38's ambulation status.

On 10/21/16, at 1:37 p.m. the assistant director of nursing (ADON) confirmed R38's ambulation/maintenance program had never been implemented in July. ADON confirmed R38's referral for ambulation maintenance program directed staff to ambulate with R38 with a front wheeled walker up to 40 feet twice daily. ADON stated she would expect R38's ambulation program to be implemented to maintain and

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F 280	Continued From page 56 prevent further decline her ambulation. On 10/24/16, at 9:27 a.m. nurse manager (NM)-A stated she had understood the nursing assistants had been assisting R38 with ambulation. NM-A stated she was not aware R38 could not longer ambulate. NM-A stated she was not sure why R38's ambulation/maintenance program had not been started. A facility policy titled, Restorative Program, dated 4/1/08 identified residents would be assessed on admission for a restorative program such as ambulation. If a ambulation program was an identified need, a plan would be individualized to meet resident needs and goals. The policy further identified residents would be supported and their highest level of functioning maintained. Review of facility policy, Care Plans-Comprehensive, dated 4/1/08 identified the facility would revise the resident's comprehensive care plan to meet the resident's mental and psychosocial needs as identified by comprehensive assessment.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in 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 resident care	F 282	F 282 Services provided by qualified person/per care plan	12/14/16

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F 282	Continued From page 57 plan interventions were implemented for bathing preferences for 1 of 3 residents (R61) reviewed for choices, ambulation programs were implemented and routinely followed for 1 of 4 residents (R44) reviewed for ambulation. In addition the facility failed to ensure resident care plan interventions were implemented for assessed repostitioning, personal cares needs for 1 of 1 resident (R18) reveiwed for urinary incontinence and for repositioning for 2 of 2 residents (R18, R66) at risk for development of pressure ulcers. . Findings include: Bathing Preferences: Review of R61's current care plan revised 1/27/16, revealed R61 required assistance of one with bathing. Review of nursing assistant care sheet provided by the facility, dated 10/17/16, directed staff to assist R61 with a bath 3 times a week, Monday, Wednesday and Fridays. On 10/19/16, at 1:26 p.m. R61 stated she had not received her bath on Monday 10/17/16, due to not enough staff on the floor. R61 stated she had been told the staff would try to help her with bathing on 10/18/16, though due to not enough staff on the floor, she had not received assistance with a bath. R61 stated the nursing assistants (NA) do not have enough time during the day to give baths, so she had changed to before bed. R61 stated she was scheduled to have 3 baths a week, Monday, Wednesday and Fridays and was still not able to get 3 baths a week due to not enough staff on the floor. R61 stated it had been	F 282	1. R 61 is being bathed according to her preference; R61 s bath schedule and care plan have been updated. Resident R44 continues on a restorative ambulation program. R 18 will be reassessed through a 3 day Bowel and Bladder Assessment to assess for incontinence patterns and assessed through a tissue tolerance test; R18 s care plans will be updated to include a turning and repositioning program in accordance with assessment findings. R66 will be assessed for tissue tolerance with update to turning and repositioning care plan according to tissue tolerance test findings. R 66 has been re-evaluated by therapy; therapy recommendations for ROM and splinting of upper extremities is being followed by nursing staff. 2. All resident have the potential to be at risk. A list of residents with a BIMS score of 12 or greater will be generated and each resident will be interviewed for bath preference including timing and frequency. All residents needing assistance with ambulation and have had a fall in the past 30 days will be reviewed for the need for a restorative ambulation program and care plans will be updated accordingly. A list of residents coded on the MDS as having a current pressure ulcer will assessed for appropriate turning and repositioning interventions and care plans updated. A list of residents currently wearing splints will be generated and care plans updated as needed. Residents who	

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"months" since she had received 3 baths a week, and indicated she understood it was due to the lack of nursing staff.

On 10/20/16, at 1:52 a.m. NA-F stated she understood R61 was supposed to receive 2 baths a week in the evenings and was not sure if R61 received her baths routinely.

On 10/21/16, at 11:02 a.m. ADON indicated she had met with R61 on 10/20/16 and confirmed R61 had not been routinely receiving her 3 baths a week as care planned.

On 10/21/16, at 1:37 p.m. during a follow up interview, ADON stated she felt staff were unable to routinely complete the number of baths based on residents preference, such as R61, due to staffing shortages.

On 10/24/16, at 9:31 a.m. nurse manager (NM)-A stated she was unaware R61's baths were not getting done 3 times a week. She stated R61's care plan should be followed.

Ambulation
Review of R44's current care plan updated 9/25/15, revealed R44 was independent with mobility in a wheelchair and required assistance with ambulation with use of a walker. R44's care plan directed staff to offer to walk with R44 to all meals.

Review of Aide Care Plan Group C form, dated 10/17/16, listed various interventions which included R44 was assist one for ADL's and directed staff to assist R44 with ambulation twice daily to 200 feet, with a rear wheeled walker and transfer belt.

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have incontinence will be check for proper incontinence care and care plans updated as needed.

3. Mandatory nursing staff education was provided on November 16 and 17, 2016 on the procedure titled, Restorative Nursing: Goals and Needs Assessment with a focus on the need for the facility to provide restorative nursing in the form of Turning and Repositioning, ROM, Splinting, and ambulation; restorative nursing documentation will be on the Maintenance Therapy Flowsheet . Residents totally incont. of bowel or bladder need to be checked and changed every two hours or according to their tissue tolerance assessment and care plan.

4. An audit was developed to monitor resident bathing choices through observation and chart review. Care plans will be updated to include bathing preference and frequency. Audit to be observational monitoring of staff performing restorative nursing programs including ambulation, ROM, and splitting and care plans have been updated. A (PIP) performance improvement project for restorative nursing programs and care planning has been started and all current residents receiving restorative interventions will be reviewed for progress. All other residents will be review for change in ADL score or decline in ADL s monthly. All residents on restorative programs will be reviewed monthly and determine if the residents

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F 282	Continued From page 59 On 10/19/16, at 8:16 a.m. R44 was seated in a standard wheelchair, propelling herself into the dining room and wheeled herself up to a circular table. R44 verbalized her breakfast order, obtained her food and ate independently. At 8:34 a.m. R44 had eaten 100% of her meal and at that time propelled herself out of the dining room. Review of a facility form titled Maintenance ADL Worksheet from April 2016, to October 2016, identified R44's was on an ambulation program twice a day (BID) long distances in the hallways with a walker and transfer belt. The worksheet also indicated R44 was to be assisted to ambulate up to 200 feet (ft.) R44's worksheets revealed the following: - Review of R44's April 2016, worksheet identified R44 had received her ambulation program 16 out of 31 days in the am hours and 25 out of 31 days in the pm hours. -Review of R44's May 21016, worksheet identified R44 had received her ambulation program 13 out of 31 days in the am and 20 days out of 31 in the pm. -Review of R44's June 2016, worksheet identified R44 had received her ambulation program 8 out of 30 days in the am and 24 out of 30 days in the pm. -Review of R44's July 2016, worksheet identified R44 had received her ambulation program 7 out of 30 days in the am and 12 out of 30 days in the pm. -Review of R44's August 2016, worksheet	F 282	has have met their goals. New referrals form therapy are reviewed weekly to ensure compliance in program participation and documentation by staff. Residents with pressure ulcers will be monitored through observations for timely turning and repositioning. Residents that fall have appropriate fall risk assessments and post fall analyses completed with current interventions listed on an updated care plan. Residents who are receiving assistance with urinary incontinence will be reviewed for a timely check and changing program. Residents with physician orders for splints will be audited for orders, documentation of application and removal of splints and accuracy of care plan. The audit will be completed by the DON, or designee, weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	

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identified R44 had received her ambulation program 8 out of 31 days in the am and pm.

-Review of R44's September 2016, worksheet identified R44 had received her ambulation program 11 days out of 30 in the am and 8 days out of 30 in the pm.

-Review of R44's October 2016, worksheet identified R44 had received her ambulation program 2 days out of 17 in the the am and 0 days out of 17 in the pm.

Review of an Occupational Therapy (OT) assessment dated 3/12/15, revealed R44 was discharged from therapy services and had been placed on the nursing gait list (ambulation program) and was to ambulate with a front wheeled walker with stand by assistance.

On 10/20/16, at 1:59 p.m. nursing assistant (NA)-F stated R44 was able to complete most cares on her own. NA-F stated R44 required assistance to ambulate in the hallways and was on an ambulation program for twice a day in the am and in the pm. NA-F stated there were days when R44 was not assisted to ambulate due to not enough nursing staff on the floor.

On 10/20/16, at 2:34 p.m. NA-B stated R44 required limited assistance with ADL's of dressing and ambulation. NA-B stated R44 was on an ambulation program for twice a day. NA-B stated residents ambulation/maintenance programs were not getting done as they should due to not enough staff and this included R44.

On 10/20/16, at 3:24 p.m. licensed practical nurse

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(LPN)-B stated R44 was on a ambulation program for twice a day in the am and pm. LPN-B stated R44 liked to walk and felt the times R44 was not assisted with ambulation was due to not enough staff on the floor.

On 10/21/16, at 10:08 a.m. R44 stated she was on a walking program which she was supposed to walk twice a day. R44 stated she used to walk up to 3 times a day and stated she was lucky if she was walked once a day. R44 stated the staff had told her they were too busy on the days she did not receive her ambulation program. R44 stated that had been happening routinely for the last several months. R44 stated she was able to walk around the entire block (200 feet square perimeter around the nursing station,) but at the time would get a bit winded due to not walking like she should. R44 stated she felt as though she was not as steady on her legs as she used to be. R44 stated she feared she would lose her ability to walk if she did not continue with her ambulation program of twice a day.

On 10/21/16, at 10:18 a.m. registered nurse (RN)-A confirmed R44 was on an ambulation program twice daily to 200 feet with assist of one, walker and gait belt. RN-A did not comment if R44 was routinely receiving her ambulation program and stated R44 would be best person to answer the question.

On 10/21/16, at 10:38 a.m. certified occupational therapy assistant (COTA) confirmed R44 had been referred to nursing for an ambulation program last year and was to be ambulated twice daily to 200 feet with one assist, gait belt and walker.

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F 282	Continued From page 62 On 10/21/16, at 11:13 a.m. assistant director of nursing (ADON) confirmed R44 was not consistently receiving her ambulation program. ADON stated she expected staff to routinely complete ambulation/maintenance programs for resident. Repositioning/personal cares: Review of R18's current care plan last updated 10/7/16, revealed R18 had severe cognitive loss, was unable to communicate her needs and was totally dependent on staff for toileting, repositioning needs and was frequently incontinent of bowel and bladder and wore an incontinent brief . The care plan listed interventions which included to assist R18 to turn and reposition every 2 hours and prn, keep skin	F 282		

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clean and dry and a gel cushion in the wheelchair. The care plan directed staff check and change R18 every 2 hours for incontinence with repositioning.

On 10/19/16, from 7:03 a.m. to 10:39 a.m., continuous observations of R18 revealed the following:

On 10/19/16, at 7:03 a.m. R18 was seated in a gel cushioned wheelchair, fully dressed in her room. R18's bed was stripped of its linens which were balled into a bundle on her bed. R18's head was hung forward in a chin to chest position and her eyes were closed.

-at 7:38 a.m. the call light to R18's room was on by R18's roommate, staff were observed to enter the room to assist R18's roommate. At that time, housekeeping staff entered R18's room and made R18's bed while she remained seated in the wheelchair. At 7:41 a.m. the housekeeping staff member wheeled R18 to the dining room. R18 had remained with her eyes closed and her head was in a chin to chest position. Housekeeping staff wheeled R18 to a table in the dining room and placed a clothing protector around her neck, at that time R18 covered her face with the clothing protector.

-at 7:56 a.m. R18 remained seated in the wheelchair in the dining room. A dietary aid (DA)brought R18 her breakfast plate, left the plate on the table in front of her and walked away. At that time nursing assistant (NA)-G approached R18, placed a hand on her shoulder and verbally prompted her to wake up. R18 opened her eyes and NA-G verbally prompted R18 to begin eating and handed her a spoon.

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R18 ate 100% of her breakfast foods independently while seated in the wheelchair. R18 remained seated in the wheelchair at the table

-at 8:46 a.m. R18 remained seated in her wheelchair at the dining room table, had made no attempt to leave from the table. R18 had completed her meal, had a glass of milk orange juice and water in front of her though made no attempt to reach for them. R18 held onto her spoon, and would repeatedly run the spoon over the lipped edge of her plate, periodically licking her spoon.

-at 9:01 a.m. R18 remained seated in her wheelchair in the dining room, having made no attempts to leave the table. NA-H approached R18 and asked how her day was, R18 did not respond, NA-H walked away. R18 continued to repeatedly run her spoon around the lipped edge of the plate, while she periodically licked her spoon. R18 had made no attempts to drink her fluids.

-at 9:18 a.m. R18 remained seated in her wheelchair in the dining room. R18 had set the spoon on the table, and had closed her eyes. Shortly after R18's head dropped forward in a chin to chest position. No staff had offered to assist R18 with repositioning.

-at 9:30 a.m. R18 remained seated in her wheelchair in the dining room. R18 had opened her eyes, looked around, took her clothing protector and covered her face it. R18 made no attempt to move away from the table and held her

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F 282	Continued From page 65 face covered with the clothing protector. -at 9:37 a.m. NA-D entered the dining room, awoke R18 and offered R18 her fluids. R18 awake, removed the clothing protector from her face and allowed NA-D to assist her to drink her juice. R18 drank 50% of her juice. NA-D then handed R18 her glass of water and R18 independently drank the water. NA-D left R18 seated in her wheelchair and exited the dining room. NA-D was not observed to offer R18 assistance with cares, repositioning or toileting needs. -at 9:42 a.m. NA-H approached R18 and assisted her to drink her remaining fluids, while R18 remained seated in her wheelchair. NA-H removed the clothing protector from R18's neck, R18 then took her shirt and covered her face with it, in a cradling position. -at 9:50 a.m. NA-H assisted R18 out of the dining room while seated in her wheelchair, brought her to her room and handed R18 a stuffed bear. NA-H attached the call light to R18's wheelchair and left R18's room. NA-H was not observed to offer R18 with any cares, including repositioning or toileting. -at 10:01 a.m. NA-D was observed to walk past R18's room, did not look in or stop in R18's room. -at 10:09 a.m. NA-E exited a room across the hallway from R18's room, briefly looked into R18's room and immediately walked away down the hallway. -at 10:39 a.m. assistant director of nursing (ADON) was notified R18 had remained seated in	F 282		

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her wheelchair for an observed 3 hours and 36 minutes. At that time the ADON confirmed R18 required assistance with repositioning and checking and changing every 2 hours. ADON confirmed R18 was at risk for skin breakdown. ADON went to R18's room while requesting assistance from other nursing staff via walkies talkie.

-at 10:39 a.m. NA-E entered R18's room and asked R18 to use the bathroom. NA-E donned a gait belt across R18's torso, NA-E and ADON assisted R18 to stand from the wheelchair, ambulate to the bathroom and removed R18's slacks and incontinent brief. R18 had a moderate amount of urine in her brief as well as a small amount of bowel. ADON confirmed R18's entire buttocks surface which had contact with the brief had deep blush pink creases and was moist surrounding her peri-rectal area, though was blanchable. NA-E and ADON assisted R18 to complete toileting needs and assisted R18 to sit back in her wheelchair.

R18 had remained in a seated position for a total of 3 hours and 36 minutes, during that time no staff were observed to offer R18 assistance with repositioning.

On 10/19/16, at 10:39 a.m. NA-E stated she thought R18 was last repositioned around 6:45 a.m. and had stated she had been too busy helping others with cares to assist R18 with repositioning and toileting needs. NA-E stated R18 was supposed to be repositioned and checked and changed every 2 hours and as needed. NA-E stated R18 was not able to verbalize hers and staff needed to anticipate R18's needs.

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On 10/20/16. at 2:36 p.m. NA-B stated R18 needs must be anticipated and was totally dependent on 2 staff for her needs, including repositioning and toileting. NA-B stated R18 required routine every 2 hour repositioning and toileting. NA-B stated R18's buttocks would get red at times, but could not recall any recent open areas on R18's buttocks.

On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff of for all of her needs. LPN-B stated R18 was at risk for skin breakdown due to incontinence and immobility.

On 10/21/16, at 1:37 p.m. during a follow up interview ADON stated she felt staff were unable to routinely repositioning and toilet residents in a timely manner, such as R18, due to staffing shortages. ADON stated they were not always able to fill in for sick calls and there were times when the facility were unable to fill holes in the schedule.

Hand splints

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R66's care plan dated 2/18/16, identified R66 was aphasic (non verbal) due to traumatic brain injury, and was unable to make her needs known. R66's care plan also identified R66 was to wear hand splints for 2 hours on and 2 hours off during the day, and was to wear the splints all night. R66's care plan failed to identify R66 had contractures, and did not identify a ROM or a restorative nursing program for R66 to prevent further decline.

Review of the Aide Care Plan, Group B dated 10/17/16, identified R66 required total assistance with cares and was to wear hand splints on and off every 2 hours during the day and leave them on all night. The Aide Care Plan did not identify R66 had contractures or that she required a ROM or restorative nursing program to prevent further decline.

On 10/19/16, observations from 7:00 a.m. to 9:47 a.m. were conducted:

-At 7:00 a.m., R66 was observed lying on her back in bed, with her eyes closed. Both R66's arms were bent at the elbow, her right hand was in a fist position on her chest, and her left hand was in a "C" shaped position with fingers bent and hand slightly tilted away from her body. Splint devices were not observed on either of R66's hands, and the splint devices were not observed in her room.

-7:49 a.m. licensed practical nurse (LPN)-A entered R66's room to provide her trachea (artificial opening at windpipe) site care. She confirmed R66 was not wearing hand splints and stated R66 had not been wearing them in the

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F 282	Continued From page 69 recent past because she thought the splints were uncomfortable for R66. LPN-A exited R66's room and did not apply R66's hand splints. -8:03 a.m. the nurse consultant walked in R66's room and immediately walked down to the nurses station. R66 remained on her back in bed, with her hands and arms in the same positron, no splints observed. -8:20 a.m. R66 remained lying in bed in the same position with R66's arms bent at her elbows and her hands rested on her chest in the same position. No hand splints were observed on R66's hands and splints were not observed in R66's room. -9:47 a.m. R66 remained in the same position in bed, no hand splints were observed on R66 or present in R66's room. On 10/19/16, at 10:03 a.m. LPN-A confirmed R66 had not worn hand splints and stated R66 did not wear the splints "at all." She stated she was not aware when R66 last had worn the splints and indicated she thought it had been in the distant past. LPN-A left room and did not apply hand splints to R66. On 10/19/16, at 10:33 am nursing assistant (NA)-E confirmed R66 did not routinely wear hand splints, and stated she could not remember the last time R66 had worn her splints. NA-E provided a copy of the a NA care sheet and confirmed the care sheet directed for R66 to wear hand splints. She stated she had not been aware R66 was to wear hand splints. NA-A and LPN-A exited R66's room and did not apply her hand splints.	F 282		

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On 10/19/16, at 10:40 a.m. NA-D stated she was not aware of how R66's care plan directed her to care for R66. She stated she was not aware if R66 had hand splints or if R66 was supposed to wear them.

On 10/19/16, at 12:10 p.m. R66 was seated in her recliner in her room with both hands resting on her chest, right hand in fist, left hand curled in a "C" shape. R66 did not have hand splints on either hand.

On 10/20/16, at 9:30 a.m., during follow up interview, NA-B stated R66 presently did not receive range of motion services or presently was not receiving a restorative nursing program.

On 10/20/16, at 9:45 a.m. assistant director of nursing stated she was not aware if R66's splints had been discontinued in the past and indicated she questioned if the splints bothered R66 and indicated she felt R66 was not anymore contracted than when she was admitted.

On 10/24/16, at 10:38 a.m. registered nurse (RN-A) stated R66 had severe cognitive impairment and was totally dependent on staff for all cares. She stated she was unaware if R66 was on a ROM program, wore her arm splints before today, or had declined in ROM to her upper extremities. She stated R66 should have received ROM and wore her arm splints according to the therapy recommendations and confirmed ROM was not on R66's care plan.

PRESSURE ULCER

R66's care plan dated 2/18/16, identified R66 was

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F 282	Continued From page 71 at risk for developing pressure ulcers related to fragile skin, not being able to turn herself, was immobile and was bed and chair bound. The care plan also identified R66 was to suspend heels off the bed or wear sheepskin boots to protect her feet, and was to be turned and repositioned according to her turning and positioning plan. The care plan further identified R66 was incontinent and was to be checked and changed every 2 hours. Review of the Aide Care Plan, Group B, dated 10/17/16, identified R66 required total assistance with cares, was to be turned and repositioned every 2 hours, and was to float heels off the bed or wear sheepskin boots. On 10/19/16, at 7:00 a.m. R66's bedroom was dark, and her door was fully open. R66 was dressed in a hospital gown, and was asleep on her back in bed. R66's arms rested on her chest and her body was covered with a blanket. R66's legs were straight, and her heels rested directly on her mattress. She was not wearing sheep skin boots. R66's sheepskin boots were observed to be piled up on R66's dresser across the room. At 7:19 a.m. R66 was in the same position in her bed, her eyes were now open, continued with loud mouth breathing and heels rested directly on the mattress and was not wearing her sheep skin boots. At 7:39 a.m. R66 was in the same position in her bed with her eyes closed. R66's heels continued to be directly on her bed and was not wearing her sheepskin boots. At 7:49 a.m. licensed practical nurse (LPN)-A entered R66's room. LPN-A stated R66's heels were not free floated and she was not wearing	F 282		

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F 282	Continued From page 72 sheep skin boots. LPN-A stated she felt R66's heels were, "kind of," floated by the bubbles in her mattress. LPN-A then pulled a flat pillow down to approximately one inch under R66's calves however it did not lift R66's heels off the mattress. LPN-A laid R66's heels directly on the bed, and immediately left the room. At 8:03 a.m. the registered nurse (RN) consultant walked in to R66's room and immediately walked out, towards the nurses station. At 8:28 a.m. R66 remained in the same position on her back, asleep. R66 remained in that position without heels floated, or sheepskin boots on until 10:05 a.m. At 10:03 a.m. LPN-A stated R66 was at risk for developing pressure ulcers. She stated she didn't think R66 had pressure ulcers in the past. LPN-A stated R66 sometimes wore her sheepskin boots and sometimes they floated R66 heels off the bed. LPN-A stated R66 had an alternating air pressure mattress and was supposed to be repositioned and checked and changed every 2 hours. LPN-A confirmed the last time R66 had been repositioned was at approximately 6:00 a.m. that morning. At 10:05 a.m. after continuous observation (3 hours and 5 minutes) LPN-A confirmed both R66's heels rested on her bed and R66 had not worn sheep skin boots. R66 heels and bottom were intact. NA-E entered R66's room and assisted LPN-A with R66's morning cares. At 10:33 a.m. NA-E stated she didn't know the last time R66 was repositioned. NA-E stated R66 was supposed to be turned and repositioned, checked and changed every 2 hours. She stated she would have to check with partner NA-D to	F 282		

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see when she repositioned R66 as they were taking care of R66 for the day. NA-E stated she felt R66 was was at risk for developing pressure ulcers, but she didn't think R66 had any skin problems. NA-E stated R66 heels could be on the bed because R66 had no breakdown at this time and had an air bed. NA-E further stated R66 didn't wear her sheep skin boots. NA-E confirmed her current care sheet did not direct the use of sheepskin boots. NA-E and LPN-A left R66's room after R66 was in her recliner with her heels floated by a pillow on the footrest of the recliner.

On 10/19/16, at 10:40 a.m. NA-D stated she didn't know if R66 was at risk for developing pressure ulcers, or what R66's care plan directed her to do for R66's skin. She stated R66 had a special mattress, and stated she assumed R66 would be at risk. NA-D stated she didn't know if R66 had a history of pressure ulcers and wasn't aware of any sheep skin boots for R66. NA-D stated she did not reposition R66 this morning, and stated she thought the last time R66 had been repositioned was at approximately 630 a.m. by the night staff.

On 10/19/16, at 12:10 p.m. R66 was seated in recliner in front of her TV. R66 did not have her heels floated on a pillow and was not wearing her sheep skin boots. R66's heels rested directly on the foot rest of her recliner.

On 10/19/16, at 1:11 p.m. R66 laid in bed on her back, legs straight out with her heels resting directly on her bed. R66 did not have her heels floated with a pillow, and was not wearing sheep skin boots.

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F 282	Continued From page 74 On 10/19/16, at 1:34 p.m. NA-B stated R66 was totally dependent on staff for cares, and stated she wasn't sure of R66's cognition. She stated she didn't think R66 was at risk for pressure ulcers, and didn't know if R66 had pressure ulcers in the past. NA-B confirmed R66's heels rested directly on her bed and she was not wearing sheepskin boots. NA-B confirmed R66's Aide Care Sheet and stated she didn't know R66 had sheepskin boots as they weren't on her sheet, but R66's heels were supposed to floated and R66 was supposed to be repositioned every 2 hours. On 10/24/16, at 10:38 a.m. registered nurse (RN)-A stated R66 was at risk for developing pressure ulcers because she couldn't reposition herself. She stated she didn't remember if R66 had ever had any skin problems. She stated R66's heels were supposed to be floated off of her bed, and the NA's were supposed reposition R66 every 2 hours. On 10/24/16, at 10:53 a.m. Unit Manager (UM-A) stated R66 had severe cognitive impairment and was dependent on staff for cares. She stated R66 was supposed to be repositioned every 2 hours, her heels were supposed to be floated off of her bed, or R66 was to wear sheepskin boots. R66 had a history of pressure ulcers. She stated she remembered R66 had a blister on her heel in February from a profo boot or splint she wore, and that's when they discontinued the boot and implemented floating R66's heels. UM-A confirmed R66's most recent care plan which directed staff to float R66's heels off the bed or wear sheep skin boots, and turn and reposition R66 every 2 hours. She stated she expected staff	F 282		

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F 282	Continued From page 75 to follow R66's care plan and float her heels or apply sheep skin boots to R66's feet, and reposition R66 every 2 hours to prevent pressure ulcers. She stated she felt nursing assistants needed more education on repositioning and floating of heels. A facility policy titled, Restorative Program, dated 4/1/08, identified residents would be assessed on admission and as needed for a restorative program including ambulation. The policy further identified residents would be supported and their highest level of functioning maintained. A facility policy titled Bowel and Bladder Management dated 4/1/08, revealed it was the facility's policy to ensure each resident with bowel or bladder incontinence would receive appropriate treatment and services to maintain normal functioning. The policy directed staff to develop an individual toileting schedule for all incontinent residents and noted on resident care plans.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure consistent	F 309	F 309 Provide care and services for highest well-being of residents	12/14/16

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F 309	Continued From page 76 implementation of routine medical treatments of blood sugar checks for 1 of 2 resident (R61) reviewed who were insulin dependent. Findings include: Review of R61's quarterly Minimum Data Set (MDS) dated 7/24/16, identified R61 was cognitively intact and had diagnoses which included, insulin dependent diabetes, congestive heart failure (CHF) and anxiety. The MDS identified R61 required extensive assistance from staff with dressing. The MDS also identified R61 received insulin injections daily. Review of R61's annual Care Area Assessment (CAA) dated 1/22/16, revealed R61 had diagnoses of depression and anxiety, was grateful for anything that was done for her and was content to stay in her room with visits from others. The CAA further revealed R61 "appeared to feel self pity in general." The CAA revealed R61 had a diagnosis of diabetes mellitus, requiring insulin and R61's blood sugars were checked 4 times a day and as needed (prn) related to erratic levels. The CAA further revealed R61 received Lantus insulin and a sliding scale insulin accordingly. Review of R61's current care plan revised 1/27/16, did not address R61's diagnosis of diabetes, blood sugar monitoring or use of insulin. On 10/19/16, at 1:08 p.m. R61 was seated in her wheelchair in her room, with a tense affect on her face (evident by, furrowed brow, tight lips, tight jaw line). R61 stated she had a horrible morning that morning. R61 stated she did not have her blood sugar checked that day until 11:30 a.m.	F 309	1. R 61 is having her blood glucose levels checked according to the physicians order. 2. All residents with a physician order for routine blood glucose monitoring have the potential to be affected in this area. A list of residents with routine blood glucose monitoring physician orders will be generated and to assess each is receiving blood glucose monitoring and documentation according to the physicians order. 3. Mandatory nursing and activity staff education was provided on November 16 and 17, 2016 educating the staff on the procedure titled, Glucometer blood Sugar Testing and Medication Administration Record with a focus on the need for licensed staff to perform blood glucose level monitoring per physician orders. 4. An audit will be developed to monitor physicians orders for blood glucose monitoring and documentation on the MAR/TAR according to physician orders. The audit will be completed by the DON, or designee, weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	

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R61 stated she felt it was important to have her blood sugar checked in the morning after sleeping all night. R61 stated she had a very low blood sugar a few times in the morning, stated it had frightened her, though it had been a long time since that had occurred. R61 stated she had worried for most of the morning and did not know whether to sit and cry or see if someone would answer her call light. R61 stated her breakfast tray had come around 9:15, so she had decided to eat just in case her blood sugar had been on the low side. R61 stated she had difficulty getting the nurses to routinely check her morning blood sugars. R61 stated she had voiced her concern during her last care conference which had been a few months ago, and had not seen an improvement. R61 stated she had been reassurance that all the nurses knew her routine for blood sugars.

Review of R61's current physician orders signed 10/6/16, revealed the following orders:

- Accu checks (blood sugar checks) 730 a.m., 11:30 a.m., 5:00 p.m., 9:00 p.m. call if blood sugar less than 100 or greater than 300 as a pattern, order was start dated 9/3/14.

- Novolog solution 100 units/ml (insulin aspart) inject per sliding scale: if 0-150 = 0 unit; 151-200 = 1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 4 units; 351-400 = 5 units; 401-500 = 6 units, > than 400 call MD, sq 3 times a say for diabetes, if blood sugar lower than 100 or greater than 300 as a pattern call MD.

- Novolog solution 100 units/ml (insulin aspart, fast acting insulin,) inject 8 units one time a day

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for diabetes.

- Lantus solution (insulin glargine, long acting insulin) inject 22 units subcutaneous (sq) one time a day related to diabetes, order was start dated 2/3/16.

- Lantus solution (insulin glargine,) inject 8 units sq at bedtime related to diabetes, order was start dated 2/3/16.

Review of R61's medication administration records (MAR) from August 2016, to October 2016, revealed the following:

-August 2016, revealed R61's 7:30 a.m. blood sugar results were blank on 7 out of 31 days 11:30 a.m. results were blank on 8 out of 31 days and 5:30 p.m. results were blank 10 out of 31 days.

- September 2016, revealed R61's 7:30 a.m. blood sugar results were blank 7 out of 30 days, 11:30 a.m. results were blank 9 out of 30 days, 5:30 p.m. results were blank 8 out of 30 days.

- October 2016, revealed R61' s 7:30 a.m. blood sugar results were blank 13 out of 21 days, 11:30 a.m. results were blank 10 out of 21 days, 5:30 p.m. results were blank 7 out of 21 days.

Review of a facility form titled, Diabetic Flow sheet dated 9/20/16, to 10/20/16, revealed R61's accu check had not been completed as scheduled on 13 out of the 30 days R61's blood sugars were recorded.

Review of R61's social service note dated 8/7/16, revealed R61 had "ruminated" about diagnoses

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and how staff changes had impacted her care regarding the timing of the med pass. The note revealed R61 had chronic temperaments and would tend to focus on medical conditions and was provided reassurance.

Review of a social service note dated 7/24/16, revealed R61 was cognitively intact and had a chronic melancholy temperament and focused on her medical issues and limitations to the exclusion of all else. The note revealed R61 had expressed distress when there was a staff change in the building, even if it did not affect her. The note further revealed R61 expressed concerns that a new staff person would not follow the routine of seasoned staff regarding medication administration. The note revealed R61 was given reassurance by the facility social worker (SW) that staff received the appropriate orientation and came with verified skill levels. The note revealed R61 had listened but not with any intent to consider the information, as she would reiterate her worry or bring up a new one. The note also revealed staff should distract R61 from her medical concerns by asking about her children.

On 10/20/16, at 9:36 a.m. licensed practical nurse (LPN)-B stated she understood R61 was supposed to have her blood sugars checked 3 times a day. LPN-B stated R61 was kind of a brittle diabetic and felt it was very important to have her blood sugars checked consistently. LPN-B stated R61 worried about her blood sugars and felt R61 would become distressed if she did not have her blood sugar done per her routine.

On 10/20/16, at 9:43 a.m. assistant director of

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nursing (ADON) stated she was not aware R61's blood sugars were not being routinely monitored on a consistent basis. The ADON stated she expected R61's physician orders to be followed as well as R61's care plan.

On 10/20/16, at 9:49 a.m. Certified Nurse Practitioner (CNP) stated she had been working with R61 for 5 years and was very familiar with R61's medical conditions including diabetes. CNP stated R61 required frequent blood sugar testing as it had been difficult to regulate her blood sugars and required insulin to maintain her blood sugars. CNP stated she expected R61's blood sugars to be consistently checked on a routine basis. CNP stated R61 had anxiety which was controlled with medication.

On 10/20/16, at 2:27 p.m. NA-B stated R61 had reported to her that her call light was not routinely answered, she did not receive her baths and her blood sugars were not being checked routinely. NA-B stated she felt R61 appeared anxious when she reported her concerns to her. NA-B stated she had reported R61's concern to a nurse about a month ago.

On 10/21/16, at 11:02 a.m. during a follow up interview, ADON confirmed R61's MAR for August, September and October had a "fair amount" of blanks in the documentation of R61's blood sugar results. ADON stated she could not say for sure R61's blood sugars had not been checked on those days, though did state if it was not documented she could not prove it was done.

On 10/24/16, at 9:31 a.m. nurse manager (NM) stated she was unaware R61's blood sugars were not routinely checked. NM stated she expected

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R61's blood sugars to be routinely checked and R61's care plan should be followed.

On 10/24/16, at 10:21 a.m. social worker (SW) stated R61 was a chronic worrier and tended to focus on her medical concerns. SW confirmed R61 had reported to her on in July and August that not all the nurses were following her routine. SW stated she did not check to see if R61's medications, treatments or care plan was being followed. SW stated R61 had reported to her at times she was afraid when new staff were working, though did not probe further. SW stated she felt it was just staff turnover that was upsetting R61 and R61 was an "anxious person." SW stated she had told R61 if she did not like how a nurse was doing something that R61 should tell that nurse she was uncomfortable. SW stated her usual practice would be to talk to the nurse regarding resident concerns with medications and treatments and thought she did. SW stated R61 tended to ruminate over things and felt R61 had an underlying mental health issue.

A facility policy titled Insulin Administration, dated April 1, 2008, revealed a facility policy which directed staff to check resident physician orders prior to insulin administration and to check blood sugars as needed or ordered.

A facility policy titled Resident Rights, dated April 1, 2008, revealed a list of resident rights which included the right to receive services in the facility with reasonable accommodation of individual needs and preferences. The policy also revealed residents right to choose activities, schedules, and health care consistent with interests, assessments and plans of care.

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F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services to prevent loss of function for 1 of 4 residents (R38) who required assistance with ambulation. R38 was not provided assistance with ambulation and was not re-assessed upon a decline in ambulation. R38's decline in the ability to ambulate resulted in actual harm. Findings include: R38's significant change Minimum Data Set (MDS) 9/26/16, identified R38 had moderate cognitive impairment and had diagnoses which included degenerative joint disease, weakness and back pain. The MDS identified R38 was independent in bed mobility, transfers and used a wheelchair independently for locomotion. Further, the MDS identified activity did not occur for turning around and facing opposite direction while walking and R38 did not walk. R38's ADL Care Area Assessment (CAA) dated 9/26/16, indicated R38 had improved ADL	F 310	F 310 ADLS do not decline unless unavoidable 1. R38 was evaluated by therapy on 10-31-16 and is currently being treated by Physical Therapy. 2. All residents that need assistance from staff with ambulation have the potential to be affected in this area and are receiving adequate assistance from staff with ambulation programs. A list of residents coded on the MDS as needing assistance from staff with ambulation and have fallen in the past 30 days will be generated and reviewed for the need for restorative programs. Care plans will be reviewed and updated as needed. A Performance improvement plan (PIP) has been created and meets at least monthly to review current restorative programs, all new referrals, and update care plans as needed. 3. Mandatory nursing staff education	12/14/16

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performance and would be addressed on care plan. The CAA did not address R38's ambulation.

R38's admission MDS dated 5/24/16, identified R38 was not steady, only able to stabilize with human assistance for walking and turning around and facing opposite direction while walking. The identified R38 had ambulated with limited assistance from staff.

R38's ADL CAA dated 5/24/16, identified R38 required assistance from staff to safely ambulate and transfer. The CAA revealed R38 was receiving therapies and her goal was to return to independence in hopes of returning home.

R38's Behavioral CAA dated 5/24/16, identified R38's goal was to cooperative with therapies in order to return home.

On 10/18/16, at 1:36 p.m. R38 was observed in the facility hallway, seated in a wheelchair, propelling herself to the activity room with both feet. R38 propelled herself up to a squared table, opened the daily newspaper and began to read the paper.

On 10/20/16, at 1:38 p.m. R38 indicated she had wheeled herself into the bathroom and slid herself to the toilet seat to use the toilet. She stated she was able to complete most cares for herself and liked to be as independent as possible. R38 proceeded to propel herself out of her room, utilizing both feet to the activity room to attend an activity. At 3:08 p.m. R38 was seated in her wheelchair in the activity room actively participating in Bingo. R38 was not observed to

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was provided on November 16 and 17, 2016 on the procedure titled, Restorative Ambulation Program with a focus on the need for residents dependent on staff for ambulation are being ambulated according to their care plan/therapy recommendations.

4. An audit was developed to monitor restorative nursing ambulation programs including care planning, participation and documentation. A monthly review of resident restorative programs will be done by a licensed nurse. The audit will be completed by the DON or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations.

5. Deficient practice will be corrected by December 14, 2016

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F 310	Continued From page 84 ambulate at any time during observations. On 10/20/16, at 1:57 p.m. nursing assistant (NA)-F stated R38 used a wheelchair for mobility and was able to propel herself to and from destinations. NA-F stated R38 was independent with all of her personal cares and liked to maintain her independence. NA-F stated she did not think R38 was able to walk and had never assisted R38 to ambulate. NA-F stated the nursing assistants were responsible to ambulate residents who were on an ambulation program and stated she did not think R38 was on an ambulation program in the facility. On 10/20/16, at 2:30 p.m. NA-B stated she had not assisted R38 with ambulation at any time in the past. NA-B stated the NA on the individual units were responsible for residents walking programs, after the program had been determined by occupational (OT) and physical therapies (PT). NA-B stated R38 had received both PT and OT upon admission for a few months and indicated she was unsure if R38 had been placed on the ambulation program. NA-B stated she felt R38 was unable to fully stand nor could R38 ambulate. NA-B stated the NA on the unit often times could not assist residents with their ambulation programs due to not enough NAs on the floor. On 10/20/16, at 3:18 p.m. licensed practical nurse (LPN)-B stated the NAs on the units were responsible to ambulate with residents who had ambulation programs in the facility. LPN-B stated she was unsure if R38 was on an ambulation program at present and after review of R38's clinical record, confirmed R38 had a referral from PT and OT dated 7/8/16, which directed R38 was	F 310		

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to be assisted with ambulation twice daily with a walker and one-person assistance up to 40 feet. LPN-B stated she did not think R38 had been assisted to ambulate since therapy ended.

On 10/21/16, at 10:35 a.m. registered nurse (RN)-A stated she was unaware if R38 was on an ambulation program and indicated she had not seen R38 ambulate with staff in the past.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated R38 had received both physical and occupational therapy upon admission to the facility in May of 2016. PTA stated R38 was discontinued from both therapies in July 2016, with a referral to nursing for R38 to be placed on an ambulation program with nursing staff. PTA stated R38 was able to ambulate with one assist and a front wheeled walker up to 40 feet consistently, when PT and OT were stopped. PTA stated she had serious concerns with residents' ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis.

On 10/21/16, at 11:30 a.m. R38 stated she was no longer able to walk and used a wheelchair to move about the facility. R38 stated she had been walking when she was admitted to the facility and had worked with therapy for her walking. R38 stated nursing staff had not assisted with her ambulation since therapy had stopped several months ago. R38 stated she had bad knees which affected her ability to walk, but felt if she had some "treatments" she would be able to walk again with help.

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F 310	Continued From page 86 On 10/21/16, at 11:36 a.m. PTA entered R38's room, and looked in her closet and various locations in her room for her walker. PTA stated R38 no longer had a walker in her room and stated she would expect R38 to have a walker available so nursing staff could assist her to walk. PTA left R38's room briefly, returned with a front wheeled walker and placed the walker in front of R38. PTA applied a transfer belt around R38's torso and cued R38 to stand from her wheelchair up to the walker while PTA pulled upwards on the gait belt. R38 was only able to lift her buttocks from the wheelchair seat approximately 7 inches. R38's knees remained bent at approximately an 80 degree angle, was unable to stand fully erect or straighten her knees. PTA attempted to stand R38 twice more and R38 continued to not able to stand erect or straighten her knees. R38 stated she could not stand up all of the way and had not stood up for a long time. R38 stated she could not remember the last time she had used a walker. PTA asked R38 when the last time she had walked and R38 responded, "with you." PTA confirmed the last time she had worked with R38 was in July, 2016. PTA confirmed R38 had lost the ability to fully stand and to ambulate. On 10/21/16, at 11:44 a.m. during a follow up interview, PTA stated when R38 was discharged from therapy, R38 had been ambulating about 40-60 feet daily with minimal assist of one and a front wheeled walker. PTA stated R38 was referred to an ambulation maintenance program and she would have expected R38 to receive assistance with walking with nursing staff twice daily. PTA stated she felt the facility had a huge problem with the facility's ambulation/maintenance program due to staffing concerns and stated she felt there were not	F 310		

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enough NAs to complete resident ambulation/maintenance programs.

Review of R38's hospital discharge summary dated 5/17/16, identified R38 had been treated for weakness and falls at home. The summary revealed R38 was having difficulty standing and walking. The summary further revealed R38 was sent to the facility for acute rehab due to lower extremity weakness.

Review of R38's physician progress note dated 8/2/16, revealed R38's primary medical doctor (MD) had seen her at the clinic. The note also revealed R38 had plateau in therapy, however, was ambulating using a walker. The note further revealed R38's daughter had concerns that R38 had exhibited regression after therapy was ended.

Review of R38's physician progress note dated 10/6/16, revealed R38 had established care with another practitioner. The note revealed R38 used a wheelchair for long distances, had received PT and OT during the spring and summer, and at that time due to increased care needs R38 was determined to be a long term patient.

R38's current care plan updated 6/10/16, indicated she was fully ambulatory with a walker and contact guard assistance. R38's care plan also indicated R38 was receiving therapy and assist to transfer with one and gait belt, and R38 wheeled self independently in wheelchair. R38's care plan did not identify any updates past 6/10/16.

Review of the Aide Care Plan Group C form,

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dated 10/17/16, listed various interventions which included R38 was assist of one for transfers, toileting and ADL's, and listed R38 received therapy for walking. The form did not list any other interventions for R38's ambulation.

Review of a facility form titled, Resident Referral Interdepartmental Communication dated 7/8/16, revealed therapy had referred R38 to nursing for a ambulation program to include ambulation twice daily with front walker and one assistance up to 40 feet. The form also identified R38 has complained of left knee pain and if nursing had any questions to call.

Review of R38's medical record revealed the record lacked further documentation of R38's ambulation status or progress and lacked documentation of facility forms maintenance ADL worksheets.

Nursing progress notes were reviewed from 5/17/16, to 10/18/16, revealed the following:

On 5/17/16, R38 was full weight bearing and required one assistance with ADL's.

On 6/10/16, the note indicated R38 was working with therapy.

On 6/11/16, R38 questioned nursing staff on when she would be able to return home.

On 8/4/16, R38 required one assist with ADL's.

R38's nursing progress notes lacked any documentation of R38's ambulation and decline in R38's ambulation status.

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F 310	Continued From page 89 On 10/21/16, at 1:37 p.m. the assistant director of nursing (ADON) confirmed R38's ambulation/maintenance program had never been implemented in July. ADON stated the nurse managers were responsible to ensure therapy referrals for ambulation/maintenance programs were started once a resident was referred. ADON stated the nurse manager was responsible to initiate a facility form titled, Maintenance Activity of Daily Living (ADL) worksheet which would direct the NA on what type of assistance with ADL the individual resident needed and the frequency of the maintenance program. ADON confirmed R38's referral for ambulation maintenance program directed staff to ambulate with R38 with a front wheeled walker up to 40 feet twice daily. ADON stated she would expect R38's ambulation program to be implemented to maintain and prevent further decline her ambulation. ADON stated she felt the facility's ambulation/maintenance program was not getting done due to staffing concerns and stated she felt the NA did not have the time to complete all residents programs, including R38. On 10/24/16, at 9:27 a.m. nurse manager (NM)-A stated she had understood the nursing assistants had been assisting R38 with ambulation. NM-A stated she was not aware R38 could not longer ambulate. NM-A stated she was not sure why R38's ambulation/maintenance program had not been started. On 10/24/16, at 9:58 a.m. R38's Advanced Practice Registered Nurse/Certified Nurse Practitioner (NP)-A stated R38 had recently established care with her in early October. NP-A stated she would expect the facility staff to follow through with therapy referrals for	F 310		

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F 310	Continued From page 90 ambulation/maintenance programs and she would have expected R38 to be assisted with ambulation per the therapy referral. NP-A stated R38's previous primary physician had last seen R38 in August and may have more to comment on R38's loss of ambulation. A message was left for R38's previous primary physician, but the physician did not call back during survey. A facility policy titled, Restorative Program, dated 4/1/08 identified residents would be assessed on admission for a restorative program such as ambulation. If a ambulation program was an identified need, a plan would be individualized to meet resident needs and goals. The policy further identified residents would be supported and their highest level of functioning maintained.	F 310		
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 consistent assistance with ambulation was provided as recommended by physical therapy (PT) for 3 of 4 residents (R44, R29, R46) who required assistance with ambulation. Findings include:	F 311	F 311 Treatment/services to improve/maintain ADLS 1. R44, R29, and R46 will continue on restorative programs according to therapy recommendations. 2. All residents that need ambulation assistance from staff have the potential to be affected in this area. A list of residents	12/14/16

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F 311	Continued From page 91 Review of R44's quarterly Minimum Data Set (MDS) dated 7/31/16, identified R44 was cognitively intact and had diagnoses which included generalized osteoarthritis, depressive disorder and anxiety. The MDS identified R44 required limited assistance to ambulate in the corridors and was independent in transfers, bed mobility and walking in her room. The MDS further identified R44 used a walker and a wheelchair for mobility. The MDS revealed R44 was steady at all times during transitions, while walking and when turning around and facing the opposite direction. Review of R44's activity of daily living (ADL) Functional/Rehabilitation Potential Care Area Assessment dated 1/29/16, identified R44 required assistance with some ADL's and was unable to ambulate any distance independently related to an unsteady gait. The CAA identified R44 ambulated with one nursing assistant (NA) a walker and a gait belt. Review of R44's Falls CAA dated 1/29/16, identified R44 had difficulty with balance upon rising from a seated position, when turning with ambulation and ambulating long distances. Review of R44's current care plan updated 9/25/15, revealed R44 was independent with mobility in a wheelchair and required assistance with ambulation with use of a walker. R44's care plan directed staff to offer to walk with R44 to all meals. Review of Aide Care Plan Group C form, dated 10/17/16, listed various interventions which included R44 was assist one for ADL's and	F 311	coded on the MDS as needing ambulation assistance from staff and have fallen in the past 30 days will be generated and reviewed to ensure they are not affected by this deficient practice. Documentation form and Care plans updated as needed. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 on the procedure titled, Restorative Ambulation Program with a focus on the need for residents dependent on staff for ambulation to be on an ambulation program. 4. An audit has been developed to monitor restorative nursing ambulation programs including care planning, participation and documentation; also including a monthly review of ambulation programs by a licensed nurse. The audit will be completed by the DON or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	

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directed staff to assist R44 with ambulation twice daily to 200 feet, with a rear wheeled walker and transfer belt.

On 10/19/16, at 8:16 a.m. R44 was seated in a standard wheelchair, propelling herself into the dining room and wheeled herself up to a circular table. R44 verbalized her breakfast order, obtained her food and ate independently. At 8:34 a.m. R44 had eaten 100% of her meal and at that time propelled herself out of the dining room.

Review of a facility form titled Maintenance ADL Worksheet from April 2016, to October 2016, identified R44's was on an ambulation program twice a day (BID) long distances in the hallways with a walker and transfer belt. The worksheet also indicated R44 was to be assisted to ambulate up to 200 feet (ft.) R44's worksheets revealed the following:

- Review of R44's April 2016, worksheet identified R44 had received her ambulation program 16 out of 31 days in the am hours and 25 out of 31 days in the pm hours.

-Review of R44's May 21016, worksheet identified R44 had received her ambulation program 13 out of 31 days in the am and 20 days out of 31 in the pm.

-Review of R44's June 2016, worksheet identified R44 had received her ambulation program 8 out of 30 days in the am and 24 out of 30 days in the pm.

-Review of R44's July 2016, worksheet identified R44 had received her ambulation program 7 out of 30 days in the am and 12 out of 30 days in the

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pm.

-Review of R44's August 2016, worksheet identified R44 had received her ambulation program 8 out of 31 days in the am and pm.

-Review of R44's September 2016, worksheet identified R44 had received her ambulation program 11 days out of 30 in the am and 8 days out of 30 in the pm.

-Review of R44's October 2016, worksheet identified R44 had received her ambulation program 2 days out of 17 in the the am and 0 days out of 17 in the pm.

Review of an Occupational Therapy (OT) assessment dated 3/12/15, revealed R44 was discharged from therapy services and had been placed on the nursing gait list (ambulation program) and was to ambulate with a front wheeled walker with stand by assistance.

A request for R44's ambulation/maintenance program referral from OT was requested, the facility was unable to provide.

Review of R44's care conference summary notes from 2/9/16 to 8/16/16 revealed the following:

-8/16/16, did not address R44's ambulation program.

-5/12/16, R44 received assistance with ambulation in am and hs(hour of sleep) with contact guard assistance of one staff.

-2/9/16, revealed R44 received frequent ambulation with stand by assistance of one staff.

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Review of R44's nursing progress notes from 4/1/16, to 10/12/16, revealed the following:

-5/14/16, revealed R44 ambulated in the hall with staff.

-10/15/16, revealed R44 ambulated in the hall with staff.

No further documentatio of R44's ambulation program and ambulation status was found in R44's nursing progress.

On 10/20/16, at 1:59 p.m. nursing assistant (NA)-F stated R44 was able to complete most cares on her own. NA-F stated R44 required assistance to ambulate in the hallways and was on an ambulation program for twice a day in the am and in the pm. NA-F stated there were days when R44 was not assisted to ambulate due to not enough nursing staff on the floor.

On 10/20/16, at 2:34 p.m. NA-B stated R44 required limited assistance with ADL's of dressing and ambulation. NA-B stated R44 was on an ambulation program for twice a day. NA-B stated residents ambulation/maintenance programs were not getting done as they should due to not enough staff and this included R44.

On 10/20/16, at 3:24 p.m. licensed practical nurse (LPN)-B stated R44 was on a ambulation program for twice a day in the am and pm. LPN-B stated R44 liked to walk and felt the times R44 was not assisted with ambulation was due to not enough staff on the floor.

On 10/21/16, at 10:08 a.m. R44 stated she was

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F 311	Continued From page 95 on a walking program which she was supposed to walk twice a day. R44 stated she used to walk up to 3 times a day and stated she was lucky if she was walked once a day. R44 stated the staff had told her they were too busy on the days she did not receive her ambulation program. R44 stated that had been happening routinely for the last several months. R44 stated she was able to walk around the entire block (200 feet square perimeter around the nursing station,) but at the time would get a bit winded due to not walking like she should. R44 stated she felt as though she was not as steady on her legs as she used to be. R44 stated she feared she would lose her ability to walk if she did not continue with her ambulation program of twice a day. R44 agreed to having therapy assess her ability to walk at that time. R44 stated she felt bad the nursing staff was working so hard and did not want to add to their burden and request to be walked. On 10/21/16, at 10:18 a.m. registered nurse (RN)-A confirmed R44 was on an ambulation program twice daily to 200 feet with assist of one, walker and gait belt. RN-A did not comment if R44 was routinely receiving her ambulation program and stated R44 would be best person to answer the question. On 10/21/16, at 10:38 a.m. certified occupational therapy assistant (COTA) confirmed R44 had been referred to nursing for an ambulation program last year and was to be ambulated twice daily to 200 feet with one assist, gait belt and walker. OTA stated she felt R44 would be able to maintain her ability to ambulate when the program was consistently implemented. COTA stated she felt there were huge problems with the facility restorative program due to not enough	F 311		

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F 311	Continued From page 96 nursing staff. COTA stated the NA's were responsible for completing residents ambulation/maintenance programs and were too busy to consistently complete each residents program. COTA stated NA's had verbalized they wished they were able to complete residents programs though were unable to due to not enough staff. On 10/21/16, at 10:46 a.m. physical therapy assistant (PTA) assisted R44 to ambulate in the hallway with a gait belt, walker and contact guard assistance. R44 had a steady gait and even steps. R44 stated she was getting, "short on air," and stated that had been happening lately when she walked. R44 ambulated to her wheelchair and sat down with contact guard assist from PTA. At that time R44 stated she never used to get short on air when she walked and she was not getting walked as far as she used to. R44 then proceeded to remove her gait belt and thanked PTA for the walk. On 10/21/16, at 10:50 a.m. PTA stated she felt R44's ability to ambulate the distance the same as when she had last seen her. PTA stated as far as she was aware R44's shortness of breath was recent and likely due to not consistently receiving her ambulation program. PTA stated she had noticed residents were not consistently receiving their ambulation/maintenance programs due to not enough staff. PTA stated she had placed residents on maintenance programs and has had them referred back to therapy for treatment due to a decline. PTA stated she felt this was due to not enough staff to consistently carry out residents programs. PTA stated the facility NA's were responsible for residents ambulation/maintenance programs, however,	F 311		

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F 311	Continued From page 97 there were not enough NA'S on the floor. PTA stated she had voiced her concerns about residents ambulation/maintenance programs to nursing and administration during the weekly medicare meeting as recently as a month or so ago. PTA stated the response she had received was the staff were going to "talk" to the NA's. On 10/21/16, at 11:13 a.m. assistant director of nursing (ADON) confirmed R44 was not consistently receiving her ambulation program. ADON stated she expected staff to routinely complete ambulation/maintenance programs for resident. ADON stated she felt the facility's ambulation/maintenance program was not getting done due to staffing concerns and stated she felt the NA's did not have the time to complete all residents programs, including R44. ADON stated she did not feel R44 had lost any ability to ambulate and would ask R44 how often she wanted to be ambulated. R29 R29 had not been receiving ambulation services as directed by physical therapy and per the nursing assistant group sheet (a reference nursing assistance used regarding specific care for residents). R29's Order Summary form dated 9/16/16, identified R29 had diagnoses which included muscle weakness, malaise, and psychosis. R29's admission Minimum Data Set (MDS) dated 7/14/16, identified R29 had severe cognitive	F 311		

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impairment, and required extensive assistance for bed mobility, transfer, locomotion on and off of the unit, dressing and hygiene. The MDS identified ambulation did not occur for R29 during the assessment period.

R29's admission CAA dated 7/14/16, identified R29 had dementia, both short term and long term memory problems, and had poor balance which appeared related to decreased weight bearing status related to fall prior to admission.

R29's current care plan revised 10/14/16, revealed R29 had an unsteady gait, used a walker with assist of one and assist with ambulation, toileting, and mobility as needed. R29's care plan directed assist of one with front wheeled walker and wheelchair for ambulation.

On 10/19/2016, at 8:46 a.m. R29 was seated in her wheelchair, at a table in the dining room. R29 propelled herself with her feet, from the dining room towards her room.
On 10/19/2016, at 9:02 a.m. R29 self propelled her wheelchair with her feet in the hall. R29 asked staff directions to her room and then continued to self propel down the hall.

On 10/19/2016, at 10:30 a.m. licensed practical nurse (LPN)-C ambulated R29 past the nurses desk with a front wheeled walker and a gait belt around R29's waist.
On 10/24/2016, at 9:57 a.m. R29 propelled her wheelchair in the hall with her feet.

The facility form titled Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed R29 receive the following: "Recommend Pt (patient)

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ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (contact guard assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps."

R29's progress notes were reviewed 6/30/16, through 10/23/16, the notes identified R29 had received therapy for strengthening; however did not note that resident had received the referral for nursing staff to ambulate resident two times a day, nor was there documentation that R29 had received ambulation services with floor staff.

R29 did not have a ambulation program sheet in the nursing assistant maintenance book.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had serious concerns with residents ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis. PTA stated residents such as R29 did not routinely receive their ambulation programs.
On 10/24/2016, at 10:14 a.m. NA-I indicated R29 was not on a walking program. NA-I indicated R29 would self transfer and staff would walk with her in her room to the bathroom.

On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program.

On 10/24/2016, at 10:32 a.m. physical therapy assistant (PTA)-G indicated residnets who had reached their goal in therapy were discontinued

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from therapy services and then continue with a ambulation or lower extremity exercise program to be completed by the nursing assistants in order to maintain the progress which was made in therapy. PTA-G verified R29 was discharged from therapy in August of 2016, and should be currently walking two times a day up to 150 feet. PTA-G indicated ambulation into the bathroom would not be enough steps to be considered a walking program.

On 10/24/16, at 10:52 a.m. the clinical manager (CM)-B indicated R29 had an ambulation program for one staff to walk the full length of the hallway with use of a gait belt and a walker. CM-B was unaware how often R29 ambulated. CM-B verified R29's Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (care giver assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps." CM-B verified R29 did not have a form which directed the ambulation program in the NA maintenance book. CM-B verified the NA group sheet was part of R29's current care plan and the group sheet did indicate R29 was to receive assistance with ambulation two times a day with CGA of one and a FWW. CM-B indicated without documentation or observations of R29's ambulation with staff , she was unaware if R29 had received the referred ambulation program two times a day up to 150 feet.

On 10/24/16, at 11:06 a.m. (PTA)-G assessed R29's ambulation ability. PTA-G assisted R29 to

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stand from the wheelchair and ambulate 1/2 the length of the hall from her room and then back to her room. PTA-G indicated R29 had not declined and had remained at the functioning level with ambulation as when she had been discharged from physical therapy services.

R46
R46 was not receiving ambulation services as directed by physical therapy.

On 10/24/2016, at 11:00 p.m. R46 was laying on top of her bed on her right side, covered with two small blankets, the call light was secured to the grab bar attached to the side of the bed, and a wheel chair was approximately 3 feet from the bed in which R46 lay.

R46's physicians orders dated 9/20/16, identified diagnoses included muscle weakness, syncope and collapse.

R46's quarterly Minimum Data Set (MDS) dated 8/11/16, identified R46 had intact cognition, and required extensive assistance for transfer, locomotion on and off of the unit, dressing and toilet use, limited assistance for bed mobility and personal hygiene. The MDS identified ambulation did not occur for R46 during the assessment period.

R46's Care Area Assessment (CAAS) dated 11/9/15, included: Cognitive Patterns- intact. Functional status: Activities of daily living status- limited assistance of one staff for transfers, limited assistance of staff to ambulate in room, ambulation in corridor did not occur.

The facility form titled Resident Referral,

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F 311	Continued From page 102 Interdepartmental Communication dated 11/6/15, to nursing from physical therapy directed R46 receive the following: "Please ambulate Pt (patient) with RW (regular walker), transfer belt, and 1 A (assist) 2 X (times) daily. Pt. amb. (ambulate) up to 200' any ? (questions) call." R46's current care plan revised 8/22/16, revieled R46 had an unsteady gait and weakness, SBA (stand by assist) of one for transfer and with walker. R46's progress notes were reviewed 4/3/16, through 10/1/16, did not note that R46 had received ambulation services with floor staff. R46 did not have a ambulation program sheet in the nursing assistant maintenance book. On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program. NA-E stated R29 could pivot transfer and take a couple steps but not walk any distance. On 10/24/2016, at 10:32 a.m. physical therapy assistant (PTA)-G indicated residnets who had reached their goal in therapy were discontinued from therapy services and then continued with a ambulation or lower extremity exercise program to be completed by the nursing assistants in order to maintain the progress which was made in therapy. PTA-G verified R46 had been discharged from therapy and should be currently walking two times a day up to 200 feet or as far as R46 tolerated. PTA-G indicated she would expect staff to be walking with R46 in the hall and the program should continue unless the resident had a decline, hospitalization or pain. PTA-G indicated	F 311		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 103 if a decline were to occur the resident should then be re-screened. PTA-G indicated ambulation into the bathroom would not be enough steps to be considered a walking program. On 10/24/16, at 10:52 a.m. the clinical manager (CM)-B indicated she had never seen R46 ambulate. CM-B indicated when a referral from therapy was received for an ambulation program or other exercise program it would be written on a form for the nursing assistants(NA) in the NA maintenance book. CM-B verified R46's Resident Referral, Interdepartmental Communication dated 11/6/15, to nursing from physical therapy directed the following: "Please ambulate Pt (patient) with RW (regular walker), transfer belt, and 1 A (assist) 2 X (times) daily. Pt. amb. (ambulate) up to 200' any ? (questions) call." CM-B verified R46 did not have a form which directed the ambulation program in the NA maintenance book. With review of R46's chart, CM-B verified the ambulation program had been in place for the months of December 2015, April, May, June and July 2016, but no further ambulation program documentation was found. The CM-B verified R46's ambulation program was not currently being performed. On 10/24/16, at 11:11 a.m. R46 verified the nursing staff did not walk with her in the hall and had not asked her to walk with them. While walking with the use of a walker, gait belt and PTA-G, R46 stated," I can feel I have not walked in a while, I can feel it in my arms." R46 walked approximately 8 feet, stopped and requested to stop a while to rest her arms. After resting a few minutes, R46 continued to walk with PTA-G back to her room. R46 was breathing heavily when she reached her room.	F 311		

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F 311	Continued From page 104 On 10/24/16, at 11:11 a.m. (PTA)-G assessed R46's ambulation ability. PTA-G assisted R46 to stand from bed and ambulate out of her room into the hall. R46 was able to ambulate 1/2 of the hall from her room toward the nurses desk and then back to her room. PTA-G indicated R46 had not declined and had remained at the functioning level with ambulation as when she had been discharged from physical therapy services. On 10/24/16, at 11:24 a.m. a follow up interview with R46 identified she was aware she should walk more; however, believed the facility staff were very busy and she required a lot of assistance and took a lot of the staffs time. On 10/24/16, at 2:00 p.m. physician assistant (PA)-A indicated she would expect facility staff to follow resident care plans and to initiate recommended walking or exercise programs to prevent resident functional decline and a decline in the residnets quality of life. PA-A stated, " Sadly not providing recommended restorative exercises is not uncommon here." A facility policy titled, Restorative Program, dated 4/1/08, identified residents would be assessed on admission and as needed for a restorative program including ambulation. The policy further identified residents would be supported and their highest level of functioning maintained.	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	F 312		12/14/16

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F 312	Continued From page 105 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure personal cares were completed in a timely manner for 1 of 3 residents (R18) reviewed for urinary incontinence and on who were on a routine check and change program. Findings include: Review of R18's quarterly Minimum Data Set (MDS) dated 7/26/16, identified R18 had severe cognitive impairment, was unable to communicate with staff and had diagnoses which included, dementia, depression and anxiety. The MDS identified R18 was totally dependent on staff for activities of daily living (ADL's) and required 2 staff for assistance with bed mobility, personal hygiene and toileting. The MDS identified R18 was frequently incontinent of bowel and bladder. The MDS identified R18 was not on a toileting program for bowel or bladder incontinence. Review of R18's annual MDS dated 4/26/16, identified R18 was totally dependent on staff for ADL's. The MDS identified R18 was frequently incontinent of bowel and bladder. The MDS identified R18 was not on a toileting program for bowel or bladder incontinence. Review of R18's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 4/26/16, identified R18 had cognitive loss related to dementia and was unable to coherently verbalize her needs.	F 312	F 312 Assistance with ADLs provided for dependent residents 1. R18 currently is receiving timely assistance with toileting. A three day bowel and bladder assessment will be completed for R18; R18 s care plan will be updated according to assessment findings. 2. All residents that require assistance with personal cares with urinary incontinence have the potential to be affected in this area. A list of residents that are frequently incontinent will be generated and will be care planned for an every two hour check and change program. Care plan updated as needed. 3. Mandatory nursing staff education was provided on November 16 and 17 on the procedure titled Activities of Daily Living with a focus on the need for timely toileting and three day bowel and bladder assessments upon admission, annually, or with a change in continence status. 4. An audit will be developed to monitor residents through observations and documentation review to ensure residents that are completely incontinent of urine are receiving timely assistance with every two hour check and change programs and	

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Continued From page 106

The CAA revealed R18's needs were to be met in spite of her inability to make requests. R18's Communication CAA identified R18's needs must be anticipated by facility staff. Urinary Incontinence CAA identified R18 was frequently incontinent of bowel and bladder and needed assistance with all mobility and was toileted or changed as needed.

Review of a Bowel and Bladder Functional Evaluation tool reviewed 7/26/16, revealed R18 had functional urinary incontinence and was totally dependent on staff for toileting needs. The tool revealed R18 required assistance to toilet every 2 hours during the day and to change and change the 1st and 3rd rounds during the night.

Review of R18's physician progress note dated 10/6/16, revealed R18 had severe dementia and Alzheimer's disease and to be dependent on facility staff for her needs.

Review of R18's current care plan last updated 10/7/16, revealed R18 had severe cognitive loss, was unable to communicate her needs and was totally dependent on staff for toileting, repositioning needs and was frequently incontinent of bowel and bladder and wore an incontinent brief . The care plan directed staff check and change R18 every 2 hours for incontinence with repositioning.

On 10/19/16, from 7:03 a.m. to 10:39 a.m., continuous observations of R18 revealed the following:

On 10/19/16, at 7:03 a.m. R18 was seated in a

F 312

care planned appropriately. The audit will be completed by the DON, or designee, and monitors the cleanliness of resident bed linens on all three shifts. The audit will be completed 2-3 per week on all three shifts X 4 weeks, the weekly for 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations

5. Deficient practice will be corrected by December 14, 2016

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F 312	Continued From page 107 gel cushioned wheelchair, fully dressed in her room. R18's bed was stripped of its linens which were balled into a bundle on her bed. R18's head was hung forward in a chin to chest position and her eyes were closed. -at 7:38 a.m. the call light to R18's room was on by R18's roommate, staff were observed to enter the room to assist R18's roommate. At that time, housekeeping staff entered R18's room and made R18's bed while she remained seated in the wheelchair. At 7:41 a.m. the housekeeping staff member wheeled R18 to the dining room. R18 had remained with her eyes closed and her head was in a chin to chest position. Housekeeping staff wheeled R18 to a table in the dining room and placed a clothing protector around her neck, at that time R18 covered her face with the clothing protector. -at 7:56 a.m. R18 remained seated in the wheelchair in the dining room. A dietary aid (DA)brought R18 her breakfast plate, left the plate on the table in front of her and walked away. At that time nursing assistant (NA)-G approached R18, placed a hand on her shoulder and verbally prompted her to wake up. R18 opened her eyes and NA-G verbally prompted R18 to begin eating and handed her a spoon. R18 ate 100% of her breakfast foods independently while seated in the wheelchair. R18 remained seated in the wheelchair at the table -at 8:46 a.m. R18 remained seated in her wheelchair at the dining room table, had made no attempt to leave from the table. R18 had completed her meal, had a glass of milk orange	F 312		

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F 312	Continued From page 108	F 312		

juice and water in front of her though made no attempt to reach for them. R18 held onto her spoon, and would repeatedly run the spoon over the lipped edge of her plate, periodically licking her spoon.

-at 9:01 a.m. R18 remained seated in her wheelchair in the dining room, having made no attempts to leave the table. NA-H approached R18 and asked how her day was, R18 did not respond, NA-H walked away. R18 continued to repeatedly run her spoon around the lipped edge of the plate, while she periodically licked her spoon. R18 had made no attempts to drink her fluids.

-at 9:18 a.m. R18 remained seated in her wheelchair in the dining room. R18 had set the spoon on the table, and had closed her eyes. Shortly after R18's head dropped forward in a chin to chest position. No staff had offered to assist R18 with repositioning.

-at 9:30 a.m. R18 remained seated in her wheelchair in the dining room. R18 had opened her eyes, looked around, took her clothing protector and covered her face it. R18 made no attempt to move away from the table and held her face covered with the clothing protector.

-at 9:37 a.m. NA-D entered the dining room, awoke R18 and offered R18 her fluids. R18 awake, removed the clothing protector from her face and allowed NA-D to assist her to drink her juice. R18 drank 50% of her juice. NA-D then handed R18 her glass of water and R18 independently drank the water. NA-D left R18 seated in her wheelchair and exited the dining

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F 312	Continued From page 109	F 312		

room. NA-D was not observed to offer R18 assistance with cares, repositioning or toileting needs.

-at 9:42 a.m. NA-H approached R18 and assisted her to drink her remaining fluids, while R18 remained seated in her wheelchair. NA-H removed the clothing protector from R18's neck, R18 then took her shirt and covered her face with it, in a cradling position.

-at 9:50 a.m. NA-H assisted R18 out of the dining room while seated in her wheelchair, brought her to her room and handed R18 a stuffed bear. NA-H attached the call light to R18's wheelchair and left R18's room. NA-H was not observed to offer R18 with any cares, including repositioning or toileting.

-at 10:01 a.m. NA-D was observed to walk past R18's room, did not look in or stop in R18's room.

-at 10:09 a.m. NA-E exited a room across the hallway from R18's room, briefly looked into R18's room and immediately walked away down the hallway.

-at 10:39 a.m. assistant director of nursing (ADON) was notified R18 had remained seated in her wheelchair for an observed 3 hours and 36 minutes. At that time the ADON confirmed R18 required assistance with repositioning and checking and changing every 2 hours. ADON confirmed R18 was at risk for skin breakdown. ADON went to R18's room while requesting assistance from other nursing staff via walkies talkie.

-at 10:39 a.m. NA-E entered R18's room and

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asked R18 to use the bathroom. NA-E donned a gait belt across R18's torso, NA-E and ADON assisted R18 to stand from the wheelchair, ambulate to the bathroom and removed R18's slacks and incontinent brief. R18 had a moderate amount of urine in her brief as well as a small amount of bowel. ADON confirmed R18's entire buttocks surface which had contact with the brief had deep blush pink creases and was moist surrounding her peri-rectal area, though was blanchable. NA-E and ADON assisted R18 to complete toileting needs and assisted R18 to sit back in her wheelchair.

R18 had remained in a seated position for a total of 3 hours and 36 minutes, during that time no staff were observed to offer R18 assistance with repositioning.

On 10/19/16, at 10:39 a.m. NA-E stated she thought R18 was last repositioned around 6:45 a.m. and had stated she had been too busy helping others with cares to assist R18 with repositioning and toileting needs. NA-E stated R18 was supposed to be repositioned and checked and changed every 2 hours and as needed. NA-E stated R18 was not able to verbalize hers and staff needed to anticipate R18's needs.

On 10/20/16. at 2:36 p.m. NA-B stated R18 needs must be anticipated and was totally dependent on 2 staff for her needs, including repositioning and toileting. NA-B stated R18 required routine every 2 hour repositioning and toileting. NA-B stated R18's buttocks would get red at times, but could not recall any recent open areas on R18's buttocks.

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F 312	Continued From page 111 On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff of for all of her needs. LPN-B stated R18 was not able to verbalize her needs and staff needed to anticipate them. LPN-B stated R18 was at risk for skin breakdown due to incontinence and immobility. On 10/21/16, at 1:37 p.m. during a follow up interview ADON stated she felt staff were unable to routinely repositioning and toilet residents in a timely manner, such as R18, due to staffing shortages. ADON stated they were not always able to fill in for sick calls and there were times when the facility were unable to fill holes in the schedule. A facility policy titled Bowel and Bladder Management dated 4/1/08, revealed it was the facility's policy to ensure each resident with bowel or bladder incontinence would receive appropriate treatment and services to maintain normal functioning. The policy directed staff to develop an individual toileting schedule for all incontinent residents and noted on resident care plans. .	F 312		
F 314 SS=D	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	F 314		12/14/16

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F 314	Continued From page 112 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility the facility failed to complete timely repositioning for residents on a turn and repositioning program and who were assessed to be at risk for pressure ulcers for 2 of 4 residents (R18, R66) reviewed for pressure ulcers. Findings include: Review of R18's quarterly Minimum Data Set (MDS) dated 7/26/16, identified R18 had severe cognitive impairment, was unable to communicate with staff and had diagnoses which included, dementia, depression and anxiety. The MDS identified R18 was totally dependent on staff for activities of daily living (ADL's) and required 2 staff for assistance with bed mobility. The MDS identified R18 was at risk for developing pressure ulcers and had interventions in place which included a pressure reducing device for the chair and R18 was on a turning and repositioning program. Review of R18's annual MDS dated 4/26/16, identified R18 was totally dependent on staff for ADL's. The MDS identified R18 was at risk for developing pressure ulcers and had interventions in place which included a pressure reducing device for the chair and R18 was on a turning and	F 314	F 314 Treatment/Services to prevent/heal pressure sores 1. R18 and R66 will be assessed for tissue tolerance; R18 s and R66 s care plan for turning and repositioning will be updated according to assessment findings. 2. All residents with a Braden score of 15 or less for or with current pressure ulcers have the potential to be affected in this area. A list of residents at high risk (Braden less than 15) for or with pressure ulcers will be generated and reviewed for tissue tolerance assessment. Residents at high risk for skin breakdown are listed on the CNA pocket worksheet and their care plans are updated to ensure new skin issues to not develop. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 on the procedure titled, Positioning and Pressure Ulcer Education Your Skin with a focus on the need for residents at risk for or with pressure ulcers to be repositioned frequently to prevent, manage, and heal pressure	

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F 314	Continued From page 113 repositioning program. Review of R18's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 4/26/16, identified R18 had cognitive loss related to dementia and was unable to coherently verbalize her needs. The CAA revealed R18's needs were to be met in spite of her inability to make her needs known. R18's Communication CAA identified R18's needs must be anticipated by facility staff. R18's Pressure Ulcer CAA identified R18 had a potential for skin breakdown related to incontinence, decreased mobility and her inability to make her needs known. The CAA revealed R18 could move independently in bed but required staff assistance to reposition when in a sitting position. The CAA identified R18 required a regular schedule of turning and had a pressure relieving cushion in wheelchair. Review of a Comprehensive Analysis of Skin form dated 7/26/16, revealed R18 was at high risk for skin breakdown based on a Braden scale (assessment for predicting pressure sores) score of 14 and a tissue tolerance test. The form revealed interventions were put in place which included, gel cushion in wheelchair and R18 required turning and repositioning with check and change every 2 hours and as needed (PRN). Review of R18's physician progress note dated 10/6/16, revealed R18 had been seen for a routine nursing home visit. The note revealed R18 had severe dementia and Alzheimer's disease and was dependent on facility staff for her needs. Review of R18's current care plan last updated 10/7/16, revealed R18 had severe cognitive loss,	F 314	ulcers. Licensed nurse will complete a tissue tolerance assessment for dependent residents upon admission and care planning for turning and repositioning will be based on individual resident assessment findings. Documentation of turning and repositioning programs will be on the TAR for nurses to sign off as completed. 4. An observation and chart audit has been developed to monitor skin assessments, appropriate care planning to prevent/heal impaired skin integrity, implementation of interventions including turning and repositioning, positioning, seating/mattress pressure reduction, notification and collaboration with dietician and physician (assuring physician orders are being followed), notification and updating of responsible parties, and also daily nurse wound documentation on the MAR/TAR and also the weekly RN wound review on the wound data collection assessment. The audit will be completed by the DON or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA with follow-up to committee findings. 5. Deficient practice will be corrected by December 14, 2016	

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was unable to communicate her needs and was totally dependent on staff for toileting, repositioning needs and had a potential risk for skin breakdown. The care plan listed interventions which included to assist R18 to turn and reposition every 2 hours and prn, keep skin clean and dry and a gel cushion in the wheelchair.

On 10/19/16, from 7:03 a.m. to 10:39 a.m., continuous observations of R18 revealed the following:

At 7:03 a.m. R18 was seated in a wheelchair with a gel cushion, fully dressed in her room. R18's bed was stripped of its linens. R18's head was hung forward in a chin to chest position and her eyes were closed.

At 7:21 a.m. R18 remained seated in the wheelchair in her room. No staff were observed to enter R18's room.

At 7:38 a.m. the call light to R18's room was on by R18's roommate, staff was observed to enter the room to assist R18's roommate. At that time, housekeeping staff entered R18's room and made R18's bed while she remained seated in the wheelchair. At 7:41 a.m. the housekeeping staff member wheeled R18 to the dining room. R18 remained with her eyes closed and her head was in a chin to chest position. Housekeeping staff wheeled R18 to a table in the dining room and placed a clothing protector around her neck. At that time R18 covered her face with the clothing protector.

At 7:56 a.m. R18 remained seated in the wheelchair in the dining room. A dietary aid

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FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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(DA)brought R18 her breakfast plate, left the plate on the table in front of her and walked away. At that time nursing assistant (NA)-G approached R18, verbally prompted her to begin eating and handed her a spoon. R18 ate 100% of her breakfast foods independently. R18 remained seated in the wheelchair at the table.

At 8:46 a.m. R18 remained seated in her wheelchair at the dining room table, and made no attempt to leave the table.

At 9:01 a.m. R18 remained seated in her wheelchair in the dining room, having made no attempts to leave the table.

At 9:18 a.m. R18 remained seated in her wheelchair in the dining room. R18 closed her eyes. Shortly after R18's head dropped forwards in a chin to chest position. No staff offered to assist R18 with repositioning.

At 9:30 a.m. R18 remained seated in her wheelchair in the dining room. R18 had opened her eyes, looked around, took her clothing protector and covered her face it. R18 made no attempt to move away from the table and left her face covered with the clothing protector.

At 9:37 a.m. NA-D entered the dining room, woke R18 and offered her fluids. R18 awoke, removed the clothing protector from her face and allowed NA-D to assist her to drink her juice. R18 drank 50% of her juice. NA-D then handed R18 her glass of water and R18 independently drank the water. NA-D left R18 seated in her wheelchair and left the dining room. NA-D was not observed to offer R18 assistance with personal needs, including repositioning and toileting needs.

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At 9:42 a.m. medical records (MR) approached R18 and assisted her to drink her remaining fluids, while R18 remained seated in her wheelchair. MR removed the clothing protector from R18's neck, R18 then took her shirt and covered her face with it, in a cradling position.

At 9:50 a.m. MR assisted R18 out of the dining room in her wheelchair, brought her to her room and handed R18 a stuffed bear. MR attached the call light to R18's wheelchair and left the room. MR was not observed to offer R18 assistance with any cares, including repositioning or toileting.

At 10:01 a.m. NA-D was observed to walk past R18's room, did not look in.

At 10:09 a.m. NA-E walked out of a room across from R18's room, looked into R18's room and walked away.

At 10:39 a.m. the Assistant Director of Nursing (ADON) was notified R18 had remained seated in her wheelchair for an observed 3 hours and 36 minutes. At that time the ADON confirmed R18 required assistance with repositioning and checking and changing every 2 hours. At that time, the ADON confirmed R18 was at risk for skin breakdown. ADON went to R18's room while requesting assistance via walkie talkies.

At 10:39 a.m. NA-E entered R18's room and asked R18 to use the bathroom. NA-E placed a gait belt around R18's torso. NA-E and the ADON assisted R18 to stand from the wheelchair, ambulate to the bathroom and removed R18's slacks and incontinence brief. R18 had a moderate amount of urine in her brief as well as a

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small amount of stool. R18's entire buttocks surface which had contact with the brief had deep pink creases and was moist surrounding her peri-rectal area. NA-E and the ADON assisted R18 to complete toileting and assisted R18 to sit back in her wheelchair.

On 10/19/16, at 10:39 a.m. NA-E stated she thought R18 was last repositioned around 6:45 a.m. and stated she had been too busy helping others with cares to assist R18 with repositioning and toileting needs. NA-E stated R18 was supposed to be repositioned and checked/changed every 2 hours and as needed. NA-E stated R18 was not able to verbalize her needs and staff was to anticipate R18's needs.

On 10/20/16, at 2:36 p.m. NA-B stated R18's needs must be anticipated as she was totally dependent on 2 staff for her needs, including repositioning and toileting. NA-B stated R18 required routine every 2 hour repositioning and toileting. NA-B stated R18's buttocks would get red at times, but could not recall any recent open areas on R18's buttocks.

On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff for all of her needs. LPN-B stated R18 was not able to verbalize her needs and staff needed to anticipate them. LPN-B stated R18 was at risk for skin breakdown due to incontinence and immobility.

On 10/21/16, at 1:37 p.m. during a follow up interview the ADON stated she felt staff was unable to routinely reposition and toilet residents in a timely manner, due to staffing shortages. The ADON stated they were not always able to fill in

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for sick calls and there were times when the facility were unable to fill holes in the schedule.

Review of facility policy, Pressure Ulcer/Skin Integrity/Wound Management identified residents determined at risk for loss of skin integrity would receive the proper treatment/services which included specific physician ordered treatments, pressure reliving equipment, and repositioning per resident assessment.
R66's Admission Minimum Data Set (MDS), dated 1/11/16, identified R66 had severe cognitive impairment, was totally dependent of staff for activities of daily living (ADLs) and required 2 or more staff to assist with bed mobility The MDS further identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS also identified R66 was at risk for developing pressure ulcers, required a pressure reducing device for her chair and bed, and required a turning and repositioning program.

R66's quarterly Minimum Data Set (MDS), dated 7/13/16 identified R66 had severe cognitive impairment, and was totally dependent of staff for activities of daily living (ADLs), and required 2 or more staff to assist with bed mobility. The MDS further identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS also identified R66 was at risk for developing pressure ulcers, required a pressure reducing device for her chair and bed, and required a turning and repositioning program.

R66's Care Area Assessment (CAA), dated 1/11/16 identified R66 suffered from a traumatic brain injury, had a decreased ability to make herself understood, and had an inability to

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perform ADLs without significant assistance from staff. The CAA further identified R66 was at high risk for developing pressure ulcers related to her inability to move herself or ask for help when she was uncomfortable, and staff were to anticipate her needs and ensure she was repositioned. The CAA further identified R66 required a special mattress and wheelchair cushion, and required a regular schedule of turning and repositioning to prevent pressure.

R66's care plan dated 2/18/16, identified R66 was at risk for developing pressure ulcers related to fragile skin, not being able to turn herself, was immobile and was bed and chair bound. The care plan also identified R66 was to suspend heels off the bed or wear sheepskin boots to protect her feet, and was to be turned and repositioned according to her turning and positioning plan. The care plan further identified R66 was incontinent and was to be checked and changed every 2 hours.

Review of the Aide Care Plan, Group B, dated 10/17/16, identified R66 required total assistance with cares, was to be turned and repositioned every 2 hours, and was to float heels off the bed or wear sheepskin boots.

Review of a physician note dated 12/31/15, identified R66's left heel was at risk for developing pressure ulcers, Eucerin cream was to be applied to heels twice a day and heels were to be floated off the bed.

Review of physician note dated 8/29/16, identified R66's heels were not floated off the bed.

Review of current physician's orders dated,

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10/5/16, identified R66 had orders to suspend her heels off of her bed every shift for preventing alteration in skin integrity.

R66's comprehensive analysis of skin dated 1/4/16, identified R66 had pink heels on admission and had been free floated for precaution.

R66's Braden Scale (assessment for predicting pressure sores) dated 7/13/16, identified R66 was at high risk for developing pressure ulcers. The document also identified R66 had a special mattress, heels were to be kept off the bed and R66 continued to need to be repositioned and had special cushion in her wheelchair because R66 had a history of pressure ulcers.

R66's tissue tolerance test (length of time resident could be in the same position without skin damage) dated 7/13/16, identified R66 required 2 hour repositiong to prevent pressure ulcers.

R66's progress notes reviewed from 12/31/15 to 10/17/16 identified:

2/3/16, R66 had a 2 cm X 0.5 cm area on her right shin and ankle from possible rubbing on PROFO boot, staff removed boot and floated her heels. R66's wheelchair had built-in pressure relief pedals.

2/4/16, R66 had an intact blister on her right ankle

2/6/16, Family expressed concern with R66's right ankle. Nurse explained areas were from boot and brace in wheelchair.

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2/8/16, R66's areas to right skin and ankle were resolving

2/9/16, R66 had superficial, abraded/scraped area on her shin from profo boot and a blister to her inner ankle from being up in her wheelchair with socks off and suspected foot rubbed on foot pedal

2/10/16, blister healing, heels free floated

2/13/16, areas to right foot/ankle and right shin resolved.

On 10/19/16, at 7:00 a.m. R66's bedroom was dark, and her door was fully open. R66 was dressed in a hospital gown, and was asleep on her back in bed. R66's arms rested on her chest and her body was covered with a blanket. R66's legs were straight, and her heels rested directly on her mattress. She was not wearing sheep skin boots. R66's sheepskin boots were observed to be piled up on R66's dresser across the room. At 7:19 a.m. R66 was in the same position in her bed, her eyes were now open, continued with loud mouth breathing and heels rested directly on the mattress and was not wearing her sheep skin boots. At 7:39 a.m. R66 was in the same position in her bed with her eyes closed. R66's heels continued to be directly on her bed and was not wearing her sheepskin boots.

At 7:49 a.m. licensed practical nurse (LPN)-A entered R66's room. LPN-A stated R66's heels were not free floated and she was not wearing sheep skin boots. LPN-A stated she felt R66's heels were, "kind of," floated by the bubbles in her mattress. LPN-A then pulled a flat pillow down

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to approximately one inch under R66's calves however it did not lift R66's heels off the mattress. LPN-A laid R66's heels directly on the bed, and immediately left the room.

At 8:03 a.m. the registered nurse (RN) consultant walked in to R66's room and immediately walked out, towards the nurses station. At 8:28 a.m. R66 remained in the same position on her back, asleep. R66 remained in that position without heels floated, or sheepskin boots on until 10:05 a.m.

At 10:03 a.m. LPN-A stated R66 was at risk for developing pressure ulcers. She stated she didn't think R66 had pressure ulcers in the past. LPN-A stated R66 sometimes wore her sheepskin boots and sometimes they floated R66 heels off the bed. LPN-A stated R66 had an alternating air pressure mattress and was supposed to be repositioned and checked and changed every 2 hours. LPN-A confirmed the last time R66 had been repositioned was at approximately 6:00 a.m. that morning. At 10:05 a.m. after continuous observation (3 hours and 5 minutes) LPN-A confirmed both R66's heels rested on her bed and R66 had not worn sheep skin boots. R66 heels and bottom were intact. NA-E entered R66's room and assisted LPN-A with R66's morning cares.

At 10:33 a.m. NA-E stated she didn't know the last time R66 was repositioned. NA-E stated R66 was supposed to be turned and repositioned, checked and changed every 2 hours. She stated she would have to check with partner NA-D to see when she repositioned R66 as they were taking care of R66 for the day. NA-E stated she felt R66 was was at risk for developing pressure

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ulcers, but she didn't think R66 had any skin problems. NA-E stated R66 heels could be on the bed because R66 had no breakdown at this time and had an air bed. NA-E further stated R66 didn't wear her sheep skin boots. NA-E confirmed her current care sheet did not direct the use of sheepskin boots. NA-E and LPN-A left R66's room after R66 was in her recliner with her heels floated by a pillow on the footrest of the recliner.

On 10/19/16, at 10:40 a.m. NA-D stated she didn't know if R66 was at risk for developing pressure ulcers, or what R66's care plan directed her to do for R66's skin. She stated R66 had a special mattress, and stated she assumed R66 would be at risk. NA-D stated she didn't know if R66 had a history of pressure ulcers and wasn't aware of any sheep skin boots for R66. NA-D stated she did not reposition R66 this morning, and stated she thought the last time R66 had been repositioned was at approximately 630 a.m. by the night staff.

On 10/19/16, at 12:10 p.m. R66 was seated in recliner in front of her TV. R66 did not have her heels floated on a pillow and was not wearing her sheep skin boots. R66's heels rested directly on the foot rest of her recliner.

On 10/19/16, at 1:03 p.m. during follow-up interview NA-E stated R66 was totally dependent on staff for cares, and stated she couldn't really tell what R66's cognition was since she didn't talk.

On 10/19/16, at 1:06 p.m. during follow-up interview, NA-D stated R66 was dependent on staff for her cares, and stated she wasn't sure what R66's cognition was because she didn't talk.

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On 10/19/16, at 1:11 p.m. R66 laid in bed on her back, legs straight out with her heels resting directly on her bed. R66 did not have her heels floated with a pillow, and was not wearing sheep skin boots.

On 10/19/16, at 1:16 p.m. during follow up interview, LPN-A stated R66 was totally dependent on staff for cares, and stated she felt R66 was clearer some day's versus others and stated she thought R66 understood them when she was clearer.

On 10/19/16, at 1:34 p.m. NA-B stated R66 was totally dependent on staff for cares, and stated she wasn't sure of R66's cognition. She stated she didn't think R66 was at risk for pressure ulcers, and didn't know if R66 had pressure ulcers in the past. NA-B confirmed R66's heels rested directly on her bed and she was not wearing sheepskin boots. NA-B confirmed R66's Aide Care Sheet and stated she didn't know R66 had sheepskin boots as they weren't on her sheet, but R66's heels were supposed to floated and R66 was supposed to be repositioned every 2 hours.

On 10/24/16, at 10:38 a.m. registered nurse (RN)-A stated R66 had severe cognitive impairment and was totally dependent on staff for cares. She stated R66 was at risk for developing pressure ulcers because she couldn't reposition herself. She stated she didn't remember if R66 had ever had any skin problems. She stated R66's heels were supposed to be floated off of her bed, and the NA's were supposed reposition R66 every 2 hours.

On 10/24/16, at 10:53 a.m. Unit Manager (UM-A)

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stated R66 had severe cognitive impairment and was dependent on staff for cares. She stated R66 was supposed to be repositioned every 2 hours, her heels were supposed to be floated off of her bed, or R66 was to wear sheepskin boots. R66 had a history of pressure ulcers. She stated she remembered R66 had a blister on her heel in February from a profo boot or splint she wore, and that's when they discontinued the boot and implemented floating R66's heels. UM-A confirmed R66's most recent care plan which directed staff to float R66's heels off the bed or wear sheep skin boots, and turn and reposition R66 every 2 hours. She stated she expected staff to follow R66's care plan and float her heels or apply sheep skin boots to R66's feet, and reposition R66 every 2 hours to prevent pressure ulcers. She stated she felt nursing assistants needed more education on repositioning and floating of heels.

On 10/24/16, at 1:45 p.m. nurse practitioner (NP)-A confirmed R66's left heel was at risk for pressure ulcers on admission, and there was a physician's order to float R66's heels since 12/31/15. NP-A confirmed there was not a physician's or nursing order to use the sheepskin boots.
On 10/25/16, at 5:05 p.m. family member (FM)-A stated R66 could barely move her arms now. She stated R66 had developed a deep ulcer on her shin, and about a quarter size blister on the inside of her ankle on her right foot after she got to the facility. She stated they told her it was from her boot rubbing on her skin, and the boot was too tight. She stated she questioned them because R66 didn't move her legs and feet enough to cause blisters. She stated no staff went into R66's room unless they had to.

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F 314	Continued From page 126 Review of facility policy, Pressure Ulcer/Skin Integrity/Wound Management identified residents determined at risk for loss of skin integrity would receive the proper treatment/services which included specific physician ordered treatments, pressure reliving equipment, and repositioning per resident assessment.	F 314		
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion (ROM) services and hand splints to prevent further decline in ROM for upper extremities for 1 of 4 residents (R66) reviewed for ROM. This deficient practice resulted in actual harm for R66. Findings include: R66's quarterly Minimum Data Set (MDS) dated 7/13/16, identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS identified R66 had severe cognitive impairment, and was totally dependent on staff for assistance with all	F 318	F 318 Increase/Prevent decrease in ROM - 1. R66 was re-evaluated by therapy with resumption of restorative nursing staff performing upper extremity ROM and splinting. Residents ADL scores will be reviewed quarterly with referrals to therapy as appropriate. Facility Restorative Nursing PIP team has been established and will be meeting monthly beginning November 17, 2016; team will include representatives from Nursing and therapy. 2. All residents have the potential to be affected in this area. A list of residents coded on the MDS as having a decline in	12/14/16

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F 318	Continued From page 127 activities of daily living (ADLs). R66's MDS identified R66 had functional limitations in range of motion on both sides, upper and lower extremities, and did not receive therapy services or restorative nursing services. R66's annual MDS dated 1/11/16, identified R66 had severe cognitive impairment, and was totally dependent on staff for assistance with all ADLs. The MDS identified R66 had functional limitations on both sides, upper and lower extremities, and did not receive therapy services or restorative nursing services. R66's Care Area Assessment (CAA) dated 1/11/16, identified R66 was dependent on staff for all ADLs related to traumatic brain injury over the last year, and had difficulty with mobility, communication and cognition. R66's care plan dated 2/18/16, identified R66 was aphasic (non verbal) due to traumatic brain injury, and was unable to make her needs known. R66's care plan also identified R66 was to wear hand splints for 2 hours on and 2 hours off during the day, and was to wear the splints all night. R66's care plan failed to identify R66 had contractures, and did not identify a ROM or a restorative nursing program for R66 to prevent further decline. Review of the Aide Care Plan, Group B dated 10/17/16, identified R66 required total assistance with cares and was to wear hand splints on and off every 2 hours during the day and leave them on all night. The Aide Care Plan did not identify R66 had contractures or that she required a ROM or restorative nursing program to prevent further decline.	F 318	ROM has been generated and all current residents will be reviewed and receive adequate assistance with ROM and splinting restorative nursing programs. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 on the procedure titled, Restorative Nursing ROM Program with a focus on the requirement to prevent avoidable decline of residents in ADLS/ROM. 4. An observation and chart audit was developed to monitor identification of ROM/ADL score decline and appropriate therapy referrals; restorative nursing care plan and documentation accuracy, monthly review and documentation of restorative programs by licensed nurse and MDSs accuracy of section O on the MDS. The audit will be completed by the DON or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	

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R66's Admission Assessment form dated 12/31/15, indicated R66 was non verbal, was non-weight bearing, transferred with a mechanical lift, and had elbow contractures. R66's Admission Assessment form indicated R66's hand grasps had not been assessed.

Review of R66's Resident Referral Interdepartmental Communication form dated 1/12/16, identified directions for nursing to complete R66's passive range of motion (PROM) to both upper extremities, active range of motion (AROM) to left hand, and included instruction to have R66 open and close fingers and to have R66 squeeze staff's hand with her left hand daily to maintain strength.

Review of a second Resident Referral from therapy dated 2/18/16, identified R66's hand splint wearing schedule as for R66 to wear splints 2 hours on, 2 hours off throughout the day and on at night.

R66's progress notes reviewed from 1/3/16 to 10/17/16 identified:

-1/3/16, R66 reached over and grabbed the TV remote with her left hand and could hold her TV remote in her left hand.

-1/21/16, R66 was changing TV channels with remote.

R66's progress notes lacked further documentation regarding communication skills or techniques and lacked any documentation of

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upper extremity motion, exercises, or decline in function.

Review of R66's physician progress notes from 2/9/16 to 10/16/16 identified:

-2/9/16, identified R66 suffered a traumatic brain injury in 12/14, had been in a former long term care facility, but family had requested a transfer closer to their home. R66's could not communicate verbally. Nursing had reported R66 did not communicate verbally but was able to push her call light button and could change the channel on her TV with her TV remote.

-3/17/16, identified R66 still had some movement which involved the left upper extremity, and the physician would make sure therapy had a maintenance regimen from a contracture and general limb standpoint for R66.

-10/6/16, identified R66 could squeeze his fingers with left hand.

On 10/19/16, observations from 7:00 a.m. to 9:47 a.m. were conducted:

-At 7:00 a.m., R66 was observed lying on her back in bed, with her eyes closed. Both R66's arms were bent at the elbow, her right hand was in a fist position on her chest, and her left hand was in a "C" shaped position with fingers bent and hand slightly tilted away from her body. Splint devices were not observed on either of R66's hands, and the splint devices were not observed in her room.

-7:49 a.m. licensed practical nurse (LPN)-A

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entered R66's room to provide her trachea (artificial opening at windpipe) site care. She confirmed R66 was not wearing hand splints and stated R66 had not been wearing them in the recent past because she thought the splints were uncomfortable for R66. LPN-A exited R66's room and did not apply R66's hand splints.

-8:03 a.m. the nurse consultant walked in R66's room and immediately walked down to the nurses station. R66 remained on her back in bed, with her hands and arms in the same positron, no splints observed.

-8:20 a.m. R66 remained lying in bed in the same position with R66's arms bent at her elbows and her hands rested on her chest in the same position. No hand splints were observed on R66's hands and splints were not observed in R66's room.

-9:47 a.m. R66 remained in the same position in bed, no hand splints were observed on R66 or present in R66's room.

On 10/19/16, at 10:03 a.m. LPN-A confirmed R66 had not worn hand splints and stated R66 did not wear the splints "at all." She stated she was not aware when R66 last had worn the splints and indicated she thought it had been in the distant past. LPN-A left room and did not apply hand splints to R66.

On 10/19/16, at 10:33 am nursing assistant (NA)-E confirmed R66 did not routinely wear hand splints, and stated she could not remember the last time R66 had worn her splints. NA-E provided a copy of the a NA care sheet and confirmed the care sheet directed for R66 to

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wear hand splints. She stated she had not been aware R66 was to wear hand splints. NA-A and LPN-A exited R66's room and did not apply her hand splints.

On 10/19/16, at 10:40 a.m. NA-D stated she was not aware of how R66's care plan directed her to care for R66. She stated she was not aware if R66 had hand splints or if R66 was supposed to wear them.

On 10/19/16, at 12:10 p.m. R66 was seated in her recliner in her room with both hands resting on her chest, right hand in fist, left hand curled in a "C" shape. R66 did not have hand splints on either hand.

On 10/20/16, at 9:30 a.m., during follow up interview, NA-B stated R66 presently did not receive range of motion services or presently was not receiving a restorative nursing program.

On 10/20/2016, at 9:36 a.m., during follow up interview, NA-D stated R66 did not routinely use her hands and was not aware if R66's hand stiffness had gotten worse. She stated she was not aware if R66 was on a restorative program or received range of motion services. NA-D reviewed the therapy referral in the nursing assistant reference book at the nursing station and stated she felt R66's therapy screening was not current, and R66 did not need range of motion services and did not need to wear splints since the screen was old (February 2016) She stated she was sure R66 got enough range of motion when they dressed her.

On 10/20/16, at 9:45 a.m. assistant director of nursing stated she was not aware if R66's splints

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had been discontinued in the past and indicated she questioned if the splints bothered R66 and indicated she felt R66 was not anymore contracted than when she was admitted.

On 10/20/16, at 10:03 a.m. occupational therapist (OT)-A stated R66 had worn hand splints at the time of admission, and indicated she was not aware if R66 had contractures on admission. She confirmed R66's therapy screens on 1/12/16 and 2/18/16, and indicated the therapy screen on 2/18/16, was completed after the facility changed the style of splint for R66 per family request. She stated a comprehensive assessment of R66's contractures had not been completed because the facility did not have a physician order for a consult. She stated she was not aware of R66's baseline for her contractures as the screen did not include measurements of limitations and stated the ROM and hand splints were recommended for R66 to prevent further contracture and discomfort in the future for R66.

OT-A stated the facility NAs were responsible for providing ROM services, restorative program and applying R66's splints and indicated the facility had a book of recommendations for residents' programs at the nurses desk. She confirmed R66 was unable to move both hands or her fingers independently. She stated she felt R66's left fingers were tighter, and flexion and extension was slightly limited, and stated she felt R66's limitations were within normal limits. She stated she felt R66's hands weren't contracted but had high tone. She confirmed the ROM and the splints were recommended treatments for R66's high tone. She stated she would expect R66 to wear the splints all night and alternating on and off every 2 hours throughout the day since

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12/31/15, and should have received ROM services since 1/12/16.

At approximately 10:10 a.m., NA-B entered R66's room and OT-A asked her to locate R66's hand splints. NA-B looked in R66's bedroom in various locations and found them on R66's wheelchair underneath blankets and equipment. OT-A stated R66 should have been wearing her hand splints according to the schedule to prevent further functional decline. NA-B stated R66 had not worn the hand splints in awhile, and stated she was not sure why R66 had not been wearing them.

On 10/20/16, at 10:35 a.m. LPN-A stated she felt R66's care plan did not include a restorative program or ROM that she knew of. She confirmed R66's care plan and stated that ROM services were not on R66's care plan. She stated R66 had never used hand splints, and she felt R66's ROM, "Was about the same."

On 10/20/16, at 10:37 a.m. certified occupational therapy assistant (COTA)
stated their usual process for implementing a ROM program for residents was to complete a therapy screen and give a copy of the recommended ROM program to the clinical manager (CM.) She stated once the CM received the plan she was expected to implement the program with NAs and set up the "Maintenance ADL Worksheet," in the NA Book for documenting ROM provided. She confirmed there was no documentation that ROM services were provided for R66 in her medical record or in the NA Book. She confirmed R66 should have received ROM services since 1/12/16, and stated she could not explain why she never received ROM services.

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On 10/20/16, at 10:40 a.m. NA-B stated she felt R66's stiffness had gotten worse and her arms were more stiff now. She stated she noticed R66 was more stiff when they dressed her, and stated they really had to manipulate her arms when they put her shirts on.

On 10/20/16, at 11:45 a.m. OT evaluated R66's elbow ROM while R66 was awake in her bed. OT physically picked up R66's right arm and after she manipulated both arms, she confirmed R66's right elbow lacked 25% extension. She confirmed R66 was a little tight with initial right side movements, and confirmed R66 grimaced in pain with movement. She confirmed R66 also had pain and grimaced with movement of her left arm, and R66's left elbow lacked about 10% for extension.

On 10/20/2016 at 12:00 p.m. NA-D stated sometimes R66 was a little more stiff in her upper extremities, and staff had to manipulate her arms more depending on the shirt they were putting on her.

On 10/21/16, at 10:14 a.m. NA-A stated R66 was totally dependent on staff for all of her cares. She stated she was unsure if R66 was on a ROM program , but stated she felt R66 should be. She stated she knew R66's right arm was more stiff than her left arm. She stated R66 just started wearing hand splints to both hands today and stated she had never seen R66 wear see hand splints until today.

On 10/21/16, at 2:16 p.m. R66 was observed on her back in bed with both arms resting on chest, right hand in a fist, left hand in a "C" shape. No splints were observed on either of R66's hands. A

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8.5 X 11" white piece of paper with both typed instructions and hand-written notes, dated 8/3/16, was observed posted on R66's bedroom wall across from her recliner and identified R66's TV show preferences.

On 10/21/16, at 2:55 p.m. speech language pathologist (SLP) stated she had been working with R66 on communication techniques and assessed her ability to use her hands and elbows in the past. SLP repeated her functional assessment of R66. R66 was reclined in bed and SLP held "Yes and No" flash cards above R66's chest. SLP instructed R66 to point at the card that answered her questions. R66 unable to point or motion hand toward cards. SLP instructed R66 to use her eyes to look at either card to answer her questions. R66 was unable to participate in the assessment at all. R66 began crying and SLP ended assessment. SLP confirmed R66 had 0% success today, where R66 responded correctly to 60% of her questions during a past assessment.

On 10/24/16, at 9:50 a.m. NA-B stated at present, she was not aware if R66 could use her call light , and stated she did not know if R66 could hold a TV remote or use it.

On 10/24/16, at 10:14 a.m. NA-D stated R66 might be able to use her call light or TV remote if you put them in her hand, but wasn't sure.

On 10/24/16, at 10:38 a.m. registered nurse (RN-A) stated R66 had severe cognitive impairment and was totally dependent on staff for all cares. She stated she was unaware if R66 was on a ROM program, wore her arm splints before today, or had declined in ROM to her upper extremities. She stated R66 should have received

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ROM and wore her arm splints according to the therapy recommendations and confirmed ROM was not on R66's care plan.

On 10/24/16, at 10:53 a.m. clinical manager (CM)-A stated R66 had severe cognitive impairment, and was dependent on staff for cares. She indicated she thought R66 had contractures on admission, but stated she did not remember where the contractures were, or which side of R66's body was affected. CM-A stated she remembered talking to the physician in the distant past about R66's contractures after admission and stated she told him she saw R66 use her TV remote in her room.

CM-A stated R66 was supposed to get ROM since 1/12/16, and was to wear hand splints on and off during the day, and keep on all night. She stated she expected R66 to wear her hand splints according to the schedule and receive ROM services from the NA's. She confirmed there was no documentation in R66's medical record or in the NA book that R66 had ever received ROM services since admission. She confirmed ROM services were not on R66's care plan.

On 10/24/16, at 12:00 p.m. COTA evaluated R66 while she was awake and sat in her recliner. COTA picked up R66's right arm by her elbow and put her call light in between R66's finger and adjusted her fingers to hold call light. R66's fingers were very weak and her fingers and hand didn't move and the call light fell on her lap. COTA picked up R66's left arm by the elbow, placed her call light between R66's fingers. R66's left hand and fingers did not move. R66 hand and fingers were very weak and call light just sat loose in her hand and R66 could not grasp or activate her call

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light. COTA also evaluated R66 for holding her TV remote. COTA attempted to place R66's TV remote in R66's right hand while she supported R66's arm by her elbow. R66 was unable to hold the TV remote at all with her right hand or fingers. COTA lifted R66's left arm up by the elbow and put the remote between R66's left fingers. The TV remote slipped in R66's hand and pointed up to the ceiling. R66 was unable to hold the remote towards her TV or activate the remote with her left hand and fingers. She stated she was sure R66 declined in her upper extreme ROM.

On 10/24/16, at 12:27 p.m. Activities Director (AD) confirmed activity staff had posted a paper in R66's room at the time of admission, which listed TV shows R66 like to watch. AD indicated at the time the sign was originally posted, R66 could hold and use the remote, and liked to channel surf on the TV and would stop on the shows she liked to watch.

On 10/24/16, at 1:45 p.m. nurse practitioner (NP) stated she felt if R66 was unable to use her remote or call light now, and could on admission, it was evidence of a functional decline. She stated the failure to provide ROM services was not a new concern for her and stated she had brought her concerns to administration in the past, but continued to be a long standing problem in the facility.

On 10/25/16, at 5:05 p.m. family member (FM)-A stated when R66 first got to the facility she could use her TV remote, change the channels, use her call light, and write her name and the word Mom. She stated when R66 was first admitted to the facility R66 could also pull her covers up, put her

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F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		12/14/16

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to comprehensively assess a resident's falls to determine whether new interventions should have been implemented to decrease the risk of further falls for 1 of 3 residents (R78) reviewed for accident hazards. This deficient practice resulted in harm for R78 who sustained a hip fracture with a fall.

Findings include:

R78's quarterly Minimum Data Set (MDS) dated 6/14/16, identified R78 had diagnoses which included Alzheimers disease, unspecified fall, and atrial fibrillation. The MDS identified R78 had moderate cognitive impairment, required limited assist to transfer, walking, toilet use and was occasionally incontinent of urine, continent of bowel and was not on a toileting plan.

R78's quarterly MDS dated 9/14/16, identified R78 had intact cognition, required limited assistance to transfer, walk, toilet and for personal hygiene, was occasionally incontinent of urine, continent of bowel and was not on a toileting plan.

R78's significant change MDS dated 10/3/16, identified R78 had moderate cognitive impairment, was totally dependent upon staff for transfers, dressing and toileting, was occasionally incontinent of urine, continent of bowel and was not on a toileting plan.

R78's Care Area Assessment (CAA) dated 10/3/16, identified R78 had confusion, disorientation, forgetfulness and needed

F 323

F 323 Free of accidents/hazards/supervision/Devices-actual harm G

1. R78 s fall risk assessment was reviewed and updated on November 17, 2016. A bowel and bladder assessment was completed for R78 on 10-20-2016; care plan was reviewed and revised according to all assessment findings. Falls reports will be analyzed monthly for characteristics and trends.

2. All residents have the potential to be affected in this area. A list of residents that have fallen in the past 30 days will be generated, reviewed for assessment, and care plans updated as needed to ensure compliance in this area.

3. Mandatory nursing staff education was provided on November 16 and 17, 2016 on the procedure titled, Accident/Falls with a focus on the need for the facility to comprehensively assess a resident to determine what new interventions could be implemented to decrease the risk of future falls.

System change: Daily review of all incidents and accidents by facility management.

4. An audit was developed to monitor fall risk assessments, fall prevention care plan interventions for residents identified at risk for falls, post fall incident reports, timely reporting of falls to administration,

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F 323	Continued From page 140 reassurance, reminders to help make sense of things. The CAA identified R78 had experienced a decline in condition related to fall with fracture and surgical intervention and incontinence. R78 was receiving therapy services with goal established for toileting transfers. R78 had been impulsive leading to poor safety awareness and had a history of falls and experienced a fall resulting in a fracture with surgical intervention. R78's care plan revised 9/28/16, indicated R78 had a self care deficit related to cognitive loss, unsteady gait and transfers, was at risk for falls related to history of falls, unsteady gait, incontinence and poor judgment related to dementia. The care plan indicated R78 used a urinal at night per his request, App (concave) mattress related to decreased mobility, transfer with hoyer (full body lift) and two staff, floor mats beside bed, rearrange room to allow extra room for mobility. The facility form titled Aide Care Plan Group B, dated 10/17/16, directed R78 required assist of one staff for ADL's (activity of daily living), had falls, used a mechanical lift for transfers, would request toileting and required assist of one for toileting. On 10/19/16, at 7:15 a.m. R78 was lying in bed, the room was dark and quiet. On the left side of R78's bed a thin gray fall mat on the floor and on the right side a thin brown fall mat was present. A square white personal alarm was secured to the grab bar attached to the right side of R78's bed and the call light was attached to the grab bar also. On 10/19/16, at 8:19 a.m. licensed practical	F 323	the investigation of falls and reports to OHFC as appropriate. The audit will be completed by the DON or designee weekly X 4 weeks, then monthly X 2 months. Falls trend reports and audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	

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F 323	Continued From page 141 nurse (LPN)-A propelled R78 to the dining room in a wheel chair, the white square personal alarm was secured to the back of R78's wheel chair. On 10/19/16, from 8:27 a.m. to 8:40 a.m. R78 independently ate the breakfast meal seated in a wheel chair with the personal alarm secured to the back of his wheel chair. On 10/21/16, at 10:33 a.m. R78 was seated in a wheelchair in the hall outside of his room watching the activity of staff and other residents, the personal alarm was secured to the back of the wheelchair. A review of R78's clinical record revealed the following 8 documented falls since R78 was admitted on March 7, 2016: (1) 3/8/16-at 9:50 p.m. R78 was found on floor beside his bed. Resident interview indicated R78 stated,"I was going to the bathroom." Staff initially placed a bed alarm. The interdisciplinary team (IDT) reviewed the fall on 3/18/16 (10 days following the fall). The post fall findings identified, "Resident attempts to self transfer to BRM [bathroom]. The intervention to be implemented: Placed pressure alarm. (2) 3/9/16-1:00 a.m. alarm sounded and alerted staff to R78's room. R78 was found on floor mat next to bed. R78 sustained a skin tear to the right elbow 1 cm (centimeter) by 0.8 cm. The incident note identified R78 needed to use bathroom and tried to get up. Interventions to be implemented as a result of the assessment: Bed alarm, floor mat, urinal placed. The IDT team reviewed the fall on 3/17/16 (8 days following the fall). Additional information/interventions to be communicated to	F 323		

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F 323	Continued From page 142 staff along with changes to the care plan included: floor mat (which was currently in use and not a new intervention). (3) 3/12/16-12:30 a.m. R78 was found lying face down on floor with head against night stand. Resident interview indicated R78 had stated he was getting up to go to the bathroom. R78 sustained a laceration to the right eyebrow 2.5 cm long and a laceration to the left side bridge of his nose 0.4 cm. The incident note identified a mat was on the floor next to R78's bed, when resident got up he had bare feet and slipped on the mat. The IDT reviewed the fall on 3/14/16 (2 days following the fall). Interventions to be implemented as a result of the assessment: Resident needs a concave/lipped mattress. (4) 6/10/16-4:30 a.m. R78 was found sitting on the floor mat on floor next to bed. R78 had indicated he was going to get up and into wheel chair. The nursing assistant assisted R78 to the bathroom and to get dressed for the day. The note indicated R78 indicated he slipped on the mat by the bed was bare footed. The note indicated R78 had a problem with safety awareness, recently completed therapy and recommendations were to continue to receive help, does not comply and continues to attempt self transfer. (5) 7/15/16- 3:00 a.m. R78's fall occurred in his room and it was unknown what R78 was doing prior to the fall. The fall occurred when R78 was transferring without assistance and did not use the call light. Interventions to be implemented as a result of the assessment: Reminded to use call light and wait for assist. The nurse's notes identified R78 was found lying on floor near bed.	F 323		

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F 323	Continued From page 143 Resident was unable to identify what he had been doing. The nurses notes also indicated the IDT reviewed the fall on 7/15/16, did not remember he should use call light to alert staff for assistance, will add a lipped mattress to bed to define perimeters. (6) 7/27/16- 6:20 p.m. R78's fall occurred in residents room and prior to the fall R78 was lying in bed. The form identified alarms had been inititated at time of fall. The note did not include an analysis of fall and had been reviewed by the IDT on 8/2/16 (6 days after the fall) (7) 9/19/16-5:20 a.m. indicated R78's fall occurred in room and prior to the fall, had been sleeping. The note faxed to the physician identified-found lying on floor in room in front of bathroom door, resident stated he had slipped. The notes indicated R78 was confused at times, forgetful and had a history of falls, lack of safety awareness. The notes lacked documentation of interventions to be implemented as a result of the fall for R78. The IDT team had reviewed the fall on 9/27/16 (8 days later) (8) 9/22/16-8:15 a.m. indicated staff were alerted to room by roommate. R78 was found sitting sideways on floor of BR (bathroom) states finished going and stood up and slipped. The note indicated R78's left shoe off and was underneath resident and right shoe falling off foot. Further, the incident note identified R78 had a have BM (bowel movement) in BR (bathroom) prior to fall. The post fall physical assessment identified R78 complained of pain with range of motion of left leg and R78's left leg was noted to be shorter than the right. The ambulance was called to transport R78 to the emergency room.	F 323		

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R78's hospital discharge interagency referral form for readmission to the nursing home dated, 9/26/16, indicated R78 had left trochanteric fixation and nailing (surgical repair of the hip) of the left hip fracture on 9/23/16.

Review of R78's Fall Risk Assessment form dated 3/7/16, identified R78 had three falls in last week, was weak, incontinent of bladder, used a walker and was able to use call light independently.

Review of R78's Fall Risk Assessment form dated 6/23/16, indicated R78's assessment remained current with the following minor changes: "Has had multiple falls since admission. Is reminded to use call light but doesn't."

The Fall Risk Assessment forms completed failed to comprehensively assess R78's risk for falls to include but not limited to trends/patterns to falls, factors that may be causing the falls, and effectiveness of interventions.

No Further Fall Risk Assessments were found in R78's record

Review of R78's Bowel and Bladder Functional Evaluation Tool dated 3/14/16, revealed R78 was incontinent of urine and bowel, awoke at night to void, and was able to identify the need to void/defecate. The tool identified R78 was able to use call light, able to ask to go to the bathroom, required assist to ambulate and transfer to toilet/commode, and was able to use the toilet majority of time. The evaluation tool did not identify a toileting plan for R78.

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Review of R78's Bowel and Bladder Function Evaluation Tool dated 6/23/16, identified R78 was continent of bowel and was incontinent of urine 1-2 times weekly.

Review of R78's Resident Referral Interdepartmental Communication forms between nursing and physical therapy revealed the following:
- 4/1/16, Physical Therapy-"Please encourage Pt. [patient] to transfer and toilet with stand-by-assist only. We are working towards independent transfers and getting rid of alarm. Any? [questions] call. Nursing responded on 4/6/16- Cont [continue] with alarm for now. SBA [stand by assist] and encourage him to do himself. Working on getting back up breaks.
-5/8/16, Physical Therapy-Pt. [patient] has been D/C [discharged] from therapy please ambulate with RW [regular walker], transfer belt and SBA, 2 x [times] daily Pt. amb 600 feet without difficulty." The form included a nurses signature, however, lacked any response to the communication from therapy.

Review of R78's undated Pro Rehab Nursing Referral For Therapy Screen form indicated R78 had been demonstrating independence in transfers and ambulation, alarms had been removed and nursing had requested a therapy screen. The form included documentation from therapy personnel, signed on 6/24/16, which directed that R78 was able to complete transfers and ambulation with SBA at day of discharge from therapy. R78 remained assist of one due to issues with safety awareness. The therapy note recommended R78 remained assist of one.

Review of R78's Nursing Quarterly ADL

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F 323	Continued From page 146 Assessment dated 6/13/16, identified R78 had Alzheimer's, and a history of falls. The assessment identified R78 had moderately impaired cognitive skills for daily decision making, decisions poor, cues/supervision required, and required limited assistance with transferring and walking and supervision with toileting. On 10/19/16, at 1:17 p.m. a review of R78's fall reports and progress notes was conducted with the assistant director of nursing (ADON) present. The ADON verified R78's multiple falls, although was unsure what interventions were currently in place. The ADON identified following a resident's fall the post- fall clinical team which included nursing, the administrator and social services, reviewed the facility form titled Fall Risk Post- Fall Assessment. The form was initiated by the floor nurse when resident falls occurred and the team reviewed for appropriate interventions. The ADON indicated R78's fall reviews were difficult to interpret what interventions were initiated following the falls. The ADON indicated she believed the falls were fully assessed and appropriate interventions were initiated for R78's falls. ADON confirmed R78 had sustained a hip fracture after the fall on 9/22/16. Review of R78's progress noted dated 3/10/16 to 9/22/16, included various notes which identified R78 received assistance with ADLS, transfers, and self transferred at times. The progress notes included: -5/18/16, Did a four day trial of alarms off resident. Resident did well, toileted self, transferred bed/chair/wheelchair without incident Removed alarms at this time. - 7/24/16, found on knees in front of closet,minimal one person assist up.	F 323		

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-9/19/16, R78's roommate alerted nurse R78 was on the floor. R78 found on his back, on the floor in front of the bathroom door, trying to sit up. R78 stated he must of slipped on something, gripper socks on.
-9/22/16, R78 found on floor in bathroom, sitting on buttocks and stated went to bathroom, finished, stood up and fell, slipped. Complained of much pain left hip with internal rotation, shortening of left leg. Ambulance called to transport. The note indicated R78 had sustained a fractured hip and would probably have surgery the following day.

On 10/20/16, at 10:11 a.m. nurse manager (NM)-B stated she felt the lack of sufficient staffing in the facility must have something to do with the large amount of resident falls in the facility.

On 10/20/16, at 10:45 a.m. nursing assistant (NA)-I indicated R78 was independent to go to the bathroom by himself prior to the fall and indicated since R78's hospital stay he needed assistance to go to the bathroom. NA-I indicated R78 did not always remember to check if the wheel chair brakes were on and now had brakes on the wheel chair that locked automatically.

On 10/21/16, at 1:31 p.m. NA-B verified R78 had a recent decline because of a fall with fractured hip. NA-B verified R78's frequent falls were usually related to going to the bathroom or when coming back from the bathroom. NA-B stated she felt R78 was independent to take himself to the toilet prior to the fall and would turn the call light on for assistance when needed to pull up his pants or to shave. NA-B identified R78 at times used the call light appropriately and other times did not. NA-B indicated a toileting program may

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have been beneficial for R78 prior to his fall with a fractured hip.

On 10/21/16, at 2:13 p.m. NA-J indicated R78 was independent with dressing, hygiene and toileting before the fall and hip fracture. NA-J identified prior to the hip fracture R78 was always trying to go to the bathroom.

On 10/21/16, at 2:39 p.m. NA-A indicated she/he did not work often with R78 and stated, "He will be sitting in the hall and say 'hey', have to go to the bathroom" and staff would assist him.

On 10/21/16, at 2:49 p.m. NM-B indicated prior to R78's fall resulting in a fracture, R78 required assistance of one to transfer and remind R78 to ask for help to toilet because he was reluctant to ask or did not ask for help. NM-B indicated R78's toileting program was to sound call light when he needed to go to the bathroom or he attempted to transfer himself. NM-B stated, "He [R78] calls or transfers self when he needs toilet." NM-B reviewed the 8 falls and interventions. After review of the falls, NM-B stated she felt there had been a pattern of the falls was going to or coming off of the toilet. NM-B confirmed R78 was not on a toileting program and stated," It may have been a good idea."

On 10/21/16, at 3:07 p.m. a follow up interview with the ADON verified prior to R78's hospitalization the facility had not initiated a toileting plan for R78. The ADON felt R78's falls had been assessed, and appropriate interventions had been in to place. ADON stated had not identified a pattern with R78's falls, however, indicated evaluation for a pattern for falls was not part of the comprehensive

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F 323	Continued From page 149 assessment for R78. On 10/24/16, at 2:00 p.m. nurse practitioner (NP)-A indicated she expected the facility staff to assess falls routinely and attempt to identify a pattern or reason for the falls in an attempt to minimize further falls. On 10/24/16, at 4:17 p.m. a phone interview with R78's physician (MD)-A verified he was aware R78 had a fall which resulted in a fractured hip, however, was unaware of the number of falls. MD-A indicated R78 was demented and was not easily redirected. MD-A verified he would expect facility nursing staff to assess the falls and if going to the bathroom is the common reason with the falls, he would expect staff to provide an appropriate intervention related to R78's toileting needs. The requested facility policy regarding facility falls was not provided.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334		12/14/16

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immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

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F 334	Continued From page 151 (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Pneumococcal Conjugate Vaccine-13 (PCV13) as recommended by the Centers for Disease Control (CDC) were offered to 3 of 5 residents (R3, R66, R83) whose vaccination histories were reviewed. Findings include: The CDC identified the Advisory Committee on Immunization Practices (ACIP) recommends that all adults 65 years of age or older receive a dose of PCV13 followed by a dose of PPSV23 at least 1 year later. R3's Immunization Record dated 9/2/08, indicated the 73 year old had received Pneumovax dose 1 on 9/4/08. However, the medical record lacked evidence R3 received or was offered the PCV-13 vaccination as recommended by the CDC. R66's undated Immunization Record, indicated the 50 year old had not received the PCV-13 vaccination. R66's medical record lacked evidence R66 was offered the PCV-13	F 334	F 334 Influenza and pneumococcal immunizations 1. R3 s POA is being contacted for consent to administer the PVC 13 vaccination. Once the consent is received, the residents vaccination will be done and documented in the MAR and legal medical record. R66 s POA is being contacted for consent for PVC13 vaccination. R83 was discharged from facility shortly following annual facility survey. The CDC immunization guideline was provided to each staff member at the educational meetings. 2. All residents have the potential to be affected in this area and will be offered the PVC13 at their next care conference and all residents will be reviewed within 3 months. After a signed consent and education received and provided, the residents PVC 13 vaccination will be administered and documented in the legal medical record.	

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F 334	Continued From page 152 vaccination as recommended by the CDC. R83's undated Immunization Record, indicated the 91 year old had not received the PCV-13 vaccination. R83's medical record lacked evidence R83 was offered the PCV-13 vaccination as recommended by the CDC. When interviewed on 10/24/16, at 2:00 p.m. unit manager (UM)-B who was responsible for the facility's infection control program confirmed the facility was aware of the CDC recommendation related to PCV13 vaccination. UM-B reported she had discussed the PCV13 vaccination guidelines with the medical director at the last quarterly quality meeting, but did not get any direction or orders on implementing the CDC recommendations. UM-B confirmed the facility did not have an active plan in place to offer or implement the PCV13 vaccination to residents per the CDC recommendation. The facility's Pneumococcal Vaccine Policy dated 11/14, indicated all residents would be encouraged to obtain both the pneumococcal PCV13 and PPSV23 vaccines unless contraindicated. The policy also indicated if a resident was offered the vaccine and refused, education of risks and benefits would be reviewed with the resident; if the resident still refused, the refusal would be documented in the medical record.	F 334	System change: Immunization form has been updated to include PVC13 vaccination. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 on the procedure titled, Immunizations: Pneumococcal Vaccine a focus on the CDC recommendations for all nursing home residents to receive two pneumococcal vaccinations that include the PCV 13 and PSSV23 according to a recommended schedule. 4. An audit was developed to monitor vaccinations. The audit will monitor the physician s order for PCV 13 and PVC23, resident signed consent form, vaccination information sheet (VIS), and documentation of administration of vaccination. Immunization records will be reviewed bi-monthly to identify timing of needed subsequent recommended/ordered vaccinations. The audit will be completed by the infection control nurse or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations. 5. Deficient practice will be corrected by December 14, 2016	
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to	F 353		12/14/16

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F 353	Continued From page 153 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, resident, staff and family interview and document review the facility failed to ensure sufficient staffing was available to meet resident needs related to assistance with ambulation (R38, R44, R29, R46), range of motion (ROM) services for (R66), prevention of pressure ulcers (R18) personal cares (R18) fall prevention (R78) choices and provision of services (R61.) The deficient practice had the potential to affect all 52 residents currently residing in the facility. Because of the deficient practice, the facility caused actual harm for R38, R66 and R78. Findings include:	F 353	F353 Sufficient 24 hour Nursing Staff per Care Plans F353 Sufficient 24 hour Nursing Staff per Care Plans 1. System change: Reorganization of resident rooms to increase resident room proximity and nursing structure was completed on 11-16-2016. Staffing committee established and meeting weekly discussing staffing status and hiring efforts. Facility applied to provide for CNA training at facility. Utilizing nurse and CNA agency staff currently. New DON started 10-24-2016.	

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R38 did not receive any ambulation services as directed by therapy due to insufficient staffing, see F310.

R18 did not receive timely repositioning and personal cares as directed by care plan, see F314 and F312.

R44, R29 and R46 did not receive ambulation program as directed by therapy, see F311.

R78 did not receive accurate assessments related to a pattern of multiple falls due to insufficient staffing, see F323.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had concerns residents had not been receiving restorative programs including ROM and ambulation due to insufficient staffing. PTA stated she had seen some residents lose their abilities and/or decline in ambulation and ROM including R66 and R38 due to not receiving restorative services. PTA stated she had voiced her concerns to facility management in weekly medicare meetings, which both the facility administrator and director of nursing (DON) would attend. PTA stated she had been told by both the administrator and the DON they were working on staffing. PTA stated she had voiced concerns about staffing for the last 4-5 months and had not seen any improvement with staffing.

On 10/21/16, at 1:43 p.m. the assistant director of nursing (ADON) stated the facility had been working on staffing concerns since last year. ADON stated the administrator, director of nursing (DON) and human resources (HR) had

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2. All residents have the potential to be negatively affected by insufficient staffing and all residents are receiving adequate assistance with cares.

3. Mandatory nurse education provided on November 16 and 17, 2016 on the procedure titled, Nursing Administration Staffing with a focus on the need of staff to meet the residents needs. Staff was educated on the plan to merge all residents into one nurses station. The audit will monitor staff call ins, analysis of fall patterns monthly with goals to increase nursing per diem hours

4. Observational and documentation review audit has been created to monitor staff call ins, resident counsel satisfaction and DON attendance, monthly fall trending and analysis, monthly review of facility Quality Measures, monitoring of assistance with ADL s, review of restorative nursing program documentation, call light response time, urinary incontinence checks every 2 hour, and routine monthly cna and licensed nurse meetings for ongoing education and input on identified concerns. The audit will be completed by the DON or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations.

5. Deficient practice will be corrected by December 14, 2016

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F 353	Continued From page 155 been working on staffing with weekly meetings. ADON stated she had not been attending those meetings as she had been trying to back out of that role due to having to work nights along with another registered nurse (RN.) ADON stated she felt call ins were a problem as well as not enough number of staff as a whole. ADON stated the facility had used nursing pool staff last in September, however they had been unable to find staff from any agency in the last month and a half. ADON stated she felt there were times the NA were unable to complete tasks in a timely manner and cares would get missed due to insufficient staffing. ADON stated she felt she and the other nurse managers (NM) were unable to provide oversight of cares to ensure cares were according to care plans and completed timely. ADON stated she felt resident assessments and care plans were not completed and/or updated on a consistent basis due to insufficient staffing. ADON stated she had routine complaints from residents and staff regarding sufficient staffing. ADON stated NA had reported to her resident cares were not consistently completed due to staffing concerns. ADON stated the staff worked together in an attempt to meet residents needs, however was difficult due to insufficient staffing. ADON stated she was aware the facility restorative programs had not been consistently implemented or started due to not enough staff to complete the required programs on a routine basis. ADON stated she felt there had been in increase in skin rashes due to insufficient staffing. ADON stated the facility continued to take admissions though would screen residents to look at acuity. R27's annual MDS dated 8/17/16, identified R27 was cognitively intact, required extensive	F 353		

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F 353	Continued From page 156 assistance Activities of Daily Living (ADL's,) including transfers, dressing, toileting and personal hygiene. On 10/17/16, at 6:47 p.m. R27 indicated she believed the facility did not have enough staff because she had to wait for staff to get to her. R27 identified she often waited for assistance to go to the bathroom or go to bed. R27 stated,"I have had to wait an hour or more." R27 indicated she had told staff about the long wait times for assistance; however, did not remember whom she had told. R27 indicated being incontinent of urine because of the long wait for assistance. R27 stated,"it make me feel miserable;" however had not told staff how it made her feel. R61's quarterly Minimum Data Set (MDS) dated 7/24/16, identified R61 was cognitively intact and had diagnoses which included, insulin dependent diabetes, congestive heart failure (CHF) and anxiety. The MDS identified R61 required extensive assistance from staff with dressing. The MDS also identified R61 received insulin injections daily. On 10/20/16, at 10:03 a.m. R61 stated when she had concerns and needed assistance she would only use her call light when certain staff were working. R61 stated some nursing assistants (NA) would walk past her room when the call light was on and others would come into her room, shut the light off and leave stating that they would be back. R61 stated most of the time they did not return. R61 stated she had voiced her concerns about her call light, baths and blood sugars to staff at her care conferences and her son and	F 353		

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was not sure if he had spoken with staff.

On 10/19/2016, at 8:50 a.m. licensed practical nurse (LPN)-C stated at that time the facility census was 52. LPN-C indicated the day shift usual staff schedule included three floor nurses, and five nursing assistants (NA), however today there were four NA's. At 9:17 a.m. LPN-C indicated the facility did not have sufficient staffing and as recent as last weekend there was short staffing on both the day and the night shift. LPN-C indicated she had reported the recent incidents of short staffing to the facility scheduler and the HR. LPN-C stated the facility had a lot of call-ins and overall staff did not consistently come in for scheduled shifts. LPN-C stated she was unaware of what administration had planned for staffing shortages.

On 10/19/2016, at 1:01:33 p.m. house keeping staff (HC)-A indicated at that time the nursing assistants (NA) were working short. HC-A stated when there were not enough staff to answer call lights, she would answer them and inform the residents the NA were busy and would have to wait longer. HC-A stated she felt when the facility was short staffed it took longer to attend to resident needs.

On 10/20/2016, at 10:11 a.m. nurse manager (NM)-B indicated staffing had not improved in the past year. NM-B stated she was often working on the floor and was unable to routinely complete her managerial work. NM-B stated she felt if staff had to continue to work under the conditions at that time, they would get burned out. NM-B stated the lack of staff on the floor must have had

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something to do with the large amount of resident falls, such as R78.

On 10/20/16, at 2:00 p.m. NA-F stated the facility had lost staff left and right the last 5 months. NA-F stated she did not feel there was sufficient staff in the facility to routinely meet resident needs on a consistent basis. NA-F stated the she had heard staff, family and residents complain about staffing shortages. NA-F stated she had noticed an increase in resident falls, skin rashes, incontinence and behaviors. NA-F stated she felt staff were burning out due to working too many hours. NA-F stated she felt residents who required 2 staff assist (such as R18, R26, R15, R27,) and those who could not/would not verbalize their needs (R61) were the residents who had not routinely received the cares they needed.

On 10/20/16, at 2:43 p.m. NA-B stated she felt the facility had a chronic insufficient staffing which had been going on for the last year. NA-B stated she felt it was impossible to routinely meet residents needs due to insufficient staffing. NA-B stated the facility had call-ins on at least a weekly basis and often were not able to replace the staff. NA-B stated she felt residents were not receiving routine repositioning, toileting, ambulation, ROM and bathing, such as R27, R37, R18, R47, R66, R44, and R61. NA-B stated she had spoken with the interim DON approximately ago a month about insufficient staffing. NA-B stated she had been told it was like that everywhere and they had to just work together. NA-B stated she felt staffing had gotten so bad there were times R51 would throw himself on the floor to get staffs attention.

On 10/21/16, at 11:20 a.m. physical therapy

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assistant (PTA) stated she had serious concerns with residents ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis. PTA confirmed a decline in ambulation for R38 and stated residents such as R44 and R29 did not routinely receive their ambulation programs.

On 10/21/2016, at 1:35 p.m. during a follow up interview, NA-B stated she felt R37 had an increase in skin irritation from incontinence due to not receiving cares routinely because of short staff.

On 10/21/2016, at 2:17 p.m. NA-J stated she felt there was not an adequate amount of staff to meet resident needs. NA-J stated she felt there had not been sufficient staff to meet residents needs for the last several months. NA-J stated there were times when only 3 NA's would be working for the evening shift when there were to be 5 on the shift. NA-J stated that would occur weekly. NA-J stated routine cares would not get done in a timely manner such as toileting, repositioning, ambulation and baths on a consistent basis. NA-J stated she felt the administrator and DON were aware of resident needs not being met consistently, but was unaware of any actions the admininstrator or DON had taken to improve staffing.

On 10/21/2016, as 2:32 p.m. NA-A stated she felt staffing was getting "tough." NA-A stated they would routinely work with 3 or 4 NA's when they were supposed to have 5-6 NA's on a shift. NA-A stated she felt residents cares such as toileting

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and repositioning were not being done routinely or timely. NA-A stated she felt R46 would use her call light to alert staff of her toileting needs, however due to insufficient staffing R46 would not get assistance timely and would be incontinent. NA-A also stated she felt R44 did not receive assistance with her care planned ambulation program.

On 10/21/16, at 2:53 p.m. a family member and representative of family council (FM)-B stated she felt there was not enough staff in the facility to meet all of the residents needs. FM-B stated she was at the facility every day and often saw other residents call lights had gone unanswered for long periods of time. FM-B stated has recent as a few days ago her family members bedding had been soiled and covered with a blanket. FM-B stated she continued to reported concerns to the nursing staff about soiled linens and wheelchair of her family member. FM-B stated she felt the staff cut corners to save time had verbalized her concerns at a family council meeting in August, 2016. FM-B stated she had been told that was not the place to voice concerns about staffing and had been directed to fill out a grievance form. FM-B stated she been told the facility had "plenty" of staff. FM-B stated she had also voiced her concerns about sufficient staffing in the last care conference for her family member and had been told again the facility had plenty of staff. FM-B stated she felt she had to make sure her family members linens and wheelchair were clean on a daily basis.

On 10/24/16, at 9:35 a.m. NM-A stated she had not heard any recent staffing complaints from residents or family members. NM-A stated she

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had been working nights due to an unfilled night nursing position.

On 10/24/16, at 1:15 p.m. the Licensed social worker (LSW) stated she could not recall any complaints regarding staffing by residents, family members or staff. LSW stated her usual process when a complaint was brought forward would be to write a grievance form. LSW stated she felt the facility had met the "state requirements," for staffing. LSW stated there were times when staff would be tied up with a bariatric (obese) resident (who required 3 staff assistance,) but felt overall there were sufficient staff to meet resident needs on a routine basis.

On 10/24/16, at 1:35 p.m. dietary manager (DM) stated she had heard casual comments such as "seems like we're short today", from residents in the dining room during meals on a weekly basis. DM stated she had verbalized concerns about insufficient nursing staff from residents to the HR director, NM's, DON and administrator in the last few months. DM stated she felt the administrator was aware of staffing concerns in the facility though, has not seen any improvement.

On 10/24/16, at 2:00 p.m. Advanced Practice Registered Nurse/Certified Nurse Practitioner(NP)-A indicated she expected the facility staff to assess falls routinely and attempt to identify a pattern or reason for the falls in an attempt to minimize further falls. NP-A indicated she would expect floor staff to follow resident care plans and provide restorative ambulation and exercise. NP-A stated," Sadly not providing recommended restorative exercises is not uncommon here."

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On 10/24/16, at 2:40 p.m. the medicals records (MR)-B staff indicated the number of staff scheduled is determined by the resident census for the shift. If there is a question regarding the number of staff to schedule MR-B would consult the administrator. MR-B indicated at this time with 52 residents in house she attempted to schedule five NA's for the day shift, five NA's for the evening shift, and two NA's for the overnight shift. Review of the facilities daily assignments sheets from 9/5/16 to 10/20/16, revealed the facility had varied number of staff scheduled and did not consistently have the staffing ratios the facility had identified as appropriate. The following inconsistencies were found:

- the day shift did not have the staffing determined by the administrator for 20 out of 48 days
- the evening shift did not have the staffing determined by the administrator for 14 out of 48 days
- the night shift did not have the staffing determined by the administrator for 2 of 48 days, on these two night shifts one nursing assistant was scheduled rather than two for 55 residnets and then 56 residents.
-9/26/16, one NA to care for 55 residents-no increase in licensed staff for the shift.

On 10/24/16, at 3:03 p.m. during a follow up interview, LSW stated she attended the facility's family council meetings when they had attendees. LSW stated the facility's routine family council members had quit going to the meetings when they did not want to volunteer for remodeling or decorating. LSW stated a family member had started to complain about staffing at one meeting and had been directed to fill out a grievance form

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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versus discussing the concern at the meeting. LSW stated she kept a log of all grievances and the family member did not fill out a grievance form. LSW stated she felt residents needs were met on a routine basis.

On 10/24/16, at 3:28 p.m. the interim DON stated she felt there was a staffing concern in the facility, however felt residents needs were being met. DON stated she felt the facility had difficulty in finding licensed and unlicensed nursing staff. DON stated the facility had tried to obtain staff from nursing pool agencies and due to a "cap" they had been unable to up to that point. DON stated as of November 1st, the facility will have one agency pool nurse coming in. DON stated she was unaware resident cares were not getting done according to resident care plans as she had not been told by any NA's. DON stated she had attended a recent resident council meeting in which call light wait times were brought up by residents. DON stated a call light audit had been completed and had felt the matter was resolved. DON also stated she felt a 5-15 minute wait time for a call light to be answered was acceptable. DON further stated she had not had any complaints from residents, family members or staff regarding insufficient staffing, only about staff performance. DON stated the administrator would be the one to set the number of licensed and unlicensed staff.

On 10/24/16, at 3:41 p.m. the administrator stated he had been working on staffing since last Monday (when he started,) and had planned to meet with the clinical managers to identify resident acuity. He stated he was unsure if the staffing in the facility was sufficient. The administrator stated he felt the facility had an

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adequate number of staff and stated he felt the problem was with full and part time ratios. He stated the facility had 4 licensed nursing positions open, 4 NA positions at that time. FA stated at that time he had not implemented any action plans for staffing, though had just received a staff recruitment plan from HR. FM stated he planned to work on employee relations, though had not implemented at that time.

On 10/24/16, at 4:08 p.m. the activities director (AD) stated she brought up resident concerns from resident council verbally during morning meetings to all department heads, and resident concerns were always brought up at monthly quality assurance meetings. She stated sometimes she filled out a Resident Council Concern Follow-up form, and delivered it to nursing, or put the form in their mailboxes. She stated nursing completed and returned the form to her before the next scheduled resident council meeting.

On 10/24/16, at 5:05 p.m. family member (FM)-A stated she had never seen staff do any exercises with R66 for her hands and arms, and stated she didn't know if they ever had. She stated R66 received ROM all the time before admission to this facility. She stated she had asked facility staff why R66 did not get ROM exercises and stated she had been told by staff they felt her brain was not working enough for them to do that. FM-A stated she R66 could no longer do things she could before she came to the facility (less than one full calander year ago,) such as using her call light, the TV remote and write her name and the word mom. FM-A stated she felt there were not enough staff in the facility to ensure R66's needs were routinely met.

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Review of resident council meeting minutes from July 2016, to September 2016, revealed the following:

- resident council minutes dated 7/27/16, revealed 8 residents had attended the meeting and a concern over call light wait time of up to 2 hours was voiced. An undated and unsigned resident council response note revealed nursing had completed call light monitoring and audits and there had been room for improvement. The response also revealed nursing staff had been educated, the FA and department heads had been notified of the concern.

- resident council minutes dated 8/31/16, revealed 11 residents had attended the meeting and voiced concerns over call light wait time. The response from nursing dated 8/31/16, revealed the concern had been communicated to nursing staff, FA and the regional director.

- resident council minutes dated 9/28/16, revealed 10 residents had attended the meeting and voiced concerns over call light wait times had averaged 30 to 60 minute wait time which had occurred at all hours of the day. An undated response from nursing form revealed on 10/5, 10/6, and 10/7/16, call light audits had been completed regarding response and call light placement. The note further revealed FA and regional director had been informed of the concern.

Review of facility family council meeting minutes from July, 2016 to September 2016, revealed no concerns related to sufficient staffing.

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F 353	Continued From page 166 A facility policy for staffing was requested, and not provided.	F 353		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dental services were provided and/or offered for 1 of 3 residents (R41) reviewed with broken/missing natural teeth in poor repair. Findings include: R41's quarterly Minimum Data Set (MDS) dated 7/21/16, identified diagnoses which included: diabetes mellitus, depression and anxiety. The MDS indicated R41 had severe cognition impairments, and required extensive assistance for all activities of daily living (ADLs) and extensive assistance of one staff for personal hygiene and eating. Further, the MDS indicated R41 had no oral or dental problems and a mechanical soft diet.	F 412	F 412 Routine/Emergency Dental Services in SNF 1. R41 had a dental assessment completed on 10-29-16 with subsequent dentist appointment scheduled. R41 s dental care plan implemented. 2. All residents have the potential to be affected in this area. All residents will have their dental assessment reviewed and updated as needed. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 to educate staff on the procedure titled, Dental Services with a focus on the need to assess resident s dental status on admission and offer dental services as	12/14/16

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R41's care plan was revised on 10/17/16, indicated R41 had upper dentures and natural teeth on the bottom of her mouth. The care plan indicated R41 was to have oral cares done every morning, evening, and as needed and required assistance of one staff for dental care.

Review of the current Aid Care Plan Group C, indicated staff would assist R41 with oral cares.

Review of Frazee Care Center Quarterly ADL Assessment dated 10/17/16 indicated R41 needed daily cleaning of teeth or daily mouth care by staff. R41 was unable to remember how to brush her teeth.

Review of Nutritional Review (NR) dated 7/28/16 indicated R41's teeth were in poor condition, had partial dentures and was eating a regular diet. On 10/20/16 The NR also indicated R41's teeth were in poor condition, had partial dentures and was eating a regular mechanical soft diet.

During observations on 10/19/16 at 8:45 a.m. nursing assistant (NA)-A was assisting R41 with her activities of daily living (ADL's) and called for assistance. NA-D entered the room at 8:51 a.m. and assisted NA-A to transfer R41 from her bed to her wheelchair via mechanical lift. NA-D then left the room. R41 was noted to have upper dentures and missing/broken/cracked irregular natural teeth across the bottom of her gum line. The broken off natural teeth around the bottom of her gum line were noted to be black/gray in color with no signs of acute infection. R41 was unable to answer whether she experienced pain from the bottom teeth. At 8:59 a.m. NA-A wheeled R41 down to the dining room for breakfast, positioned her up to the table and placed a clothing protector

needed et ongoing thereafter. Physician will be informed of dental needs. If the responsible party doesn t wish the resident to have outside dental examinations, a waiver for dental services will be obtained. Resident dental needs will be care planned.

4. An audit has been developed to audit completion of dental assessments and receipt of assessed needed dental services/interventions. The audit will be completed by the LSW or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations.

5. Deficient practice will be corrected by December 14, 2016

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on her chest area. At 9:09 a.m. R41 was served a mechanical soft diet for breakfast, which consisted of scrambled eggs, oatmeal, toast, orange juice, hot chocolate and water. NA-H assisted R41 to cut up her toast in small bite sizes, sat down next to her and began to feed R41 her breakfast.

Review of R41 Frazee Care Center Resident Care Conference Summary dated 1/26/16 and 10/18/16 failed to address any issues with R41's teeth or dental concerns. Further review of R41's medical record lacked documentation of any oral exams, identification of missing, broken, cracked, decayed teeth or dental services completed, offered or discussed with R41 and/or her family since her admission on 4/14/15.

On 10/19/16 at 12:38 p.m. NA-A confirmed R41 needed staff assistance with her dental hygiene and stated "we brush her teeth or swab them sometimes."

On 10/24/16 at 11:15 a.m. NA-F confirmed R41 needed staff assistance with her dental hygiene and stated "she does not have a cup for dentures, so not sure what she has." NA-F indicated she would look at her aid care plan to see what care R41 needed.

On 10/24/16 at 11:26 a.m. unit manager (UM)-B confirmed R41 needed staff assistance with her dental hygiene and had an upper denture with natural teeth on the bottom that are in poor condition. UM-B also indicated she had reviewed R41 medical chart and could not find any documentation R41 was offered any oral exam or dental services since she was admitted to the facility on 4/15/15. UM-B also indicated residents

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F 412	Continued From page 169 were assessed for dental care on admission and offered dental services if needed at the time of admission. UM-B also indicated R41's dental issues were not addressed with her or her family and stated "knowing that they [teeth] would have been in poor shape, I would of asked them." Review of facility policy titled, Dental Services (General) dated 4/1/08 indicated the facility provide or obtains, from outside resource, routine and emergency dental services to meet the need of each resident.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		12/14/16

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F 431	Continued From page 170 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eye drops were labeled with open or discard dates after they were opened for 2 of 5 residents (R31, R43). In addition, the facility failed to implement a system for consistent and timely destruction of discontinued narcotics to prevent loss or potential diversion in 2 of 2 medication rooms reviewed for medication storage. Findings include: On 10/24/16, at 1:00 p.m. medication cart B was observed to have the following bottles of eye drops were opened without a date identified so the discard date could be determined: -R31's Timolol Maleate PF Solution 0.5%, dispensed on 6/4/16. -R43's Latanoprost Solution 0.005%, dispensed on 8/8/16. R31's signed physician orders dated 9/27/16, indicated R31 was prescribed Timolol Maleate PF Solution 0.5% Solution, 1 drop in left eye one time a day for glaucoma, with an ordered start date of	F 431	F 431 Drug records, Proper Label/Storage of Drugs & Biologicals 1. R31 (date unlabeled) eye drop Timolol Maleate PF Solution 0.5% was replaced. R42 (date unlabeled) eye drop Latanoprost Solution 0.555% was replaced . Discontinued Narcotic medications stored in A wing medication room have been destroyed by 2 facility nurses. 2. All residents receiving medications with specific expiration dates can be negatively affected by this deficient practice. All residents that receive eye medications will have their eye drops prescriptions review for date opened. All residents who receive narcotic medication have the potential to be negatively affected in this area. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 to educate staff on the procedure	

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F 431	Continued From page 171 4/16/16.	F 431	titled, Drugs and Biological Storage-Labeling, Medications-Disposition of Discontinued Controlled Medication-Discontinued narcotics of deceased or discharged residents with a focus on the need to date all medications with specific expiration dates; i.e. eye drop bottles, with date opened . Staff were also educated on Medication: Narcotic medication with a focus on the need for two nurses to destroy narcotic medication timely upon discontinuation of narcotic, documenting destruction in the narcotic leather bound book.	
	R43's signed physician orders dated 10/6/16, indicated R43 was prescribed Latanoprost Solution 0.005%, 1 drop in both eyes at bedtime for glaucoma, with an ordered4 start date of 2/5/15.		4. Observational audits of staff handling soiled linens has been started and Medication carts will be audited for proper labeling of medications of date opened and removal of discontinued medications from medication carts. Narcotic storage areas will be audited for timely disposal and documentation of disposed narcotics. The audits will be completed by the DON or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations.	
	At the time of observation, registered nurse (RN)-D confirmed the eye drop medication bottles were not dated when they were opened, and stated they should have been. RN-D reported she did not work on the B medication cart often, but stated any nurse can date the drops when they are opened. RN-D also reported a pharmacist comes to the facility monthly to review the medication carts for expired medications.		5. Deficient practice will be corrected by December 14, 2016	
	On 10/24/16, at 1:36 p.m. the assistant director of nursing (ADON) stated the expectation was to date the eye drops when opened, and it should have been done. The ADON then stated she was surprised the pharmacist did not flag the undated opened eye drop medications.			
	The facility policy for Labeling and Storing Medicine dated 3/14 and 4/15, did not address the dating of medication bottles or indicate when to discard eye drop medications once they were opened.			
	The Remedy's RX Specialty Pharmacy Eye Drop Expiration Guidelines indicated Timolol would be expired 28 days after opened, and Latanoprost would be expired 6 weeks after opened.			
	On 10/24/16, at 1:17 p.m. observations were conducted of the facility's medication storage rooms. At 1:17 p.m. licensed practical nurse			

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F 431	Continued From page 172 (LPN)-C unlocked a double locked cupboard in the west medication room. In the cupboard were two shelves filled with narcotics which were discontinued and waiting for destruction. Multiple bottles of morphine were observed on the upper shelf, some with pharmacy label dates of January 2015 and September 2015. The lower self was filled with various narcotics such as oxycodone, morphine, hydromorphone and fentanyl patches. On the outside of the cupboard door was taped the destruction of controlled substances form, also on the counter below the narcotic cupboard were 12 bound narcotic ledgers. On 10/24/16, at 1:25 p.m. the assistant director of nursing (ADON) unlocked a double locked cupboard in the east medication room. In the cupboard were two smaller shelves filled with narcotics which were discontinued and waiting for destruction. One bound narcotic ledger was noted adjacent to the narcotic cupboard. The Inventory And Destruction Of Controlled Substances Form: Long-Term Care Facilities was affixed to the west medication room cupboard. The document identified the prescription number, drug name, strength, quantity, date the medication was placed in the cupboard and signature of the nurse. There were 24 total entries from 8/31/16 to 10/25/16 identified on the document. During interview on 10/24/16, at 1:20 p.m. LPN-C stated all discontinued narcotic medications were stored in the double locked cupboard. LPN-C reported when a narcotic was discontinued, nurses were to document in the narcotic bound ledger, and on the sheet taped to the cupboard what the medication was and how many were	F 431		

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placed in the cupboard. LPN-C stated the medications were not counted again until they were destroyed. LPN-C reported discontinued narcotics in the facility had not been destroyed in a long time. LPN-C stated 3 different nurses and nurse managers had keys to the discontinued narcotic cupboards. LPN-C indicated she did not want to be responsible for the large volume of discontinued narcotic medications in the facility. She stated the current facility practice of storing large amounts of discontinued narcotics for long periods of time "scared" her.

During interview on 10/24/16, at 1:30 p.m. the ADON confirmed both medication rooms contained many discontinued narcotics in the double locked cupboard accumulated over several months. The ADON stated the prior DON started destroying them with another staff member, but did not destroy all of the medications. The ADON confirmed the Certificate Of The Inventory And Destruction Of Controlled Substances Form was not a complete list of all discontinued narcotics waiting for destruction. The ADON confirmed all of the medications not on the form were documented in the narcotic bound ledger, and would be cross referenced at the time of destruction. The ADON stated there was a large quantity of discontinued narcotics in the facility. The ADON also stated multiple nurses had access to the keys which opened the discontinued narcotic cupboard, and confirmed the medications were not counted again after they were placed in the locked cupboard. The ADON confirmed the facility lacked a consistent process for storage and destruction of discontinued narcotics.

The facility's Controlled Medication policy dated

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F 431	Continued From page 174 3/1/14, indicated unused controlled medications and the control record be taken to the nursing director's office, and should be locked up until time for destruction in accordance with State Pharmacy Board.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		12/14/16

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(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident symptoms, analysis of the surveillance and investigation of patterns identified. This had the potential to affect all 52 residents who resided in the facility. In addition, the facility failed to ensure proper handling of soiled clothing and linens during personal cares for 1 of 4 residents (R18) observed for personal cares.

Findings include:

The facility's Infection Control Logs were reviewed from 4/11/16, through 9/22/16. The logs identified tracked only residents with infections for which antibiotics were prescribed. The facility's surveillance processes also lacked identification of the following: location of the resident within the facility, if the infection was healthcare or community associated, site of infection, date onset of symptoms, specific symptoms that were present, cultures performed/ organism identified, treatment provided and the date the infection resolved. Furthermore, the logs lacked analysis and/or investigation of patterns identified.

During interview on 10/24/16, at 2:00 p.m. unit

F 441

F 441 Infection control, prevention, and spread
1. R18 is asymptomatic for signs and systems of infection and is receiving timely assistance with toileting and personal hygiene. R18 s care plan has been reviewed; bowel and bladder assessment will be completed. Observation findings are that soiled linen is not thrown on the floor. Nursing staff will bring soiled linen disposal receptacles down hallways to place soiled linens in.
.

2. All residents have the potential to be negatively affected by this practice. The educating and monitoring of resident cleanliness and the completing of the monthly infection control log with the inclusion of infections not treated by antibiotics including viral infections and analysis of all infections, rates, and patterns will ensure compliance in infection prevention and spread.

3. Mandatory nursing staff education was provided on November 16 and 17, 2016 to educate staff on the procedure titled, Linens-Handling and infection Control and Infection Control and NO

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	245299	A. BUILDING ______ B. WING ______	10/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 441	Continued From page 176	F 441		

manager (UM)-B who was responsible for the facility's infection control program, confirmed the monthly infection logs were not completed thoroughly for each resident identified. UM-B stated in her lack of time the logs were incomplete. UM-B also stated the facility only tracked infections which were treated with antibiotics, and confirmed there was no system currently in place to track and trend any other viral illnesses's such as the common cold, gastroenteritis or influenza. UM-B stated when she was assigned responsibility of the infection control program, she did not receive any training or direction on what should have been included in the program. UM-B confirmed the facility luckily has not had any outbreaks.

Review of the facility's undated Infection Prevention and Control Program policy, it indicated the facility had developed and maintained an infection prevention and control program that provided a safe, sanitary and comfortable environment to help prevent the development and transmission of infection.

Review of R18's quarterly Minimum Data Set (MDS) dated 7/26/16, identified R18 had severe cognitive impairment, was unable to communicate with staff and had diagnoses which included, dementia, depression and anxiety. The MDS identified R18 was totally dependent on staff for activities of daily living (ADL's) and required 2

placing solid linens on the floor and the timely provision of assistance with personal hygiene cares. Infection Control Nurse was educated on the tracking and trending (surveillance) of all facility infections, including those not treated with antibiotics.

4. An observation and chart audit was developed to monitor handling of linens, completion of infection surveillance within the center with the tracking/trending of resident infections (including infections not treated with antibiotics), care planning for short term infections, and communication of infections on the CNA pocket worksheets. The audit will be completed by the Infection Control Nurse or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with follow-up to committee recommendations. Infections, patterns and rates will be reported (ongoing) monthly at monthly QA meetings.

5. Deficient practice will be corrected by December 14, 2016

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F 441	Continued From page 177 staff for assistance with bed mobility, personal hygiene and toileting. The MDS identified R18 was frequently incontinent of bowel and bladder. The MDS identified R18 was not on a toileting program for bowel or bladder incontinence. Review of R18's annual MDS dated 4/26/16, identified R18 was totally dependent on staff for ADL's. The MDS identified R18 was frequently incontinent of bowel and bladder. The MDS identified R18 was not on a toileting program for bowel or bladder incontinence. Review of R18's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 4/26/16, identified R18 had cognitive loss related to dementia and was unable to coherently verbalize her needs. The CAA revealed R18's needs were to be met in spite of her inability to make requests. R18's Communication CAA identified R18's needs must be anticipated by facility staff. Urinary Incontinence CAA identified R18 was frequently incontinent of bowel and bladder and needed assistance with all mobility and was toileted or changed as needed. Review of R18's current care plan last updated 10/7/16, revealed R18 had severe cognitive loss, was unable to communicate her needs and was totally dependent on staff for toileting, repositioning needs and was frequently incontinent of bowel and bladder and wore an incontinent brief . The care plan directed staff check and change R18 every 2 hours for incontinence with repositioning. On 10/17/16, at 3:40 p.m. R18 was seated in a wheelchair in her room, her shirt was over her head. R18's right hand rested on her right thigh	F 441		

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F 441	Continued From page 178 and had fecal matter on her right hand, covering up to her first knuckles on all of her fingers and her thumb. R18's right upper (thigh height) pant leg also had smeared fecal matter the size of her entire hand. R18 began to move her fecal covered right hand towards the front of her. At that time the director of nursing was walking down the hall and was notified of R18's condition. At 3:41 p.m. nursing assistant (NA)-H entered R18's room and asked R18 if she wanted to use the bathroom, R18 lifted her head out of her shirt, reached up with her right hand and touched her hair. NA-H took a packaged pre-moistened wipe and cleansed R18's right hand. R18 repeatedly reached down with her hand and touched the soiled area on her slacks while NA-H was obtaining clean clothes from her closet. NA-H would re-wipe R18's hand, and R18 would again reach down and handle the soiled slacks several times. At that time NA-H stated R18 was totally dependent on 2 staff for all of her cares and was frequently incontinent of bowel and bladder. At 3:44 p.m. NA-H requested assistance with R18's cares. R18 continued to repeat the process of re-soiling her right hand with the bowel on her pant leg and NA-H would re-wipe her hand with the wipes. -At 3:53 p.m. NA-H used her walkie talkie and requested assistance, NA-H then stated there were times when she had to wait a long time for another staff member to help with residents requiring 2 staff assistance, including R18. NA-H stated she had been assigned to another wing when the DON pulled her into R18's room. At 3:56 p.m. NA-H left R18's room to physically seek out assistance without covering the bowel on R18's pant leg. R18 re-soiled her right hand immediately after NA-H left the room.	F 441		

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F 441	Continued From page 179	F 441		

-At 3:59 p.m. NA-F entered R18's room, stepped in a grape sized amount of bowel which was on the floor near R18's front right wheelchair wheel as she approached R18. NA-F washed R18's hands with a washcloth. R18 pushed NA-F away, NA-F backed away, reproached R18, donned a gait belt across R18's torso and NA-H entered R18's room, both NA-F and NA-H transferred R18 from the wheelchair, assisted R18 to walk to the bathroom. NA-F removed R18's slacks and incontinent brief which were saturated with bowel and bladder and bladder. NA-F discarded R18's incontinent brief in the garbage and placed R18's soiled slacks on the floor. NA-H removed R18's shirt and placed it on the floor next to R18's soiled slacks. NA-F and NA-H assisted R18 with cleansing, applied a clean brief and donned clean clothing for R18. NA-H checked R18's seat cushion and stated she felt it was clean, washed the floor with a wipe. NA-F picked up R18's soiled shirt and slacks and soiled washcloths from the floor with her gloved hands, left the room and entered the soiled hopper room. NA-H provided R18 with a baby doll, her call light and left R18's room.

On 10/17/16, at 4:17 p.m. NA-F stated it was not usual practice to placed soiled clothing on the floor. NA-F stated the usual practice would be place the soiled clothing in a bag and bring the bag to the soiled hopper room. NA-F also stated she was unaware of the last time R18 had been assisted with toileting. NA-F stated she used to get a report from the previous shift NA of when resident cares were last completed, though did not that day. NA-F stated she had not been getting report from the previous shift NA on a

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F 441	Continued From page 180 consistent basis due to short staffing. On 10/21/16, at 1:37 p.m. the assistant director of nursing stated it was not usual practice to place soiled clothing on the floor. ADON stated the usual practice was to place soiled clothing in bags, then to bring the closed bags into the hopper rooms to be rinsed and placed in laundry bags. The ADON stated she expected staff to follow the facility policy. Review of a facility policy titled., Linens-Handling, dated 4/1/08, revealed it was the facility's policy when handling, processing and transporting linens, staff were to use specific procedures to prevent the spread of infection. The policy directed staff to immediately remove soiled linens from the residents room and taken to a utility room.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520		12/14/16

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F 520	Continued From page 181 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility Quality Assessment and Assurance (QA&A) committee failed to develop and implement appropriate action plans for previously identified areas of concern related to insufficient staffing, and the lack of implementation and documentation of rehabilitative nursing services which included ambulation and range of motion cares as directed by physical and occupational therapy. The failure to develop and implement action plans caused harm for 1 of 1 resident (R66) who had a decline in range of motion (ROM), (R38) who had a decline in ambulation, (R78,) who had a pattern of multiple falls. This deficient practice had the potential to affect all 52 residents currently residing in the facility. Findings include: See F353 the facility failed to ensure sufficient staffing was available to meet resident needs. On 10/21/16, at 10:50 a.m. PTA stated she had noticed residents were not consistently receiving their ambulation/maintenance programs due to	F 520	F 520 Quality Committee-members meet quarterly 1. Resident grievances and resident counsel concerns will be reviewed at each monthly QA meeting for further suggestions on ensure compliance in these areas. Each survey deficiency audit will be analyzed and the finding will be reported to the QA committee for further recommendation to ensure ongoing compliance. Staffing numbers and patterns will be reviewed. Recruitment interventions and success will be reviewed. 2. All residents have the potential to be negatively affected due to insufficient staffing and deficient practices. Quality Assurance performance improvement team (PIP) meetings will be created for improvements in Staffing, Nursing rehabilitation programs, and Falls. 3. Mandatory nursing staff education was provided on November 16 and 17, 2016 to educate staff on the procedure titled, Quality Council Assurance and	

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F 520	Continued From page 182 not enough staff. PTA stated she had placed residents on maintenance programs and has had them referred back to therapy for treatment due to a decline. PTA stated she felt this was due to not enough staff to consistently carry out residents programs. PTA stated the facility NA's were responsible for residents ambulation/maintenance programs, however, there were not enough NA'S on the floor. PTA stated she had voiced her concerns about residents ambulation/maintenance programs to nursing and administration during the weekly medicare meeting as recently as a month or so ago. PTA stated the response she had received was the staff were going to "talk" to the NA's. On 10/24/16, at 3:41 p.m. the administrator stated he had started employment in the facility on 10/17/16, one week prior. He stated he was not aware of the facility nursing had been working on staffing since last Monday (when he started,) and had planned to meet with the clinical managers to identify resident acuity. The administrator stated he was unsure if the staffing in the facility was sufficient. The administrator stated the facility had 4 licensed nursing positions open, 4 NA positions at that time. He stated at that time he had not implemented any action plans for staffing, though had just received a staff recruitment plan from HR. The administrator stated in the future he planned to work on employee relations, though had not implemented at that time. On 10/24/16, at 4:08 p.m. the activity director (AD) stated she routinely attended the facility QA meetings. AD stated in the past staffing concerns and call light wait times had been discussed at	F 520	Improvement and Nursing Services: Quality of Resident Care with a focus on the need for performance improvement projects with team committee involvement on adequate staffing, Nursing Rehabilitation programs, and Prevention and management of Falls. 4. An audit has been developed to monitor progress of PIP team meetings monthly, to monitor the completion and progress (findings) of all post survey audits. QA committee will provide additional auditing and recommendations until resolution of concerns identified. Audits will be completed by the Executive Director or designee monthly x 3 months. 5. Deficient practice will be corrected by December 14, 2016	

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the QA meetings and felt no plan had been discussed or implemented to improve staffing conditions. AD stated residents who had attended resident council routinely in the last 3 months had voiced complaints regarding long call light wait times, up to 2 hours. AD stated she had reported resident concerns to the administrator and DON each month after resident council meetings.

On 10/24/16, at approximately 5:00 p.m. interim director of nursing (DON) stated at that time no one person in the facility was responsible for QA, though the QA committee continued to meet. DON stated the facility QA committee members included administrator, DON, department managers, pharmacy and social services. DON stated the QA committee would meet monthly and again quarterly with the medical director present. DON stated the committee had discussed staffing concerns in the past such as staff recruitment and retention. DON stated the QA committee had also discussed resident falls and pressure ulcers. DON was unable to identify a current action plan was in place for the following areas: sufficient staffing, falls, restorative nursing services for ambulation and range of motion. DON confirmed the facility had no current monitoring and had not completed audits of cares to ensure residents needs were met and indicated the facility continued to accept resident admissions to the facility.

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _______	**10/19/2016**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 18, 2015. At the time of this survey Frazee Care Center 01 Main Building was found not in substantial compliance with The requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/17/2016

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

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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The facility was inspected as one building: Frazee Care Center was constructed at three different times. The original building was constructed in 1971, is 1-story without a basement and was determined to be of a Type II(111) construction. In 1979 the north 200 wing addition was built. It is 1-story without a basement, was determined to be of a Type II (000) construction, and is separated with 2- hour fire barriers from the main building. Additions to the 1979 building in 1993 include an activities addition to the west and the business/ main entrance addition to the east. These areas were determined to be Type V (111) construction and the business / main entrance addition is separated from the apartment building with a 2-hour fire barrier, so the Apartment Building was not surveyed at this time.

The facility is divided into 5 smoke zones with

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K 000	Continued From page 2 smoke barrier walls of 30 minutes and 90 minute rated fire barriers. The facility is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). In the 1971 building is now fully sprinkler protected. The facility has a capacity of 74 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and	K 018		11/17/16

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

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K 018	Continued From page 3 made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 1 resident room door according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 13 of the 53 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2016 observations and staff interview revealed the door on resident room 106 did not fit tightly in the frame. This deficient condition was confirmed by the Maintenance Supervisor.	K 018	K 018 Resident room 106 door replaced on 11-17-2016 by maintenance.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of 6 hazardous areas	K 029	K 029 Hole patched with concrete with remaining	11/17/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**10/19/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96** **FRAZEE, MN 56544**

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K 029	Continued From page 4 located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the corridor and adjacent areas making them untenable, which could negatively affect the exiting capabilities for 23 of the 53 of residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2016 observations and staff interview revealed a penetration approximately 2.5 inches in diameter in the boiler room wall separating the corridor. This deficient condition was confirmed by the Maintenance Supervisor.	K 029	cracks sealed with fire caulk on 10-21-2016 by the maintenance director.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system would function properly in the event of a fire and could negatively affect 13 of	K 062	Ceiling title replaced by maintenance director on 10-21-2016.	11/17/16

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	245299	A. BUILDING 01 - MAIN BUILDING B. WING	10/19/2016

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K 062	Continued From page 5 the 53 residents, and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2016 observations and staff interview revealed a hole in a corridor ceiling tile in the Wymar wing near the cross corridor doors. This deficient condition was confirmed by the Maintenance Supervisor.	K 062		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101 (2000 edition) Chapter 7, Section 7.1.10. This deficient practice could interfere with the convenient and effective exiting of all residents, staff or visitors using the dining room in an emergency situation,. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2016 observations and staff interview revealed combustible storage in the vestibule exiting the dining room.	K 072	K 072 The area was cleared of obstructions on 10-27-2016 by maintenance director. All residents have the potential to be affected in this area. Education provided to nursing and activity staff on November 16 and November 17, 2016 on the procedure "Clearing of egress doors and Fire Risk". The area will be audited for no obstructions weekly X 4 weeks, the then monthly for 2 months. The audit results will be reported to the QA committee for further recommendations. The audit will be completed by the maintenance director.	11/17/16

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

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING	**10/19/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 072	Continued From page 6 This deficient condition was confirmed by the Maintenance Supervisor.	K 072		

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 10, 2016

Mr. Brad Molgard, Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, Minnesota 56544

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5299028

Dear Mr. Mogard:

The above facility was surveyed on October 17, 2016 through October 24, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rulesd. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

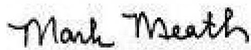
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson by phone at (218) 332-5140 or email: gail.anderson@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: ______ B. WING ______	10/24/2016

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the Minnesota Department of

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2 000	Continued From page 1	2 000		

Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On January 17-24, 2016 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of these orders for your records and return the original to the address below:

Minnesota Department of Health
1505 Pebble Lake Road, Suite 300, Fergus Falls, MN 56537
c/o Gail Anderson, Unit Supervisor

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings

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2 000	Continued From page 2 are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility Quality Assessment and Assurance (QA&A) committee failed to develop and implement appropriate action plans for	2 255	corrected.	11/17/16

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2 255	Continued From page 3	2 255		

previously identified areas of concern related to insufficient staffing, and the lack of implementation and documentation of rehabilitative nursing services which included ambulation and range of motion cares as directed by physical and occupational therapy. The failure to develop and implement action plans caused harm for 1 of 1 resident (R66) who had a decline in range of motion (ROM), (R38) who had a decline in ambulation, (R78,) who had a pattern of multiple falls. This deficient practice had the potential to affect all 52 residents currently residing in the facility.

Findings include:

See F353 the facility failed to ensure sufficient staffing was available to meet resident needs.

On 10/21/16, at 10:50 a.m. PTA stated she had noticed residents were not consistently receiving their ambulation/maintenance programs due to not enough staff. PTA stated she had placed residents on maintenance programs and has had them referred back to therapy for treatment due to a decline. PTA stated she felt this was due to not enough staff to consistently carry out residents programs. PTA stated the facility NA's were responsible for residents ambulation/maintenance programs, however, there were not enough NA'S on the floor. PTA stated she had voiced her concerns about residents ambulation/maintenance programs to nursing and administration during the weekly medicare meeting as recently as a month or so ago. PTA stated the response she had received was the staff were going to "talk" to the NA's.

On 10/24/16, at 3:41 p.m. the administrator

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2 255	Continued From page 4	2 255		

stated he had started employment in the facility on 10/17/16, one week prior. He stated he was not aware of the facility nursing had been working on staffing since last Monday (when he started,) and had planned to meet with the clinical managers to identify resident acuity. The administrator stated he was unsure if the staffing in the facility was sufficient. The administrator stated the facility had 4 licensed nursing positions open, 4 NA positions at that time. He stated at that time he had not implemented any action plans for staffing, though had just received a staff recruitment plan from HR. The administrator stated in the future he planned to work on employee relations, though had not implemented at that time.

On 10/24/16, at 4:08 p.m. the activity director (AD) stated she routinely attended the facility QA meetings. AD stated in the past staffing concerns and call light wait times had been discussed at the QA meetings and felt no plan had been discussed or implemented to improve staffing conditions. AD stated residents who had attended resident council routinely in the last 3 months had voiced complaints regarding long call light wait times, up to 2 hours. AD stated she had reported resident concerns to the administrator and DON each month after resident council meetings.

On 10/24/16, at approximately 5:00 p.m. interim director of nursing (DON) stated at that time no one person in the facility was responsible for QA, though the QA committee continued to meet. DON stated the facility QA committee members included administrator, DON, department managers, pharmacy and social services. DON stated the QA committee would meet monthly and again quarterly with the medical director present.

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2 255	Continued From page 5 DON stated the committee had discussed staffing concerns in the past such as staff recruitment and retention. DON stated the QA committee had also discussed resident falls and pressure ulcers. DON was unable to identify a current action plan was in place for the following areas: sufficient staffing, falls, restorative nursing services for ambulation and range of motion. DON confirmed the facility had no current monitoring and had not completed audits of cares to ensure residents needs were met and indicated the facility continued to accept resident admissions to the facility. Suggested Method of Correction: The administrator could work with the DON or designee, medical director, and governing body to update polices and procedures, identify issues and develop improvement plans. The administrator and DON could audit cares to ensure resident needs are met, audit charts for delinquencies and report results to the quality committee. Time Period for Correction: Twenty-one (21) days.	2 255		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with	2 555		11/17/16

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2 555	Continued From page 6 responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to revise the plan of care for 1 of 3 residents(R66) who was dependent on staff to provide all leisure activities. In addition, the facility failed to revise the care plan for ambulation for 3 of 4 residents (R29, R46, R38) reviewed for ambulation services. Findings include: R66's admission Minimum Data Set (MDS), dated 1/11/16 identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS identified R66 had severe cognitive impairment, and was totally dependent of staff for activities of daily living (ADLs), and required 2 staff to assist with transfers and locomotion off the unit. The MDS identified R66 enjoyed listening to music, being around animals such as pets, keeping up with the news, doing things with groups of people, participating in favorite activities and spending time outdoors. R66's Care Area Assessment (CAA), dated 1/11/16 identified R66 suffered from a traumatic brain injury, was unable to speak and make needs known and was dependent on staff for all her ADL. The CAA further identified R66 followed people with her eyes and blinked to answer yes or no questions and appeared to watch TV when	2 555	corrected	

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2 555	Continued From page 7	2 555		

Continued From page 7

it was on.

R66's care plan dated 2/18/16 identified R66 was a big fan of duck Dynasty and Keeping up with the Kardashians. R66's care plan indicated she liked to browse through gossip magazines and enjoyed a good book at times. R66's care plan directed activity staff had posted a sign in her room to inform all staff that she enjoys Duck Dynasty and Keeping up with the Kardashians, activity staff were to complete 4 1:1 visits a week, and activity staff would provide gossip magazines (people, Us Weekly, Star) and would read to her during 1:1 visits and would see if she was up to enjoy story time. R66's care plan further directed R66 required a mechanical lift and 2 staff to get her up and into her wheelchair, and R66 would be wheeled to all of her destinations as desired and in a timely manner.

R66's Recreation/Therapeutic Programs Assessment dated 1/4/16, identified activities staff indicated they would try to bring her to activities to let her observe and be around people, and indicated R66 was in bed a lot. The assessment further identified R66's past interests included cards and games and plan included large group programs and entertainment, small group activities such as manicures, 1:1 programing would be needed, and R66 also enjoyed watching the birds and TV.

Review of R66's activities quarterly progress note dated 7/26/16, identified R66's activity involvement was fair and participation was passive, R66 was unable to structure her time in a meaningful way. The note identified R66 watched TV on a daily basis, and sometimes watched movies. The note indicated R66 would sometimes watch the birds, but staff felt R66

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would rather watch TV and R66 would have 4, 1:1 visits by staff each week. The note also indicated family visited once per week and took her outside.

Review of activities quarterly progress note dated 10/11/16, identified R66's activity involvement was fair, participation level remained passive and R66 was unable to structure her time in a meaningful way. The note indicated R66 loved TV also watches movies on her personal DVD player. The note further identified R66 would have 4, 1:1 visits by activity staff each week and they would sometimes read her a book. The note also indicated family visited once per week and wheeled her around or took her outside if the weather was nice. The progress note identified R66's activity plan was appropriate, had met her goal for the last 3 months, activity interventions were effective. and no changes were recommended for R66's activity program.

Review of the facility activity calendar for residents from 4/16 to 10/16 identified 4-5 activities per week which R66 had special interest in such as music, Bingo, movies, outside walks and manicures.

Review of R66's Resident Activity Attendance Chart forms from 4/1/16 to 10/17/16 revealed R66 consistently watched TV and family visited. However, the attendance charts did not include consistent 1:1 visits, and did not consistently include attendance at either large or small group acclivities. The monthly documentation as follows:

-4/16, 6 out of 16 opportunities of 1:1 visits from staff for the month, and 3 unable and 1 refused. No other documentation of large or small group

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2 555	Continued From page 9 activities or activities out of room -5/16, 7 out of 18 opportunities for 1:1 visits from staff for the month, 1 in family lounge, 1 in activities room, 1 mail reading, and 2 cleaning glasses. -6/16, 9 out of 16 opportunities of 1:1 visits from staff for the month, 1 mail reading,1 glider, and 4 unable. -7/16, 5 of out 18 opportunities for 1:1 visits from staff for the month, 1 special event, 1 bird watching, 2 cleaning glasses, 2 outside, 1 glider and 3 unable -8/16, 7 out of 18 opportunities for 1:1 visits for the month, 1 bird watching, 1 wheeling, 1 outside, 1 cleaning glasses, and 1 unable -9/16, 7 out of 18 opportunities for 1:1 visits for the month, 1 outside, 1 cleaning glasses, and 1 unable -10/1-10/24/16, 7 out of 13 opportunities for 1:1 visits, 1 sitting in family lounge, 2 cleaning glasses, 1 outside On 10/19/16, during observation from 7:00 a.m. to 10:03 a.m. R66's room was dark and quiet, and her bedroom door was open. R66 was observed on her back in bed, dressed in a hospital gown. R66 remained in the same position with no meaningful activity for 3 hours and 3 minutes. R66 had a monthly activities calendar posted on her closet door across from the foot of her bed, and a hand written 8.5 X 11 sign was posted on the wall across from R66's recliner and identified:	2 555		

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-R66 was to be changed during check ups
-No more Kardashians'!
-Family Feud on channel 11:00 a.m.
-Wheel of fortune
-Jeopardy 5:00 p.m.
-Judge Judy 9:00 a.m. & 11:00 a.m.
-get movie going early in the am or at bedtime

On 10/19/16, at 10:35 a.m. LPN-A and NA-E were in R66's room after R66 was dressed and in her recliner. LPN-A asked R66, "What are you going to watch on TV today?, I know you like those Kardashian girls." LPN-A stated she gave R66 a hard time about the Kardashians' because you never now what their gonna do on the show.

On 10/19/16, at 12:10 p.m. R66 was dressed and seated in her recliner, in front of the TV. A political type program was on TV and R66 eyes were turned away from the TV and out her bedroom window.

On 10/20/16, at 9:42 a.m. R66 was in her bed dressed in a hospital gown. R66's TV was off, and her eyes were focused on the ceiling.

On 10/21/16, at 10:24 a.m. licensed practical nurse (LPN-A) stated R66 was totally dependent on staff for ADLs. She stated the usual routine was after R66 got up, she spent her day watching TV in her recliner.

On 10/24/16, at 10:08 a.m. activities aide (AA-A) stated R66 spent her day watching TV and would get 1:1 visits. She stated during 1:1 visits they open curtains, and sit with her talk to her about the TV shows she liked, or put a movie on. She stated she didn't know how often R66 came out of her room, and stated sometimes they had her sit at the nurses desk. She stated R66 slept a lot,

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2 555	Continued From page 11 and missed 1:1 visits because she was in bed and asleep. She stated activity staff tried to provide 1:1 visits on an attempt basis. She stated it was hard to provide activities for R66 because R66 required so much care, and was difficult to get up. She stated she felt R66 was probably up in her chair when family visited, and staff had tried to get her out to story time but it was too difficult. On 10/24/16, at 10:53 a.m. clinical manager (CM-A) stated staff would get her up in her recliner and she watched the Kardashians' because they were on a lot, otherwise R66 was in bed or her Broda chair in her room the majority of the time. She confirmed R66's current care plan and stated she understood activities staff spent time with her in her room. On 10/24/16, at 12:27 p.m. activities director (AD) stated activity staff had posted a sign in R66's room which told staff what TV shows R66 liked and stated R6 also had a portable DVD player in her room. AD indicated in the past activities staff had wanted to bring R66 to the Afternoon Adventure activity, which was scheduled daily during the week, but struggled to get R66 to attend because she was not in her chair. She stated R66 used to get her nails done but activity staff struggled with finding staff to get her up in her wheelchair to attend the activity. She stated she would like R66 to attend music programs but it was such a hassle to find staff to get her up in her wheelchair, and R66 was usually in her bed or recliner. AD confirmed R66's care plan and stated her care plan could be updated. She stated her care plan was TV focused and the portable DVD player also. AD confirmed R66's activity records and stated R66 mostly watched TV. She confirmed the sign posted in room and	2 555		

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R66's care plan had not been updated with current information.

R29

R29's Order Summary form dated 9/16/16, identified R29 had diagnoses which included muscle weakness, malaise, and psychosis.

R29's admission Minimum Data Set (MDS) dated 7/14/16, identified R29 had severe cognitive impairment, and required extensive assistance for bed mobility, transfer, locomotion on and off of the unit, dressing and hygiene. The MDS identified ambulation did not occur for R29 during the assessment period.

R29's admission CAA dated 7/14/16, identified R29 had dementia, both short term and long term memory problems, and had poor balance which appeared related to decreased weight bearing status related to fall prior to admission.

R29's current care plan revised 10/14/16, revealed R29 had an unsteady gait, used a walker with assist of one and assist with ambulation, toileting, and mobility as needed. R29's care plan directed assist of one with front wheeled walker and wheelchair for ambulation.

On 10/19/2016, at 8:46 a.m. R29 was seated in her wheelchair, at a table in the dining room. R29 propelled herself with her feet, from the dining room towards her room.
On 10/19/2016, at 9:02 a.m. R29 self propelled her wheelchair with her feet in the hall. R29 asked staff directions to her room and then continued to self propel down the hall.

On 10/19/2016, at 10:30 a.m. licensed practical

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nurse (LPN)-C ambulated R29 past the nurses desk with a front wheeled walker and a gait belt around R29's waist.
On 10/24/2016, at 9:57 a.m. R29 propelled her wheelchair in the hall with her feet.

The facility form titled Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed R29 receive the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (contact guard assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps."

R29's progress notes were reviewed 6/30/16, through 10/23/16, the notes identified R29 had received therapy for strengthening; however did not note that resident had received the referral for nursing staff to ambulate resident two times a day, nor was there documentation that R29 had received ambulation services with floor staff.

R29 did not have a ambulation program sheet in the nursing assistant maintenance book.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had serious concerns with residents ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis. PTA stated residents such as R29 did not routinely receive their ambulation programs.
On 10/24/2016, at 10:14 a.m. NA-I indicated R29 was not on a walking program. NA-I indicated R29 would self transfer and staff would walk with her in her room to the bathroom.

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2 555	Continued From page 14 On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program. On 10/24/2016, at 10:32 a.m. physical therapy assistant (PTA)-G indicated residnets who had reached their goal in therapy were discontinued from therapy services and then continue with a ambulation or lower extremity exercise program to be completed by the nursing assistants in order to maintain the progress which was made in therapy. PTA-G verified R29 was discharged from therapy in August of 2016, and should be currently walking two times a day up to 150 feet. PTA-G indicated ambulation into the bathroom would not be enough steps to be considered a walking program. On 10/24/16, at 10:52 a.m. the clinical manager (CM)-B indicated R29 had an ambulation program for one staff to walk the full length of the hallway with use of a gait belt and a walker. CM-B was unaware how often R29 ambulated. CM-B verified R29's Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (care giver assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps." CM-B verified R29 did not have a form which directed the ambulation program in the NA maintenance book. CM-B verified the NA group sheet was part of R29's current care plan and the group sheet did indicate R29 was to receive assistance with ambulation two times a day with CGA of one and a FWW. CM-B indicated without documentation or	2 555		

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observations of R29's ambulation with staff , she was unaware if R29 had received the referred ambulation program two times a day up to 150 feet.

R46

On 10/24/2016, at 11:00 p.m. R46 was laying on top of her bed on her right side, covered with two small blankets, the call light was secured to the grab bar attached to the side of the bed, and a wheel chair was approximately 3 feet from the bed in which R46 lay.

R46's physicians orders dated 9/20/16, identified diagnoses included muscle weakness, syncope and collapse.

R46's quarterly Minimum Data Set (MDS) dated 8/11/16, identified R46 had intact cognition, and required extensive assistance for transfer, locomotion on and off of the unit, dressing and toilet use, limited assistance for bed mobility and personal hygiene. The MDS identified ambulation did not occur for R46 during the assessment period.

R46's Care Area Assessment (CAAS) dated 11/9/15, included: Cognitive Patterns- intact. Functional status: Activities of daily living status- limited assistance of one staff for transfers, limited assistance of staff to ambulate in room, ambulation in corridor did not occur.

The facility form titled Resident Referral, Interdepartmental Communication dated 11/6/15, to nursing from physical therapy directed R46 receive the following: "Please ambulate Pt (patient) with RW (regular walker), transfer belt, and 1 A (assist) 2 X (times) daily. Pt. amb.

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(ambulate) up to 200' any ? (questions) call."

R46's current care plan revised 8/22/16, revieled R46 had an unsteady gait and weakness, SBA (stand by assist) of one for transfer and with walker.

R46's progress notes were reviewed 4/3/16, through 10/1/16, did not note that R46 had received ambulation services with floor staff.

R46 did not have a ambulation program sheet in the nursing assistant maintenance book.

On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program. NA-E stated R29 could pivot transfer and take a couple steps but not walk any distance.

On 10/24/2016, at 10:32 a.m. physical therapy assistant (PTA)-G indicated residnets who had reached their goal in therapy were discontinued from therapy services and then continued with a ambulation or lower extremity exercise program to be completed by the nursing assistants in order to maintain the progress which was made in therapy. PTA-G verified R46 had been discharged from therapy and should be currently walking two times a day up to 200 feet or as far as R46 tolerated. PTA-G indicated she would expect staff to be walking with R46 in the hall and the program should continue unless the resident had a decline, hospitalization or pain. PTA-G indicated if a decline were to occur the resident should then be re-screened. PTA-G indicated ambulation into the bathroom would not be enough steps to be considered a walking program.

On 10/24/16, at 10:52 a.m. the clinical manager

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2 555	Continued From page 17 (CM)-B indicated she had never seen R46 ambulate. CM-B indicated when a referral from therapy was received for an ambulation program or other exercise program it would be written on a form for the nursing assistants(NA) in the NA maintenance book. CM-B verified R46's Resident Referral, Interdepartmental Communication dated 11/6/15, to nursing from physical therapy directed the following: "Please ambulate Pt (patient) with RW (regular walker), transfer belt, and 1 A (assist) 2 X (times) daily. Pt. amb. (ambulate) up to 200' any ? (questions) call." CM-B verified R46 did not have a form which directed the ambulation program in the NA maintenance book. With review of R46's chart, CM-B verified the ambulation program had been in place for the months of December 2015, April, May, June and July 2016, but no further ambulation program documentation was found. The CM-B verified R46's ambulation program was not currently being performed. On 10/24/16, at 11:11 a.m. R46 verified the nursing staff did not walk with her in the hall and had not asked her to walk with them. While walking with the use of a walker, gait belt and PTA-G, R46 stated," I can feel I have not walked in a while, I can feel it in my arms." R46 walked approximately 8 feet, stopped and requested to stop a while to rest her arms. After resting a few minutes, R46 continued to walk with PTA-G back to her room. R46 was breathing heavily when she reached her room. On 10/24/16, at 11:24 a.m. a follow up interview with R46 identified she was aware she should walk more; however, believed the facility staff were very busy and she required a lot of assistance and took a lot of the staffs time.	2 555		

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On 10/24/16, at 2:00 p.m. physician assistant (PA)-A indicated she would expect facility staff to follow resident care plans and to initiate recommended walking or exercise programs to prevent resident functional decline and a decline in the residnets quality of life. PA-A stated, " Sadly not providing recommended restorative exercises is not uncommon here."

R38's significant change Minimum Data Set (MDS) 9/26/16, identified R38 had moderate cognitive impairment and had diagnoses which included degenerative joint disease, weakness and back pain. The MDS identified R38 was independent in bed mobility, transfers and used a wheelchair independently for locomotion. Further, the MDS identified activity did not occur for turning around and facing opposite direction while walking and R38 did not walk.

R38's ADL Care Area Assessment (CAA) dated 9/26/16, indicated R38 had improved ADL performance and would be addressed on care plan. The CAA did not address R38's ambulation.

R38's admission MDS dated 5/24/16, identified R38 was not steady, only able to stabilize with human assistance for walking and turning around and facing opposite direction while walking. The identified R38 had ambulated with limited assistance from staff.

R38's ADL CAA dated 5/24/16, identified R38 required assistance from staff to safely ambulate and transfer. The CAA revealed R38 was receiving therapies and her goal was to return to independence in hopes of returning home.

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R38's Behavioral CAA dated 5/24/16, identified R38's goal was to cooperative with therapies in order to return home.

R38's current care plan updated 6/10/16, indicated she was fully ambulatory with a walker and contact guard assistance. R38's care plan also indicated R38 was receiving therapy and assist to transfer with one and gait belt, and R38 wheeled self independently in wheelchair. R38's care plan did not identify any updates past 6/10/16.

Review of the Aide Care Plan Group C form, dated 10/17/16, listed various interventions which included R38 was assist of one for transfers, toileting and ADL's, and listed R38 received therapy for walking. The form did not list any other interventions for R38's ambulation.

On 10/18/16, at 1:36 p.m. R38 was observed in the facility hallway, seated in a wheelchair, propelling herself to the activity room with both feet. R38 propelled herself up to a squared table, opened the daily newspaper and began to read the paper.

On 10/20/16, at 1:38 p.m. R38 indicated she had wheeled herself into the bathroom and slid herself to the toilet seat to use the toilet. She stated she was able to complete most cares for herself and liked to be as independent as possible. R38 proceeded to propel herself out of her room, utilizing both feet to the activity room to attend an activity. At 3:08 p.m. R38 was seated in her wheelchair in the activity room actively participating in Bingo. R38 was not observed to ambulate at any time during observations.

On 10/20/16, at 1:57 p.m. nursing assistant

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(NA)-F stated R38 used a wheelchair for mobility and was able to propel herself to and from destinations. NA-F stated R38 was independent with all of her personal cares and liked to maintain her independence. NA-F stated she did not think R38 was able to walk and had never assisted R38 to ambulate. NA-F stated the nursing assistants were responsible to ambulate residents who were on an ambulation program and stated she did not think R38 was on an ambulation program in the facility.

On 10/20/16, at 2:30 p.m. NA-B stated she had not assisted R38 with ambulation at any time in the past. NA-B stated the NA on the individual units were responsible for residents walking programs, after the program had been determined by occupational (OT) and physical therapies (PT). NA-B stated R38 had received both PT and OT upon admission for a few months and indicated she was unsure if R38 had been placed on the ambulation program. NA-B stated she felt R38 was unable to fully stand nor could R38 ambulate. NA-B stated the NA on the unit often times could not assist residents with their ambulation programs due to not enough NAs on the floor.

On 10/20/16, at 3:18 p.m. licensed practical nurse (LPN)-B stated the NAs on the units were responsible to ambulate with residents who had ambulation programs in the facility. LPN-B stated she was unsure if R38 was on an ambulation program at present and after review of R38's clinical record, confirmed R38 had a referral from PT and OT dated 7/8/16, which directed R38 was to be assisted with ambulation twice daily with a walker and one-person assistance up to 40 feet. LPN-B stated she did not think R38 had been assisted to ambulate since therapy ended.

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2 555	Continued From page 21 On 10/21/16, at 10:35 a.m. registered nurse (RN)-A stated she was unaware if R38 was on an ambulation program and indicated she had not seen R38 ambulate with staff in the past. On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated R38 had received both physical and occupational therapy upon admission to the facility in May of 2016. PTA stated R38 was discontinued from both therapies in July 2016, with a referral to nursing for R38 to be placed on an ambulation program with nursing staff. PTA stated R38 was able to ambulate with one assist and a front wheeled walker up to 40 feet consistently, when PT and OT were stopped. PTA stated she had serious concerns with residents' ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis. On 10/21/16, at 11:30 a.m. R38 stated she was no longer able to walk and used a wheelchair to move about the facility. R38 stated she had been walking when she was admitted to the facility and had worked with therapy for her walking. R38 stated nursing staff had not assisted with her ambulation since therapy had stopped several months ago. R38 stated she had bad knees which affected her ability to walk, but felt if she had some "treatments" she would be able to walk again with help. On 10/21/16, at 11:36 a.m. PTA entered R38's room, and looked in her closet and various locations in her room for her walker. PTA stated R38 no longer had a walker in her room and stated she would expect R38 to have a walker	2 555		

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available so nursing staff could assist her to walk. PTA left R38's room briefly, returned with a front wheeled walker and placed the walker in front of R38. PTA applied a transfer belt around R38's torso and cued R38 to stand from her wheelchair up to the walker while PTA pulled upwards on the gait belt. R38 was only able to lift her buttocks from the wheelchair seat approximately 7 inches. R38's knees remained bent at approximately an 80 degree angle, was unable to stand fully erect or straighten her knees. PTA attempted to stand R38 twice more and R38 continued to not able to stand erect or straighten her knees. R38 stated she could not stand up all of the way and had not stood up for a long time. R38 stated she could not remember the last time she had used a walker. PTA asked R38 when the last time she had walked and R38 responded, "with you." PTA confirmed the last time she had worked with R38 was in July, 2016. PTA confirmed R38 had lost the ability to fully stand and to ambulate.

On 10/21/16, at 11:44 a.m. during a follow up interview, PTA stated when R38 was discharged from therapy, R38 had been ambulating about 40-60 feet daily with minimal assist of one and a front wheeled walker. PTA stated R38 was referred to an ambulation maintenance program and she would have expected R38 to receive assistance with walking with nursing staff twice daily. PTA stated she felt the facility had a huge problem with the facility's ambulation/maintenance program due to staffing concerns and stated she felt there were not enough NAs to complete resident ambulation/maintenance programs.

Review of R38's hospital discharge summary dated 5/17/16, identified R38 had been treated for weakness and falls at home. The summary

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revealed R38 was having difficulty standing and walking. The summary further revealed R38 was sent to the facility for acute rehab due to lower extremity weakness.

Review of R38's physician progress note dated 8/2/16, revealed R38's primary medical doctor (MD) had seen her at the clinic. The note also revealed R38 had plateau in therapy, however, was ambulating using a walker. The note further revealed R38's daughter had concerns that R38 had exhibited regression after therapy was ended.

Review of R38's physician progress note dated 10/6/16, revealed R38 had established care with another practitioner. The note revealed R38 used a wheelchair for long distances, had received PT and OT during the spring and summer, and at that time due to increased care needs R38 was determined to be a long term patient.

Review of a facility form titled, Resident Referral Interdepartmental Communication dated 7/8/16, revealed therapy had referred R38 to nursing for a ambulation program to include ambulation twice daily with front walker and one assistance up to 40 feet. The form also identified R38 has complained of left knee pain and if nursing had any questions to call.

Review of R38's medical record revealed the record lacked further documentation of R38's ambulation status or progress and lacked documentation of facility forms maintenance ADL worksheets.

Nursing progress notes were reviewed from 5/17/16, to 10/18/16, revealed the following:

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On 5/17/16, R38 was full weight bearing and required one assistance with ADL's.

On 6/10/16, the note indicated R38 was working with therapy.

On 6/11/16, R38 questioned nursing staff on when she would be able to return home.

On 8/4/16, R38 required one assist with ADL's.

R38's nursing progress notes lacked any documentation of R38's ambulation and decline in R38's ambulation status.

On 10/21/16, at 1:37 p.m. the assistant director of nursing (ADON) confirmed R38's ambulation/maintenance program had never been implemented in July. ADON confirmed R38's referral for ambulation maintenance program directed staff to ambulate with R38 with a front wheeled walker up to 40 feet twice daily. ADON stated she would expect R38's ambulation program to be implemented to maintain and prevent further decline her ambulation.

On 10/24/16, at 9:27 a.m. nurse manager (NM)-A stated she had understood the nursing assistants had been assisting R38 with ambulation. NM-A stated she was not aware R38 could not longer ambulate. NM-A stated she was not sure why R38's ambulation/maintenance program had not been started.

A facility policy titled, Restorative Program, dated 4/1/08 identified residents would be assessed on admission for a restorative program such as ambulation. If a ambulation program was an identified need, a plan would be individualized to meet resident needs and goals. The policy further

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2 555	Continued From page 25 identified residents would be supported and their highest level of functioning maintained. Review of facility policy, Care Plans-Comprehensive, dated 4/1/08 identified the facility would revise the resident's comprehensive care plan to meet the resident's mental and psychosocial needs as identified by comprehensive assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is revised and followed. The director of nursing or designee could develop a system to educate staff and a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by:	2 560		11/17/16

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	Based on observation, interview and document review the facility failed to develop a plan of care which included a therapy recommended range of motion (ROM) program for 1 of 4 residents (R66) who had functional decline in her upper extremeties.		corrected	

Findings include:

R66's quarterly Minimum Data Set (MDS) dated 7/13/16, identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS identified R66 had severe cognitive impairment, and was totally dependent on staff for assistance with all activities of daily living (ADLs). R66's MDS identified R66 had functional limitations in range of motion on both sides, upper and lower extremities, and did not receive therapy services or restorative nursing services.

R66's annual MDS dated 1/11/16, identified R66 had severe cognitive impairment, and was totally dependent on staff for assistance with all ADLs. The MDS identified R66 had functional limitations on both sides, upper and lower extremities, and did not receive therapy services or restorative nursing services.

R66's Care Area Assessment (CAA) dated 1/11/16, identified R66 was dependent on staff for all ADLs related to traumatic brain injury over the last year, and had difficulty with mobility, communication and cognition.

R66's care plan dated 2/18/16, identified R66 was aphasic (non verbal) due to traumatic brain injury, and was unable to make her needs known. R66's care plan also identified R66 was to wear hand splints for 2 hours on and 2 hours off during the

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day, and was to wear the splints all night. R66's care plan failed to identify R66 had contractures, and did not identify a ROM or a restorative nursing program for R66 to prevent further decline.

Review of the Aide Care Plan, Group B dated 10/17/16, identified R66 required total assistance with cares and was to wear hand splints on and off every 2 hours during the day and leave them on all night. The Aide Care Plan did not identify R66 had contractures or that she required a ROM or restorative nursing program to prevent further decline.

R66's Admission Assessment form dated 12/31/15, indicated R66 was non verbal, was non-weight bearing, transferred with a mechanical lift, and had elbow contractures. R66's Admission Assessment form indicated R66's hand grasps had not been assessed.

Review of R66's Resident Referral Interdepartmental Communication form dated 1/12/16, identified directions for nursing to complete R66's passive range of motion (PROM) to both upper extremities, active range of motion (AROM) to left hand, and included instruction to have R66 open and close fingers and to have R66 squeeze staff's hand with her left hand daily to maintain strength.

Review of a second Resident Referral from therapy dated 2/18/16, identified R66's hand splint wearing schedule as for R66 to wear splints 2 hours on, 2 hours off throughout the day and on at night.

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R66's progress notes reviewed from 1/3/16 to 10/17/16 identified:

-1/3/16, R66 reached over and grabbed the TV remote with her left hand and could hold her TV remote in her left hand.

-1/21/16, R66 was changing TV channels with remote.

R66's progress notes lacked further documentation regarding communication skills or techniques and lacked any documentation of upper extremity motion, exercises, or decline in function.

Review of R66's physician progress notes from 2/9/16 to 10/16/16 identified:

-2/9/16, identified R66 suffered a traumatic brain injury in 12/14, had been in a former long term care facility, but family had requested a transfer closer to their home. R66's could not communicate verbally. Nursing had reported R66 did not communicate verbally but was able to push her call light button and could change the channel on her TV with her TV remote.

-3/17/16, identified R66 still had some movement which involved the left upper extremity, and the physician would make sure therapy had a maintenance regimen from a contracture and general limb standpoint for R66.

-10/6/16, identified R66 could squeeze his fingers with left hand.

On 10/19/16, observations from 7:00 a.m. to 9:47 a.m. were conducted:

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-At 7:00 a.m., R66 was observed lying on her back in bed, with her eyes closed. Both R66's arms were bent at the elbow, her right hand was in a fist position on her chest, and her left hand was in a "C" shaped position with fingers bent and hand slightly tilted away from her body. Splint devices were not observed on either of R66's hands, and the splint devices were not observed in her room.

-7:49 a.m. licensed practical nurse (LPN)-A entered R66's room to provide her trachea (artificial opening at windpipe) site care. She confirmed R66 was not wearing hand splints and stated R66 had not been wearing them in the recent past because she thought the splints were uncomfortable for R66. LPN-A exited R66's room and did not apply R66's hand splints.

-8:03 a.m. the nurse consultant walked in R66's room and immediately walked down to the nurses station. R66 remained on her back in bed, with her hands and arms in the same positron, no splints observed.

-8:20 a.m. R66 remained lying in bed in the same position with R66's arms bent at her elbows and her hands rested on her chest in the same position. No hand splints were observed on R66's hands and splints were not observed in R66's room.

-9:47 a.m. R66 remained in the same position in bed, no hand splints were observed on R66 or present in R66's room.

On 10/19/16, at 10:03 a.m. LPN-A confirmed R66 had not worn hand splints and stated R66 did not wear the splints "at all." She stated she was not

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aware when R66 last had worn the splints and indicated she thought it had been in the distant past. LPN-A left room and did not apply hand splints to R66.

On 10/19/16, at 10:33 am nursing assistant (NA)-E confirmed R66 did not routinely wear hand splints, and stated she could not remember the last time R66 had worn her splints. NA-E provided a copy of the a NA care sheet and confirmed the care sheet directed for R66 to wear hand splints. She stated she had not been aware R66 was to wear hand splints. NA-A and LPN-A exited R66's room and did not apply her hand splints.

On 10/19/16, at 10:40 a.m. NA-D stated she was not aware of how R66's care plan directed her to care for R66. She stated she was not aware if R66 had hand splints or if R66 was supposed to wear them.

On 10/19/16, at 12:10 p.m. R66 was seated in her recliner in her room with both hands resting on her chest, right hand in fist, left hand curled in a "C" shape. R66 did not have hand splints on either hand.

On 10/20/16, at 9:30 a.m., during follow up interview, NA-B stated R66 presently did not receive range of motion services or presently was not receiving a restorative nursing program.

On 10/20/2016, at 9:36 a.m., during follow up interview, NA-D stated R66 did not routinely use her hands and was not aware if R66's hand stiffness had gotten worse. She stated she was not aware if R66 was on a restorative program or received range of motion services. NA-D reviewed the therapy referral in the nursing

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assistant reference book at the nursing station and stated she felt R66's therapy screening was not current, and R66 did not need range of motion services and did not need to wear splints since the screen was old (February 2016) She stated she was sure R66 got enough range of motion when they dressed her.

On 10/20/16, at 9:45 a.m. assistant director of nursing stated she was not aware if R66's splints had been discontinued in the past and indicated she questioned if the splints bothered R66 and indicated she felt R66 was not anymore contracted than when she was admitted.

On 10/20/16, at 10:03 a.m. occupational therapist (OT)-A stated R66 had worn hand splints at the time of admission, and indicated she was not aware if R66 had contractures on admission. She confirmed R66's therapy screens on 1/12/16 and 2/18/16, and indicated the therapy screen on 2/18/16, was completed after the facility changed the style of splint for R66 per family request. She stated a comprehensive assessment of R66's contractures had not been completed because the facility did not have a physician order for a consult. She stated she was not aware of R66's baseline for her contractures as the screen did not include measurements of limitations and stated the ROM and hand splints were recommended for R66 to prevent further contracture and discomfort in the future for R66.

OT-A stated the facility NAs were responsible for providing ROM services, restorative program and applying R66's splints and indicated the facility had a book of recommendations for residents' programs at the nurses desk. She confirmed R66 was unable to move both hands or her fingers independently. She stated she felt R66's left

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fingers were tighter, and flexion and extension was slightly limited, and stated she felt R66's limitations were within normal limits. She stated she felt R66's hands weren't contracted but had high tone. She confirmed the ROM and the splints were recommended treatments for R66's high tone. She stated she would expect R66 to wear the splints all night and alternating on and off every 2 hours throughout the day since 12/31/15, and should have received ROM services since 1/12/16.

At approximately 10:10 a.m., NA-B entered R66's room and OT-A asked her to locate R66's hand splints. NA-B looked in R66's bedroom in various locations and found them on R66's wheelchair underneath blankets and equipment. OT-A stated R66 should have been wearing her hand splints according to the schedule to prevent further functional decline. NA-B stated R66 had not worn the hand splints in awhile, and stated she was not sure why R66 had not been wearing them.

On 10/20/16, at 10:35 a.m. LPN-A stated she felt R66's care plan did not include a restorative program or ROM that she knew of. She confirmed R66's care plan and stated that ROM services were not on R66's care plan. She stated R66 had never used hand splints, and she felt R66's ROM, "Was about the same."

On 10/20/16, at 10:37 a.m. certified occupational therapy assistant (COTA)
stated their usual process for implementing a ROM program for residents was to complete a therapy screen and give a copy of the recommended ROM program to the clinical manager (CM.) She stated once the CM received the plan she was expected to implement the program with NAs and set up the "Maintenance

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ADL Worksheet," in the NA Book for documenting ROM provided. She confirmed there was no documentation that ROM services were provided for R66 in her medical record or in the NA Book. She confirmed R66 should have received ROM services since 1/12/16, and stated she could not explain why she never received ROM services.

On 10/20/16, at 10:40 a.m. NA-B stated she felt R66's stiffness had gotten worse and her arms were more stiff now. She stated she noticed R66 was more stiff when they dressed her, and stated they really had to manipulate her arms when they put her shirts on.

On 10/20/16, at 11:45 a.m. OT evaluated R66's elbow ROM while R66 was awake in her bed. OT physically picked up R66's right arm and after she manipulated both arms, she confirmed R66's right elbow lacked 25% extension. She confirmed R66 was a little tight with initial right side movements, and confirmed R66 grimaced in pain with movement. She confirmed R66 also had pain and grimaced with movement of her left arm, and R66's left elbow lacked about 10% for extension.

On 10/20/2016 at 12:00 p.m. NA-D stated sometimes R66 was a little more stiff in her upper extremities, and staff had to manipulate her arms more depending on the shirt they were putting on her.

On 10/21/16, at 10:14 a.m. NA-A stated R66 was totally dependent on staff for all of her cares. She stated she was unsure if R66 was on a ROM program , but stated she felt R66 should be. She stated she knew R66's right arm was more stiff than her left arm. She stated R66 just started wearing hand splints to both hands today and

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stated she had never seen R66 wear see hand splints until today.

On 10/21/16, at 2:16 p.m. R66 was observed on her back in bed with both arms resting on chest, right hand in a fist, left hand in a "C" shape. No splints were observed on either of R66's hands. A 8.5 X 11" white piece of paper with both typed instructions and hand-written notes, dated 8/3/16, was observed posted on R66's bedroom wall across from her recliner and identified R66's TV show preferences.

On 10/21/16, at 2:55 p.m. speech language pathologist (SLP) stated she had been working with R66 on communication techniques and assessed her ability to use her hands and elbows in the past. SLP repeated her functional assessment of R66. R66 was reclined in bed and SLP held "Yes and No" flash cards above R66's chest. SLP instructed R66 to point at the card that answered her questions. R66 unable to point or motion hand toward cards. SLP instructed R66 to use her eyes to look at either card to answer her questions. R66 was unable to participate in the assessment at all. R66 began crying and SLP ended assessment. SLP confirmed R66 had 0% success today, where R66 responded correctly to 60% of her questions during a past assessment.

On 10/24/16, at 9:50 a.m. NA-B stated at present, she was not aware if R66 could use her call light , and stated she did not know if R66 could hold a TV remote or use it.

On 10/24/16, at 10:14 a.m. NA-D stated R66 might be able to use her call light or TV remote if you put them in her hand, but wasn't sure.

On 10/24/16, at 10:38 a.m. registered nurse

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(RN-A) stated R66 had severe cognitive impairment and was totally dependent on staff for all cares. She stated she was unaware if R66 was on a ROM program, wore her arm splints before today, or had declined in ROM to her upper extremities. She stated R66 should have received ROM and wore her arm splints according to the therapy recommendations and confirmed ROM was not on R66's care plan.

On 10/24/16, at 10:53 a.m. clinical manager (CM)-A stated R66 had severe cognitive impairment, and was dependent on staff for cares. She indicated she thought R66 had contractures on admission, but stated she did not remember where the contractures were, or which side of R66's body was affected. CM-A stated she remembered talking to the physician in the distant past about R66's contractures after admission and stated she told him she saw R66 use her TV remote in her room.

CM-A stated R66 was supposed to get ROM since 1/12/16, and was to wear hand splints on and off during the day, and keep on all night. She stated she expected R66 to wear her hand splints according to the schedule and receive ROM services from the NA's. She confirmed there was no documentation in R66's medical record or in the NA book that R66 had ever received ROM services since admission. She confirmed ROM services were not on R66's care plan.

On 10/24/16, at 12:00 p.m. COTA evaluated R66 while she was awake and sat in her recliner. COTA picked up R66's right arm by her elbow and put her call light in between R66's finger and adjusted her fingers to hold call light. R66's fingers were very weak and her fingers and hand didn't move and the call light fell on her lap. COTA

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2 560	Continued From page 36 picked up R66's left arm by the elbow, placed her call light between R66's fingers. R66's left hand and fingers did not move. R66 hand and fingers were very weak and call light just sat loose in her hand and R66 could not grasp or activate her call light. COTA also evaluated R66 for holding her TV remote. COTA attempted to place R66's TV remote in R66's right hand while she supported R66's arm by her elbow. R66 was unable to hold the TV remote at all with her right hand or fingers. COTA lifted R66's left arm up by the elbow and put the remote between R66's left fingers. The TV remote slipped in R66's hand and pointed up to the ceiling. R66 was unable to hold the remote towards her TV or activate the remote with her left hand and fingers. She stated she was sure R66 declined in her upper extreme ROM. On 10/24/16, at 12:27 p.m. Activities Director (AD) confirmed activity staff had posted a paper in R66's room at the time of admission, which listed TV shows R66 like to watch. AD indicated at the time the sign was originally posted, R66 could hold and use the remote, and liked to channel surf on the TV and would stop on the shows she liked to watch. On 10/24/16, at 1:45 p.m. nurse practitioner (NP) stated she felt if R66 was unable to use her remote or call light now, and could on admission, it was evidence of a functional decline. She stated the failure to provide ROM services was not a new concern for her and stated she had brought her concerns to administration in the past, but continued to be a long standing problem in the facility. On 10/25/16, at 5:05 p.m. family member (FM)-A stated when R66 first got to the facility she could	2 560		

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2 560	Continued From page 37 use her TV remote, change the channels, use her call light, and write her name and the word Mom. She stated when R66 was first admitted to the facility R66 could also pull her covers up, put her arms in the arm holes of her night gown. FM-A stated R66 could no longer do any of those things and indicated she felt R66 was sad and frequently cried. She stated R66's right side was most affected by her brain injury. She stated she had visited R66 over the previous weekend and noticed staff were now putting the hand splints on both hands. and stated she felt the facility should of been using the hand splints for R66 " the whole time." FM-A stated she had never seen staff do any exercises with R66 for her hands and arms, and stated she didn't know if they ever had. She stated R66 received ROM all the time before admission to this facility. She stated she had asked facility staff why R66 did not get ROM exercises and stated she had been told by staff they felt her brain was not working enough for them to do that. Review of facility policy, Restorative Program, dated 4/1/08 identified residents would be assessed on admission for a restorative program such as ROM. If a ROM program was an identified need, a plan would be individualized to meet resident needs and goals. The policy further identified residents would be supported and their highest level of functioning maintained. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is revised and followed. The director of nursing or designee could develop a system to educate staff and a monitoring system to ensure ongoing compliance.	2 560		

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2 560	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident care plan interventions were implemented for bathing preferences for 1 of 3 residents (R61) reviewed for choices, ambulation programs were implemented and routinely followed for 1 of 4 residents (R44) reviewed for ambulation. In addition the facility failed to ensure resident care plan interventions were implemented for assessed repostitioning, personal cares needs for 1 of 1 resident (R18) reveiwed for urinary incontinence and for repositioning for 2 of 2 residents (R18, R66) at risk for development of pressure ulcers. . Findings include: Bathing Preferences: Review of R61's current care plan revised 1/27/16, revealed R61 required assistance of one with bathing.	2 565	corrected	11/17/16

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Review of nursing assistant care sheet provided by the facility, dated 10/17/16, directed staff to assist R61 with a bath 3 times a week, Monday, Wednesday and Fridays.

On 10/19/16, at 1:26 p.m. R61 stated she had not received her bath on Monday 10/17/16, due to not enough staff on the floor. R61 stated she had been told the staff would try to help her with bathing on 10/18/16, though due to not enough staff on the floor, she had not received assistance with a bath. R61 stated the nursing assistants (NA) do not have enough time during the day to give baths, so she had changed to before bed. R61 stated she was scheduled to have 3 baths a week, Monday, Wednesday and Fridays and was still not able to get 3 baths a week due to not enough staff on the floor. R61 stated it had been "months" since she had received 3 baths a week, and indicated she understood it was due to the lack of nursing staff.

On 10/20/16, at 1:52 a.m. NA-F stated she understood R61 was supposed to receive 2 baths a week in the evenings and was not sure if R61 received her baths routinely.

On 10/21/16, at 11:02 a.m. ADON indicated she had met with R61 on 10/20/16 and confirmed R61 had not been routinely receiving her 3 baths a week as care planned.

On 10/21/16, at 1:37 p.m. during a follow up interview, ADON stated she felt staff were unable to routinely complete the number of baths based on residents preference, such as R61, due to staffing shortages.

On 10/24/16, at 9:31 a.m. nurse manager (NM)-A stated she was unaware R61's baths were not

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getting done 3 times a week. She stated R61's care plan should be followed.

Ambulation
Review of R44's current care plan updated 9/25/15, revealed R44 was independent with mobility in a wheelchair and required assistance with ambulation with use of a walker. R44's care plan directed staff to offer to walk with R44 to all meals.

Review of Aide Care Plan Group C form, dated 10/17/16, listed various interventions which included R44 was assist one for ADL's and directed staff to assist R44 with ambulation twice daily to 200 feet, with a rear wheeled walker and transfer belt.

On 10/19/16, at 8:16 a.m. R44 was seated in a standard wheelchair, propelling herself into the dining room and wheeled herself up to a circular table. R44 verbalized her breakfast order, obtained her food and ate independently. At 8:34 a.m. R44 had eaten 100% of her meal and at that time propelled herself out of the dining room.

Review of a facility form titled Maintenance ADL Worksheet from April 2016, to October 2016, identified R44's was on an ambulation program twice a day (BID) long distances in the hallways with a walker and transfer belt. The worksheet also indicated R44 was to be assisted to ambulate up to 200 feet (ft.) R44's worksheets revealed the following:

- Review of R44's April 2016, worksheet identified R44 had received her ambulation program 16 out of 31 days in the am hours and 25 out of 31 days in the pm hours.

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-Review of R44's May 21016, worksheet identified R44 had received her ambulation program 13 out of 31 days in the am and 20 days out of 31 in the pm.

-Review of R44's June 2016, worksheet identified R44 had received her ambulation program 8 out of 30 days in the am and 24 out of 30 days in the pm.

-Review of R44's July 2016, worksheet identified R44 had received her ambulation program 7 out of 30 days in the am and 12 out of 30 days in the pm.

-Review of R44's August 2016, worksheet identified R44 had received her ambulation program 8 out of 31 days in the am and pm.

-Review of R44's September 2016, worksheet identified R44 had received her ambulation program 11 days out of 30 in the am and 8 days out of 30 in the pm.

-Review of R44's October 2016, worksheet identified R44 had received her ambulation program 2 days out of 17 in the the am and 0 days out of 17 in the pm.

Review of an Occupational Therapy (OT) assessment dated 3/12/15, revealed R44 was discharged from therapy services and had been placed on the nursing gait list (ambulation program) and was to ambulate with a front wheeled walker with stand by assistance.

On 10/20/16, at 1:59 p.m. nursing assistant (NA)-F stated R44 was able to complete most cares on her own. NA-F stated R44 required

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assistance to ambulate in the hallways and was on an ambulation program for twice a day in the am and in the pm. NA-F stated there were days when R44 was not assisted to ambulate due to not enough nursing staff on the floor.

On 10/20/16, at 2:34 p.m. NA-B stated R44 required limited assistance with ADL's of dressing and ambulation. NA-B stated R44 was on an ambulation program for twice a day. NA-B stated residents ambulation/maintenance programs were not getting done as they should due to not enough staff and this included R44.

On 10/20/16, at 3:24 p.m. licensed practical nurse (LPN)-B stated R44 was on a ambulation program for twice a day in the am and pm. LPN-B stated R44 liked to walk and felt the times R44 was not assisted with ambulation was due to not enough staff on the floor.

On 10/21/16, at 10:08 a.m. R44 stated she was on a walking program which she was supposed to walk twice a day. R44 stated she used to walk up to 3 times a day and stated she was lucky if she was walked once a day. R44 stated the staff had told her they were too busy on the days she did not receive her ambulation program. R44 stated that had been happening routinely for the last several months. R44 stated she was able to walk around the entire block (200 feet square perimeter around the nursing station,) but at the time would get a bit winded due to not walking like she should. R44 stated she felt as though she was not as steady on her legs as she used to be. R44 stated she feared she would lose her ability to walk if she did not continue with her ambulation program of twice a day.

On 10/21/16, at 10:18 a.m. registered nurse

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(RN)-A confirmed R44 was on an ambulation program twice daily to 200 feet with assist of one, walker and gait belt. RN-A did not comment if R44 was routinely receiving her ambulation program and stated R44 would be best person to answer the question.

On 10/21/16, at 10:38 a.m. certified occupational therapy assistant (COTA) confirmed R44 had been referred to nursing for an ambulation program last year and was to be ambulated twice daily to 200 feet with one assist, gait belt and walker.

On 10/21/16, at 11:13 a.m. assistant director of nursing (ADON) confirmed R44 was not consistently receiving her ambulation program. ADON stated she expected staff to routinely complete ambulation/maintenance programs for resident.

Repositioning/personal cares:

Review of R18's current care plan last updated 10/7/16, revealed R18 had severe cognitive loss, was unable to communicate her needs and was totally dependent on staff for toileting, repositioning needs and was frequently incontinent of bowel and bladder and wore an incontinent brief . The care plan listed interventions which included to assist R18 to turn and reposition every 2 hours and prn, keep skin clean and dry and a gel cushion in the wheelchair. The care plan directed staff check and change R18 every 2 hours for incontinence with repositioning.

On 10/19/16, from 7:03 a.m. to 10:39 a.m., continuous observations of R18 revealed the following:

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On 10/19/16, at 7:03 a.m. R18 was seated in a gel cushioned wheelchair, fully dressed in her room. R18's bed was stripped of its linens which were balled into a bundle on her bed. R18's head was hung forward in a chin to chest position and her eyes were closed.

-at 7:38 a.m. the call light to R18's room was on by R18's roommate, staff were observed to enter the room to assist R18's roommate. At that time, housekeeping staff entered R18's room and made R18's bed while she remained seated in the wheelchair. At 7:41 a.m. the housekeeping staff member wheeled R18 to the dining room. R18 had remained with her eyes closed and her head was in a chin to chest position. Housekeeping staff wheeled R18 to a table in the dining room and placed a clothing protector around her neck, at that time R18 covered her face with the clothing protector.

-at 7:56 a.m. R18 remained seated in the wheelchair in the dining room. A dietary aid (DA)brought R18 her breakfast plate, left the plate on the table in front of her and walked away. At that time nursing assistant (NA)-G approached R18, placed a hand on her shoulder and verbally prompted her to wake up. R18 opened her eyes and NA-G verbally prompted R18 to begin eating and handed her a spoon. R18 ate 100% of her breakfast foods independently while seated in the wheelchair. R18 remained seated in the wheelchair at the table

-at 8:46 a.m. R18 remained seated in her wheelchair at the dining room table, had made no attempt to leave from the table. R18 had

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completed her meal, had a glass of milk orange juice and water in front of her though made no attempt to reach for them. R18 held onto her spoon, and would repeatedly run the spoon over the lipped edge of her plate, periodically licking her spoon.

-at 9:01 a.m. R18 remained seated in her wheelchair in the dining room, having made no attempts to leave the table. NA-H approached R18 and asked how her day was, R18 did not respond, NA-H walked away. R18 continued to repeatedly run her spoon around the lipped edge of the plate, while she periodically licked her spoon. R18 had made no attempts to drink her fluids.

-at 9:18 a.m. R18 remained seated in her wheelchair in the dining room. R18 had set the spoon on the table, and had closed her eyes. Shortly after R18's head dropped forward in a chin to chest position. No staff had offered to assist R18 with repositioning.

-at 9:30 a.m. R18 remained seated in her wheelchair in the dining room. R18 had opened her eyes, looked around, took her clothing protector and covered her face it. R18 made no attempt to move away from the table and held her face covered with the clothing protector.

-at 9:37 a.m. NA-D entered the dining room, awoke R18 and offered R18 her fluids. R18 awake, removed the clothing protector from her face and allowed NA-D to assist her to drink her juice. R18 drank 50% of her juice. NA-D then handed R18 her glass of water and R18 independently drank the water. NA-D left R18 seated in her wheelchair and exited the dining

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room. NA-D was not observed to offer R18 assistance with cares, repositioning or toileting needs.

-at 9:42 a.m. NA-H approached R18 and assisted her to drink her remaining fluids, while R18 remained seated in her wheelchair. NA-H removed the clothing protector from R18's neck, R18 then took her shirt and covered her face with it, in a cradling position.

-at 9:50 a.m. NA-H assisted R18 out of the dining room while seated in her wheelchair, brought her to her room and handed R18 a stuffed bear. NA-H attached the call light to R18's wheelchair and left R18's room. NA-H was not observed to offer R18 with any cares, including repositioning or toileting.

-at 10:01 a.m. NA-D was observed to walk past R18's room, did not look in or stop in R18's room.

-at 10:09 a.m. NA-E exited a room across the hallway from R18's room, briefly looked into R18's room and immediately walked away down the hallway.

-at 10:39 a.m. assistant director of nursing (ADON) was notified R18 had remained seated in her wheelchair for an observed 3 hours and 36 minutes. At that time the ADON confirmed R18 required assistance with repositioning and checking and changing every 2 hours. ADON confirmed R18 was at risk for skin breakdown. ADON went to R18's room while requesting assistance from other nursing staff via walkies talkie.

-at 10:39 a.m. NA-E entered R18's room and asked R18 to use the bathroom. NA-E donned a

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gait belt across R18's torso, NA-E and ADON assisted R18 to stand from the wheelchair, ambulate to the bathroom and removed R18's slacks and incontinent brief. R18 had a moderate amount of urine in her brief as well as a small amount of bowel. ADON confirmed R18's entire buttocks surface which had contact with the brief had deep blush pink creases and was moist surrounding her peri-rectal area, though was blanchable. NA-E and ADON assisted R18 to complete toileting needs and assisted R18 to sit back in her wheelchair.

R18 had remained in a seated position for a total of 3 hours and 36 minutes, during that time no staff were observed to offer R18 assistance with repositioning.

On 10/19/16, at 10:39 a.m. NA-E stated she thought R18 was last repositioned around 6:45 a.m. and had stated she had been too busy helping others with cares to assist R18 with repositioning and toileting needs. NA-E stated R18 was supposed to be repositioned and checked and changed every 2 hours and as needed. NA-E stated R18 was not able to verbalize hers and staff needed to anticipate R18's needs.

On 10/20/16. at 2:36 p.m. NA-B stated R18 needs must be anticipated and was totally dependent on 2 staff for her needs, including repositioning and toileting. NA-B stated R18 required routine every 2 hour repositioning and toileting. NA-B stated R18's buttocks would get red at times, but could not recall any recent open areas on R18's buttocks.

On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on

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staff of for all of her needs. LPN-B stated R18 was at risk for skin breakdown due to incontinence and immobility.

On 10/21/16, at 1:37 p.m. during a follow up interview ADON stated she felt staff were unable to routinely repositioning and toilet residents in a timely manner, such as R18, due to staffing shortages. ADON stated they were not always able to fill in for sick calls and there were times when the facility were unable to fill holes in the schedule.

Hand splints

R66's care plan dated 2/18/16, identified R66 was aphasic (non verbal) due to traumatic brain injury, and was unable to make her needs known. R66's care plan also identified R66 was to wear hand splints for 2 hours on and 2 hours off during the day, and was to wear the splints all night. R66's care plan failed to identify R66 had contractures, and did not identify a ROM or a restorative nursing program for R66 to prevent further decline.

Review of the Aide Care Plan, Group B dated 10/17/16, identified R66 required total assistance with cares and was to wear hand splints on and off every 2 hours during the day and leave them on all night. The Aide Care Plan did not identify R66 had contractures or that she required a ROM or restorative nursing program to prevent further decline.

On 10/19/16, observations from 7:00 a.m. to 9:47 a.m. were conducted:

-At 7:00 a.m., R66 was observed lying on her back in bed, with her eyes closed. Both R66's

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arms were bent at the elbow, her right hand was in a fist position on her chest, and her left hand was in a "C" shaped position with fingers bent and hand slightly tilted away from her body. Splint devices were not observed on either of R66's hands, and the splint devices were not observed in her room.

-7:49 a.m. licensed practical nurse (LPN)-A entered R66's room to provide her trachea (artificial opening at windpipe) site care. She confirmed R66 was not wearing hand splints and stated R66 had not been wearing them in the recent past because she thought the splints were uncomfortable for R66. LPN-A exited R66's room and did not apply R66's hand splints.

-8:03 a.m. the nurse consultant walked in R66's room and immediately walked down to the nurses station. R66 remained on her back in bed, with her hands and arms in the same positron, no splints observed.

-8:20 a.m. R66 remained lying in bed in the same position with R66's arms bent at her elbows and her hands rested on her chest in the same position. No hand splints were observed on R66's hands and splints were not observed in R66's room.

-9:47 a.m. R66 remained in the same position in bed, no hand splints were observed on R66 or present in R66's room.

On 10/19/16, at 10:03 a.m. LPN-A confirmed R66 had not worn hand splints and stated R66 did not wear the splints "at all." She stated she was not aware when R66 last had worn the splints and indicated she thought it had been in the distant past. LPN-A left room and did not apply hand

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2 565	Continued From page 50 splints to R66. On 10/19/16, at 10:33 am nursing assistant (NA)-E confirmed R66 did not routinely wear hand splints, and stated she could not remember the last time R66 had worn her splints. NA-E provided a copy of the a NA care sheet and confirmed the care sheet directed for R66 to wear hand splints. She stated she had not been aware R66 was to wear hand splints. NA-A and LPN-A exited R66's room and did not apply her hand splints. On 10/19/16, at 10:40 a.m. NA-D stated she was not aware of how R66's care plan directed her to care for R66. She stated she was not aware if R66 had hand splints or if R66 was supposed to wear them. On 10/19/16, at 12:10 p.m. R66 was seated in her recliner in her room with both hands resting on her chest, right hand in fist, left hand curled in a "C" shape. R66 did not have hand splints on either hand. On 10/20/16, at 9:30 a.m., during follow up interview, NA-B stated R66 presently did not receive range of motion services or presently was not receiving a restorative nursing program. On 10/20/16, at 9:45 a.m. assistant director of nursing stated she was not aware if R66's splints had been discontinued in the past and indicated she questioned if the splints bothered R66 and indicated she felt R66 was not anymore contracted than when she was admitted. On 10/24/16, at 10:38 a.m. registered nurse (RN-A) stated R66 had severe cognitive impairment and was totally dependent on staff for	2 565		

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all cares. She stated she was unaware if R66 was on a ROM program, wore her arm splints before today, or had declined in ROM to her upper extremities. She stated R66 should have received ROM and wore her arm splints according to the therapy recommendations and confirmed ROM was not on R66's care plan.

PRESSURE ULCER

R66's care plan dated 2/18/16, identified R66 was at risk for developing pressure ulcers related to fragile skin, not being able to turn herself, was immobile and was bed and chair bound. The care plan also identified R66 was to suspend heels off the bed or wear sheepskin boots to protect her feet, and was to be turned and repositioned according to her turning and positioning plan. The care plan further identified R66 was incontinent and was to be checked and changed every 2 hours.

Review of the Aide Care Plan, Group B, dated 10/17/16, identified R66 required total assistance with cares, was to be turned and repositioned every 2 hours, and was to float heels off the bed or wear sheepskin boots.

On 10/19/16, at 7:00 a.m. R66's bedroom was dark, and her door was fully open. R66 was dressed in a hospital gown, and was asleep on her back in bed. R66's arms rested on her chest and her body was covered with a blanket. R66's legs were straight, and her heels rested directly on her mattress. She was not wearing sheep skin boots. R66's sheepskin boots were observed to be piled up on R66's dresser across the room. At 7:19 a.m. R66 was in the same position in her bed, her eyes were now open, continued with

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loud mouth breathing and heels rested directly on the mattress and was not wearing her sheep skin boots. At 7:39 a.m. R66 was in the same position in her bed with her eyes closed. R66's heels continued to be directly on her bed and was not wearing her sheepskin boots.

At 7:49 a.m. licensed practical nurse (LPN)-A entered R66's room. LPN-A stated R66's heels were not free floated and she was not wearing sheep skin boots. LPN-A stated she felt R66's heels were, "kind of," floated by the bubbles in her mattress. LPN-A then pulled a flat pillow down to approximately one inch under R66's calves however it did not lift R66's heels off the mattress. LPN-A laid R66's heels directly on the bed, and immediately left the room.

At 8:03 a.m. the registered nurse (RN) consultant walked in to R66's room and immediately walked out, towards the nurses station. At 8:28 a.m. R66 remained in the same position on her back, asleep. R66 remained in that position without heels floated, or sheepskin boots on until 10:05 a.m.

At 10:03 a.m. LPN-A stated R66 was at risk for developing pressure ulcers. She stated she didn't think R66 had pressure ulcers in the past. LPN-A stated R66 sometimes wore her sheepskin boots and sometimes they floated R66 heels off the bed. LPN-A stated R66 had an alternating air pressure mattress and was supposed to be repositioned and checked and changed every 2 hours. LPN-A confirmed the last time R66 had been repositioned was at approximately 6:00 a.m. that morning. At 10:05 a.m. after continuous observation (3 hours and 5 minutes) LPN-A confirmed both R66's heels rested on her bed and R66 had not worn sheep skin boots. R66

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2 565	Continued From page 53 heels and bottom were intact. NA-E entered R66's room and assisted LPN-A with R66's morning cares. At 10:33 a.m. NA-E stated she didn't know the last time R66 was repositioned. NA-E stated R66 was supposed to be turned and repositioned, checked and changed every 2 hours. She stated she would have to check with partner NA-D to see when she repositioned R66 as they were taking care of R66 for the day. NA-E stated she felt R66 was was at risk for developing pressure ulcers, but she didn't think R66 had any skin problems. NA-E stated R66 heels could be on the bed because R66 had no breakdown at this time and had an air bed. NA-E further stated R66 didn't wear her sheep skin boots. NA-E confirmed her current care sheet did not direct the use of sheepskin boots. NA-E and LPN-A left R66's room after R66 was in her recliner with her heels floated by a pillow on the footrest of the recliner. On 10/19/16, at 10:40 a.m. NA-D stated she didn't know if R66 was at risk for developing pressure ulcers, or what R66's care plan directed her to do for R66's skin. She stated R66 had a special mattress, and stated she assumed R66 would be at risk. NA-D stated she didn't know if R66 had a history of pressure ulcers and wasn't aware of any sheep skin boots for R66. NA-D stated she did not reposition R66 this morning, and stated she thought the last time R66 had been repositioned was at approximately 630 a.m. by the night staff. On 10/19/16, at 12:10 p.m. R66 was seated in recliner in front of her TV. R66 did not have her heels floated on a pillow and was not wearing her sheep skin boots. R66's heels rested directly on the foot rest of her recliner.	2 565		

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On 10/19/16, at 1:11 p.m. R66 laid in bed on her back, legs straight out with her heels resting directly on her bed. R66 did not have her heels floated with a pillow, and was not wearing sheep skin boots.

On 10/19/16, at 1:34 p.m. NA-B stated R66 was totally dependent on staff for cares, and stated she wasn't sure of R66's cognition. She stated she didn't think R66 was at risk for pressure ulcers, and didn't know if R66 had pressure ulcers in the past. NA-B confirmed R66's heels rested directly on her bed and she was not wearing sheepskin boots. NA-B confirmed R66's Aide Care Sheet and stated she didn't know R66 had sheepskin boots as they weren't on her sheet, but R66's heels were supposed to floated and R66 was supposed to be repositioned every 2 hours.

On 10/24/16, at 10:38 a.m. registered nurse (RN)-A stated R66 was at risk for developing pressure ulcers because she couldn't reposition herself. She stated she didn't remember if R66 had ever had any skin problems. She stated R66's heels were supposed to be floated off of her bed, and the NA's were supposed reposition R66 every 2 hours.

On 10/24/16, at 10:53 a.m. Unit Manager (UM-A) stated R66 had severe cognitive impairment and was dependent on staff for cares. She stated R66 was supposed to be repositioned every 2 hours, her heels were supposed to be floated off of her bed, or R66 was to wear sheepskin boots. R66 had a history of pressure ulcers. She stated she remembered R66 had a blister on her heel in

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February from a profo boot or splint she wore, and that's when they discontinued the boot and implemented floating R66's heels. UM-A confirmed R66's most recent care plan which directed staff to float R66's heels off the bed or wear sheep skin boots, and turn and reposition R66 every 2 hours. She stated she expected staff to follow R66's care plan and float her heels or apply sheep skin boots to R66's feet, and reposition R66 every 2 hours to prevent pressure ulcers. She stated she felt nursing assistants needed more education on repositioning and floating of heels.

A facility policy titled, Restorative Program, dated 4/1/08, identified residents would be assessed on admission and as needed for a restorative program including ambulation. The policy further identified residents would be supported and their highest level of functioning maintained.

A facility policy titled Bowel and Bladder Management dated 4/1/08, revealed it was the facility's policy to ensure each resident with bowel or bladder incontinence would receive appropriate treatment and services to maintain normal functioning. The policy directed staff to develop an individual toileting schedule for all incontinent residents and noted on resident care plans.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and a monitoring system to ensure ongoing compliance.

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2 565	Continued From page 56 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents are not inappropriately discharged from the facility for 1 of 1 (R103) residents reviewed for discharge requirements. Findings include: R103's undated diagnoses list identified diagnoses which included, alcohol cirrhosis of the liver with ascites, hepatic encephalopathy, alcohol induced insomnia, uncontrolled diabetes and chronic obstructive pulmonary disease (COPD). R103's Admission Assessment form dated 10/20/16, identified R103 was alert, oriented and had clear speech. R103's assessment also	2 690	corrected	11/17/16

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revealed R103 was independent in mobility and was full weight bearing.

R103's Individual Resident Care Plan dated 10/20/16, identified R103 was alert and oriented and was independent with activities of daily living (ADL's) including ambulation.

Review of R103's nurses progress notes from 10/20/16 to 10/21/16 revealed the following:

-10/20/16, at 2:00 p.m. R103 was admitted to the facility, was independent with ambulation, had been wandering in the facility and was forgetful at times.

-10/20/16, 5:45 p.m. R103 was alert, asked and answered questions appropriately and ate poorly at the evening meal.

- 10/21/16, at 6:00 a.m. R103 had only slept for short periods of time. R103 requested Tums for a stomach ache and Melatonin (supplement used for insomnia) and had been up to the bathroom 3 times during the night.

-10/21/16, at 8:30 a.m. nursing staff had attempted to reach R103's medical doctor, and had left a message with the MD's nurse. R103 had been wandering constantly and his mood had been fluctuating. R103 had yelled at a nurse consultant and had physically hit the door when the staff member attempted to assist him. R103 had verbally threatened to kill the nurse and had been sitting on a dining room table which was occupied by other residents, threatening others in the facility. The note identified at 8:40 a.m. the nurse spoke with R103's MD and an order was obtained to send R103 back to the hospital.

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FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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2 690	Continued From page 58	2 690		

- 10/21/16, late entry at 10:00 a.m. R103 had been up wandering since 6:00 a.m. and had been redirected to return to his room to watch TV. R103 was observed lying in the hallway by his room, made the statement, "I gotta sleep somewhere." R103 got up off of the floor on his own and stated to the nurse he was sick. R103 took all of his a.m. medications, stated that was it and he was all done. R103 became threatening towards the nurse, stated he would kill her. R103 had reported to the nurse the day prior that all of the bruises on his arms were not from IV's but from the nurses hitting him. The note revealed the facility nurse had heard R103 yelling in his room to stop hitting him, though no person was in R103's room. R103's behavior continued to escalate and act erratically, the ambulance arrived at 9:00 a.m. and R103 was transported to the emergency room with his clothing, glasses and shoes sent with him.

Review of R103 social services notes from 10/20/16 to 10/21/16 revealed the following:

-10/20/16, R103 had been admitted to the facility following a 3 month hospital stay which was for an altered mental status. R103 had been living with various relatives in the last year and a half. R103 had orders for therapy and length of stay had not been determined at that time. R103 had declined to complete the admission paperwork as he requested to play bingo.

-10/21/16, at 3:30 p.m. R103 was transported to the emergency room following a 911 call due to R103 acting erratically and had been threatening staff and residents. R103 was issued a Notice of Immediate Discharge via fax to the hospital where R103 had been transported to. SW had notified R103's daughter of his discharge from the

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2 690	Continued From page 59 facility and the daughter had applied for a guardian several weeks prior with a case manager from White Earth Reservation where R103 was a member. The note also revealed SW contacted Hennepin County (where R103 had an open case) and White Earth regarding R103's admission and discharge. Review of R103's physician orders, revealed a telephone order dated 10/21/16, to send R103 to the hospital by ambulance. R103's medical record did not have any futher documentation by R103's physician. On 10/24/16, at approximately 3:00 p.m., during telephone interview with hospital social worker (HSW), she stated R103 had been transferred from the nursing home to the hospital on 10/21/16. The nursing home had sent his personal belongings with him and shortly after he arrived the facility had sent a Notice of Discharge via fax from the nursing home. The fax cover sheet had instructed to give the notice to R103. HSW stated R103 had been admitted because of acute complications from liver problems, presented to the ER "sedated" and with treatment was now alert, cooperative and ambulating himself without difficulty and was ready for discharge from the hospital. She indicated she had been in contact with the nursing home, most recently, 10/24/16, and was told the facility would not be accepting R103 back to the nursing home. HSW indicated she had been told the facility would not take him back due to R103 being a threat to himself and others. HSW stated R103 had told her he was looking forward to returning to the facility, and had told her he liked the staff in the facility and was looking forward to playing bingo.	2 690		

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2 690	Continued From page 60	2 690		

Review of an untitled Frazee Care Center form, dated 10/21/16, revealed a Notice to Discharge Pursuant to Minnesota Statutes 144.651, subd. 29 and 42 U.S.C 1369 r. had been issued to R103 via fax from the facility. A letter head cover sheet timed 10:20 a.m., was attached to the notice requesting the hospital emergency room department to deliver the notice to R103. The notice revealed R103 had been immediately discharged from the facility due to the safety of individuals had been endangered and R103 had been threatening the life of other residents and caregivers in the facility. The notice also revealed the health of individuals in the facility would be endangered. The notice was signed by the facility administrator (FM.)

Review of R103's facility discharge summary dated 10/21/16, revealed R103 was discharged to the hospital due to wandering, placing self on the floor and sitting on occupied dining room tables. The summary revealed R103 had been sent to the hospital by ambulance with all belongings sent with.

Review of the hospital discharge planning assessment dated 10/24/16, revealed R103 had been admitted with a diagnosis of hepatic encephalopathy and had exhibited no behavioral disturbances since he had arrived at the hospital. The note revealed R103 had requested to return to the facility. The note revealed no information regarding R103's threatening behavior had been sent with R103 to the emergency room. The note further revealed R103 had not received a 30 day notice from the facility regarding an intent to discharge and the hospital social worker would consult the MN Office of Ombudsman for Long Term Care.

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2 690	Continued From page 61 On 10/24/16, at 3:52 p.m. the administrator stated he was aware of R103 being transferred to the hospital as well as being subsequently discharged from the facility. The administrator stated he had been told R103 was extremely uncooperative, lying on the floors and standing on the dining room tables. Administrator stated R103 had also threatened staff and other residents, and added he had spoken with the hospital social service worker at that time and had felt the facility was not the best place for R103 and wanted to make sure R103 was going to receive the best care. Administrator stated the regional director of operations was consulted on 10/21/16, the morning R103 was transferred to the emergency room and had made the decision to discharge R103 from the facility and not to re-admit R103 when his acute illness resolved. On 10/24/16, at 4:02 p.m. the social worker (SW) stated she had been with R103 when he was admitted on 10/20/16. SW stated R103 would not complete all of his admission paperwork as he wanted to attend bingo. SW stated she felt R103 was acting out of sorts but felt he settled in for the evening. SW stated when she arrived to the facility the am of 10/21/16, she had been met in the hallway by staff stating R103 was threatening staff and residents as well being uncooperative. SW stated it had taken several nurse managers to de-escalate R103 and get him off of the dining room tables. SW stated others residents had been fearful of R103 so she had spoken directly with the director of operations and a discharge note (due to violence) was sent to the hospital R103 was sent to, as well as 3 different counties in which R103 had resided and the local vulnerable adult reporting agency. SW stated she had spoken with R103's daughter and had	2 690		

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2 690	Continued From page 62 been told R103's behavior had been escalating for 6 months and he had been acting strangely before his last hospitalization. SW stated she felt the previous hospital had dumped on them by sending R103 to the facility with orders for physical and occupational therapies as a guise as R103 was independent with all mobility. On 10/24/16, at 4:12 p.m. nurse manager (NM)-C stated she had completed R103's admission paperwork and had worked with him. NM-C stated R103's cognition had fluctuated and his behavior would also fluctuate from appropriate to inappropriate. NM-C stated R103 did not sleep very well the night before he was sent to the hospital and the morning R103 was sent to the hospital he had become very threatening towards staff and residents. NM-C stated the director of operations told them to call 911 and apparently had made the decision to discharge R103. Suggested Method of Correction: The director of nursing (DON) or desigee could work with the medical director to update policies and procedures for when to notify the resident(s) and the new placement of pertinent information about the resident's immediate care and sufficient information to ensure continuity of care, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the residents had been notified as appropriate. Time Period for Correction: Thirty (30) days.	2 690		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements	2 800		11/17/16

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2 800	Continued From page 63 Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, resident, staff and family interview and document review the facility failed to ensure sufficient staffing was available to meet resident needs related to assistance with ambulation (R38, R44, R29, R46), range of motion (ROM) services for (R66), prevention of pressure ulcers (R18) personal cares (R18) fall prevention (R78) choices and provision of services (R61.) The deficient practice had the potential to affect all 52 residents currently residing in the facility. Because of the deficient practice, the facility caused actual harm for R38, R66 and R78. Findings include: R38 did not receive any ambulation services as directed by therapy due to insufficient staffing, see F310. R18 did not receive timely repositioning and personal cares as directed by care plan, see F314 and F312. R44, R29 and R46 did not receive ambulation program as directed by therapy, see F311.	2 800	corrected	

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R78 did not receive accurate assessments related to a pattern of multiple falls due to insufficient staffing, see F323.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had concerns residents had not been receiving restorative programs including ROM and ambulation due to insufficient staffing. PTA stated she had seen some residents lose their abilities and/or decline in ambulation and ROM including R66 and R38 due to not receiving restorative services. PTA stated she had voiced her concerns to facility management in weekly medicare meetings, which both the facility administrator and director of nursing (DON) would attend. PTA stated she had been told by both the administrator and the DON they were working on staffing. PTA stated she had voiced concerns about staffing for the last 4-5 months and had not seen any improvement with staffing.

On 10/21/16, at 1:43 p.m. the assistant director of nursing (ADON) stated the facility had been working on staffing concerns since last year. ADON stated the administrator, director of nursing (DON) and human resources (HR) had been working on staffing with weekly meetings. ADON stated she had not been attending those meetings as she had been trying to back out of that role due to having to work nights along with another registered nurse (RN.) ADON stated she felt call ins were a problem as well as not enough number of staff as a whole. ADON stated the facility had used nursing pool staff last in September, however they had been unable to find staff from any agency in the last month and a half. ADON stated she felt there were times the NA were unable to complete tasks in a timely manner and cares would get missed due to

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2 800	Continued From page 65 insufficient staffing. ADON stated she felt she and the other nurse managers (NM) were unable to provide oversight of cares to ensure cares were according to care plans and completed timely. ADON stated she felt resident assessments and care plans were not completed and/or updated on a consistent basis due to insufficient staffing. ADON stated she had routine complaints from residents and staff regarding sufficient staffing. ADON stated NA had reported to her resident cares were not consistently completed due to staffing concerns. ADON stated the staff worked together in an attempt to meet residents needs, however was difficult due to insufficient staffing. ADON stated she was aware the facility restorative programs had not been consistently implemented or started due to not enough staff to complete the required programs on a routine basis. ADON stated she felt there had been in increase in skin rashes due to insufficient staffing. ADON stated the facility continued to take admissions though would screen residents to look at acuity. R27's annual MDS dated 8/17/16, identified R27 was cognitively intact, required extensive assistance Activities of Daily Living (ADL's,) including transfers, dressing, toileting and personal hygiene. On 10/17/16, at 6:47 p.m. R27 indicated she believed the facility did not have enough staff because she had to wait for staff to get to her. R27 identified she often waited for assistance to go to the bathroom or go to bed. R27 stated,"I have had to wait an hour or more." R27 indicated she had told staff about the long wait times for assistance; however, did not remember whom she had told. R27 indicated being incontinent of	2 800		

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urine because of the long wait for assistance. R27 stated,"it make me feel miserable;" however had not told staff how it made her feel.

R61's quarterly Minimum Data Set (MDS) dated 7/24/16, identified R61 was cognitively intact and had diagnoses which included, insulin dependent diabetes, congestive heart failure (CHF) and anxiety. The MDS identified R61 required extensive assistance from staff with dressing. The MDS also identified R61 received insulin injections daily.

On 10/20/16, at 10:03 a.m. R61 stated when she had concerns and needed assistance she would only use her call light when certain staff were working. R61 stated some nursing assistants (NA) would walk past her room when the call light was on and others would come into her room, shut the light off and leave stating that they would be back. R61 stated most of the time they did not return. R61 stated she had voiced her concerns about her call light, baths and blood sugars to staff at her care conferences and her son and was not sure if he had spoken with staff.

On 10/19/2016, at 8:50 a.m. licensed practical nurse (LPN)-C stated at that time the facility census was 52. LPN-C indicated the day shift usual staff schedule included three floor nurses, and five nursing assistants (NA), however today there were four NA's. At 9:17 a.m. LPN-C indicated the facility did not have sufficient staffing and as recent as last weekend there was short staffing on both the day and the night shift. LPN-C indicated she had reported the recent incidents of short staffing to the facility scheduler and the HR. LPN-C stated the facility had a lot of

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call-ins and overall staff did not consistently come in for scheduled shifts. LPN-C stated she was unaware of what administration had planned for staffing shortages.

On 10/19/2016, at 1:01:33 p.m. house keeping staff (HC)-A indicated at that time the nursing assistants (NA) were working short. HC-A stated when there were not enough staff to answer call lights, she would answer them and inform the residents the NA were busy and would have to wait longer. HC-A stated she felt when the facility was short staffed it took longer to attend to resident needs.

On 10/20/2016, at 10:11 a.m. nurse manager (NM)-B indicated staffing had not improved in the past year. NM-B stated she was often working on the floor and was unable to routinely complete her managerial work. NM-B stated she felt if staff had to continue to work under the conditions at that time, they would get burned out. NM-B stated the lack of staff on the floor must have had something to do with the large amount of resident falls, such as R78.

On 10/20/16, at 2:00 p.m. NA-F stated the facility had lost staff left and right the last 5 months. NA-F stated she did not feel there was sufficient staff in the facility to routinely meet resident needs on a consistent basis. NA-F stated the she had heard staff, family and residents complain about staffing shortages. NA-F stated she had noticed an increase in resident falls, skin rashes, incontinence and behaviors. NA-F stated she felt staff were burning out due to working too many hours. NA-F stated she felt residents who required 2 staff assist (such as R18, R26, R15, R27,) and those who could not/would not

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verbalize their needs (R61) were the residents who had not routinely received the cares they needed.

On 10/20/16, at 2:43 p.m. NA-B stated she felt the facility had a chronic insufficient staffing which had been going on for the last year. NA-B stated she felt it was impossible to routinely meet residents needs due to insufficient staffing. NA-B stated the facility had call-ins on at least a weekly basis and often were not able to replace the staff. NA-B stated she felt residents were not receiving routine repositioning, toileting, ambulation, ROM and bathing, such as R27, R37, R18, R47, R66, R44, and R61. NA-B stated she had spoken with the interim DON approximately ago a month about insufficient staffing. NA-B stated she had been told it was like that everywhere and they had to just work together. NA-B stated she felt staffing had gotten so bad there were times R51 would throw himself on the floor to get staffs attention.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had serious concerns with residents ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis. PTA confirmed a decline in ambulation for R38 and stated residents such as R44 and R29 did not routinely receive their ambulation programs.

On 10/21/2016, at 1:35 p.m. during a follow up interview, NA-B stated she felt R37 had an increase in skin irritation from incontinence due to not receiving cares routinely because of short staff.

On 10/21/2016, at 2:17 p.m. NA-J stated she felt

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2 800	Continued From page 69 there was not an adequate amount of staff to meet resident needs. NA-J stated she felt there had not been sufficient staff to meet residents needs for the last several months. NA-J stated there were times when only 3 NA's would be working for the evening shift when there were to be 5 on the shift. NA-J stated that would occur weekly. NA-J stated routine cares would not get done in a timely manner such as toileting, repositioning, ambulation and baths on a consistent basis. NA-J stated she felt the administrator and DON were aware of resident needs not being met consistently, but was unaware of any actions the admininstrator or DON had taken to improve staffing. On 10/21/2016, as 2:32 p.m. NA-A stated she felt staffing was getting "tough." NA-A stated they would routinely work with 3 or 4 NA's when they were supposed to have 5-6 NA's on a shift. NA-A stated she felt residents cares such as toileting and repositioning were not being done routinely or timely. NA-A stated she felt R46 would use her call light to alert staff of her toileting needs, however due to insufficient staffing R46 would not get assistance timely and would be incontinent. NA-A also stated she felt R44 did not receive assistance with her care planned ambulation program. On 10/21/16, at 2:53 p.m. a family member and representative of family council (FM)-B stated she felt there was not enough staff in the facility to meet all of the residents needs. FM-B stated she was at the facility every day and often saw other residents call lights had gone unanswered for long periods of time. FM-B stated has recent as a few days ago her family members bedding had	2 800		

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been soiled and covered with a blanket. FM-B stated she continued to reported concerns to the nursing staff about soiled linens and wheelchair of her family member. FM-B stated she felt the staff cut corners to save time had verbalized her concerns at a family council meeting in August, 2016. FM-B stated she had been told that was not the place to voice concerns about staffing and had been directed to fill out a grievance form. FM-B stated she been told the facility had "plenty" of staff. FM-B stated she had also voiced her concerns about sufficient staffing in the last care conference for her family member and had been told again the facility had plenty of staff. FM-B stated she felt she had to make sure her family members linens and wheelchair were clean on a daily basis.

On 10/24/16, at 9:35 a.m. NM-A stated she had not heard any recent staffing complaints from residents or family members. NM-A stated she had been working nights due to an unfilled night nursing position.

On 10/24/16, at 1:15 p.m. the Licensed social worker (LSW) stated she could not recall any complaints regarding staffing by residents, family members or staff. LSW stated her usual process when a complaint was brought forward would be to write a grievance form. LSW stated she felt the facility had met the "state requirements," for staffing. LSW stated there were times when staff would be tied up with a bariatric (obese) resident (who required 3 staff assistance,) but felt overall there were sufficient staff to meet resident needs on a routine basis.

On 10/24/16, at 1:35 p.m. dietary manager (DM) stated she had heard casual comments such as "seems like we're short today", from residents in

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the dining room during meals on a weekly basis. DM stated she had verbalized concerns about insufficient nursing staff from residents to the HR director, NM's, DON and administrator in the last few months. DM stated she felt the administrator was aware of staffing concerns in the facility though, has not seen any improvement.

On 10/24/16, at 2:00 p.m. Advanced Practice Registered Nurse/Certified Nurse Practitioner(NP)-A indicated she expected the facility staff to assess falls routinely and attempt to identify a pattern or reason for the falls in an attempt to minimize further falls. NP-A indicated she would expect floor staff to follow resident care plans and provide restorative ambulation and exercise. NP-A stated," Sadly not providing recommended restorative exercises is not uncommon here."

On 10/24/16, at 2:40 p.m. the medicals records (MR)-B staff indicated the number of staff scheduled is determined by the resident census for the shift. If there is a question regarding the number of staff to schedule MR-B would consult the administrator. MR-B indicated at this time with 52 residents in house she attempted to schedule five NA's for the day shift, five NA's for the evening shift, and two NA's for the overnight shift. Review of the facilities daily assignments sheets from 9/5/16 to 10/20/16, revealed the facility had varied number of staff scheduled and did not consistently have the staffing ratios the facility had identified as appropriate. The following inconsistencies were found:

- the day shift did not have the staffing determined by the administrator for 20 out of 48 days
- the evening shift did not have the staffing

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determined by the administrator for 14 out of 48 days
- the night shift did not have the staffing determined by the administrator for 2 of 48 days, on these two night shifts one nursing assistant was scheduled rather than two for 55 residnets and then 56 residents.
-9/26/16, one NA to care for 55 residents-no increase in licensed staff for the shift.

On 10/24/16, at 3:03 p.m. during a follow up interview, LSW stated she attended the facility's family council meetings when they had attendees. LSW stated the facility's routine family council members had quit going to the meetings when they did not want to volunteer for remodeling or decorating. LSW stated a family member had started to complain about staffing at one meeting and had been directed to fill out a grievance form versus discussing the concern at the meeting. LSW stated she kept a log of all grievances and the family member did not fill out a grievance form. LSW stated she felt residents needs were met on a routine basis.

On 10/24/16, at 3:28 p.m. the interim DON stated she felt there was a staffing concern in the facility, however felt residents needs were being met. DON stated she felt the facility had difficulty in finding licensed and unlicensed nursing staff. DON stated the facility had tried to obtain staff from nursing pool agencies and due to a "cap" they had been unable to up to that point. DON stated as of November 1st, the facility will have one agency pool nurse coming in. DON stated she was unaware resident cares were not getting done according to resident care plans as she had not been told by any NA's. DON stated she had attended a recent resident council meeting in which call light wait times were brought up by

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residents. DON stated a call light audit had been completed and had felt the matter was resolved. DON also stated she felt a 5-15 minute wait time for a call light to be answered was acceptable. DON further stated she had not had any complaints from residents, family members or staff regarding insufficient staffing, only about staff performance. DON stated the administrator would be the one to set the number of licensed and unlicensed staff.

On 10/24/16, at 3:41 p.m. the administrator stated he had been working on staffing since last Monday (when he started,) and had planned to meet with the clinical managers to identify resident acuity. He stated he was unsure if the staffing in the facility was sufficient. The administrator stated he felt the facility had an adequate number of staff and stated he felt the problem was with full and part time ratios. He stated the facility had 4 licensed nursing positions open, 4 NA positions at that time. FA stated at that time he had not implemented any action plans for staffing, though had just received a staff recruitment plan from HR. FM stated he planned to work on employee relations, though had not implemented at that time.

On 10/24/16, at 4:08 p.m. the activities director (AD) stated she brought up resident concerns from resident council verbally during morning meetings to all department heads, and resident concerns were always brought up at monthly quality assurance meetings. She stated sometimes she filled out a Resident Council Concern Follow-up form, and delivered it to nursing, or put the form in their mailboxes. She stated nursing completed and returned the form to her before the next scheduled resident council meeting.

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On 10/24/16, at 5:05 p.m. family member (FM)-A stated she had never seen staff do any exercises with R66 for her hands and arms, and stated she didn't know if they ever had. She stated R66 received ROM all the time before admission to this facility. She stated she had asked facility staff why R66 did not get ROM exercises and stated she had been told by staff they felt her brain was not working enough for them to do that. FM-A stated she R66 could no longer do things she could before she came to the facility (less than one full calander year ago,) such as using her call light, the TV remote and write her name and the word mom. FM-A stated she felt there were not enough staff in the facility to ensure R66's needs were routinely met.

Review of resident council meeting minutes from July 2016, to September 2016, revealed the following:

- resident council minutes dated 7/27/16, revealed 8 residents had attended the meeting and a concern over call light wait time of up to 2 hours was voiced. An undated and unsigned resident council response note revealed nursing had completed call light monitoring and audits and there had been room for improvement. The response also revealed nursing staff had been educated, the FA and department heads had been notified of the concern.

- resident council minutes dated 8/31/16, revealed 11 residents had attended the meeting and voiced concerns over call light wait time. The response from nursing dated 8/31/16, revealed the concern had been communicated to nursing staff, FA and the regional director.

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2 800	Continued From page 75 - resident council minutes dated 9/28/16, revealed 10 residents had attended the meeting and voiced concerns over call light wait times had averaged 30 to 60 minute wait time which had occurred at all hours of the day. An undated response from nursing form revealed on 10/5, 10/6, and 10/7/16, call light audits had been completed regarding response and call light placement. The note further revealed FA and regional director had been informed of the concern. Review of facility family council meeting minutes from July, 2016 to September 2016, revealed no concerns related to sufficient staffing. A facility policy for staffing was requested, and not provided. SUGGESTED METHOD FOR CORRECTION: The DON and administrator could review the staffing patterns and the acuity levels of the residents in the facility. The administrator could implement a restorative nursing program who would be responsible for completing ambulation and range of motion programs for the residents. The DON could provide training for all appropriate staff on policies and procedures related to resident cares. The DON could monitor to assure all residents are receiving adequate and appropriate care. The quality assessment and assurance committee could audit care to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 800		

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a resident's falls to determine whether new interventions should have been implemented to decrease the risk of further falls for 1 of 3 residents (R78) reviewed for accident hazards. This deficient practice resulted in harm for R78 who sustained a hip fracture with a fall. In addition, the facility failed to ensure consistent implementation of routine medical treatments of blood sugar checks for 1 of 2 resident (R61) reviewed who were insulin dependent. Findings include: Review of R61's quarterly Minimum Data Set (MDS) dated 7/24/16, identified R61 was cognitively intact and had diagnoses which included, insulin dependent diabetes, congestive heart failure (CHF) and anxiety. The MDS	2 830	corrected	11/17/16

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2 830	Continued From page 77 identified R61 required extensive assistance from staff with dressing. The MDS also identified R61 received insulin injections daily. Review of R61's annual Care Area Assessment (CAA) dated 1/22/16, revealed R61 had diagnoses of depression and anxiety, was grateful for anything that was done for her and was content to stay in her room with visits from others. The CAA further revealed R61 "appeared to feel self pity in general." The CAA revealed R61 had a diagnosis of diabetes mellitus, requiring insulin and R61's blood sugars were checked 4 times a day and as needed (prn) related to erratic levels. The CAA further revealed R61 received Lantus insulin and a sliding scale insulin accordingly. Review of R61's current care plan revised 1/27/16, did not address R61's diagnosis of diabetes, blood sugar monitoring or use of insulin. On 10/19/16, at 1:08 p.m. R61 was seated in her wheelchair in her room, with a tense affect on her face (evident by, furrowed brow, tight lips, tight jaw line). R61 stated she had a horrible morning that morning. R61 stated she did not have her blood sugar checked that day until 11:30 a.m. R61 stated she felt it was important to have her blood sugar checked in the morning after sleeping all night. R61 stated she had a very low blood sugar a few times in the morning, stated it had frightened her, though it had been a long time since that had occurred. R61 stated she had worried for most of the morning and did not know whether to sit and cry or see if someone would answer her call light. R61 stated her breakfast tray had come around 9:15, so she had decided to eat just in case her blood sugar had been on the low side. R61 stated she had difficulty getting	2 830		

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the nurses to routinely check her morning blood sugars. R61 stated she had voiced her concern during her last care conference which had been a few months ago, and had not seen an improvement. R61 stated she had been reassurance that all the nurses knew her routine for blood sugars.

Review of R61's current physician orders signed 10/6/16, revealed the following orders:

- Accu checks (blood sugar checks) 730 a.m., 11:30 a.m., 5:00 p.m., 9:00 p.m. call if blood sugar less than 100 or greater than 300 as a pattern, order was start dated 9/3/14.

- Novolog solution 100 units/ml (insulin aspart) inject per sliding scale: if 0-150 = 0 unit; 151-200 = 1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 4 units; 351-400 = 5 units; 401-500 = 6 units, > than 400 call MD, sq 3 times a say for diabetes, if blood sugar lower than 100 or greater than 300 as a pattern call MD.

- Novolog solution 100 units/ml (insulin aspart, fast acting insulin,) inject 8 units one time a day for diabetes.

- Lantus solution (insulin glargine, long acting insulin) inject 22 units subcutaneous (sq) one time a day related to diabetes, order was start dated 2/3/16.

- Lantus solution (insulin glargine,) inject 8 units sq at bedtime related to diabetes, order was start dated 2/3/16.

Review of R61's medication administration records (MAR) from August 2016, to October

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2016, revealed the following:

-August 2016, revealed R61's 7:30 a.m. blood sugar results were blank on 7 out of 31 days 11:30 a.m. results were blank on 8 out of 31 days and 5:30 p.m. results were blank 10 out of 31 days.

- September 2016, revealed R61's 7:30 a.m. blood sugar results were blank 7 out of 30 days, 11:30 a.m. results were blank 9 out of 30 days, 5:30 p.m. results were blank 8 out of 30 days.

- October 2016, revealed R61' s 7:30 a.m. blood sugar results were blank 13 out of 21 days, 11:30 a.m. results were blank 10 out of 21 days, 5:30 p.m. results were blank 7 out of 21 days.

Review of a facility form titled, Diabetic Flow sheet dated 9/20/16, to 10/20/16, revealed R61's accu check had not been completed as scheduled on 13 out of the 30 days R61's blood sugars were recorded.

Review of R61's social service note dated 8/7/16, revealed R61 had "ruminated" about diagnoses and how staff changes had impacted her care regarding the timing of the med pass. The note revealed R61 had chronic temperaments and would tend to focus on medical conditions and was provided reassurance.

Review of a social service note dated 7/24/16, revealed R61 was cognitively intact and had a chronic melancholy temperament and focused on her medical issues and limitations to the exclusion of all else. The note revealed R61 had expressed distress when there was a staff change in the building, even if it did not affect her. The note further revealed R61 expressed

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concerns that a new staff person would not follow the routine of seasoned staff regarding medication administration. The note revealed R61 was given reassurance by the facility social worker (SW) that staff received the appropriate orientation and came with verified skill levels. The note revealed R61 had listened but not with any intent to consider the information, as she would reiterate her worry or bring up a new one. The note also revealed staff should distract R61 from her medical concerns by asking about her children.

On 10/20/16, at 9:36 a.m. licensed practical nurse (LPN)-B stated she understood R61 was supposed to have her blood sugars checked 3 times a day. LPN-B stated R61 was kind of a brittle diabetic and felt it was very important to have her blood sugars checked consistently. LPN-B stated R61 worried about her blood sugars and felt R61 would become distressed if she did not have her blood sugar done per her routine.

On 10/20/16, at 9:43 a.m. assistant director of nursing (ADON) stated she was not aware R61's blood sugars were not being routinely monitored on a consistent basis. The ADON stated she expected R61's physician orders to be followed as well as R61's care plan.

On 10/20/16, at 9:49 a.m. Certified Nurse Practitioner (CNP) stated she had been working with R61 for 5 years and was very familiar with R61's medical conditions including diabetes. CNP stated R61 required frequent blood sugar testing as it had been difficult to regulate her blood sugars and required insulin to maintain her blood sugars. CNP stated she expected R61's blood sugars to be consistently checked on a routine

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2 830	Continued From page 81 basis. CNP stated R61 had anxiety which was controlled with medication. On 10/20/16, at 2:27 p.m. NA-B stated R61 had reported to her that her call light was not routinely answered, she did not receive her baths and her blood sugars were not being checked routinely. NA-B stated she felt R61 appeared anxious when she reported her concerns to her. NA-B stated she had reported R61's concern to a nurse about a month ago. On 10/21/16, at 11:02 a.m. during a follow up interview, ADON confirmed R61's MAR for August, September and October had a "fair amount" of blanks in the documentation of R61's blood sugar results. ADON stated she could not say for sure R61's blood sugars had not been checked on those days, though did state if it was not documented she could not prove it was done. On 10/24/16, at 9:31 a.m. nurse manager (NM) stated she was unaware R61's blood sugars were not routinely checked. NM stated she expected R61's blood sugars to be routinely checked and R61's care plan should be followed. On 10/24/16, at 10:21 a.m. social worker (SW) stated R61 was a chronic worrier and tended to focus on her medical concerns. SW confirmed R61 had reported to her on in July and August that not all the nurses were following her routine. SW stated she did not check to see if R61's medications, treatments or care plan was being followed. SW stated R61 had reported to her at times she was afraid when new staff were working, though did not probe further. SW stated she felt it was just staff turnover that was upsetting R61 and R61 was an "anxious person." SW stated she had told R61 if she did not like	2 830		

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how a nurse was doing something that R61 should tell that nurse she was uncomfortable. SW stated her usual practice would be to talk to the nurse regarding resident concerns with medications and treatments and thought she did. SW stated R61 tended to ruminate over things and felt R61 had an underlying mental health issue.

A facility policy titled Insulin Administration, dated April 1, 2008, revealed a facility policy which directed staff to check resident physician orders prior to insulin administration and to check blood sugars as needed or ordered.

A facility policy titled Resident Rights, dated April 1, 2008, revealed a list of resident rights which included the right to receive services in the facility with reasonable accommodation of individual needs and preferences. The policy also revealed residents right to choose activities, schedules, and health care consistent with interests, assessments and plans of care.

R78's quarterly Minimum Data Set (MDS) dated 6/14/16, identified R78 had diagnoses which included Alzheimers disease, unspecified fall, and atrial fibrillation. The MDS identified R78 had moderate cognitive impairment, required limited assist to transfer, walking, toilet use and was occasionally incontinent of urine, continent of bowel and was not on a toileting plan.

R78's quarterly MDS dated 9/14/16, identified R78 had intact cognition, required limited assistance to transfer, walk, toilet and for personal hygiene, was occasionally incontinent of

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urine, continent of bowel and was not on a toileting plan.

R78's significant change MDS dated 10/3/16, identified R78 had moderate cognitive impairment, was totally dependent upon staff for transfers, dressing and toileting, was occasionally incontinent of urine, continent of bowel and was not on a toileting plan.

R78's Care Area Assessment (CAA) dated 10/3/16, identified R78 had confusion, disorientation, forgetfulness and needed reassurance, reminders to help make sense of things. The CAA identified R78 had experienced a decline in condition related to fall with fracture and surgical intervention and incontinence. R78 was receiving therapy services with goal established for toileting transfers. R78 had been impulsive leading to poor safety awareness and had a history of falls and experienced a fall resulting in a fracture with surgical intervention.

R78's care plan revised 9/28/16, indicated R78 had a self care deficit related to cognitive loss, unsteady gait and transfers, was at risk for falls related to history of falls, unsteady gait, incontinence and poor judgment related to dementia. The care plan indicated R78 used a urinal at night per his request, App (concave) mattress related to decreased mobility, transfer with hoyer (full body lift) and two staff, floor mats beside bed, rearrange room to allow extra room for mobility.

The facility form titled Aide Care Plan Group B, dated 10/17/16, directed R78 required assist of one staff for ADL's (activity of daily living), had falls, used a mechanical lift for transfers, would request toileting and required assist of one for

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toileting.

On 10/19/16, at 7:15 a.m. R78 was lying in bed, the room was dark and quiet. On the left side of R78's bed a thin gray fall mat on the floor and on the right side a thin brown fall mat was present. A square white personal alarm was secured to the grab bar attached to the right side of R78's bed and the call light was attached to the grab bar also.

On 10/19/16, at 8:19 a.m. licensed practical nurse (LPN)-A propelled R78 to the dining room in a wheel chair, the white square personal alarm was secured to the back of R78's wheel chair.

On 10/19/16, from 8:27 a.m. to 8:40 a.m. R78 independently ate the breakfast meal seated in a wheel chair with the personal alarm secured to the back of his wheel chair.

On 10/21/16, at 10:33 a.m. R78 was seated in a wheelchair in the hall outside of his room watching the activity of staff and other residents, the personal alarm was secured to the back of the wheelchair.

A review of R78's clinical record revealed the following 8 documented falls since R78 was admitted on March 7, 2016:

(1) 3/8/16-at 9:50 p.m. R78 was found on floor beside his bed. Resident interview indicated R78 stated,"I was going to the bathroom." Staff initially placed a bed alarm. The interdisciplinary team (IDT) reviewed the fall on 3/18/16 (10 days following the fall). The post fall findings identified, "Resident attempts to self transfer to BRM [bathroom]. The intervention to be implemented: Placed pressure alarm.

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(2) 3/9/16-1:00 a.m. alarm sounded and alerted staff to R78's room. R78 was found on floor mat next to bed. R78 sustained a skin tear to the right elbow 1 cm (centimeter) by 0.8 cm. The incident note identified R78 needed to use bathroom and tried to get up. Interventions to be implemented as a result of the assessment: Bed alarm, floor mat, urinal placed. The IDT team reviewed the fall on 3/17/16 (8 days following the fall). Additional information/interventions to be communicated to staff along with changes to the care plan included: floor mat (which was currently in use and not a new intervention).

(3) 3/12/16-12:30 a.m. R78 was found lying face down on floor with head against night stand. Resident interview indicated R78 had stated he was getting up to go to the bathroom. R78 sustained a laceration to the right eyebrow 2.5 cm long and a laceration to the left side bridge of his nose 0.4 cm. The incident note identified a mat was on the floor next to R78's bed, when resident got up he had bare feet and slipped on the mat. The IDT reviewed the fall on 3/14/16 (2 days following the fall). Interventions to be implemented as a result of the assessment: Resident needs a concave/lipped mattress.

(4) 6/10/16-4:30 a.m. R78 was found sitting on the floor mat on floor next to bed. R78 had indicated he was going to get up and into wheel chair. The nursing assistant assisted R78 to the bathroom and to get dressed for the day. The note indicated R78 indicated he slipped on the mat by the bed was bare footed. The note indicated R78 had a problem with safety awareness, recently completed therapy and recommendations were to continue to receive help, does not comply and continues to attempt

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self transfer.

(5) 7/15/16- 3:00 a.m. R78's fall occurred in his room and it was unknown what R78 was doing prior to the fall. The fall occurred when R78 was transferring without assistance and did not use the call light. Interventions to be implemented as a result of the assessment: Reminded to use call light and wait for assist. The nurse's notes identified R78 was found lying on floor near bed. Resident was unable to identify what he had been doing. The nurses notes also indicated the IDT reviewed the fall on 7/15/16, did not remember he should use call light to alert staff for assistance, will add a lipped mattress to bed to define perimeters.

(6) 7/27/16- 6:20 p.m. R78's fall occurred in residents room and prior to the fall R78 was lying in bed. The form identified alarms had been inititated at time of fall. The note did not include an analysis of fall and had been reviewed by the IDT on 8/2/16 (6 days after the fall)

(7) 9/19/16-5:20 a.m. indicated R78's fall occurred in room and prior to the fall, had been sleeping. The note faxed to the physician identified-found lying on floor in room in front of bathroom door, resident stated he had slipped. The notes indicated R78 was confused at times, forgetful and had a history of falls, lack of safety awareness. The notes lacked documentation of interventions to be implemented as a result of the fall for R78. The IDT team had reviewed the fall on 9/27/16 (8 days later)

(8) 9/22/16-8:15 a.m. indicated staff were alerted to room by roommate. R78 was found sitting sideways on floor of BR (bathroom) states finished going and stood up and slipped. The

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note indicated R78's left shoe off and was underneath resident and right shoe falling off foot. Further, the incident note identified R78 had a have BM (bowel movement) in BR (bathroom) prior to fall. The post fall physical assessment identified R78 complained of pain with range of motion of left leg and R78's left leg was noted to be shorter than the right. The ambulance was called to transport R78 to the emergency room.

R78's hospital discharge interagency referral form for readmission to the nursing home dated, 9/26/16, indicated R78 had left trochanteric fixation and nailing (surgical repair of the hip) of the left hip fracture on 9/23/16.

Review of R78's Fall Risk Assessment form dated 3/7/16, identified R78 had three falls in last week, was weak, incontinent of bladder, used a walker and was able to use call light independently.

Review of R78's Fall Risk Assessment form dated 6/23/16, indicated R78's assessment remained current with the following minor changes: "Has had multiple falls since admission. Is reminded to use call light but doesn't."

The Fall Risk Assessment forms completed failed to comprehensively assess R78's risk for falls to include but not limited to trends/patterns to falls, factors that may be causing the falls, and effectiveness of interventions.

No Further Fall Risk Assessments were found in R78's record

Review of R78's Bowel and Bladder Functional Evaluation Tool dated 3/14/16, revealed R78 was incontinent of urine and bowel, awoke at night to

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void, and was able to identify the need to void/defecate. The tool identified R78 was able to use call light, able to ask to go to the bathroom, required assist to ambulate and transfer to toilet/commode, and was able to use the toilet majority of time. The evaluation tool did not identify a toileting plan for R78.

Review of R78's Bowel and Bladder Function Evaluation Tool dated 6/23/16, identified R78 was continent of bowel and was incontinent of urine 1-2 times weekly.

Review of R78's Resident Referral Interdepartmental Communication forms between nursing and physical therapy revealed the following:
- 4/1/16, Physical Therapy-"Please encourage Pt. [patient] to transfer and toilet with stand-by-assist only. We are working towards independent transfers and getting rid of alarm. Any? [questions] call. Nursing responded on 4/6/16- Cont [continue] with alarm for now. SBA [stand by assist] and encourage him to do himself. Working on getting back up breaks.
-5/8/16, Physical Therapy-Pt. [patient] has been D/C [discharged] from therapy please ambulate with RW [regular walker], transfer belt and SBA, 2 x [times] daily Pt. amb 600 feet without difficulty." The form included a nurses signature, however, lacked any response to the communication from therapy.

Review of R78's undated Pro Rehab Nursing Referral For Therapy Screen form indicated R78 had been demonstrating independence in transfers and ambulation, alarms had been removed and nursing had requested a therapy screen. The form included documentation from therapy personnel, signed on 6/24/16, which

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directed that R78 was able to complete transfers and ambulation with SBA at day of discharge from therapy. R78 remained assist of one due to issues with safety awareness. The therapy note recommended R78 remained assist of one.

Review of R78's Nursing Quarterly ADL Assessment dated 6/13/16, identified R78 had Alzheimer's, and a history of falls. The assessment identified R78 had moderately impaired cognitive skills for daily decision making, decisions poor, cues/supervision required, and required limited assistance with transferring and walking and supervision with toileting.

On 10/19/16, at 1:17 p.m. a review of R78's fall reports and progress notes was conducted with the assistant director of nursing (ADON) present. The ADON verified R78's multiple falls, although was unsure what interventions were currently in place. The ADON identified following a resident's fall the post- fall clinical team which included nursing, the administrator and social services, reviewed the facility form titled Fall Risk Post- Fall Assessment. The form was initiated by the floor nurse when resident falls occurred and the team reviewed for appropriate interventions. The ADON indicated R78's fall reviews were difficult to interpret what interventions were initiated following the falls. The ADON indicated she believed the falls were fully assessed and appropriate interventions were initiated for R78's falls. ADON confirmed R78 had sustained a hip fracture after the fall on 9/22/16.

Review of R78's progress noted dated 3/10/16 to 9/22/16, included various notes which identified R78 received assistance with ADLS, transfers, and self transferred at times.
The progress notes included:

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-5/18/16, Did a four day trial of alarms off resident. Resident did well, toileted self, transferred bed/chair/wheelchair without incident Removed alarms at this time.
- 7/24/16, found on knees in front of closet,minimal one person assist up.
-9/19/16, R78's roommate alerted nurse R78 was on the floor. R78 found on his back, on the floor in front of the bathroom door, trying to sit up. R78 stated he must of slipped on something, gripper socks on.
-9/22/16, R78 found on floor in bathroom, sitting on buttocks and stated went to bathroom, finished, stood up and fell, slipped. Complained of much pain left hip with internal rotation, shortening of left leg. Ambulance called to transport. The note indicated R78 had sustained a fractured hip and would probably have surgery the following day.

On 10/20/16, at 10:11 a.m. nurse manager (NM)-B stated she felt the lack of sufficient staffing in the facility must have something to do with the large amount of resident falls in the facility.

On 10/20/16, at 10:45 a.m. nursing assistant (NA)-I indicated R78 was independent to go to the bathroom by himself prior to the fall and indicated since R78's hospital stay he needed assistance to go to the bathroom. NA-I indicated R78 did not always remember to check if the wheel chair brakes were on and now had brakes on the wheel chair that locked automatically.

On 10/21/16, at 1:31 p.m. NA-B verified R78 had a recent decline because of a fall with fractured hip. NA-B verified R78's frequent falls were usually related to going to the bathroom or when coming back from the bathroom. NA-B stated she felt R78 was independent to take himself to the

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2 830	Continued From page 91 toilet prior to the fall and would turn the call light on for assistance when needed to pull up his pants or to shave. NA-B identified R78 at times used the call light appropriately and other times did not. NA-B indicated a toileting program may have been beneficial for R78 prior to his fall with a fractured hip. On 10/21/16, at 2:13 p.m. NA-J indicated R78 was independent with dressing, hygiene and toileting before the fall and hip fracture. NA-J identified prior to the hip fracture R78 was always trying to go to the bathroom. On 10/21/16, at 2:39 p.m. NA-A indicated she/he did not work often with R78 and stated, "He will be sitting in the hall and say 'hey', have to go to the bathroom" and staff would assist him. On 10/21/16, at 2:49 p.m. NM-B indicated prior to R78's fall resulting in a fracture, R78 required assistance of one to transfer and remind R78 to ask for help to toilet because he was reluctant to ask or did not ask for help. NM-B indicated R78's toileting program was to sound call light when he needed to go to the bathroom or he attempted to transfer himself. NM-B stated, "He [R78] calls or transfers self when he needs toilet." NM-B reviewed the 8 falls and interventions. After review of the falls, NM-B stated she felt there had been a pattern of the falls was going to or coming off of the toilet. NM-B confirmed R78 was not on a toileting program and stated," It may have been a good idea." On 10/21/16, at 3:07 p.m. a follow up interview with the ADON verified prior to R78's hospitalization the facility had not initiated a toileting plan for R78. The ADON felt R78's falls had been assessed, and appropriate	2 830		

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interventions had been in to place. ADON stated had not identified a pattern with R78's falls, however, indicated evaluation for a pattern for falls was not part of the comprehensive assessment for R78.

On 10/24/16, at 2:00 p.m. nurse practitioner (NP)-A indicated she expected the facility staff to assess falls routinely and attempt to identify a pattern or reason for the falls in an attempt to minimize further falls.
On 10/24/16, at 4:17 p.m. a phone interview with R78's physician (MD)-A verified he was aware R78 had a fall which resulted in a fractured hip, however, was unaware of the number of falls. MD-A indicated R78 was demented and was not easily redirected. MD-A verified he would expect facility nursing staff to assess the falls and if going to the bathroom is the common reason with the falls, he would expect staff to provide an appropriate intervention related to R78's toileting needs.

The requested facility policy regarding facility falls was not provided.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring accidents, range of motion and restorative nursing services. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of

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2 830	Continued From page 93 Nursing or her designee could develop a monitoring system to ensure residents receive the appropriate care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 830		
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services to prevent loss of function for 1 of 4 residents (R38) who required assistance with ambulation. R38 was not provided assistance with ambulation and was not re-assessed upon a decline in ambulation. R38's decline in the ability to ambulate resulted in actual harm. Findings include: R38's significant change Minimum Data Set (MDS) 9/26/16, identified R38 had moderate cognitive impairment and had diagnoses which included degenerative joint disease, weakness	2 885	corrected	11/17/16

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and back pain. The MDS identified R38 was independent in bed mobility, transfers and used a wheelchair independently for locomotion. Further, the MDS identified activity did not occur for turning around and facing opposite direction while walking and R38 did not walk.

R38's ADL Care Area Assessment (CAA) dated 9/26/16, indicated R38 had improved ADL performance and would be addressed on care plan. The CAA did not address R38's ambulation.

R38's admission MDS dated 5/24/16, identified R38 was not steady, only able to stabilize with human assistance for walking and turning around and facing opposite direction while walking. The identified R38 had ambulated with limited assistance from staff.

R38's ADL CAA dated 5/24/16, identified R38 required assistance from staff to safely ambulate and transfer. The CAA revealed R38 was receiving therapies and her goal was to return to independence in hopes of returning home.

R38's Behavioral CAA dated 5/24/16, identified R38's goal was to cooperative with therapies in order to return home.

On 10/18/16, at 1:36 p.m. R38 was observed in the facility hallway, seated in a wheelchair, propelling herself to the activity room with both feet. R38 propelled herself up to a squared table, opened the daily newspaper and began to read the paper.

On 10/20/16, at 1:38 p.m. R38 indicated she had wheeled herself into the bathroom and slid herself

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2 885	Continued From page 95 to the toilet seat to use the toilet. She stated she was able to complete most cares for herself and liked to be as independent as possible. R38 proceeded to propel herself out of her room, utilizing both feet to the activity room to attend an activity. At 3:08 p.m. R38 was seated in her wheelchair in the activity room actively participating in Bingo. R38 was not observed to ambulate at any time during observations. On 10/20/16, at 1:57 p.m. nursing assistant (NA)-F stated R38 used a wheelchair for mobility and was able to propel herself to and from destinations. NA-F stated R38 was independent with all of her personal cares and liked to maintain her independence. NA-F stated she did not think R38 was able to walk and had never assisted R38 to ambulate. NA-F stated the nursing assistants were responsible to ambulate residents who were on an ambulation program and stated she did not think R38 was on an ambulation program in the facility. On 10/20/16, at 2:30 p.m. NA-B stated she had not assisted R38 with ambulation at any time in the past. NA-B stated the NA on the individual units were responsible for residents walking programs, after the program had been determined by occupational (OT) and physical therapies (PT). NA-B stated R38 had received both PT and OT upon admission for a few months and indicated she was unsure if R38 had been placed on the ambulation program. NA-B stated she felt R38 was unable to fully stand nor could R38 ambulate. NA-B stated the NA on the unit often times could not assist residents with their ambulation programs due to not enough NAs on the floor. On 10/20/16, at 3:18 p.m. licensed practical nurse	2 885		

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(LPN)-B stated the NAs on the units were responsible to ambulate with residents who had ambulation programs in the facility. LPN-B stated she was unsure if R38 was on an ambulation program at present and after review of R38's clinical record, confirmed R38 had a referral from PT and OT dated 7/8/16, which directed R38 was to be assisted with ambulation twice daily with a walker and one-person assistance up to 40 feet. LPN-B stated she did not think R38 had been assisted to ambulate since therapy ended.

On 10/21/16, at 10:35 a.m. registered nurse (RN)-A stated she was unaware if R38 was on an ambulation program and indicated she had not seen R38 ambulate with staff in the past.

On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated R38 had received both physical and occupational therapy upon admission to the facility in May of 2016. PTA stated R38 was discontinued from both therapies in July 2016, with a referral to nursing for R38 to be placed on an ambulation program with nursing staff. PTA stated R38 was able to ambulate with one assist and a front wheeled walker up to 40 feet consistently, when PT and OT were stopped. PTA stated she had serious concerns with residents' ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis.

On 10/21/16, at 11:30 a.m. R38 stated she was no longer able to walk and used a wheelchair to move about the facility. R38 stated she had been walking when she was admitted to the facility and had worked with therapy for her walking. R38 stated nursing staff had not assisted with her

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ambulation since therapy had stopped several months ago. R38 stated she had bad knees which affected her ability to walk, but felt if she had some "treatments" she would be able to walk again with help.

On 10/21/16, at 11:36 a.m. PTA entered R38's room, and looked in her closet and various locations in her room for her walker. PTA stated R38 no longer had a walker in her room and stated she would expect R38 to have a walker available so nursing staff could assist her to walk. PTA left R38's room briefly, returned with a front wheeled walker and placed the walker in front of R38. PTA applied a transfer belt around R38's torso and cued R38 to stand from her wheelchair up to the walker while PTA pulled upwards on the gait belt. R38 was only able to lift her buttocks from the wheelchair seat approximately 7 inches. R38's knees remained bent at approximately an 80 degree angle, was unable to stand fully erect or straighten her knees. PTA attempted to stand R38 twice more and R38 continued to not able to stand erect or straighten her knees. R38 stated she could not stand up all of the way and had not stood up for a long time. R38 stated she could not remember the last time she had used a walker. PTA asked R38 when the last time she had walked and R38 responded, "with you." PTA confirmed the last time she had worked with R38 was in July, 2016. PTA confirmed R38 had lost the ability to fully stand and to ambulate.

On 10/21/16, at 11:44 a.m. during a follow up interview, PTA stated when R38 was discharged from therapy, R38 had been ambulating about 40-60 feet daily with minimal assist of one and a front wheeled walker. PTA stated R38 was referred to an ambulation maintenance program and she would have expected R38 to receive

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assistance with walking with nursing staff twice daily. PTA stated she felt the facility had a huge problem with the facility's ambulation/maintenance program due to staffing concerns and stated she felt there were not enough NAs to complete resident ambulation/maintenance programs.

Review of R38's hospital discharge summary dated 5/17/16, identified R38 had been treated for weakness and falls at home. The summary revealed R38 was having difficulty standing and walking. The summary further revealed R38 was sent to the facility for acute rehab due to lower extremity weakness.

Review of R38's physician progress note dated 8/2/16, revealed R38's primary medical doctor (MD) had seen her at the clinic. The note also revealed R38 had plateau in therapy, however, was ambulating using a walker. The note further revealed R38's daughter had concerns that R38 had exhibited regression after therapy was ended.

Review of R38's physician progress note dated 10/6/16, revealed R38 had established care with another practitioner. The note revealed R38 used a wheelchair for long distances, had received PT and OT during the spring and summer, and at that time due to increased care needs R38 was determined to be a long term patient.

R38's current care plan updated 6/10/16, indicated she was fully ambulatory with a walker and contact guard assistance. R38's care plan also indicated R38 was receiving therapy and assist to transfer with one and gait belt, and R38 wheeled self independently in wheelchair. R38's

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care plan did not identify any updates past 6/10/16.

Review of the Aide Care Plan Group C form, dated 10/17/16, listed various interventions which included R38 was assist of one for transfers, toileting and ADL's, and listed R38 received therapy for walking. The form did not list any other interventions for R38's ambulation.

Review of a facility form titled, Resident Referral Interdepartmental Communication dated 7/8/16, revealed therapy had referred R38 to nursing for a ambulation program to include ambulation twice daily with front walker and one assistance up to 40 feet. The form also identified R38 has complained of left knee pain and if nursing had any questions to call.

Review of R38's medical record revealed the record lacked further documentation of R38's ambulation status or progress and lacked documentation of facility forms maintenance ADL worksheets.

Nursing progress notes were reviewed from 5/17/16, to 10/18/16, revealed the following:

On 5/17/16, R38 was full weight bearing and required one assistance with ADL's.

On 6/10/16, the note indicated R38 was working with therapy.

On 6/11/16, R38 questioned nursing staff on when she would be able to return home.

On 8/4/16, R38 required one assist with ADL's.

R38's nursing progress notes lacked any

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documentation of R38's ambulation and decline in R38's ambulation status.

On 10/21/16, at 1:37 p.m. the assistant director of nursing (ADON) confirmed R38's ambulation/maintenance program had never been implemented in July. ADON stated the nurse managers were responsible to ensure therapy referrals for ambulation/maintenance programs were started once a resident was referred. ADON stated the nurse manager was responsible to initiate a facility form titled, Maintenance Activity of Daily Living (ADL) worksheet which would direct the NA on what type of assistance with ADL the individual resident needed and the frequency of the maintenance program. ADON confirmed R38's referral for ambulation maintenance program directed staff to ambulate with R38 with a front wheeled walker up to 40 feet twice daily. ADON stated she would expect R38's ambulation program to be implemented to maintain and prevent further decline her ambulation. ADON stated she felt the facility's ambulation/maintenance program was not getting done due to staffing concerns and stated she felt the NA did not have the time to complete all residents programs, including R38.

On 10/24/16, at 9:27 a.m. nurse manager (NM)-A stated she had understood the nursing assistants had been assisting R38 with ambulation. NM-A stated she was not aware R38 could not longer ambulate. NM-A stated she was not sure why R38's ambulation/maintenance program had not been started.

On 10/24/16, at 9:58 a.m. R38's Advanced Practice Registered Nurse/Certified Nurse Practitioner (NP)-A stated R38 had recently established care with her in early October. NP-A

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stated she would expect the facility staff to follow through with therapy referrals for ambulation/maintenance programs and she would have expected R38 to be assisted with ambulation per the therapy referral. NP-A stated R38's previous primary physician had last seen R38 in August and may have more to comment on R38's loss of ambulation.

A message was left for R38's previous primary physician, but the physician did not call back during survey.

A facility policy titled, Restorative Program, dated 4/1/08 identified residents would be assessed on admission for a restorative program such as ambulation. If a ambulation program was an identified need, a plan would be individualized to meet resident needs and goals. The policy further identified residents would be supported and their highest level of functioning maintained.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring residnet physical abilities and provide appropriate restorative nursing services. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensure residents receive the appropriate care.

TIME PERIOD FOR CORRECTION: Twenty One (21) Days

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility the facility failed to complete timely repositioning for residents on a turn and repositioning program and who were assessed to be at risk for pressure ulcers for 2 of 4 residents (R18, R66) reviewed for pressure ulcers. Findings include: Review of R18's quarterly Minimum Data Set (MDS) dated 7/26/16, identified R18 had severe cognitive impairment, was unable to communicate with staff and had diagnoses which included, dementia, depression and anxiety. The MDS identified R18 was totally dependent on staff for activities of daily living (ADL's) and required 2 staff for assistance with bed mobility. The MDS	2 900	corrected	11/17/16

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2 900	Continued From page 103 identified R18 was at risk for developing pressure ulcers and had interventions in place which included a pressure reducing device for the chair and R18 was on a turning and repositioning program. Review of R18's annual MDS dated 4/26/16, identified R18 was totally dependent on staff for ADL's. The MDS identified R18 was at risk for developing pressure ulcers and had interventions in place which included a pressure reducing device for the chair and R18 was on a turning and repositioning program. Review of R18's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 4/26/16, identified R18 had cognitive loss related to dementia and was unable to coherently verbalize her needs. The CAA revealed R18's needs were to be met in spite of her inability to make her needs known. R18's Communication CAA identified R18's needs must be anticipated by facility staff. R18's Pressure Ulcer CAA identified R18 had a potential for skin breakdown related to incontinence, decreased mobility and her inability to make her needs known. The CAA revealed R18 could move independently in bed but required staff assistance to reposition when in a sitting position. The CAA identified R18 required a regular schedule of turning and had a pressure relieving cushion in wheelchair. Review of a Comprehensive Analysis of Skin form dated 7/26/16, revealed R18 was at high risk for skin breakdown based on a Braden scale (assessment for predicting pressure sores) score of 14 and a tissue tolerance test. The form revealed interventions were put in place which included, gel cushion in wheelchair and R18 required turning and repositioning with check and	2 900		

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change every 2 hours and as needed (PRN).

Review of R18's physician progress note dated 10/6/16, revealed R18 had been seen for a routine nursing home visit. The note revealed R18 had severe dementia and Alzheimer's disease and was dependent on facility staff for her needs.

Review of R18's current care plan last updated 10/7/16, revealed R18 had severe cognitive loss, was unable to communicate her needs and was totally dependent on staff for toileting, repositioning needs and had a potential risk for skin breakdown. . The care plan listed interventions which included to assist R18 to turn and reposition every 2 hours and prn, keep skin clean and dry and a gel cushion in the wheelchair.

On 10/19/16, from 7:03 a.m. to 10:39 a.m., continuous observations of R18 revealed the following:

At 7:03 a.m. R18 was seated in a wheelchair with a gel cushion, fully dressed in her room. R18's bed was stripped of its linens. R18's head was hung forward in a chin to chest position and her eyes were closed.

At 7:21 a.m. R18 remained seated in the wheelchair in her room. No staff were observed to enter R18's room.

At 7:38 a.m. the call light to R18's room was on by R18's roommate, staff was observed to enter the room to assist R18's roommate. At that time, housekeeping staff entered R18's room and made R18's bed while she remained seated in the wheelchair. At 7:41 a.m. the housekeeping

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staff member wheeled R18 to the dining room. R18 remained with her eyes closed and her head was in a chin to chest position. Housekeeping staff wheeled R18 to a table in the dining room and placed a clothing protector around her neck. At that time R18 covered her face with the clothing protector.

At 7:56 a.m. R18 remained seated in the wheelchair in the dining room. A dietary aid (DA)brought R18 her breakfast plate, left the plate on the table in front of her and walked away. At that time nursing assistant (NA)-G approached R18, verbally prompted her to begin eating and handed her a spoon. R18 ate 100% of her breakfast foods independently. R18 remained seated in the wheelchair at the table.

At 8:46 a.m. R18 remained seated in her wheelchair at the dining room table, and made no attempt to leave the table.

At 9:01 a.m. R18 remained seated in her wheelchair in the dining room, having made no attempts to leave the table.

At 9:18 a.m. R18 remained seated in her wheelchair in the dining room. R18 closed her eyes. Shortly after R18's head dropped forwards in a chin to chest position. No staff offered to assist R18 with repositioning.

At 9:30 a.m. R18 remained seated in her wheelchair in the dining room. R18 had opened her eyes, looked around, took her clothing protector and covered her face it. R18 made no attempt to move away from the table and left her face covered with the clothing protector.

At 9:37 a.m. NA-D entered the dining room, woke

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R18 and offered her fluids. R18 awoke, removed the clothing protector from her face and allowed NA-D to assist her to drink her juice. R18 drank 50% of her juice. NA-D then handed R18 her glass of water and R18 independently drank the water. NA-D left R18 seated in her wheelchair and left the dining room. NA-D was not observed to offer R18 assistance with personal needs, including repositioning and toileting needs.

At 9:42 a.m. medical records (MR) approached R18 and assisted her to drink her remaining fluids, while R18 remained seated in her wheelchair. MR removed the clothing protector from R18's neck, R18 then took her shirt and covered her face with it, in a cradling position.

At 9:50 a.m. MR assisted R18 out of the dining room in her wheelchair, brought her to her room and handed R18 a stuffed bear. MR attached the call light to R18's wheelchair and left the room. MR was not observed to offer R18 assistance with any cares, including repositioning or toileting.

At 10:01 a.m. NA-D was observed to walk past R18's room, did not look in.

At 10:09 a.m. NA-E walked out of a room across from R18's room, looked into R18's room and walked away.

At 10:39 a.m. the Assistant Director of Nursing (ADON) was notified R18 had remained seated in her wheelchair for an observed 3 hours and 36 minutes. At that time the ADON confirmed R18 required assistance with repositioning and checking and changing every 2 hours. At that time, the ADON confirmed R18 was at risk for skin breakdown. ADON went to R18's room while requesting assistance via walkie talkies.

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2 900	Continued From page 107 At 10:39 a.m. NA-E entered R18's room and asked R18 to use the bathroom. NA-E placed a gait belt around R18's torso. NA-E and the ADON assisted R18 to stand from the wheelchair, ambulate to the bathroom and removed R18's slacks and incontinence brief. R18 had a moderate amount of urine in her brief as well as a small amount of stool. R18's entire buttocks surface which had contact with the brief had deep pink creases and was moist surrounding her peri-rectal area. NA-E and the ADON assisted R18 to complete toileting and assisted R18 to sit back in her wheelchair. On 10/19/16, at 10:39 a.m. NA-E stated she thought R18 was last repositioned around 6:45 a.m. and stated she had been too busy helping others with cares to assist R18 with repositioning and toileting needs. NA-E stated R18 was supposed to be repositioned and checked/changed every 2 hours and as needed. NA-E stated R18 was not able to verbalize her needs and staff was to anticipate R18's needs. On 10/20/16, at 2:36 p.m. NA-B stated R18's needs must be anticipated as she was totally dependent on 2 staff for her needs, including repositioning and toileting. NA-B stated R18 required routine every 2 hour repositioning and toileting. NA-B stated R18's buttocks would get red at times, but could not recall any recent open areas on R18's buttocks. On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff for all of her needs. LPN-B stated R18 was not able to verbalize her needs and staff needed to anticipate them. LPN-B stated R18 was at risk for skin breakdown due to incontinence and	2 900		

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2 900	Continued From page 108 immobility. On 10/21/16, at 1:37 p.m. during a follow up interview the ADON stated she felt staff was unable to routinely reposition and toilet residents in a timely manner, due to staffing shortages. The ADON stated they were not always able to fill in for sick calls and there were times when the facility were unable to fill holes in the schedule. R66's Admission Minimum Data Set (MDS), dated 1/11/16, identified R66 had severe cognitive impairment, was totally dependent of staff for activities of daily living (ADLs) and required 2 or more staff to assist with bed mobility The MDS further identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS also identified R66 was at risk for developing pressure ulcers, required a pressure reducing device for her chair and bed, and required a turning and repositioning program. R66's quarterly Minimum Data Set (MDS), dated 7/13/16 identified R66 had severe cognitive impairment, and was totally dependent of staff for activities of daily living (ADLs), and required 2 or more staff to assist with bed mobility. The MDS further identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS also identified R66 was at risk for developing pressure ulcers, required a pressure reducing device for her chair and bed, and required a turning and repositioning program. R66's Care Area Assessment (CAA), dated 1/11/16 identified R66 suffered from a traumatic brain injury, had a decreased ability to make herself understood, and had an inability to	2 900		

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2 900	Continued From page 109 perform ADLs without significant assistance from staff. The CAA further identified R66 was at high risk for developing pressure ulcers related to her inability to move herself or ask for help when she was uncomfortable, and staff were to anticipate her needs and ensure she was repositioned. The CAA further identified R66 required a special mattress and wheelchair cushion, and required a regular schedule of turning and repositioning to prevent pressure. R66's care plan dated 2/18/16, identified R66 was at risk for developing pressure ulcers related to fragile skin, not being able to turn herself, was immobile and was bed and chair bound. The care plan also identified R66 was to suspend heels off the bed or wear sheepskin boots to protect her feet, and was to be turned and repositioned according to her turning and positioning plan. The care plan further identified R66 was incontinent and was to be checked and changed every 2 hours. Review of the Aide Care Plan, Group B, dated 10/17/16, identified R66 required total assistance with cares, was to be turned and repositioned every 2 hours, and was to float heels off the bed or wear sheepskin boots. Review of a physician note dated 12/31/15, identified R66's left heel was at risk for developing pressure ulcers, Eucerin cream was to be applied to heels twice a day and heels were to be floated off the bed. Review of physician note dated 8/29/16, identified R66's heels were not floated off the bed. Review of current physician's orders dated, 10/5/16, identified R66 had orders to suspend her	2 900		

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heels off of her bed every shift for preventing alteration in skin integrity.

R66's comprehensive analysis of skin dated 1/4/16, identified R66 had pink heels on admission and had been free floated for precaution.

R66's Braden Scale (assessment for predicting pressure sores) dated 7/13/16, identified R66 was at high risk for developing pressure ulcers. The document also identified R66 had a special mattress, heels were to be kept off the bed and R66 continued to need to be repositioned and had special cushion in her wheelchair because R66 had a history of pressure ulcers.

R66's tissue tolerance test (length of time resident could be in the same position without skin damage) dated 7/13/16, identified R66 required 2 hour repositiong to prevent pressure ulcers.

R66's progress notes reviewed from 12/31/15 to 10/17/16 identified:

2/3/16, R66 had a 2 cm X 0.5 cm area on her right shin and ankle from possible rubbing on PROFO boot, staff removed boot and floated her heels. R66's wheelchair had built-in pressure relief pedals.

2/4/16, R66 had an intact blister on her right ankle

2/6/16, Family expressed concern with R66's right ankle. Nurse explained areas were from boot and brace in wheelchair.

2/8/16, R66's areas to right skin and ankle were

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resolving

2/9/16, R66 had superficial, abraded/scraped area on her shin from profo boot and a blister to her inner ankle from being up in her wheelchair with socks off and suspected foot rubbed on foot pedal

2/10/16, blister healing, heels free floated

2/13/16, areas to right foot/ankle and right shin resolved.

On 10/19/16, at 7:00 a.m. R66's bedroom was dark, and her door was fully open. R66 was dressed in a hospital gown, and was asleep on her back in bed. R66's arms rested on her chest and her body was covered with a blanket. R66's legs were straight, and her heels rested directly on her mattress. She was not wearing sheep skin boots. R66's sheepskin boots were observed to be piled up on R66's dresser across the room. At 7:19 a.m. R66 was in the same position in her bed, her eyes were now open, continued with loud mouth breathing and heels rested directly on the mattress and was not wearing her sheep skin boots. At 7:39 a.m. R66 was in the same position in her bed with her eyes closed. R66's heels continued to be directly on her bed and was not wearing her sheepskin boots.

At 7:49 a.m. licensed practical nurse (LPN)-A entered R66's room. LPN-A stated R66's heels were not free floated and she was not wearing sheep skin boots. LPN-A stated she felt R66's heels were, "kind of," floated by the bubbles in her mattress. LPN-A then pulled a flat pillow down to approximately one inch under R66's calves however it did not lift R66's heels off the mattress. LPN-A laid R66's heels directly on the bed, and

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immediately left the room.

At 8:03 a.m. the registered nurse (RN) consultant walked in to R66's room and immediately walked out, towards the nurses station. At 8:28 a.m. R66 remained in the same position on her back, asleep. R66 remained in that position without heels floated, or sheepskin boots on until 10:05 a.m.

At 10:03 a.m. LPN-A stated R66 was at risk for developing pressure ulcers. She stated she didn't think R66 had pressure ulcers in the past. LPN-A stated R66 sometimes wore her sheepskin boots and sometimes they floated R66 heels off the bed. LPN-A stated R66 had an alternating air pressure mattress and was supposed to be repositioned and checked and changed every 2 hours. LPN-A confirmed the last time R66 had been repositioned was at approximately 6:00 a.m. that morning. At 10:05 a.m. after continuous observation (3 hours and 5 minutes) LPN-A confirmed both R66's heels rested on her bed and R66 had not worn sheep skin boots. R66 heels and bottom were intact. NA-E entered R66's room and assisted LPN-A with R66's morning cares.

At 10:33 a.m. NA-E stated she didn't know the last time R66 was repositioned. NA-E stated R66 was supposed to be turned and repositioned, checked and changed every 2 hours. She stated she would have to check with partner NA-D to see when she repositioned R66 as they were taking care of R66 for the day. NA-E stated she felt R66 was was at risk for developing pressure ulcers, but she didn't think R66 had any skin problems. NA-E stated R66 heels could be on the bed because R66 had no breakdown at this time and had an air bed. NA-E further stated R66

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didn't wear her sheep skin boots. NA-E confirmed her current care sheet did not direct the use of sheepskin boots. NA-E and LPN-A left R66's room after R66 was in her recliner with her heels floated by a pillow on the footrest of the recliner.

On 10/19/16, at 10:40 a.m. NA-D stated she didn't know if R66 was at risk for developing pressure ulcers, or what R66's care plan directed her to do for R66's skin. She stated R66 had a special mattress, and stated she assumed R66 would be at risk. NA-D stated she didn't know if R66 had a history of pressure ulcers and wasn't aware of any sheep skin boots for R66. NA-D stated she did not reposition R66 this morning, and stated she thought the last time R66 had been repositioned was at approximately 630 a.m. by the night staff.

On 10/19/16, at 12:10 p.m. R66 was seated in recliner in front of her TV. R66 did not have her heels floated on a pillow and was not wearing her sheep skin boots. R66's heels rested directly on the foot rest of her recliner.

On 10/19/16, at 1:03 p.m. during follow-up interview NA-E stated R66 was totally dependent on staff for cares, and stated she couldn't really tell what R66's cognition was since she didn't talk.

On 10/19/16, at 1:06 p.m. during follow-up interview, NA-D stated R66 was dependent on staff for her cares, and stated she wasn't sure what R66's cognition was because she didn't talk.

On 10/19/16, at 1:11 p.m. R66 laid in bed on her back, legs straight out with her heels resting directly on her bed. R66 did not have her heels floated with a pillow, and was not wearing sheep skin boots.

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On 10/19/16, at 1:16 p.m. during follow up interview, LPN-A stated R66 was totally dependent on staff for cares, and stated she felt R66 was clearer some day's versus others and stated she thought R66 understood them when she was clearer.

On 10/19/16, at 1:34 p.m. NA-B stated R66 was totally dependent on staff for cares, and stated she wasn't sure of R66's cognition. She stated she didn't think R66 was at risk for pressure ulcers, and didn't know if R66 had pressure ulcers in the past. NA-B confirmed R66's heels rested directly on her bed and she was not wearing sheepskin boots. NA-B confirmed R66's Aide Care Sheet and stated she didn't know R66 had sheepskin boots as they weren't on her sheet, but R66's heels were supposed to floated and R66 was supposed to be repositioned every 2 hours.

On 10/24/16, at 10:38 a.m. registered nurse (RN)-A stated R66 had severe cognitive impairment and was totally dependent on staff for cares. She stated R66 was at risk for developing pressure ulcers because she couldn't reposition herself. She stated she didn't remember if R66 had ever had any skin problems. She stated R66's heels were supposed to be floated off of her bed, and the NA's were supposed reposition R66 every 2 hours.

On 10/24/16, at 10:53 a.m. Unit Manager (UM-A) stated R66 had severe cognitive impairment and was dependent on staff for cares. She stated R66 was supposed to be repositioned every 2 hours, her heels were supposed to be floated off of her bed, or R66 was to wear sheepskin boots. R66 had a history of pressure ulcers. She stated she

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remembered R66 had a blister on her heel in February from a profo boot or splint she wore, and that's when they discontinued the boot and implemented floating R66's heels. UM-A confirmed R66's most recent care plan which directed staff to float R66's heels off the bed or wear sheep skin boots, and turn and reposition R66 every 2 hours. She stated she expected staff to follow R66's care plan and float her heels or apply sheep skin boots to R66's feet, and reposition R66 every 2 hours to prevent pressure ulcers. She stated she felt nursing assistants needed more education on repositioning and floating of heels.

On 10/24/16, at 1:45 p.m. nurse practitioner (NP)-A confirmed R66's left heel was at risk for pressure ulcers on admission, and there was a physician's order to float R66's heels since 12/31/15. NP-A confirmed there was not a physician's or nursing order to use the sheepskin boots.
On 10/25/16, at 5:05 p.m. family member (FM)-A stated R66 could barely move her arms now. She stated R66 had developed a deep ulcer on her shin, and about a quarter size blister on the inside of her ankle on her right foot after she got to the facility. She stated they told her it was from her boot rubbing on her skin, and the boot was too tight. She stated she questioned them because R66 didn't move her legs and feet enough to cause blisters. She stated no staff went into R66's room unless they had to.
Review of facility policy, Pressure Ulcer/Skin Integrity/Wound Management identified residents determined at risk for loss of skin integrity would receive the proper treatment/services which included specific physician ordered treatments, pressure reliving equipment, and repositioning per resident assessment.

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2 900	Continued From page 116 The Director of Nursing or her designee could review the policies and procedures for prevention and healing of pressure ulcers. The Director of Nursing or her designee could educate all appropriate staff on the polices and procedures related to pressure ulcers. The Director of Nursing or her designee could develop a monitoring system to ensure residents are assessed and receive interventions to prevent the development of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced	2 915		11/17/16

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2 915	Continued From page 117 by: Based on observation, interview and document review, the facility failed to ensure consistent assistance with ambulation was provided as recommended by physical therapy (PT) for 3 of 4 residents (R44, R29, R46) who required assistance with ambulation. Findings include: Review of R44's quarterly Minimum Data Set (MDS) dated 7/31/16, identified R44 was cognitively intact and had diagnoses which included generalized osteoarthritis, depressive disorder and anxiety. The MDS identified R44 required limited assistance to ambulate in the corridors and was independent in transfers, bed mobility and walking in her room. The MDS further identified R44 used a walker and a wheelchair for mobility. The MDS revealed R44 was steady at all times during transitions, while walking and when turning around and facing the opposite direction. Review of R44's activity of daily living (ADL) Functional/Rehabilitation Potential Care Area Assessment dated 1/29/16, identified R44 required assistance with some ADL's and was unable to ambulate any distance independently related to an unsteady gait. The CAA identified R44 ambulated with one nursing assistant (NA) a walker and a gait belt. Review of R44's Falls CAA dated 1/29/16, identified R44 had difficulty with balance upon rising from a seated position, when turning with ambulation and ambulating long distances. Review of R44's current care plan updated	2 915	corrected	

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9/25/15, revealed R44 was independent with mobility in a wheelchair and required assistance with ambulation with use of a walker. R44's care plan directed staff to offer to walk with R44 to all meals.

Review of Aide Care Plan Group C form, dated 10/17/16, listed various interventions which included R44 was assist one for ADL's and directed staff to assist R44 with ambulation twice daily to 200 feet, with a rear wheeled walker and transfer belt.

On 10/19/16, at 8:16 a.m. R44 was seated in a standard wheelchair, propelling herself into the dining room and wheeled herself up to a circular table. R44 verbalized her breakfast order, obtained her food and ate independently. At 8:34 a.m. R44 had eaten 100% of her meal and at that time propelled herself out of the dining room.

Review of a facility form titled Maintenance ADL Worksheet from April 2016, to October 2016, identified R44's was on an ambulation program twice a day (BID) long distances in the hallways with a walker and transfer belt. The worksheet also indicated R44 was to be assisted to ambulate up to 200 feet (ft.) R44's worksheets revealed the following:

- Review of R44's April 2016, worksheet identified R44 had received her ambulation program 16 out of 31 days in the am hours and 25 out of 31 days in the pm hours.

-Review of R44's May 21016, worksheet identified R44 had received her ambulation program 13 out of 31 days in the am and 20 days out of 31 in the pm.

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-Review of R44's June 2016, worksheet identified R44 had received her ambulation program 8 out of 30 days in the am and 24 out of 30 days in the pm.

-Review of R44's July 2016, worksheet identified R44 had received her ambulation program 7 out of 30 days in the am and 12 out of 30 days in the pm.

-Review of R44's August 2016, worksheet identified R44 had received her ambulation program 8 out of 31 days in the am and pm.

-Review of R44's September 2016, worksheet identified R44 had received her ambulation program 11 days out of 30 in the am and 8 days out of 30 in the pm.

-Review of R44's October 2016, worksheet identified R44 had received her ambulation program 2 days out of 17 in the the am and 0 days out of 17 in the pm.

Review of an Occupational Therapy (OT) assessment dated 3/12/15, revealed R44 was discharged from therapy services and had been placed on the nursing gait list (ambulation program) and was to ambulate with a front wheeled walker with stand by assistance.

A request for R44's ambulation/maintenance program referral from OT was requested, the facility was unable to provide.

Review of R44's care conference summary notes from 2/9/16 to 8/16/16 revealed the following:

-8/16/16, did not address R44's ambulation program.

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-5/12/16, R44 received assistance with ambulation in am and hs(hour of sleep) with contact guard assistance of one staff.

-2/9/16, revealed R44 received frequent ambulation with stand by assistance of one staff.

Review of R44's nursing progress notes from 4/1/16, to 10/12/16, revealed the following:

-5/14/16, revealed R44 ambulated in the hall with staff.

-10/15/16, revealed R44 ambulated in the hall with staff.

No further documentatio of R44's ambulation program and ambulation status was found in R44's nursing progress.

On 10/20/16, at 1:59 p.m. nursing assistant (NA)-F stated R44 was able to complete most cares on her own. NA-F stated R44 required assistance to ambulate in the hallways and was on an ambulation program for twice a day in the am and in the pm. NA-F stated there were days when R44 was not assisted to ambulate due to not enough nursing staff on the floor.

On 10/20/16, at 2:34 p.m. NA-B stated R44 required limited assistance with ADL's of dressing and ambulation. NA-B stated R44 was on an ambulation program for twice a day. NA-B stated residents ambulation/maintenance programs were not getting done as they should due to not enough staff and this included R44.

On 10/20/16, at 3:24 p.m. licensed practical nurse (LPN)-B stated R44 was on a ambulation

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program for twice a day in the am and pm. LPN-B stated R44 liked to walk and felt the times R44 was not assisted with ambulation was due to not enough staff on the floor.

On 10/21/16, at 10:08 a.m. R44 stated she was on a walking program which she was supposed to walk twice a day. R44 stated she used to walk up to 3 times a day and stated she was lucky if she was walked once a day. R44 stated the staff had told her they were too busy on the days she did not receive her ambulation program. R44 stated that had been happening routinely for the last several months. R44 stated she was able to walk around the entire block (200 feet square perimeter around the nursing station,) but at the time would get a bit winded due to not walking like she should. R44 stated she felt as though she was not as steady on her legs as she used to be. R44 stated she feared she would lose her ability to walk if she did not continue with her ambulation program of twice a day. R44 agreed to having therapy assess her ability to walk at that time. R44 stated she felt bad the nursing staff was working so hard and did not want to add to their burden and request to be walked.

On 10/21/16, at 10:18 a.m. registered nurse (RN)-A confirmed R44 was on an ambulation program twice daily to 200 feet with assist of one, walker and gait belt. RN-A did not comment if R44 was routinely receiving her ambulation program and stated R44 would be best person to answer the question.

On 10/21/16, at 10:38 a.m. certified occupational therapy assistant (COTA) confirmed R44 had been referred to nursing for an ambulation program last year and was to be ambulated twice daily to 200 feet with one assist, gait belt and

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2 915	Continued From page 122 walker. OTA stated she felt R44 would be able to maintain her ability to ambulate when the program was consistently implemented. COTA stated she felt there were huge problems with the facility restorative program due to not enough nursing staff. COTA stated the NA's were responsible for completing residents ambulation/maintenance programs and were too busy to consistently complete each residents program. COTA stated NA's had verbalized they wished they were able to complete residents programs though were unable to due to not enough staff. On 10/21/16, at 10:46 a.m. physical therapy assistant (PTA) assisted R44 to ambulate in the hallway with a gait belt, walker and contact guard assistance. R44 had a steady gait and even steps. R44 stated she was getting, "short on air," and stated that had been happening lately when she walked. R44 ambulated to her wheelchair and sat down with contact guard assist from PTA. At that time R44 stated she never used to get short on air when she walked and she was not getting walked as far as she used to. R44 then proceeded to remove her gait belt and thanked PTA for the walk. On 10/21/16, at 10:50 a.m. PTA stated she felt R44's ability to ambulate the distance the same as when she had last seen her. PTA stated as far as she was aware R44's shortness of breath was recent and likely due to not consistently receiving her ambulation program. PTA stated she had noticed residents were not consistently receiving their ambulation/maintenance programs due to not enough staff. PTA stated she had placed residents on maintenance programs and has had them referred back to therapy for treatment due to a decline. PTA stated she felt this was due to	2 915		

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not enough staff to consistently carry out residents programs. PTA stated the facility NA's were responsible for residents ambulation/maintenance programs, however, there were not enough NA'S on the floor. PTA stated she had voiced her concerns about residents ambulation/maintenance programs to nursing and administration during the weekly medicare meeting as recently as a month or so ago. PTA stated the response she had received was the staff were going to "talk" to the NA's.

On 10/21/16, at 11:13 a.m. assistant director of nursing (ADON) confirmed R44 was not consistently receiving her ambulation program. ADON stated she expected staff to routinely complete ambulation/maintenance programs for resident. ADON stated she felt the facility's ambulation/maintenance program was not getting done due to staffing concerns and stated she felt the NA's did not have the time to complete all residents programs, including R44. ADON stated she did not feel R44 had lost any ability to ambulate and would ask R44 how often she wanted to be ambulated.

R29
R29 had not been receiving ambulation services as directed by physical therapy and per the nursing assistant group sheet (a reference nursing assistance used regarding specific care for residents).

R29's Order Summary form dated 9/16/16, identified R29 had diagnoses which included muscle weakness, malaise, and psychosis.

R29's admission Minimum Data Set (MDS) dated 7/14/16, identified R29 had severe cognitive impairment, and required extensive assistance

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for bed mobility, transfer, locomotion on and off of the unit, dressing and hygiene. The MDS identified ambulation did not occur for R29 during the assessment period.

R29's admission CAA dated 7/14/16, identified R29 had dementia, both short term and long term memory problems, and had poor balance which appeared related to decreased weight bearing status related to fall prior to admission.

R29's current care plan revised 10/14/16, revealed R29 had an unsteady gait, used a walker with assist of one and assist with ambulation, toileting, and mobility as needed. R29's care plan directed assist of one with front wheeled walker and wheelchair for ambulation.

On 10/19/2016, at 8:46 a.m. R29 was seated in her wheelchair, at a table in the dining room. R29 propelled herself with her feet, from the dining room towards her room.
On 10/19/2016, at 9:02 a.m. R29 self propelled her wheelchair with her feet in the hall. R29 asked staff directions to her room and then continued to self propel down the hall.

On 10/19/2016, at 10:30 a.m. licensed practical nurse (LPN)-C ambulated R29 past the nurses desk with a front wheeled walker and a gait belt around R29's waist.
On 10/24/2016, at 9:57 a.m. R29 propelled her wheelchair in the hall with her feet.

The facility form titled Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed R29 receive the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (contact guard assist)

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2 915	Continued From page 125 x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps." R29's progress notes were reviewed 6/30/16, through 10/23/16, the notes identified R29 had received therapy for strengthening; however did not note that resident had received the referral for nursing staff to ambulate resident two times a day, nor was there documentation that R29 had received ambulation services with floor staff. R29 did not have a ambulation program sheet in the nursing assistant maintenance book. On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had serious concerns with residents ambulation and maintenance programs being completed consistently. PTA stated felt there was not enough nursing staff in the facility to complete ambulation and maintenance programs on a routine basis. PTA stated residents such as R29 did not routinely receive their ambulation programs. On 10/24/2016, at 10:14 a.m. NA-I indicated R29 was not on a walking program. NA-I indicated R29 would self transfer and staff would walk with her in her room to the bathroom. On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program. On 10/24/2016, at 10:32 a.m. physical therapy assistant (PTA)-G indicated residnets who had reached their goal in therapy were discontinued from therapy services and then continue with a ambulation or lower extremity exercise program to be completed by the nursing assistants in order	2 915		

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2 915	Continued From page 126 to maintain the progress which was made in therapy. PTA-G verified R29 was discharged from therapy in August of 2016, and should be currently walking two times a day up to 150 feet. PTA-G indicated ambulation into the bathroom would not be enough steps to be considered a walking program. On 10/24/16, at 10:52 a.m. the clinical manager (CM)-B indicated R29 had an ambulation program for one staff to walk the full length of the hallway with use of a gait belt and a walker. CM-B was unaware how often R29 ambulated. CM-B verified R29's Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (care giver assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps." CM-B verified R29 did not have a form which directed the ambulation program in the NA maintenance book. CM-B verified the NA group sheet was part of R29's current care plan and the group sheet did indicate R29 was to receive assistance with ambulation two times a day with CGA of one and a FWW. CM-B indicated without documentation or observations of R29's ambulation with staff , she was unaware if R29 had received the referred ambulation program two times a day up to 150 feet. On 10/24/16, at 11:06 a.m. (PTA)-G assessed R29's ambulation ability. PTA-G assisted R29 to stand from the wheelchair and ambulate 1/2 the length of the hall from her room and then back to her room. PTA-G indicated R29 had not declined and had remained at the functioning level with	2 915		

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ambulation as when she had been discharged from physical therapy services.

R46
R46 was not receiving ambulation services as directed by physical therapy.

On 10/24/2016, at 11:00 p.m. R46 was laying on top of her bed on her right side, covered with two small blankets, the call light was secured to the grab bar attached to the side of the bed, and a wheel chair was approximately 3 feet from the bed in which R46 lay.

R46's physicians orders dated 9/20/16, identified diagnoses included muscle weakness, syncope and collapse.

R46's quarterly Minimum Data Set (MDS) dated 8/11/16, identified R46 had intact cognition, and required extensive assistance for transfer, locomotion on and off of the unit, dressing and toilet use, limited assistance for bed mobility and personal hygiene. The MDS identified ambulation did not occur for R46 during the assessment period.

R46's Care Area Assessment (CAAS) dated 11/9/15, included: Cognitive Patterns- intact. Functional status: Activities of daily living status- limited assistance of one staff for transfers, limited assistance of staff to ambulate in room, ambulation in corridor did not occur.

The facility form titled Resident Referral, Interdepartmental Communication dated 11/6/15, to nursing from physical therapy directed R46 receive the following: "Please ambulate Pt (patient) with RW (regular walker), transfer belt, and 1 A (assist) 2 X (times) daily. Pt. amb.

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(ambulate) up to 200' any ? (questions) call."

R46's current care plan revised 8/22/16, revieled R46 had an unsteady gait and weakness, SBA (stand by assist) of one for transfer and with walker.

R46's progress notes were reviewed 4/3/16, through 10/1/16, did not note that R46 had received ambulation services with floor staff.

R46 did not have a ambulation program sheet in the nursing assistant maintenance book.

On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program. NA-E stated R29 could pivot transfer and take a couple steps but not walk any distance.

On 10/24/2016, at 10:32 a.m. physical therapy assistant (PTA)-G indicated residnets who had reached their goal in therapy were discontinued from therapy services and then continued with a ambulation or lower extremity exercise program to be completed by the nursing assistants in order to maintain the progress which was made in therapy. PTA-G verified R46 had been discharged from therapy and should be currently walking two times a day up to 200 feet or as far as R46 tolerated. PTA-G indicated she would expect staff to be walking with R46 in the hall and the program should continue unless the resident had a decline, hospitalization or pain. PTA-G indicated if a decline were to occur the resident should then be re-screened. PTA-G indicated ambulation into the bathroom would not be enough steps to be considered a walking program.

On 10/24/16, at 10:52 a.m. the clinical manager

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2 915	Continued From page 129 (CM)-B indicated she had never seen R46 ambulate. CM-B indicated when a referral from therapy was received for an ambulation program or other exercise program it would be written on a form for the nursing assistants(NA) in the NA maintenance book. CM-B verified R46's Resident Referral, Interdepartmental Communication dated 11/6/15, to nursing from physical therapy directed the following: "Please ambulate Pt (patient) with RW (regular walker), transfer belt, and 1 A (assist) 2 X (times) daily. Pt. amb. (ambulate) up to 200' any ? (questions) call." CM-B verified R46 did not have a form which directed the ambulation program in the NA maintenance book. With review of R46's chart, CM-B verified the ambulation program had been in place for the months of December 2015, April, May, June and July 2016, but no further ambulation program documentation was found. The CM-B verified R46's ambulation program was not currently being performed. On 10/24/16, at 11:11 a.m. R46 verified the nursing staff did not walk with her in the hall and had not asked her to walk with them. While walking with the use of a walker, gait belt and PTA-G, R46 stated," I can feel I have not walked in a while, I can feel it in my arms." R46 walked approximately 8 feet, stopped and requested to stop a while to rest her arms. After resting a few minutes, R46 continued to walk with PTA-G back to her room. R46 was breathing heavily when she reached her room. On 10/24/16, at 11:11 a.m. (PTA)-G assessed R46's ambulation ability. PTA-G assisted R46 to stand from bed and ambulate out of her room into the hall. R46 was able to ambulate 1/2 of the hall from her room toward the nurses desk and then back to her room. PTA-G indicated R46 had not	2 915		

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declined and had remained at the functioning level with ambulation as when she had been discharged from physical therapy services.

On 10/24/16, at 11:24 a.m. a follow up interview with R46 identified she was aware she should walk more; however, believed the facility staff were very busy and she required a lot of assistance and took a lot of the staffs time.

On 10/24/16, at 2:00 p.m. physician assistant (PA)-A indicated she would expect facility staff to follow resident care plans and to initiate recommended walking or exercise programs to prevent resident functional decline and a decline in the residnets quality of life. PA-A stated, " Sadly not providing recommended restorative exercises is not uncommon here."

A facility policy titled, Restorative Program, dated 4/1/08, identified residents would be assessed on admission and as needed for a restorative program including ambulation. The policy further identified residents would be supported and their highest level of functioning maintained.

SUGGESTED METHOD OF CORRECTION:

The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding resident ambulation services. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.

TIME PERIOD FOR CORRECTION:

Twenty-one (21) days.

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2 920	Continued From page 131	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure personal cares were completed in a timely manner for 1 or residents (R18) reviewed for urinary incontinence and on who were on a routine check and change program. Findings include: Review of R18's quarterly Minimum Data Set (MDS) dated 7/26/16, identified R18 had severe cognitive impairment, was unable to communicate with staff and had diagnoses which included, dementia, depression and anxiety. The MDS identified R18 was totally dependent on staff for activities of daily living (ADL's) and required 2 staff for assistance with bed mobility, personal hygiene and toileting. The MDS identified R18 was frequently incontinent of bowel and bladder. The MDS identified R18 was not on a toileting program for bowel or bladder incontinence. Review of R18's annual MDS dated 4/26/16, identified R18 was totally dependent on staff for ADL's. The MDS identified R18 was frequently incontinent of bowel and bladder. The MDS identified R18 was not on a toileting program for	2 920	corrected	11/17/16

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2 920	Continued From page 132 bowel or bladder incontinence. Review of R18's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 4/26/16, identified R18 had cognitive loss related to dementia and was unable to coherently verbalize her needs. The CAA revealed R18's needs were to be met in spite of her inability to make requests. R18's Communication CAA identified R18's needs must be anticipated by facility staff. Urinary Incontinence CAA identified R18 was frequently incontinent of bowel and bladder and needed assistance with all mobility and was toileted or changed as needed. Review of a Bowel and Bladder Functional Evaluation tool reviewed 7/26/16, revealed R18 had functional urinary incontinence and was totally dependent on staff for toileting needs. The tool revealed R18 required assistance to toilet every 2 hours during the day and to change and change the 1st and 3rd rounds during the night. Review of R18's physician progress note dated 10/6/16, revealed R18 had severe dementia and Alzheimer's disease and to be dependent on facility staff for her needs. Review of R18's current care plan last updated 10/7/16, revealed R18 had severe cognitive loss, was unable to communicate her needs and was totally dependent on staff for toileting, repositioning needs and was frequently incontinent of bowel and bladder and wore an incontinent brief . The care plan directed staff check and change R18 every 2 hours for incontinence with repositioning. On 10/19/16, from 7:03 a.m. to 10:39 a.m.,	2 920		

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2 920	Continued From page 133	2 920		

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continuous observations of R18 revealed the following:

On 10/19/16, at 7:03 a.m. R18 was seated in a gel cushioned wheelchair, fully dressed in her room. R18's bed was stripped of its linens which were balled into a bundle on her bed. R18's head was hung forward in a chin to chest position and her eyes were closed.

-at 7:38 a.m. the call light to R18's room was on by R18's roommate, staff were observed to enter the room to assist R18's roommate. At that time, housekeeping staff entered R18's room and made R18's bed while she remained seated in the wheelchair. At 7:41 a.m. the housekeeping staff member wheeled R18 to the dining room. R18 had remained with her eyes closed and her head was in a chin to chest position. Housekeeping staff wheeled R18 to a table in the dining room and placed a clothing protector around her neck, at that time R18 covered her face with the clothing protector.

-at 7:56 a.m. R18 remained seated in the wheelchair in the dining room. A dietary aid (DA)brought R18 her breakfast plate, left the plate on the table in front of her and walked away. At that time nursing assistant (NA)-G approached R18, placed a hand on her shoulder and verbally prompted her to wake up. R18 opened her eyes and NA-G verbally prompted R18 to begin eating and handed her a spoon. R18 ate 100% of her breakfast foods independently while seated in the wheelchair. R18 remained seated in the wheelchair at the table

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	00730	A. BUILDING: ______ B. WING ______	10/24/2016

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FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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2 920	Continued From page 134 -at 8:46 a.m. R18 remained seated in her wheelchair at the dining room table, had made no attempt to leave from the table. R18 had completed her meal, had a glass of milk orange juice and water in front of her though made no attempt to reach for them. R18 held onto her spoon, and would repeatedly run the spoon over the lipped edge of her plate, periodically licking her spoon. -at 9:01 a.m. R18 remained seated in her wheelchair in the dining room, having made no attempts to leave the table. NA-H approached R18 and asked how her day was, R18 did not respond, NA-H walked away. R18 continued to repeatedly run her spoon around the lipped edge of the plate, while she periodically licked her spoon. R18 had made no attempts to drink her fluids. -at 9:18 a.m. R18 remained seated in her wheelchair in the dining room. R18 had set the spoon on the table, and had closed her eyes. Shortly after R18's head dropped forward in a chin to chest position. No staff had offered to assist R18 with repositioning. -at 9:30 a.m. R18 remained seated in her wheelchair in the dining room. R18 had opened her eyes, looked around, took her clothing protector and covered her face it. R18 made no attempt to move away from the table and held her face covered with the clothing protector. -at 9:37 a.m. NA-D entered the dining room, awoke R18 and offered R18 her fluids. R18 awake, removed the clothing protector from her face and allowed NA-D to assist her to drink her juice. R18 drank 50% of her juice. NA-D then	2 920		

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2 920	Continued From page 135 handed R18 her glass of water and R18 independently drank the water. NA-D left R18 seated in her wheelchair and exited the dining room. NA-D was not observed to offer R18 assistance with cares, repositioning or toileting needs. -at 9:42 a.m. NA-H approached R18 and assisted her to drink her remaining fluids, while R18 remained seated in her wheelchair. NA-H removed the clothing protector from R18's neck, R18 then took her shirt and covered her face with it, in a cradling position. -at 9:50 a.m. NA-H assisted R18 out of the dining room while seated in her wheelchair, brought her to her room and handed R18 a stuffed bear. NA-H attached the call light to R18's wheelchair and left R18's room. NA-H was not observed to offer R18 with any cares, including repositioning or toileting. -at 10:01 a.m. NA-D was observed to walk past R18's room, did not look in or stop in R18's room. -at 10:09 a.m. NA-E exited a room across the hallway from R18's room, briefly looked into R18's room and immediately walked away down the hallway. -at 10:39 a.m. assistant director of nursing (ADON) was notified R18 had remained seated in her wheelchair for an observed 3 hours and 36 minutes. At that time the ADON confirmed R18 required assistance with repositioning and checking and changing every 2 hours. ADON confirmed R18 was at risk for skin breakdown. ADON went to R18's room while requesting assistance from other nursing staff via walkies talkie.	2 920		

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2 920	Continued From page 136	2 920		

Continued From page 136

-at 10:39 a.m. NA-E entered R18's room and asked R18 to use the bathroom. NA-E donned a gait belt across R18's torso, NA-E and ADON assisted R18 to stand from the wheelchair, ambulate to the bathroom and removed R18's slacks and incontinent brief. R18 had a moderate amount of urine in her brief as well as a small amount of bowel. ADON confirmed R18's entire buttocks surface which had contact with the brief had deep blush pink creases and was moist surrounding her peri-rectal area, though was blanchable. NA-E and ADON assisted R18 to complete toileting needs and assisted R18 to sit back in her wheelchair.

R18 had remained in a seated position for a total of 3 hours and 36 minutes, during that time no staff were observed to offer R18 assistance with repositioning.

On 10/19/16, at 10:39 a.m. NA-E stated she thought R18 was last repositioned around 6:45 a.m. and had stated she had been too busy helping others with cares to assist R18 with repositioning and toileting needs. NA-E stated R18 was supposed to be repositioned and checked and changed every 2 hours and as needed. NA-E stated R18 was not able to verbalize hers and staff needed to anticipate R18's needs.

On 10/20/16. at 2:36 p.m. NA-B stated R18 needs must be anticipated and was totally dependent on 2 staff for her needs, including repositioning and toileting. NA-B stated R18 required routine every 2 hour repositioning and toileting. NA-B stated R18's buttocks would get red at times, but could not recall any recent open areas on R18's buttocks.

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2 920	Continued From page 137 On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff of for all of her needs. LPN-B stated R18 was not able to verbalize her needs and staff needed to anticipate them. LPN-B stated R18 was at risk for skin breakdown due to incontinence and immobility. On 10/21/16, at 1:37 p.m. during a follow up interview ADON stated she felt staff were unable to routinely repositioning and toilet residents in a timely manner, such as R18, due to staffing shortages. ADON stated they were not always able to fill in for sick calls and there were times when the facility were unable to fill holes in the schedule. A facility policy titled Bowel and Bladder Management dated 4/1/08, revealed it was the facility's policy to ensure each resident with bowel or bladder incontinence would receive appropriate treatment and services to maintain normal functioning. The policy directed staff to develop an individual toileting schedule for all incontinent residents and noted on resident carte plans. SUGGESTED METHOD OF CORRECTION: The director of nursing could re-educate all staff to follow care plans in regards to specific resident cares and services, and could develop a system to audit and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		11/17/16

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21375	Continued From page 138 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident symptoms, analysis of the surveillance and investigation of patterns identified. This had the potential to affect all 52 residents who resided in the facility. In addition, the facility failed to ensure proper handling of soiled clothing and linens during personal cares for 1 of 4 residents (R18) observed for personal cares. Findings include: The facility's Infection Control Logs were reviewed from 4/11/16, through 9/22/16. The logs identified tracked only residents with infections for which antibiotics were prescribed. The facility's surveillance processes also lacked identification of the following: location of the resident within the facility, if the infection was healthcare or community associated, site of infection, date onset of symptoms, specific symptoms that were present, cultures performed/ organism identified, treatment provided and the date the infection resolved. Furthermore, the logs lacked analysis and/or investigation of patterns identified. During interview on 10/24/16, at 2:00 p.m. unit manager (UM)-B who was responsible for the facility's infection control program, confirmed the	21375	MN 144A.04 Tuberculosis Prevention and Control 1. Tuberculosis screening has been completed for R42 and R92. Tuberculin Skin Testing has been completed for R42. Tuberculin skin testing has completed for E1. Facility has completed an annual facility TB risk assessment. 2. All residents are at risk due to deficient practice. 3. Mandatory staff education of the Tuberculosis Control Program will be provided November 30, 2016. Infection control nurse will be educated on completion of facility annual TB risk assessment. 4. All current employee and resident health/medical records have been audited for 2 step TSTs. Newly hired employee and newly admitted resident records will be audited weekly x 3 months. 5. Deficient practice will be corrected by December 14, 2016.	

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monthly infection logs were not completed thoroughly for each resident identified. UM-B stated in her lack of time the logs were incomplete. UM-B also stated the facility only tracked infections which were treated with antibiotics, and confirmed there was no system currently in place to track and trend any other viral illnesses's such as the common cold, gastroenteritis or influenza. UM-B stated when she was assigned responsibility of the infection control program, she did not receive any training or direction on what should have been included in the program. UM-B confirmed the facility luckily has not had any outbreaks.

Review of the facility's undated Infection Prevention and Control Program policy, it indicated the facility had developed and maintained an infection prevention and control program that provided a safe, sanitary and comfortable environment to help prevent the development and transmission of infection.

Review of R18's quarterly Minimum Data Set (MDS) dated 7/26/16, identified R18 had severe cognitive impairment, was unable to communicate with staff and had diagnoses which included, dementia, depression and anxiety. The MDS identified R18 was totally dependent on staff for activities of daily living (ADL's) and required 2 staff for assistance with bed mobility, personal hygiene and toileting. The MDS identified R18 was frequently incontinent of bowel and bladder. The MDS identified R18 was not on a toileting program for bowel or bladder incontinence.

Review of R18's annual MDS dated 4/26/16, identified R18 was totally dependent on staff for

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21375	Continued From page 140 ADL's. The MDS identified R18 was frequently incontinent of bowel and bladder. The MDS identified R18 was not on a toileting program for bowel or bladder incontinence. Review of R18's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 4/26/16, identified R18 had cognitive loss related to dementia and was unable to coherently verbalize her needs. The CAA revealed R18's needs were to be met in spite of her inability to make requests. R18's Communication CAA identified R18's needs must be anticipated by facility staff. Urinary Incontinence CAA identified R18 was frequently incontinent of bowel and bladder and needed assistance with all mobility and was toileted or changed as needed. Review of R18's current care plan last updated 10/7/16, revealed R18 had severe cognitive loss, was unable to communicate her needs and was totally dependent on staff for toileting, repositioning needs and was frequently incontinent of bowel and bladder and wore an incontinent brief . The care plan directed staff check and change R18 every 2 hours for incontinence with repositioning. On 10/17/16, at 3:40 p.m. R18 was seated in a wheelchair in her room, her shirt was over her head. R18's right hand rested on her right thigh and had fecal matter on her right hand, covering up to her first knuckles on all of her fingers and her thumb. R18's right upper (thigh height) pant leg also had smeared fecal matter the size of her entire hand. R18 began to move her fecal covered right hand towards the front of her. At that time the director of nursing was walking down the hall and was notified of R18's condition. At 3:41 p.m. nursing assistant (NA)-H entered	21375		

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R18's room and asked R18 if she wanted to use the bathroom, R18 lifted her head out of her shirt, reached up with her right hand and touched her hair. NA-H took a packaged pre-moistened wipe and cleansed R18's right hand. R18 repeatedly reached down with her hand and touched the soiled area on her slacks while NA-H was obtaining clean clothes from her closet. NA-H would re-wipe R18's hand, and R18 would again reach down and handle the soiled slacks several times. At that time NA-H stated R18 was totally dependent on 2 staff for all of her cares and was frequently incontinent of bowel and bladder. At 3:44 p.m. NA-H requested assistance with R18's cares. R18 continued to repeat the process of re-soiling her right hand with the bowel on her pant leg and NA-H would re-wipe her hand with the wipes.

-At 3:53 p.m. NA-H used her walkie talkie and requested assistance, NA-H then stated there were times when she had to wait a long time for another staff member to help with residents requiring 2 staff assistance, including R18. NA-H stated she had been assigned to another wing when the DON pulled her into R18's room. At 3:56 p.m. NA-H left R18's room to physically seek out assistance without covering the bowel on R18's pant leg. R18 re-soiled her right hand immediately after NA-H left the room.

-At 3:59 p.m. NA-F entered R18's room, stepped in a grape sized amount of bowel which was on the floor near R18's front right wheelchair wheel as she approached R18. NA-F washed R18's hands with a washcloth. R18 pushed NA-F away, NA-F backed away, reproached R18, donned a gait belt across R18's torso and NA-H entered R18's room, both NA-F and NA-H transferred

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R18 from the wheelchair, assisted R18 to walk to the bathroom. NA-F removed R18's slacks and incontinent brief which were saturated with bowel and bladder and bladder. NA-F discarded R18's incontinent brief in the garbage and placed R18's soiled slacks on the floor. NA-H removed R18's shirt and placed it on the floor next to R18's soiled slacks. NA-F and NA-H assisted R18 with cleansing, applied a clean brief and donned clean clothing for R18. NA-H checked R18's seat cushion and stated she felt it was clean, washed the floor with a wipe. NA-F picked up R18's soiled shirt and slacks and soiled washcloths from the floor with her gloved hands, left the room and entered the soiled hopper room. NA-H provided R18 with a baby doll, her call light and left R18's room.

On 10/17/16, at 4:17 p.m. NA-F stated it was not usual practice to placed soiled clothing on the floor. NA-F stated the usual practice would be place the soiled clothing in a bag and bring the bag to the soiled hopper room. NA-F also stated she was unaware of the last time R18 had been assisted with toileting. NA-F stated she used to get a report from the previous shift NA of when resident cares were last completed, though did not that day. NA-F stated she had not been getting report from the previous shift NA on a consistent basis due to short staffing.

On 10/21/16, at 1:37 p.m. the assistant director of nursing stated it was not usual practice to place soiled clothing on the floor. ADON stated the usual practice was to place soiled clothing in bags, then to bring the closed bags into the hopper rooms to be rinsed and placed in laundry bags. The ADON stated she expected staff to follow the facility policy.

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21375	Continued From page 143 Review of a facility policy titled., Linens-Handling, dated 4/1/08, revealed it was the facility's policy when handling, processing and transporting linens, staff were to use specific procedures to prevent the spread of infection. The policy directed staff to immediately remove soiled linens from the residents room and taken to a utility room. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to a comprehensive infection control program, to include tracking, trending and investigating all illnesses in the facility. The DON or designee could review and educate staff on proper infection control practices for resident cares and linen handling. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis	21426		11/17/16

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21426	Continued From page 144 infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure a Tuberculin (TB) baseline screening had been completed for 2 of 5 residents (R42,R94) upon admission, and failed to provide a second Tuberculosis Skin Test (TST) for 1 of 5 residents (R42). In addition, the facility failed to provide the second TST within the required timeframe for 1 of 5 newly hired employees (E1) reviewed for Tuberculosis (TB) program. In addition, the facility failed to produce the required written TB risk assessment. Findings include: R42 was admitted to the facility in 2016. Review of the R42's immunization record revealed the TB baseline symptom screening form had not been completed upon admission to the facility. In addition, the immunization record revealed R42's second TST was not given. R94 was admitted to the facility in 2016. Review of R94's immunization record revealed the TB baseline symptom screening form had not been	21426	corrected	

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completed upon admission to the facility.

E1 was a newly hired employee. The first TST was given on 6/3/16, and was read on 6/6/16 with a result documented as negative. The second TST was not given until 7/25/16, and was read on 7/28/16 with a result documented as negative.

During interview on 10/24/16, at 2:00 p.m. unit manager (UM)-B who was responsible for the facility's TB program confirmed all residents upon admission and newly hired employees were required to have the TB baseline symptom screening and two-step TST completed. UM-B reported the facility's TB risk was low, however, was not able to produce the required TB written assessment for review.

Review of the facility policy titled TB Control Plan, undated, revealed TB symptom screening and two-step skin testing would be completed for all residents upon admission and newly hired employees. The policy also indicated a TB risk assessment would be completed, at least annually, to determine the risk of exposure to TB at the facility.

SUGGESTED METHOD OF CORRECTION:
The infection control coordinator/nurse or designee could review the TB policies and procedures to ensure required information is included. Appropriate staff could be educated regarding requirements. Audits could be could be conducted and the results reviewed at the quality committee meetings.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to provide meaningful activities identified in the comprehensive assessment for 1 of 3 residents (R66) who was dependent on staff to provide all leisure activities. Findings include: R66's admission Minimum Data Set (MDS), dated 1/11/16 identified R66 had diagnoses which included traumatic brain injury, seizure disorder and diabetes. The MDS identified R66 had severe cognitive impairment, and was totally dependent of staff for activities of daily living (ADLs), and required 2 staff to assist with transfers and locomotion off the unit. The MDS identified R66 enjoyed listening to music, being around animals such as pets, keeping up with the news, doing things with groups of people,	21435	corrected	11/17/16

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participating in favorite activities and spending time outdoors.

R66's Care Area Assessment (CAA), dated 1/11/16 identified R66 suffered from a traumatic brain injury, was unable to speak and make needs known and was dependent on staff for all her ADL. The CAA further identified R66 followed people with her eyes and blinked to answer yes or no questions and appeared to watch TV when it was on.

R66's care plan dated 2/18/16 identified R66 was a big fan of duck Dynasty and Keeping up with the Kardashians. R66's care plan indicated she liked to browse through gossip magazines and enjoyed a good book at times. R66's care plan directed activity staff had posted a sign in her room to inform all staff that she enjoys Duck Dynasty and Keeping up with the Kardashians, activity staff were to complete 4 1:1 visits a week, and activity staff would provide gossip magazines (people, Us Weekly, Star) and would read to her during 1:1 visits and would see if she was up to enjoy story time. R66's care plan further directed R66 required a mechanical lift and 2 staff to get her up and into her wheelchair, and R66 would be wheeled to all of her destinations as desired and in a timely manner.

R66's Recreation/Therapeutic Programs Assessment dated 1/4/16, identified activities staff indicated they would try to bring her to activities to let her observe and be around people, and indicated R66 was in bed a lot. The assessment further identified R66's past interests included cards and games and plan included large group programs and entertainment, small group activities such as manicures, 1:1 programing would be needed, and R66 also

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enjoyed watching the birds and TV.

Review of R66's activities quarterly progress note dated 7/26/16, identified R66's activity involvement was fair and participation was passive, R66 was unable to structure her time in a meaningful way. The note identified R66 watched TV on a daily basis, and sometimes watched movies. The note indicated R66 would sometimes watch the birds, but staff felt R66 would rather watch TV and R66 would have 4, 1:1 visits by staff each week. The note also indicated family visited once per week and took her outside.

Review of activities quarterly progress note dated 10/11/16, identified R66's activity involvement was fair, participation level remained passive and R66 was unable to structure her time in a meaningful way. The note indicated R66 loved TV also watches movies on her personal DVD player. The note further identified R66 would have 4, 1:1 visits by activity staff each week and they would sometimes read her a book. The note also indicated family visited once per week and wheeled her around or took her outside if the weather was nice. The progress note identified R66's activity plan was appropriate, had met her goal for the last 3 months, activity interventions were effective. and no changes were recommended for R66's activity program.

Review of the facility activity calendar for residents from 4/16 to 10/16 identified 4-5 activities per week which R66 had special interest in such as music, Bingo, movies, outside walks and manicures.

Review of R66's Resident Activity Attendance Chart forms from 4/1/16 to 10/17/16 revealed

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R66 consistently watched TV and family visited. However, the attendance charts did not include consistent 1:1 visits, and did not consistently include attendance at either large or small group acclivities. The monthly documentation as follows:

-4/16, 6 out of 16 opportunities of 1:1 visits from staff for the month, and 3 unable and 1 refused. No other documentation of large or small group activities or activities out of room

-5/16, 7 out of 18 opportunities for 1:1 visits from staff for the month, 1 in family lounge, 1 in activities room, 1 mail reading, and 2 cleaning glasses.

-6/16, 9 out of 16 opportunities of 1:1 visits from staff for the month, 1 mail reading,1 glider, and 4 unable.

-7/16, 5 of out 18 opportunities for 1:1 visits from staff for the month, 1 special event, 1 bird watching, 2 cleaning glasses, 2 outside, 1 glider and 3 unable

-8/16, 7 out of 18 opportunities for 1:1 visits for the month, 1 bird watching, 1 wheeling, 1 outside, 1 cleaning glasses, and 1 unable

-9/16, 7 out of 18 opportunities for 1:1 visits for the month, 1 outside, 1 cleaning glasses, and 1 unable

-10/1-10/24/16, 7 out of 13 opportunities for 1:1 visits, 1 sitting in family lounge, 2 cleaning glasses, 1 outside

On 10/19/16, during observation from 7:00 a.m. to 10:03 a.m. R66's room was dark and quiet,

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and her bedroom door was open. R66 was observed on her back in bed, dressed in a hospital gown. R66 remained in the same position with no meaningful activity for 3 hours and 3 minutes. R66 had a monthly activities calendar posted on her closet door across from the foot of her bed, and a hand written 8.5 X 11 sign was posted on the wall across from R66's recliner and identified:

-R66 was to be changed during check ups
-No more Kardashians'!
-Family Feud on channel 11:00 a.m.
-Wheel of fortune
-Jeopardy 5:00 p.m.
-Judge Judy 9:00 a.m. & 11:00 a.m.
-get movie going early in the am or at bedtime

On 10/19/16, at 10:35 a.m. LPN-A and NA-E were in R66's room after R66 was dressed and in her recliner. LPN-A asked R66, "What are you going to watch on TV today?, I know you like those Kardashian girls." LPN-A stated she gave R66 a hard time about the Kardashians' because you never now what their gonna do on the show.

On 10/19/16, at 12:10 p.m. R66 was dressed and seated in her recliner, in front of the TV. A political type program was on TV and R66 eyes were turned away from the TV and out her bedroom window.

On 10/20/16, at 9:42 a.m. R66 was in her bed dressed in a hospital gown. R66's TV was off, and her eyes were focused on the ceiling.

On 10/18/16, at 12:17 p.m. family member (FM-A) stated no facility staff visits R66 and she felt no facility staff went into her room unless they had to. She stated she visited R66 about twice a

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week and a nurse used to come and visit R66 even when she wasn't working, but she was gone now.

On 10/21/16, at 10:24 a.m. licensed practical nurse (LPN-A) stated R66 was totally dependent on staff for ADLs. She stated the usual routine was after R66 got up, she spent her day watching TV in her recliner.

On 10/24/16, at 10:08 a.m. activities aide (AA-A) stated R66 spent her day watching TV and would get 1:1 visits. She stated during 1:1 visits they open curtains, and sit with her talk to her about the TV shows she liked, or put a movie on. She stated she didn't know how often R66 came out of her room, and stated sometimes they had her sit at the nurses desk. She stated R66 slept a lot, and missed 1:1 visits because she was in bed and asleep. She stated activity staff tried to provide 1:1 visits on an attempt basis. She stated it was hard to provide activities for R66 because R66 required so much care, and was difficult to get up. She stated she felt R66 was probably up in her chair when family visited, and staff had tried to get her out to story time but it was too difficult.

On 10/24/16, at 10:53 a.m. clinical manager (CM-A) stated staff would get her up in her recliner and she watched the Kardashians' because they were on a lot, otherwise R66 was in bed or her Broda chair in her room the majority of the time. She confirmed R66's current care plan and stated she understood activities staff spent time with her in her room.

On 10/24/16, at 12:27 p.m. activities director (AD) stated activity staff had posted a sign in R66's room which told staff what TV shows R66 liked

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and stated R6 also had a portable DVD player in her room. AD indicated in the past activities staff had wanted to bring R66 to the Afternoon Adventure activity, which was scheduled daily during the week, but struggled to get R66 to attend because she was not in her chair. She stated R66 used to get her nails done but activity staff struggled with finding staff to get her up in her wheelchair to attend the activity. She stated she would like R66 to attend music programs but it was such a hassle to find staff to get her up in her wheelchair, and R66 was usually in her bed or recliner. AD confirmed R66's care plan and stated her care plan could be updated. She stated her care plan was TV focused and the portable DVD player also. AD confirmed R66's activity records and stated R66 mostly watched TV. She confirmed the sign posted in room and R66's care plan had not been updated with current information.

Review of facility policy, Activities, dated 4/1/08 identified the facility must provide an ongoing program for activities designed to meet the interests, physical, mental, and psychosocial well-being of each resident based on comprehensive assessment.

SUGGESTED METHOD OF CORRECTION:
The Activity Director or designee could develop, review, and/or revise policies and procedures to ensure resident's have an indivdualized activity program that meets their needs.
The Activity Director or designee could educate all appropriate staff on the policies and procedures.
The Activity Director or designee could develop monitoring systems to ensure ongoing compliance.

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21435	Continued From page 153 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eye drops were labeled with open or discard dates after they were opened for 2 of 5 residents (R31, R43). In addition, the facility failed to implement a system for consistent and timely destruction of discontinued narcotics to prevent loss or potential diversion in 2 of 2 medication rooms reviewed for medication storage. Findings include: On 10/24/16, at 1:00 p.m. medication cart B was observed to have the following bottles of eye drops were opened without a date identified so the discard date could be determined: -R31's Timolol Maleate PF Solution 0.5%, dispensed on 6/4/16. -R43's Latanoprost Solution 0.005%, dispensed on 8/8/16. R31's signed physician orders dated 9/27/16, indicated R31 was prescribed Timolol Maleate PF Solution 0.5% Solution, 1 drop in left eye one time a day for glaucoma, with an ordered start date of 4/16/16.	21620	corrected	11/17/16

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R43's signed physician orders dated 10/6/16, indicated R43 was prescribed Latanoprost Solution 0.005%, 1 drop in both eyes at bedtime for glaucoma, with an ordered4 start date of 2/5/15.

At the time of observation, registered nurse (RN)-D confirmed the eye drop medication bottles were not dated when they were opened, and stated they should have been. RN-D reported she did not work on the B medication cart often, but stated any nurse can date the drops when they are opened. RN-D also reported a pharmacist comes to the facility monthly to review the medication carts for expired medications.

On 10/24/16, at 1:36 p.m. the assistant director of nursing (ADON) stated the expectation was to date the eye drops when opened, and it should have been done. The ADON then stated she was surprised the pharmacist did not flag the undated opened eye drop medications.

The facility policy for Labeling and Storing Medicine dated 3/14 and 4/15, did not address the dating of medication bottles or indicate when to discard eye drop medications once they were opened.

The Remedy's RX Specialty Pharmacy Eye Drop Expiration Guidelines indicated Timolol would be expired 28 days after opened, and Latanoprost would be expired 6 weeks after opened.

On 10/24/16, at 1:17 p.m. observations were conducted of the facility's medication storage rooms. At 1:17 p.m. licensed practical nurse (LPN)-C unlocked a double locked cupboard in the west medication room. In the cupboard were two shelves filled with narcotics which were

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discontinued and waiting for destruction. Multiple bottles of morphine were observed on the upper shelf, some with pharmacy label dates of January 2015 and September 2015. The lower self was filled with various narcotics such as oxycodone, morphine, hydromorphone and fentanyl patches. On the outside of the cupboard door was taped the destruction of controlled substances form, also on the counter below the narcotic cupboard were 12 bound narcotic ledgers.

On 10/24/16, at 1:25 p.m. the assistant director of nursing (ADON) unlocked a double locked cupboard in the east medication room. In the cupboard were two smaller shelves filled with narcotics which were discontinued and waiting for destruction. One bound narcotic ledger was noted adjacent to the narcotic cupboard.

The Inventory And Destruction Of Controlled Substances Form: Long-Term Care Facilities was affixed to the west medication room cupboard. The document identified the prescription number, drug name, strength, quantity, date the medication was placed in the cupboard and signature of the nurse. There were 24 total entries from 8/31/16 to 10/25/16 identified on the document.

During interview on 10/24/16, at 1:20 p.m. LPN-C stated all discontinued narcotic medications were stored in the double locked cupboard. LPN-C reported when a narcotic was discontinued, nurses were to document in the narcotic bound ledger, and on the sheet taped to the cupboard what the medication was and how many were placed in the cupboard. LPN-C stated the medications were not counted again until they were destroyed. LPN-C reported discontinued narcotics in the facility had not been destroyed in

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21620	Continued From page 156 a long time. LPN-C stated 3 different nurses and nurse managers had keys to the discontinued narcotic cupboards. LPN-C indicated she did not want to be responsible for the large volume of discontinued narcotic medications in the facility. She stated the current facility practice of storing large amounts of discontinued narcotics for long periods of time "scared" her. During interview on 10/24/16, at 1:30 p.m. the ADON confirmed both medication rooms contained many discontinued narcotics in the double locked cupboard accumulated over several months. The ADON stated the prior DON started destroying them with another staff member, but did not destroy all of the medications. The ADON confirmed the Certificate Of The Inventory And Destruction Of Controlled Substances Form was not a complete list of all discontinued narcotics waiting for destruction. The ADON confirmed all of the medications not on the form were documented in the narcotic bound ledger, and would be cross referenced at the time of destruction. The ADON stated there was a large quantity of discontinued narcotics in the facility. The ADON also stated multiple nurses had access to the keys which opened the discontinued narcotic cupboard, and confirmed the medications were not counted again after they were placed in the locked cupboard. The ADON confirmed the facility lacked a consistent process for storage and destruction of discontinued narcotics. The facility's Controlled Medication policy dated 3/1/14, indicated unused controlled medications and the control record be taken to the nursing director's office, and should be locked up until time for destruction in accordance with State Pharmacy Board.	21620		

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21620	Continued From page 157 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to labeling medications when opened when necessary such as eye drops. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21620		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain dignity for 1 of 1 residents (R66) who was observed lying in soiled linens. Findings include: R66's quarterly Minimum Data Set (MDS), dated 7/13/16 identified R66 had severe cognitive impairment, and was totally dependent of staff for activities of daily living (ADLs), and required 2 or more staff to assist with bed mobility. The MDS further identified R66 had diagnoses which included traumatic brain injury, seizure disorder	21805	corrected	11/14/16

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and diabetes.

On 10/19/16, at 10:05 a.m. R66 was observed in her bed, on her back and dressed in a hospital gown. Licensed practical nurse (LPN)-A and nursing assistant (NA)-E were present in her room for morning cares. LPN-A pulled away R66's white sheet and white cotton blanket from R66's body and set both off to R66's right side. NA-E was positioned on R66's right side and LPN-A was positioned on R66's left side of her bed.

R66' bottom bed sheet was observed to have several dried brown streaks, and a large round, dried, yellow stain on her white cotton bed sheet which extended to the left edge of her bed sheet where LPN-A was positioned to perform cares on R66. The stains were next to R66's left arm and hand on the bed LPN-A leaned over R66's bed with her torso and scrub top resting on the multiple browns streaks and yellow stained areas on R66's sheet. LPN-A confirmed multiple brown streaks and large yellow stain were feces and urine, covered the multiple stained areas with R66's white cotton blanket and continued to perform R66's morning cares.

On 10/19/16, at 1:03 p.m. NA-E stated the usual facility practice was for resident's sheets to be changed on resident bath days, and whenever linens became soiled. She stated R66 had received a bath on Monday, and her next bath was today. NA-E indicated she was not aware how long R66's bed linens had been soiled, and indicated she thought night shift had last repositioned R66 in bed.

On 10/19/16, at 1:06 p.m. NA-D stated facility staff changed resident bed sheets on their bath

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 159	21805		

day, or whenever they had an "accident."

On 10/19/16, at 1:16 p.m. LPN-A stated the usual facility practice was for resident's sheets to be changed whenever the linens became soiled, and on bath days. She stated R66's soiled sheets should have been changed right away when they became soiled.

On 10/24/16, at 10:53 a.m. clinical manager (CM)-A stated resident bed sheets should be checked for cleanliness when staff provide resident care. She stated resident sheets should be changed whenever staff notice they are soiled, and routinely on their bath days. She stated it should have been very obvious to staff when R66's sheets became soiled, and she would expect staff to change the sheets right away.

Review of facility policy, Linens-Handling dated 3/1/14, identified soiled linen was to be immediately removed from the resident's room and taken to the laundry room. The policy further identified dirty laundry should not be close to a person's body and hands were to be washed after handling dirty laundry and prior to handling clean laundry to prevent the spread of infection.

SUGGESTED METHOD OF CORRECTION: The administrator or social services could review and revised policies on dignity and in-service all staff on the residents rights so they can be promoted for each resident. The administrator and social services could monitor cares to ensure dignified care for residents in the facility.

TIME PERIOD FOR CORRECTION: Seven (7) days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: ___ B. WING ___	10/24/2016

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21870	Continued From page 160	21870		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure resident council concerns related to sufficient staffing and long call light response times were acted upon for 5 of 5 residents (R27, R1, R2, R5, R45) who voiced concerns at the resident council. Findings include: R27's annual Minimum Data Set (MDS), dated 8/17/16, identified R27 had intact cognition and required extensive assistance from staff for personal hygiene, dressing, transferring and toilet use. On 10/24/16, at 3:31 p.m. R27 stated she routinely attended resident council meetings and she had reported at the resident council meetings she had waited frequently for at least 2 hours when she put her light on and needed help. R27 stated she was beginning to feel like she did something wrong and that was why staff didn't answer light for that long. She stated other residents had also complained of long call light responses from staff and short staff in the meetings and she felt the facility had not responded to the concerns.	21870	corrected	11/17/16

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21870	Continued From page 161	21870		

R27 stated she had also brought up the lack of staff, and long call light waits during her care conferences. She stated the facility had always told her they will look into it, but they hadn't done anything about it. She stated she felt residents weren't getting the care they needed because they were short staffed. She stated the activities director (AD) was at every resident council meeting and she would tell residents she talked to the ones she should talk to, but evidently it was not doing any good.

R27 stated she was aware of at least 4 residents who had brought up short staffing concerns and long call light wait times, and stated the facility had not given any explanation for why this concern continued. She stated the facility kept telling resident council they would look into it, and the residents continued to bring it up again, and again, and again.

Review of the resident council meeting minutes from 7/27/16, 8/31/16, and 9/28/2016 identified:

-7/27, residents were concerned about their needs to have their call lights answered sooner than 2 hours

-8/31, residents were concerned it took staff too long to answer their call lights. The minutes further identified R27 had put on her light that morning at 8:00 a.m. and her light was not answered until 10:00 a.m. The minutes also indicated R27 stated she didn't like to wait that long because she wanted to get up to go to morning activities. The minutes identified other residents had the same concerns typically in the morning.

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21870	Continued From page 162 9/28, residents had a concern that their call lights weren't being answered and residents could wait up to an hour to get their lights answered at any time during the day. Review of the resident council concern follow-up forms from 7/27/16, 8/31/16, and 9/28/16 identified: -7/27, director of nursing (DON) identified the resident council concerns and indicated audits and monitoring had been done. DON also indicated they had room for improvement and all staff had been asked to assist in answering resident call lights. DON further indicated the concerns were posted in the nursing communication board and discussed at the morning meetings with administrator and department heads. DON identified she would continue to monitor call lights and address any further complaints as needed. -8/31, nurse consultant indicated she witnessed call light response times on 8/31/16, and communicated staffing plans with regional director, facility nurses and interim administrator. She indicated she communicated call light response times and resident concerns to nursing staff. The form lacked documentation of actions to be taken to correct or improve the staffing concerns and long call lights responses. -9/28, nurse consultant indicated indicated she reviewed resident call light response time concerns and staffing plan with regional director, scheduler, nursing staff, and interim administrator. She indicated she provided education on the importance of timely call light response. The form lacked further documentation of actions to be taken or monitoring to correct or	21870		

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improve the staffing concerns and long call lights responses.

On 10/24/16, at 4:08 p.m. the activities director (AD) stated she coordinated the facility's resident council meetings and typed the meeting minutes. She stated the usual practice was to review the minutes from the last resident council meeting, review any follow up or response to previous concerns, reviewed old business, new business, and inform residents of upcoming events in the facility. She stated at every meeting she went over all of the service areas individually and asked residents to speak up if they had any concerns with any departments.

AD stated R27 routinely attended resident council meetings and R27, R1, R2, R5, and R45 had all voiced concerns regarding the facility being short-staffed and long call light waits.
She stated almost every month residents complained about nursing and long call light waits, and not enough staff. She stated she knew the assistant director of nursing and the registered nurse consultant were aware of resident concerns regarding long call light waits and being short staffed.

AD stated she brought up resident concerns from resident council also verbally during morning meetings to all department heads, and resident concerns were always brought up at monthly quality assurance meetings. She stated sometimes she filled out a Resident Council Concern Follow-up form, and delivered it to nursing, or put the form in their mailboxes. She stated nursing completed and returned the form to her before the next scheduled resident council meeting.

Minnesota Department of Health

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21870	Continued From page 164 The AD confirmed resident council meetings minutes and follow up forms in July, August, and September. AD stated she didn't always feel like residents received a straight answer for why their call lights were not being answered, and what was going to be done to fix the problem. Review of facility policy Resident Council/Family Council dated 4/1/08, identified when a resident group exists, the facility must listen to their views and act upon their concerns and recommendations of residents concerning policy and operational decisions that affected resident care and quality of life. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that residents concerns are listened to and acted upon timely. The director of nursing or designee could review policy and procedures, train staff, monitor systems, interview residents and evaluate the process to assure the facility acts upon resident council grievances, specifically related to staffing concerns. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		