

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: LZGD

Facility ID: 00429

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): On March 22, 2013 and March 13, 2013 The Departments of Health and Public Safety completed Post Certification Reivists (PCR) and verified correction of deficiencies issued at the time of the standard survey, effective March 12, 2013. Refer to the CMS 2567b for both health and life safety code. Effective March 12, 2013, the facility is certified for 85 skilled nursing facility beds.	
17. SURVEYOR SIGNATURE <u>Robin Lewis, HFE NEII</u> 03/26/2013 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Mark Meath, Program Specialist</u> 05/22/2013 (L20)

19. DETERMINATION OF ELIGIBILITY <u> X </u> 1. Facility is Eligible to Participate <u> </u> 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 : _____
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FORM CMS-1539 (7-84) (Destroy Prior Editions)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5349

May 22, 2013

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

Dear Mr. Gustason:

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

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

Effective March 12, 2013 the above facility is certified for:

85 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

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

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

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

Sincerely,

A handwritten signature in black ink that reads "Mark Meath".

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 26, 2013

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

RE: Project Number S5349023, H5349019

Dear Mr. Gustason:

On February 21, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard, completed on February 1, 2013 that included an investigation of complaint number H5349019. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 22, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 13, 2013 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 February 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 12, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 1, 2013, effective March 12, 2013 and therefore remedies outlined in our letter to you dated February 21, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

A handwritten signature in black ink that reads "Mark Meath".

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5349r13.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245349	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/22/2013
Name of Facility STEWARTVILLE CARE CENTER		Street Address, City, State, Zip Code 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 03/12/2013	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 03/12/2013	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 03/12/2013
ID Prefix F0244 Reg. # 483.15(c)(6) LSC	Correction Completed 03/12/2013	ID Prefix F0246 Reg. # 483.15(e)(1) LSC	Correction Completed 03/12/2013	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 03/12/2013
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 03/12/2013	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 03/12/2013	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 03/12/2013
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 03/12/2013	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 03/12/2013	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 03/12/2013
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 03/12/2013	ID Prefix F0329 Reg. # 483.25(i) LSC	Correction Completed 03/12/2013	ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 03/12/2013

Reviewed By State Agency	Reviewed By MM/GPN	Date: 03/26/2013	Signature of Surveyor: 30238	Date: 03/22/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245349	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/22/2013
Name of Facility STEWARTVILLE CARE CENTER		Street Address, City, State, Zip Code 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4)	Item	(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix	F0356	Correction Completed	03/12/2013	ID Prefix	F0371	Correction Completed	03/12/2013	ID Prefix	F0441	Correction Completed	03/12/2013
Reg. #	483.30(e)			Reg. #	483.35(i)			Reg. #	483.65		
LSC				LSC				LSC			
Reviewed By _____ State Agency	Reviewed By _____			Date:	Signature of Surveyor:			Date:			
Reviewed By _____ CMS RO	Reviewed By _____			Date:	Signature of Surveyor:			Date:			
Followup to Survey Completed on: 2/1/2013				_____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO							

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245349	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 3/13/2013
Name of Facility STEWARTVILLE CARE CENTER		Street Address, City, State, Zip Code 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0054	Correction Completed 02/28/2013	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
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ MM/PS	Date: _____ 03/26/2013	Signature of Surveyor: _____ 25822	Date: _____ 03/13/2013		
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____		
Followup to Survey Completed on: 1/28/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table border="0"> <tr> <td>YES</td> <td>NO</td> </tr> </table>			YES	NO
YES	NO					

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245349	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/22/2013
Name of Facility STEWARTVILLE CARE CENTER		Street Address, City, State, Zip Code 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0311</u> Reg. # <u>483.25(a)(2)</u> LSC _____	Correction Completed 03/12/2013	ID Prefix <u>F0315</u> Reg. # <u>483.25(d)</u> LSC _____	Correction Completed 03/12/2013	ID Prefix <u>F0353</u> Reg. # <u>483.30(a)</u> LSC _____	Correction Completed 03/12/2013
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	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ MM/GPN	Date: _____ 03/26/2013	Signature of Surveyor: _____ 30238	Date: _____ 03/22/2013		
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____		
Followup to Survey Completed on: 2/1/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table border="0"> <tr> <td>YES</td> <td>NO</td> </tr> </table>			YES	NO
YES	NO					



Protecting, Maintaining and Improving the Health of Minnesotans

March 26, 2013

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

Re: Enclosed Reinspection Results - Project Number S5349023, H5349019

Dear Mr. Gustason:

On March 22, 2013 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 February 1, 2013, that included an investigation of complaint number H5349019 with orders received by you on February 22, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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 letter.

Sincerely,

A handwritten signature in cursive script that reads "Mark Meath".

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5349r13lic.rtf

3/26/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00429	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/22/2013
Name of Facility STEWARTVILLE CARE CENTER	Street Address, City, State, Zip Code 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>20555</u>	Correction Completed 03/12/2013	ID Prefix <u>20560</u>	Correction Completed 03/12/2013	ID Prefix <u>20565</u>	Correction Completed 03/12/2013
Reg. # <u>MN Rule 4658.0405 Subp. 1</u>		Reg. # <u>MN Rule 4658.0405 Subp. 2</u>		Reg. # <u>MN Rule 4658.0405 Subp. 3</u>	
LSC <u></u>		LSC <u></u>		LSC <u></u>	
ID Prefix <u>20800</u>	Correction Completed 03/12/2013	ID Prefix <u>20830</u>	Correction Completed 03/12/2013	ID Prefix <u>20895</u>	Correction Completed 03/12/2013
Reg. # <u>MN Rule 4658.0510 Subp. 1</u>		Reg. # <u>MN Rule 4658.0520 Subp. 1</u>		Reg. # <u>MN Rule 4658.0525 Subp. 2.B</u>	
LSC <u></u>		LSC <u></u>		LSC <u></u>	
ID Prefix <u>20900</u>	Correction Completed 03/12/2013	ID Prefix <u>20910</u>	Correction Completed 03/12/2013	ID Prefix <u>20915</u>	Correction Completed 03/12/2013
Reg. # <u>MN Rule 4658.0525 Subp. 3</u>		Reg. # <u>MN Rule 4658.0525 Subp. 5 A.I</u>		Reg. # <u>MN Rule 4658.0525 Subp. 6 A</u>	
LSC <u></u>		LSC <u></u>		LSC <u></u>	
ID Prefix <u>21015</u>	Correction Completed 03/12/2013	ID Prefix <u>21375</u>	Correction Completed 03/12/2013	ID Prefix <u>21535</u>	Correction Completed 03/12/2013
Reg. # <u>MN Rule 4658.0610 Subp. 7</u>		Reg. # <u>MN Rule 4658.0800 Subp. 1</u>		Reg. # <u>MN Rule 4658.1315 Subp.1 AB</u>	
LSC <u></u>		LSC <u></u>		LSC <u></u>	
ID Prefix <u>21565</u>	Correction Completed 03/12/2013	ID Prefix <u>21810</u>	Correction Completed 03/12/2013	ID Prefix <u>21870</u>	Correction Completed 03/12/2013
Reg. # <u>MN Rule 4658.1325 Subp. 4</u>		Reg. # <u>MN St. Statute 144.651 Subd. 6</u>		Reg. # <u>MN St. Statute 144.651 Subd. 1</u>	
LSC <u></u>		LSC <u></u>		LSC <u></u>	

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency	MM/GPN	03/26/2013	30238	03/22/2013
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
00429		3/22/2013
Name of Facility		Street Address, City, State, Zip Code
STEWARTVILLE CARE CENTER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(Y4)	Item	(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
		Correction				Correction					
		Completed				Completed					
ID Prefix	<u>21980</u>		<u>03/12/2013</u>	ID Prefix	<u>22000</u>		<u>03/12/2013</u>				
Reg. #	<u>MN St. Statute 626.557 Subd. 3</u>			Reg. #	<u>MN St. Statute 626.557 Subd.</u>						
LSC	<u></u>			LSC	<u></u>						

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency _____	MM/GPN	03/26/2013	30238	03/22/2013
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				
Followup to Survey Completed on: _____ 2/1/2013		_____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?		
		YES NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LZGD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00429

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245349		3. NAME AND ADDRESS OF FACILITY (L3) STEWARTVILLE CARE CENTER (L4) 120 FOURTH STREET NORTHEAST (L5) STEWARTVILLE, MN (L6) 55976		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 334740100		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE		FISCAL YEAR ENDING DATE: (L35) 04/30	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		6. DATE OF SURVEY 02/01/2013 (L34)		8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	
11. LTC PERIOD OF CERTIFICATION From (a): To (b):		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: <u>1.</u> Acceptable POC <u>2.</u> Technical Personnel <u>6.</u> Scope of Services Limit <u>3.</u> 24 Hour RN <u>7.</u> Medical Director <u>4.</u> 7-Day RN (Rural SNF) <u>8.</u> Patient Room Size <u>5.</u> Life Safety Code <u>9.</u> Beds/Room			
12.Total Facility Beds 85 (L18)		X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
13.Total Certified Beds 85 (L17)					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 85 (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):

At the time of the February 1, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. In addition, two complaints were investigated, complaint number H5439018 was not substantiated and complaint number H5349019 was substantiated. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Kyla Einertson, HPR SWS	Date : 03/12/2013 (L19)	18. STATE SURVEY AGENCY APPROVAL Mark Meath, Program Specialist	Date: 03/25/2013 (L20)
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate ____ 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
22. ORIGINAL DATE OF PARTICIPATION 09/01/1986 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)	26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active		
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)			
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9271

February 21, 2013

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

RE: Project Number S5349023, H5439018, H5439019

Dear Mr. Gustason:

On February 1, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 1, 2013 standard survey the Minnesota Department of Health completed an investigation of two complaint numbers H5439018 and H5439019. Complaint number H5439018 that was found to be unsubstantiated and complaint H5439018 was found to be substantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731

Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 13, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 13, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC 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,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 1, 2013 (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

Stewartville Care Center

February 21, 2013

Page 5

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 August 1, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

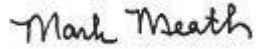
Telephone: (651) 201-7205

Fax: (651) 215-0541

Stewartville Care Center
February 21, 2013
Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Mark Meath". The signature is written in a cursive, slightly slanted style.

Mark Meath, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9796

Enclosure

cc: Licensing and Certification File

5349s13.rtf

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

RECEIVED

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ MN Dept of Health Rochester		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5439018 had not been substantiated during this survey. A complaint investigation/s had been completed at the time of the standard recertification survey and licensing survey. Investigation/s of complaint H5349019 had been completed and had been substantiated. Deficiency/s had been issued as a result of the substantiated findings at F311, F315 and F353.	F 000	STATEMENT of Compliance ATTACHMENT "A"		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by:	F 176	See ATTACHMENT #1	3-12-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Eugene L. Johnson

Administrator

3-4-13

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 COMPLIANCE

Stewartville Care Center has been providing high quality nursing home services to the community for the past 43 years. The facility's policies and procedures have been developed in accordance with State and Federal Regulations and community practice standards.

Stewartville Care Center objects to and disagrees with both the findings of noncompliance and the level of deficiencies cited.

Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agent or other individuals who draft or may be discussed in the Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by this Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency.

Accordingly, the Credible Allegation of Compliance is being submitted solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare and Medical Assistance programs.

The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegation of noncompliance or admissions by the Facility.

Attachment 1

483.10(n) Tag F176

Self-administration of Drugs

Stewartville Care Center respects the residents' right to self-administer drugs after the interdisciplinary team has determined that this practice is safe.

The policy for self-administration of medications was reviewed and found appropriate. Residents who prefer to take medications independently will be allowed to do so after 1) an assessment has been done showing the resident is capable of safely self-administering medications and 2) the physician has written an order for self-administration.

The care plan will reflect who will be responsible for storage, documentation, and the location of drug administration. The appropriateness of self-administration of drugs will be reviewed at least quarterly and more often as necessary.

During the February 26, 27 and 28, 2013 mandatory meetings, the nurses were reinstructed on the residents' right to self-administer medications and that residents are not to be left unattended during nebulizer treatment unless the interdisciplinary team has determined that the resident has the capability to safely self-administer nebulizers, self-administration of medications is addressed in the care plan, and there is a physician's order for self-administration. The records of all residents who are left unattended with nebulizers were audited to assure appropriate assessments, care planning and physician orders.

^{R19}
Resident number - A self-administration of medication assessment was completed. The resident is able to safely self-administer nebulizers that are set up and applied by the nursing staff. The nurse practitioner has written an order for resident to self-administer nebulizer treatments after set up by the nurse. The care plan has been reviewed and revised accordingly.

The Director of Nurses/designee will monitor compliance with self-administration of medication through observation and record review. Compliance will be monitored at the March Quality Assessment and Assurance Meeting.

Completion date: March 12, 2013

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

PRINTED: 02/27/2013
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <i>RECEIVED MAR 6 2013 MN Dept of Health</i>		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 176	Continued From page 1 Based on observation, interview and document review, the facility failed to determine if the practice of self-administration of a nebulizer medication utilizing a nebulizer machine was safe for 1 of 1 resident (R19) in the sample observed during medication pass. Findings include: R19 was left unattended in her room while receiving a nebulizer (inhalation) treatment. R19 did not have an order for self-administration of a nebulizer treatment and did not have an assessment to indicate if R19 was safe for self-administration of an inhaled medications. R19's diagnoses included: chronic obstructive pulmonary disease (COPD,) chronic cough, possible asthma, arthritis and joint pain. A physician order dated 12/13/12, directed staff to administer albuterol sulfate solution via a nebulizer four times a day. R19's care plan dated 12/11/12, indicated R19 had hearing and vision deficits, chronic joint pain involving shoulders, and restricted mobility and pain due to arthritis. R19's care plan indicated she required limited to extensive assistance of one staff with dressing, grooming and bathing. The care plan did not identify R19's ability or inability to safely self-administer medications. The significant change Minimum Data Set (MDS) dated 11/28/12, identified R19 as having hearing and vision impairment, and upper extremity impairment on both sides. On 1/28/13, at 11:15 a.m. licensed practical nurse (LPN)-A was observed to enter R19's room and	F 176			

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F 176	Continued From page 2 set up a nebulizer treatment. LPN-A handed R19 the prepared nebulizer and stated "I'll be back" and left the room. LPN-A was not present at any time during the treatment. During interview on 1/28/13, at 1:55 p.m. LPN-A verified R19 did not have an order for self-administration of a nebulizer treatment, and did not have an assessment to indicate if R19 was safe for self-administration. LPN-A stated "we usually put it on [nebulizer] and leave, there's no way we have time to stay in their room for 7 minutes." When interviewed on 1/28/13, at 2:10 p.m. the director of nursing (DON) indicated the expectation was that an assessment for self-administration of medication be completed when residents were left alone with a nebulizer treatment. DON verified R19 should have an assessment prior to self-administration of the nebulizer. Review of undated policy titled, Self-Administration of Medications, revealed the policy directed social services to inform each resident of their right to self-administer medications during the admission process. The policy further directed nursing staff to complete an initial assessment on self-administration of medications; the interdisciplinary team was then directed to evaluate the residents ability and judgment to self-administer medications. The policy further directed to obtain a physician's signature and inform the resident.	F 176			
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225	See ATTACHMENT # 2	3-12-13	

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

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F 225 SS=D	Continued From page 3 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225			

Attachment 2

Regulation 483.13(c) Tag F225 Staff Treatment of Residents

Stewartville Care Center policy requires that all alleged violations involving resident mistreatment, neglect, abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator and appropriate state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process.

Stewartville Care Center does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service in a resident care position are investigated and reported to the State nurse aid registry or licensing authorities.

The facility's policies and procedures for investigation/reporting of incidents were reviewed and found appropriate. The nursing assistant reporting the care concern was counseled on the importance of following facility abuse prevention plan with focus on immediate notification of the appropriate supervisory staff and/or state agency of suspected abuse, neglect, or misappropriation of property.

During the mandatory meetings February 26, 27 and 28, 2013, the staff will be instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirement for immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate government agencies and 5) the forms and procedures for appropriate and timely reporting. The staff are educated on vulnerable adult issues at least every twelve months; vulnerable adult reporting and investigation are addressed during new employee orientation.

Resident number 79 was interviewed by the Social Worker February 27, 2013 regarding satisfaction with her toileting schedule/cares. The resident reported that she has gotten to the bathroom in time. She preferred that the staff not be "quick" with cares and expressed desire for more small talk with the staff. The nursing staff were informed and the care plan has been updated accordingly.

The Social Worker will monitor compliance by auditing incident reports and tracking logs for timely and appropriate notification of the administrator and government agencies for the next month. If noncompliance is noted, additional auditing and training will be done. Compliance will be reviewed during the March and June 2013 Quality Assessment and Assurance Committee meeting and ongoing.

Completion date: March 12, 2013

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

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NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of abuse/neglect immediately for 1 of 4 residents (R79) reviewed for allegation of abuse/neglect in care. Findings include: R79 experienced neglect of care without immediate reporting of the incident to the administrator and state agency (SA) - the Office of Health Facility Complaints (OHFC). An allegation of abuse/neglect report dated 8/4/12, was reviewed for R79. The report indicated R79 had requested to be toileted several times and had not been toileted in a timely manner. This had resulted in the resident sitting in urine soaked clothes, on a urine soaked mechanical lift sling, with urine dripping onto the floor. According to the report, a nurse aide who witnessed the incident, had not reported the incident until 3 days later on 8/7/12. At that time, the nurse aide had reported it to the licensed social worker. The report identified the administrator, director of nursing, licensed social worker, and the State agency (OHFC) were notified on 8/7/12 (3 days after the incident). On 2/1/13 at 12:00 p.m., a licensed social worker (LSW) was interviewed regarding the vulnerable adult report of 8/4/12. The LSW verified the aide had not reported the incident for 3 days but should have according to the facility policy. At that same time, the director of nursing was also	F 225			

Attachment 3

Regulation 483.13(c) Tag F226 Staff Treatment of Residents

Stewartville Care Center has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures address the seven following components: screening, training, prevention, identification, investigation, protection, and reporting/response.

Stewartville Care Center staff recognizes and respects each resident's right to be free from maltreatment, neglect, and misappropriation of property and does all that is within its control to prevent such occurrences. The facility staff 1) identifies residents who are at risk for abuse, neglect, and/or misappropriation of property 2) develops intervention strategies to prevent occurrences and 3) routinely reassesses the effectiveness of the interventions and makes timely reports to the State agencies.

The policies addressing reporting and investigation of accidents/incidents were reviewed and found appropriate. The nursing assistant reporting the care concern was counseled on the importance of following facility abuse prevention plan with focus on immediate notification of the appropriate supervisory staff and/or state agency of suspected abuse, neglect, or misappropriation of property.

During the mandatory staff meetings February 26, 27 and 28, 2013 the *Vulnerable Adult Awareness and Prevention Plan* will be reviewed and the staff will be instructed on 1) the need to follow the abuse prevention policy 2) the types of incidents/accidents that need to be immediately reported to the administrative/supervisory staff and appropriate government agencies 3) procedures for notifying the administrative staff and government agencies and 4) necessary documentation related to the incident/accident.

Resident number 79 was interviewed by the Social Worker February 27, 2013 regarding satisfaction with her toileting schedule/cares. The resident reported that she has gotten to the bathroom in time. She preferred that the staff not be "quick" with cares and expressed desire for more small talk with the staff. The nursing staff were informed and the care plan has been updated accordingly.

To monitor compliance, the Social Service Director will review all incident reports for one month to determine whether the *Vulnerable Adult Awareness and Prevention Plan* was followed and incidents were reported in a timely manner. If problems are noted, additional monitoring and staff training will be done. Random monitoring will be ongoing. Compliance will be reviewed at the March and June 2013 quarterly Quality Assurance Committee meetings and ongoing.

Completion Date: March 12, 2013

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

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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 225	Continued From page 5	F 225			
F 226 SS=D	interviewed. She stated the aide involved had not been retrained about timely reporting. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their Vulnerable Adult/Abuse Prevention Policies for immediate reporting of allegations of resident abuse/neglect to the administrator and the State designated agency, for 1 of 4 residents (R79) in the sample reviewed for allegations of abuse/neglect. Findings include: A an allegation of abuse/neglect dated 8/4/12, was reviewed for R79. The allegation indicated R79 had requested to be toileted several times and had not been toileted in a timely manner. This had allegedly resulted in the resident sitting in urine soaked clothes, on a urine soaked mechanical lift sling, with urine dripping onto the floor. The report identified the administrator, director of nursing, and the State agency (office of health facility complaints- OHFC) were not notified until 8/7/12 (3 days after the incident). The facility's Vulnerable Adult Policies undated, were reviewed. The policies included: TABLE OF	F 226	See ATTACHMENT #3	3-12-13	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 6 CONTENTS: A. SCREENING B. TRAINING C. PREVENTION D. IDENTIFICATION E. REPORTING AND RESPONSE F. INVESTIGATIONS G. PROTECTION H. REPORTING ABUSE TO STATE AGENCIES & OTHER ENTITIES/INDIVIDUALS I. REPORTING SUSPECTED CASES AND /OR INCIDENTS OF RAPE J. INVESTIGATING UNEXPLAINED INJURIES K. VULNERABLE ADULT REPORTING OF ALLEGED MISAPPROPRIATION OF RESIDENT ' S PERSONAL PROPERTY L. RESIDENT-TO-RESIDENT ABUSE M. VISITATION. Under the headings B. TRAINING I. POLICY: IN-SERVICE TRAINING II. PURPOSE: All employees receive periodic in-service training relative to resident rights and our facility's abuse prevention program policies and procedures. E: I. POLICY: REPORTING/INVESTIGATING RESIDENT ACCIDENTS/INCIDENTS; PURPOSE: All accidents/incidents involving residents must be reported to the director of nursing services and immediately to the administrator. H. I. POLICY: REPORTING ABUSE TO STATE AGENCIES AND OTHER ENTITIES/INDIVIDUALS ; II. PURPOSE: All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies. On 2/1/13 at 12:00 p.m. a licensed social worker (LSW) was interviewed regarding the vulnerable adult report from 8/4/12. The LSW verified the aide had not not reported the incident for 3 days and should have according to their facility policy. The director of nursing was interviewed at that same time, she stated their had been no	F 226			

Attachment 4

Regulation 483.15(c)(6) Tag F244 Resident and Family Groups

Stewartville Care Center respects and promotes the existence of the Resident Council. The concerns and recommendations of the families and residents are reviewed and taken into consideration during decision-making and the development of policies and procedures affecting resident services. The facility attempts to accommodate the Councils' recommendations to the greatest extent possible.

The policies and procedures for communicating and addressing concerns voiced by the Resident Council members were reviewed and revised. The Resident Council meetings will be attended by the Social Worker who will facilitate discussions involving resident concerns. The Social Worker will communicate concerns to the appropriate department supervisors and track follow up and resolution of concerns. Minutes from the Resident Council meeting will now be electronically sent to all department supervisors for review; more detailed information will be provided as needed for supervisors to address concerns specific to their department.

The department supervisors have been instructed to address concerns in writing and report their actions/responses to the social worker and administrator in a timely manner. The social worker/designee will inform the resident of the response/resolution and monitor resident satisfaction with the results. Department supervisors and the administrator will continue to attend Resident Council meetings as requested. The resident/family are encouraged to express concerns during the quarterly care conferences and one-on-one social worker visits.

During the mandatory meetings February 26, 27, and 28, 2013, the staff will be reminded of the resident's right to have concerns reported and addressed in a timely manner and of the expectation that the care will be provided in a timely manner as outlined in the plan of care. To monitor timely response to call light audits will be done at various times daily for seven days then twice weekly for one month. If excessive delays in call light response are noted, additional auditing and staff training will be done. The dining room will be monitored one meal per day for seven days to assess whether meals are served in a timely manner. Staffing patterns and staff lunch/break times will be reassessed for appropriate allocation of resources and maximum availability of direct care staff.

To monitor compliance, the administrator will audit Resident Council minutes and internal electronic communication to assure that residents' concerns are being addressed in a timely manner and resolutions/responses are being reported to the Resident Council and/or specific residents as appropriate. Compliance will be addressed at the June 2013 Quality Assessment and Assurance Meeting.

Completion Date: March 12, 2013

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F 226	Continued From page 7	F 226			
F 244 SS=E	retraining done for the aide regarding timely reporting of allegations as indicated in their policy. 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility 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 prompt responses related to grievances of staffing concerns for 6 of 7 monthly resident council meeting minutes reviewed for resident council. Findings include: The facility did not respond appropriately to resident concerns related to sufficient staffing, as evidenced by resident council meeting minutes and interview with a resident council member. Resident council meeting minutes from meeting held between 6/26 and 12/27/12, were reviewed and revealed the following: The 6/26/12 resident council minutes indicated residents had voiced concerns regarding care not being as good as it used to be for both morning and evening shifts. The minutes did not reflect whether the facility had responded to the concern or discussed a plan for addressing this issue.	F 244	See ATTACHMENT # 4	3-12-13	

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F 244	Continued From page 8 The 7/31/12 resident council minutes indicated residents had voiced concerns regarding staff failure to answer call lights. The minutes did not address the previous month's concern regarding care nor did they reflect whether the facility had responded to the concern, or discussed a plan for addressing this issue. The 8/28/12 resident council minutes did not address the previous months's concerns nor did they reflect if the facility had discussed a plan for addressing this issue. The 9/25/12 resident council minutes reflected residents had voiced concerns regarding care being worse on the weekends, and on the East wing depending on which staff person was working. The minutes indicated a resident stated, "I sit all a.m. in wet clothes, don't get my bath till later." The minutes further indicated the director of nursing (DON) was to check assignment sheets to identify which staff person was responsible when the resident was left in wet clothing, and the DON directed residents to inform him if they were left to sit in wet clothing. The minutes did not reflect whether the facility had discussed a plan for addressing concerns regarding care being worse on the weekends. The 10/30/12 resident council minutes reflected residents continued to voice concerns regarding care including staff answering call lights, and assisting residents with going to bed timely. Residents reported when staff responded to call lights they [staff] had turned the call lights off, telling residents they would be right back, and then would not return for one hour or longer. The	F 244			

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F 244	Continued From page 9 minutes indicated the DON agreed East wing was heavy at that time, and the DON had reported the staff to resident ratio was one aide to 8-10 residents. The DON further reported that care level changed often on each wing, stating "if we have 80 residents and 8-9 staff they [staff] can't get you all up at a certain time." The minutes indicated the DON was to request the administrator to check call light times to identify concerns, and a discussion would be held with staff. The 11/27/12 resident council minutes reflected the administer was present at this meeting during which time a discussion was held between the administrator and residents regarding staffing concerns which resulted in unsatisfactory care. The minutes indicated the administrator had stated, "this summer our census went down to 72-73. We did not cut staff hours [the] but need to now. They will try to maintain 2 aides per wing except north. If any issues arise because of that, talk to brad or Nicole." The administrator reported the rehab program had been cut, however nursing was to help with walking residents. The administrator further reported that therapy may become involved if a decline in condition was identified. The administrator had stated, "we try to keep 1 to 10 for aides and 1-20 for nurses but call ins affect that." The minutes indicated a resident had stated, "sometimes on p.m.'s there is only 1 girl working it. The care is not good. Some are here for a paycheck. Some are good but more are not." The administrator had responded by stating, "it's just like your own checkbook, if there is not enough money, you have to make adjustments." Another resident stated, "we have to wait so long in the dining room, to be served."	F 244			

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F 244	Continued From page 10 The administrator responded by stating, "we are raising money right now for a new van, ours has over 250,000 miles on it." The minutes reflected the DON asked if there were questions related to rehab, at which time a resident had stated, "why do we wait so for meals." The DON had responded, "they are served at these times: Breakfast 7 a.m., lunch 11:30 a.m., supper 5:00 p.m." The minutes did not reflect whether the facility had discussed a plan for addressing this issue. The resident council minutes from 12/27/12, indicated residents continued to voice concerns regarding care including having to wait in the dining room, not receiving their snacks, and not receiving their medications. The minutes indicated residents had stated, "care was bad, then worse now it has hit rock bottom!" and "they dress me, they throw my dirty clothes on the ground then run over them with my easy up." The DON had reported he would talk one on one to the resident who had reported cares as being rock bottom, not receiving snacks or medication when needed. The minutes did not reflect whether the facility had discussed a plan for addressing these issues. R10, who had attended six of the seven resident council meetings was interviewed on 1/29/13, at 10:45 a.m. R10 was unable to recall whether the facility had responded to grievances regarding staffing concerns, stating "I think they talk to everyone separately." R10 verified the facility had not discussed at the council meetings what actions had been taken related staffing concerns. During interview with the activities director (AD)	F 244			

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F 244	Continued From page 11 on 1/30/13, at 1:00 p.m. the AD was unable to report what the formal grievance process was. The AD indicated hand written notes were taken during the meetings and then typed. The AD indicated concerns were highlighted and given to each department. The AD was unable to report how each department handles grievances. During interview on 1/30/13, at 1:15 p.m. the DON stated there was no formal process for following up on grievances. The DON stated that if a concern is related to the nursing department he would talk to the resident who had the concern individually. The DON indicated he did not recall the concern voiced at the 12/27/12, meeting regarding the resident who had voiced specific concerns regarding snacks, Tylenol and clothing being thrown on the floor. During interview on 1/30/13, at 3:33 p.m. the administrator verified a call light audit had not been completed. The administrator stated he has not done a call light audit for "6-8 months." The administrator reported he had no access to do one at this time. During interview on 1/31/13, at 9:20 a.m. R10 stated, "if something needs to be fixed they talk to you and say they fixed it but I don't know if it gets fixed." R10 further stated, "I don't know if things get done or not." During interview on 1/31/13, at 12:05 p.m. the DON stated he had not received a resident council concern form recently. The DON stated, "so I have not filled one out." During interview on 2/01/13, at 3:24 p.m. the	F 244			

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F 244	Continued From page 12 administrator stated the AD was responsible for recording minutes at resident council meetings. He stated if residents voiced grievances, the AD was to write the grievances out and pass them to the administrator as well as to each department involved. The administrator stated the DON would then address the grievances. The administrator also verified the accuracy of the resident council meeting minutes from 6/26/12 to 12/27/12, and further verified he did not know whether or not the grievances were addressed. Review of the Resident Council Concern Policy, dated 6/2009, revealed when writing minutes a Resident Council action form will be written for each concern or problem and directed to the department involved. The policy indicated there would be a time frame to allow each department to follow through with the concerns then the form was to be returned to activities before the next council meeting. The form and response will be shared at the next resident council meeting. The facility was unable to produce documentation that would identify whether the above grievances had been addressed.	F 244			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	See ATTACHMENT # 5	3-12-13	

Attachment 5

Regulation 483.15(e)(1) Tag F246 Accommodation of Needs

Stewartville Care Center assures that individual needs are accommodated and that each resident receives services with reasonable accommodations of their needs and preferences.

A comprehensive assessment is completed for each resident upon admission and with a significant change in condition which identifies resident preferences regarding meals, bathing, social interactions, and leisure pursuits. The goal is to provide services based on a plan of care that assists the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the greatest extent possible in accordance with the resident's life long patterns and preferences.

During the mandatory meetings February 26, 27 and 28, 2013, the nursing staff were reminded of the resident's right to have their preferences respected and that all staff is responsible for communicating the resident's preferences to the charge nurse or appropriate department supervisor. The plan of care will be updated accordingly.

Resident number 72 – The resident was interviewed by the staff and verified that he generally prefers to get up at 4:30 a.m., his lifelong pattern. The nurse aid care sheets and the resident's care plan were updated accordingly.

Adherence to the resident's expressed preferences will be monitored by the social worker during the interdisciplinary care conferences and one-to-one visits with the residents. The staff will be notified of preferences and the care plan will be updated accordingly. Compliance will be reviewed during the March and June 2013 Quality Assessment and Assurance Meeting.

Completion Date: March 12, 2013

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F 246	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate preferences of early rising for 1 of 1 resident (R72) who preferred to get up early in the mornings. Findings include: R72 was not given a choice of when to get up in the morning. R72's annual minimum data set assessment (MDS) dated 12/4/12, identified the resident's cognitive status was alert and oriented with no impairment; activities of daily living required extensive assist of one staff for all of them except eating, and the resident had a diagnoses of Parkinson's Disease. The MDS did not address a question regarding what time a resident may want to get up in the morning. Resident council notes were reviewed and did not identify any complaints from R72 although the resident had indicated it was brought up in resident council meetings. The social service notes dated 7/2, 8/23, 11/16 and 12/18/12 were reviewed. None of the notes identified concerns regarding the resident's preference about getting up in the morning. R72's care plan dated 12/18/12, was reviewed. The care plan indicated the resident had a strong identification with past roles as a farmer and community member. R72 has lived at the care center for two years but continues to long for independence back at the farm, where the	F 246			

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F 246	Continued From page 14 resident enjoyed spending time alone with the land and the animals. The notes indicated that R72 understands that Parkinsons disease is a progressive disease and felt at times there was not much to look forward to. The care plan did not address customary routine preferences for getting up early in the morning. On 1/29/13 at 10:43 a.m., R72 was interviewed. During the interview, when questioned about choice of time to get up in the mornings, R72 stated, the "Don't get me up early enough. When I ask they refuse to do it. I want to get up at 4:30 a.m. I was a farmer all my life and got up to milk cows. They get me up between 6 and 7 a.m. I prefer to get up at 4:30 a.m. I could take a nap at noon then if I got tired. In my recliner." On 1/31/13 at 7:00 a.m., nurse aide (NA)-A was interviewed about getting R72 up in the mornings. She stated that sometimes they get R72 up right when they get there at 5:30 a.m.. The aide stated she knew R72 had requested the night staff to get up at 4:30 a.m. but they couldn't because it was "too early". She also stated R72 could put the light on when ready to get up. On 1/31/13 at 12:40 PM, the licensed social worker (LSW) was interviewed regarding the resident's choice of getting up in the mornings. The LSW stated the activity director (AD) completed the initial customary routine section of the assessment which would identify that. The LSW said she didn't recall the resident saying anything about getting up early in the morning during resident council, but said R72 had only come once or twice this past year. The LSW stated she wasn't aware of this being an issue.	F 246			

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F 246	Continued From page 15 She indicated there was no reason why they couldn't get R72 up when the resident wanted to get up. In addition, the LSW stated that R72 would usually let her know when there is an issue but hadn't said anything. On 1/31/13 at 4:20 p.m, the AD was interviewed regarding resident preferences for arising in the a.m. She indicated she just asked the residents what time they want to go to bed and stated, "after a while you just know who wants to get up and who wants to stay in bed." The AD said the nurse aides should probably be telling the nurses. On 1/31/13 at 4:30 p.m., licensed practical nurse (LPN)-A stated, "Residents can get up as early as they like. No restrictions on how early they can get up. Initially ask them on admission. If nurse aides find out they tell their charge nurse and the nurses put it on the care plan and let everyone know." On 1/31/13 at 4:44 p.m., the director of nursing (DON) was interviewed regarding resident preferences for getting up in the mornings. He stated it was by resident choice, and that they try to keep staff on the same units so they know the residents. He stated he would expect staff to get residents up when they would like to get up and he would have no problems with that. The DON stated the residents should be allowed to get up per their customary routine. He said they try to assess routines within the first couple of days to learn what the preferences are and what works for that resident.	F 246			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	See ATTACHMENT #6	3-12-13	

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F 279	Continued From page 16 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 interview and document review, the facility failed to develop a plan of care for 1 of 3 residents (R99) reviewed for range of motion services. Findings include: R99 lacked development of a care plan for a restorative nursing/range of motion and ambulation program per physical and occupational therapy recommendations. R99 was admitted on 9/12/12, with diagnoses that included: stroke with hemiparesis, aphasia,	F 279			

Attachment 6

Regulation 483.20(d,k) Tag F279 Comprehensive Care Plans

Stewartville Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services.

The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. At the time of admission, a temporary care plan is implemented; the interdisciplinary care plan is developed within seven days after completion of the comprehensive assessment.

During the mandatory meetings February 26, 27, and 28, 2013, the nursing staff were 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents' care plans must be current at all times and 3) instructed that care plans must address restorative services such as ambulation and range of motion exercises.

Resident number 99 - The resident's need for restorative services has been reassessed. The resident will continue to be routinely walked and receive right upper extremity range of motion exercises. The staff have been informed of the restorative services and the care plan has been updated accordingly.

A schedule has been developed that assigns charge nurse reviews and updates of the care plans including ambulation and range of motion exercises. As part of the quarterly care conference process, the interdisciplinary team continues to review the care plans for completeness, accuracy, and relevancy. Monitoring and compliance will be reviewed during the March and June 2013 Quality Assessment and Assurance Committee meeting.

Completion Date: March 12, 2013

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F 279	Continued From page 17 aortic valve disorder, depressive disorder, congestive heart failure and Alzheimer's disease. During an observation on 1/30/13 at 4:43 p.m., R99 was observed during a transfer from a sitting position to a standing position. R99 was observed to walk fifteen feet into the bathroom with the assist of staff holding onto the gait belt. Review of the significant change Minimum Data Set (MDS) dated 12/15/12, revealed moderately impaired decision making skills for daily living, extensive assist with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. The MDS did not indicate use of restorative nursing programs. The care plan dated 12/19/12, lacked care plan interventions for range of motion/restorative nursing. A Maintenance/Restorative Program for Mobility Deficits dated 11/30/12, indicated the resident was to have the following: ambulation three to four times a day with front wheeled walker, minimal assist of one, length of the hallway. Range of motion (ROM) seated leg kick, marching and side stepping, daily for 10-15 reps [repetitions]. The Maintenance/Restorative Program for Mobility Deficits dated 1/9/12, indicated the resident was to receive ROM to right shoulder and elbow. Approximate minutes to complete: 5-10. During an interview with nursing assistant (NA)-C on 1/31/13 at 2:20 p.m., NA-C stated staff had a sheet that indicated R99 was to be walked every day. NA-C verified R99 was on a walking	F 279			

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F 279	Continued From page 18 program, but was unaware R99 was to receive ROM exercises. During an interview on 1/31/13 at 4:26 p.m., the director of nursing (DON) confirmed the care plan for R99 failed to identify the ROM exercises or ambulation program. The DON verified these programs should have been a part of the care plan for R99.	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 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan	F 280	See ATTACHMENT # 7		3-12-13

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F 280	Continued From page 19 was revised to include recent falls and interventions for 3 of 3 residents, (R63, R86 and R106) who had falls, and failed to update the care plan for 1 of 1 resident (R99) reviewed for behavioral and emotional status. Findings include: R106 lacked a revision of the care plan following falls, to identify falls and new interventions to minimize the risk of further falls. R106 was admitted to the facility on 11/30/12, with diagnoses including: osteoporosis, Parkinsonism, secondary, mild cognitive impairment, hallucinations, pain, hypertension and lewy bodies dementia. The last fall assessment was dated 11/30/12, and indicated R106 was a new admission, was at moderate risk for falls, had a fall risk score of 27, and was receiving therapy as ordered. Falls were identified 12/17/12 and 1/20/13. Review of R106's care plan dated 12/18/12, identified problem areas including: "MOBILITY- is usually independent with all mobility, uses a walker and is participating in OT (Occupational) and PT (physical therapy) had a couple of falls prior to admission". The goal included, R106 will "continue to be independent in all mobility, and will have no falls or injury." The approaches were identified as: "Staff to allow to be independent in bed mobility, repositioning, transfers, and ambulation - assist only if needed. Staff to allow to be independent in walking - using a walker. Staff to allow to transfer independently. Assist only if needed." R106's care plan had not been	F 280			

Attachment 7

Regulation 483.20 (d)(3) 483.10(k)(2) Tag F280 Comprehensive Care Plans

Stewartville Care Center staff routinely develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents' functional abilities and quality of life. The residents and their family/legal representative are encouraged to participate in the care planning process and care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary.

During the mandatory meeting February 26, 27 and 28, 2013, the nursing staff were reminded of the requirement that the residents' care plans be current at all times and reinstructed on the facility policies for care plan reviews and updates especially related to falls and behavior symptoms.

Resident number 106 – The resident's falls and safety interventions have been reassessed by a registered nurse. The resident's care plan has been updated to reflect recent falls and current safety interventions.

Resident number 63 - The resident was discharged to a long term care facility closer to her family on February 14, 2013.

Resident number 86 - The resident's falls and safety interventions have been reassessed by a registered nurse. The resident's care plan has been updated to reflect recent falls and current safety interventions.

Resident number 99 - The resident's behaviors including refusal of cares and physical and verbal abuse towards others have been reassessed. The care plan has been updated to include interventions to manage the behaviors.

A schedule has been developed that assigns charge nurse reviews and updates of the care plans including fall frequency, safety devices, behaviors, and behavior management interventions. As part of the quarterly care conference process, the interdisciplinary team continues to review the care plans for completeness, accuracy, and relevancy. Monitoring and compliance will be reviewed during the March and June 2013 Quality Assessment and Assurance Committee meeting.

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F 280	Continued From page 20 revised to include dates of fall or fall prevention interventions. On 2/1/13 at 9:16 a.m. registered nurse (RN)-A was interviewed. RN-A confirmed it would be the responsibility of the nurse on duty to update the care plan with the date of the fall, and any new interventions that were put into place to prevent further falls. RN-A verified R106's care plan had not been updated to reflect falls and interventions put into place to prevent further falls. On 2/1/13 at 9:33 a.m. the director of nursing (DON) verified staff should be updating the care plans with dates of falls and new interventions that were put into place following a fall. The DON stated, "I am aware they are not doing that". My expectation is the nurses should be updating the care plan as events occur. The DON confirmed the care plan for R106 had not been updated to include the falls or new interventions that were put into place on 12/17/12 and 1/20/13. R63 had four falls occur between 12/16/12 and 1/6/13, and the resident's care plan was not revised to reflect the falls or the interventions to be implemented for fall prevention. R63 was admitted 8/11/10 with diagnoses which included: restless leg syndrome, joint pain, congestive heart failure, heart disease and obesity. R63's quarterly minimum data set assessment dated 12/20/12 identified the resident as cognitively alert and oriented. The resident required extensive assist of one staff for mobility,	F 280			

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F 280	Continued From page 21 transfer, dressing, bathing, and ambulation in the corridor. A discharge assessment after hospitalization on 12/27/12 identified the resident with moderate cognitive impairment, short term memory loss and delirium. On 1/29/13 at 4:30 p.m., R63 was observed up in the wheelchair with a box alarm clipped to the wheelchair and the resident. A floor alarm mat was not observed to be in place next to the bed. On 1/30/13 at 1:00 p.m., R63 was observed in the bedroom in the wheelchair eating dinner. The alarm box was not on the wheelchair but was setting on the cabinet next to bed. In addition, a floor mat was at the end of the bed. At 1:40 p.m., the resident was observed to have been taken upstairs to bingo. The box alarm was observed to have been placed on the wheelchair. At 3:45 p.m., R63 remained upstairs in the dining room in the wheelchair. The box alarm was in place on the wheelchair. At 6:20 p.m., R63 was observed up in the wheelchair, having supper in the bedroom, with the alarm attached. On 1/31/13 at 7:00 a.m., R63 was observed in bed sleeping. A mat alarm was observed to be in place on the floor next to the bed, and another alarm was observed to be attached to the bed and resident. On 2/1/13 at 2:10 p.m., R63 was in the dining room playing games with 3 other women. The alarm was attached to her blouse and to the wheelchair. A physician's order dated 1/10/13, identified the use of a clip alarm and floor alarm.	F 280			

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F 280	Continued From page 22 A nurse's progress note dated 1/3/13, identified the resident as having more confusion. The note indicated the resident had a floor alarm on in her room, and a clip alarm on while in the wheelchair. R63's care plan with start date 4/25/12 was reviewed. While the care plan indicated R63 had had a history of falls, and a fall was identified as having occurred 11/15/12, the care plan had not been revised to address the use of alarms (mat and wheelchair), or the more recent falls the resident had experienced. On 2/1/13 at 8:15 a.m., the assistant director of nursing (ADON) was interviewed regarding the alarms used for R63. She indicated the resident was on a falls prevention program. She stated the program included applying interventions to alert staff when the resident got up, reinforcing the resident to use the call light, reminders to call for help, and also indicated that if the resident was in bed, the floor mat alarm was to be used. The ADON said when the resident was up, the wheelchair alarm should be on at all times. The resident's care plan did not address the resident's most recent falls with interventions or the falls prevention program. On 2/1/13 at 3:10 p.m., the ADON was interviewed. The resident's current care plan was reviewed with the ADON. She verified the care plan had not been revised to address the recent falls or interventions they were using. R86 had a lap belt intervention added for fall precaution, and the care plan had not been	F 280			

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F 280	Continued From page 23 revised to include the lap belt. R86 was admitted on 3/21/12, with diagnoses that included: dementia with Lewy Body and Parkinsons disease. During review of fall interventions in place, it was noted that the use of a lap belt had been initiated on 1/15/13, but had not been added to the care plan. During observation on 1/30/13 at 1:34 p.m., R86 was sitting in the lobby in a wheelchair with a lap belt attached on the wheelchair. At 4:09 p.m., R86 was sitting in lobby having a manicure and the lap belt was present on the wheelchair. During an interview with LPN-G on 2/1/13 at 11:31 a.m., LPN- G stated R86 had frequent falls recently and that they staff had attempted multiple interventions including, moving R86 to a room closer to the nurses' station, mat on floor, alarms and most recently had added the use of a lap belt. LPN-G verified R86 was able to remove the lap belt upon command and that it was only used when R86 was in the wheelchair. LPN-G stated the expectation would be the lap belt would be care planned. During interview on 1/30/13 at 5:51 p.m., the assistant director of nursing (ADON) verified the lap belt had not been care planned and should have been. R99 lacked a revision of the care plan to include behaviors related to refusal of care and physical and verbal abuse towards others. R99 was admitted on 9/12/12, with diagnoses that included: stroke with hemiparesis, aphasia,	F 280			

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F 280	Continued From page 24 aortic valve disorder, depressive disorder, congestive heart failure and Alzheimer ' s disease. Review of a significant change Minimum Data Set (MDS) dated 12/15/12, revealed R99 displayed behavior of physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, rejection of care and other behavioral symptoms not directed towards others. The care plan dated 12/19/12, lacked identification of, and interventions for, these behaviors. R99's plan of care dated 12/19/12, included identification of the resident's use of psychoactive medications and history of depression however, the only approaches included: administer medication as ordered, take soon after meal or snack. DISCUS to be completed every six months. Observe for side/adverse effects. Although the significant change MDS dated 12/15/12, indicated the resident had verbal and physical behaviors and refused care, the care plan had not been revised to include interventions for modifying these behaviors. On 2/1/13 at 2:26 p.m., the licensed social worker (LSW), was interviewed and verified the care plan for R99 had not been revised to include interventions for dealing with the behaviors of rejection of care, physical abuse towards others, or being disruptive to the environment. The LSW confirmed the care plan should have been revised to include R99's behaviors.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	See ATTACHMENT # 8		3-12-13

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F 282	Continued From page 25 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 document review and interview, the facility failed to follow the care plan for providing range of motion (ROM) services for 2 of 3 residents (R58, R33) reviewed who required range of motion, and failed to reposition a resident according to the care plan for 1 of 3 residents (R64) reviewed for positioning. Findings include: R58 did not received range of motion exercise as directed by the care plan. R58's record was reviewed. The resident's diagnoses included Alzheimer's disease and dementia. R58's care plan identified problem areas including decreased ROM and Alzheimer's disease. The approaches included: to provide range of motion exercises to the affected extremities per physician orders. During stage I interview on 1/28/13 at 10:07 a.m., licensed practical nurse (LPN)-A indicated R58's hands were pretty fixed, but verified the resident had not received ROM exercises. During interview on 1/31/13 at 10:53 a.m., nursing assistant (NA)-I stated she had not been	F 282			

Attachment 8

Regulation 483.20(k)(3)(ii) Tag F282 Services by Qualified Personnel per Care Plan

Stewartville Care Center assures that services are provided that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary.

During the mandatory training meetings February 26, 27, and 28, 2013, the nursing staff were reminded/instructed that the plans of care must be followed and that job performance expectations include being aware of and following the resident's plan of care. The policies and procedures for 1) assessing the resident's need for repositioning and restorative services including range of motion exercises 2) assigning cares to the appropriate direct care staff and 3) documenting the provision of cares were reviewed. Retraining the licensed nurses on range of motion exercises with return demonstrations is in process. The *NA Assignment Sheet* has been modified to facilitate documentation of the repositioning intervals.

Resident number 58 – The resident's restorative care needs were reassessed; the licensed nurses will continue to provide range of motion exercises. The care plan was reviewed and updated accordingly.

Resident number 64 – The resident's skin risk factors were reassessed. The resident's weight is stable and skin is currently intact. The tissue tolerance evaluation indicates that the resident can tolerate an every three-hour repositioning schedule. The care plan has been updated to reflect every 2-3 hour repositioning which will correspond with the resident's every 2-3 hour toileting schedule. The resident's skin will continue to be assessed on a weekly basis as part of the bathing protocol. If skin issues are noted, the resident's repositioning schedule will be reassessed and the physician/nurse practitioner notified if appropriate.

Resident number 33 - The resident's restorative needs were reassessed; the licensed nurses were providing daily range of motion exercised until the resident was hospitalized February 22, 2013. Upon return from the hospital, the resident restorative needs will be reassessed and the care plan will be revised accordingly.

Compliance with repositioning intervals will be monitored by the charge nurses through observation of staff cares. Resident care observations will be assigned by the Director of Nurses/designee at least weekly for the next two months and then randomly thereafter. The times the resident was repositioned will be tracked using the *Resident Repositioning* auditing forms. Range of motion exercises will be monitored by the Assistant Director of Nursing through routine review of the treatment administration records. If noncompliance with the plan of care is noted, additional auditing and staff training will be done. Compliance will be reviewed at the March and June 2013 Quality Assessment and Assurance Meetings.

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F 282	Continued From page 26 trained to provide range of motion exercises and had not provided range of motion to residents. During interview on 1/31/13 at 11:05 a.m., registered nurse (RN)-C indicated the nursing assistants are responsible to provide the range of motion for residents since the restorative program had been discontinued in December 2012. RN-C indicated the nurse was responsible for overseeing the range of motion. During interview on 1/31/13 at 1:00 p.m., NA-K verified the nursing assistants don't do range of motion with the residents. NA-K stated that since the restorative program had been cut, she was not sure who was responsible for providing range of motion exercises. NA-I indicated nursing assistants don't have time to get the basics done none the less give the residents range of motion. During interview on 1/31/13 at 2:33 p.m., licensed practical nurse (LPN)-B indicated nursing assistants were responsible for range of motion. LPN-B verified no range of motion had been done with R58 today, because staff had been too busy. During interview on 1/31/13 at 2:46 p.m., the assistant director of nursing (ADON) confirmed the restorative program had been turned over to the nurses in December 2012. The ADON stated the ROM was on the treatment sheets and the nurses were responsible to ensure residents received their range of motion programs. The ADON verified R58 had a current order to receive ROM. R64 was not repositioned as the care plan directed.	F 282			

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F 282	Continued From page 27 R64's diagnoses included Parkinson's disease and dementia. The care plan dated 1/29/13, identified R64 as at risk for pressure ulcers and indicated the resident was supposed to be repositioned every three hours. During observation on 1/31/13 at 9:01 a.m., R64 was transferred from bed to a maxi chair and was wheeled to the dining room. At 09:30 a.m., R64 was wheeled out of the dining room and into the lobby by the bird aviary. R64 was still sitting in the maxi chair and was not repositioned. At 9:56 a.m. R64 remained in the maxi chair in the lobby. At 10:15 a.m. R64 was wheeled to the chapel for activities and had not been repositioned. At 11:09 a.m. R64 was wheeled back to the lobby by the aviary. At 11:25 a.m. R64 remained in the maxi chair in the lobby by the aviary. At 11:38 a.m. R64 was wheeled to the dining room. At 12:20 p.m., R64 remained in dining room sitting in the maxi chair. At 12:38 p.m., R 64 remained sitting in dining room eating lunch. At 12:47 p.m., R64 was wheeled to his room by nursing assistant (NA)-I. R64 remained sitting in the maxi chair and had not been repositioned. At 1:28 p.m., R64 remained sitting in maxi chair in room. At 1:34 p.m., NA-I came into the room with NA-K to assist with the transfer of R64 from the maxi chair into bed (4 hours and 33 minutes since last repositioned). During interview on 1/31/13 at 1:30 p.m., NA-I confirmed R64 was to be repositioned every two hours. NA-I indicated R64 got up late this morning sometime around 8:30 a.m., NA-I verified R64 should have been repositioned every two hours and had not been repositioned in a	F 282			

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F 282	Continued From page 28 timely manner. During interview on 1/31/13 at 12:19 p.m., licensed practical nurse (LPN)-C confirmed an assessment of the resident's tolerance to prolonged pressure (tissue tolerance) indicated R64 was to be repositioned every three hours. However, LPN-C also said she thought R64 was to be repositioned every three hours when lying and two hours when sitting. LPN-C stated she'd completed the last tissue tolerance assessment and indicated she had not gone past the two hour repositioning due to R64 being at a high risk for pressure ulcers. During interview on 2/1/13 at 7:10 a.m., the assistant director of nursing stated all residents are on a two hour repositioning schedule. During interview on 2/1/13 at 11:46 a.m., the director of nursing stated staff should be directed by the tissue tolerance assessment results, and based on the tissue tolerance a care plan was developed. R33 did not receive restorative nursing services for range of motion (ROM) and ambulation in accordance with the written care plan. R33 had diagnoses that included contracture of the right hand, lower extremity (LE) cerebral vascular disease, and hemiplegia. Review of the care plan dated 8/20/12, revealed R33 was at a greater than normal risk for falls	F 282			

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F 282	Continued From page 29 secondary to history of cerebral vascular accident resulting in unsteady gait. The care plan indicated R33 was to receive extensive assistance for all mobility related to weakness and gave direction for restorative nursing for walking and ROM per physicians order. The most current physician's orders gave direction for passive range of motion (PROM) to right arm and hand, and active range of motion (AROM) to LE daily. R33 was observed to receive cares on 1/29/13, 1/30/13 and 1/31/13, however no ROM service or ambulation was observed to have been provided. Review of the Restorative Nursing sheets revealed the following information: November 2012, R33 had ambulated 75 feet on 21 of the 30 days, and received ROM on 22 of the 30 days. October 2012, R33 had ambulated 75 feet on 19 of the 31 days, and received ROM on 21 of the 31 days. September 2012, R33 had ambulated 75 feet on 16 of the 30 days, and received ROM on 21 of the 30 days. August 2012, R33 had ambulated 75 feet on 26 of the 31 days, and received ROM on 28 of the 31 days. Daily Ambulation Sheets were reviewed from 12/1/12 to 1/21/13. These sheets revealed the resident was not included on the list directing staff	F 282			

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F 282	Continued From page 30 to ambulate. Review of treatment sheets from 12/1/12 to 1/31/12, identified R33 was to receive PROM to left arm and hand daily with a start date of 1/19/13. The sheets revealed R33 had been provided this on care on only four of the 12 days possible. During interview on 1/30/13, at 1:02 p.m. NA-D verified R33 had not received ROM services or ambulation stating, "we move as fast as possible but can't always get everything done." During interview on 1/30/13, at 2:55 p.m. LPN-A verified R33 had not received ROM services or ambulation. On 2/1/13, at 9:33 a.m. nursing assistant (NA)-E was interviewed. NA-E stated rehab nursing was discontinued in December. NA-E indicated a book was placed at each station with information regarding restorative nursing, however the book did not identify which resident was to receive ROM. NA-E verified R 33 was not on a walk list, and stated " she used to be when we had rehab aids. " NA-E further verified R33 had not	F 282			

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F 282	Continued From page 31 received ROM or ambulation services and NA-E was unable to report which residents were to receive ROM. On 2/1/13, at 3:56 p.m. the director of nursing (DON) indicated the floor nurse is responsible for providing ROM. DON verified R33 had not received ROM and stated the NA ' s would require training prior to providing ROM.	F 282			
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 walking programs were consistently implemented for 1 of 3 residents (R63) on a walking program. Findings include: R63 was not ambulated consistently according to recent therapy recommendations. R63's quarterly minimum data set (MDS) assessment dated 12/20/12 was reviewed. It identified the resident's cognitive status as alert and oriented. The MDS indicated the resident had some verbal and other behaviors, and rejection of care. The activities of daily living data indicated the resident required extensive assist of one staff for mobility, transfer, dressing, bathing, ambulation in corridor (only did 1-2 times in 7	F 311	See ATTACHMENT # 9	3-12-13	

Attachment 9

Regulation 483.25(a) Tag F311 Ambulation

Stewartville Care Center ensures that residents are provided appropriate treatment and services to achieve and maintain the highest level of functioning and well-being possible.

Based on the residents' comprehensive assessment, the facility provides services that not only maintain, but improve the level of function whenever possible, including the ability to ambulate. A plan of care is developed and implemented with the goal for the resident to reach optimal improvement or not deteriorate within the limits of 1) recognized pathology and the normal aging process and 2) the resident's right to refuse treatment.

During the quarterly interdisciplinary care plan review process and more often if necessary, all residents will continue to be assessed for the need for nursing rehabilitative/restorative cares including ambulation assistance. The appropriate level of services and the most effective approach to deliver the cares and services will be addressed.

Due to the need for intravenous medication (IV), resident number 63, was discharged February 14, 2013 to a facility that provides IV therapy.

During the February 26, 27, and 28, 2013 mandatory staff meetings the nursing staff will be informed 1) of the performance expectation to provide resident cares as directed in the individualized plan of care 2) that care plan should promote the highest practicable level of function 3) of the need to respect the residents' right to refuse cares/services 4) of the need to inform the resident of the risks of not following the plan of care and 5) of the necessary documentation related to nursing restorative services, especially ambulation.

Resident number 63 was discharged to a long term care facility closer to her family on February 14, 2013.

Residents whose restorative nursing plan of care includes assistance with ambulation are listed on the nursing assistant *Daily Ambulation Schedule* tracking form. Compliance with the ambulation care plan will be monitored by the Assistant Director of Nurses through review of the ambulation tracking forms. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be monitored at the June Quality Assessment and Assurance Meeting.

Completion Date: March 12, 2013

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F 311	Continued From page 32 days), used a walker and wheelchair. A therapy to nursing communication written by the physical therapist (PT) dated 1/16/13 was reviewed. It included: "please walk pt (patient) 3x every day with fww (front wheeled walker), assist x1, w/c (wheelchair) following distance as tolerated (60-100 ft). Pt to walk to/from Bathroom with fww & assist x1." The daily ambulation schedule for the week of 1/14 to 1/20/13 indicated R63 had walked in room twice a day (a.m. and p.m.) Monday through Friday, not on Saturday in the morning or afternoon, and that R63 had refused Sunday in the morning and afternoon. For the week of 1/21 to 1/27/13, on Monday the resident only ambulated once in the afternoon, on Tuesday only once in the afternoon, on Wednesday ambulated twice, on Thursday did not ambulate all day, and on Friday ambulated both morning and afternoon. For Saturday, the resident did not ambulate at all and for Sunday the resident had only ambulated one time. The records indicated the ambulation provided did not follow the PT's recommendations of 3 x day. There was no documentation of how far the resident had ambulated, or when the resident was ambulated. The documentation did indicate the resident had ambulated to the bathroom, but did not identify when or if the resident was ambulated in the hall. On 1/31/13 at 2:35 p.m., the PT was interviewed. The PT indicated R63 had started therapy on 12/31/12 for basic transfer skill development and short distance walking. The resident had refused to go on a program and had therapy on and off related to that. The PT stated R63 had emotional	F 311			

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F 311	Continued From page 33 issues when he'd found out he could possibly need an amputation of a leg related to non-healing ulcers. The resident had refused any specific program they'd tried to develop. The resident had subsequently been discontinued to nursing with the recommendation to walk as tolerated 3x/day as documented on 1/16/13. The PT stated if the resident was not participating with nursing, or if nursing sees a decline, R63 should come back to us. The PT indicated she hadn't heard anything since the resident had been discharged from therapy about any issues. The PT stated, "every single session we had with the resident we explained the risks and benefits of not ambulating. The resident did not have insight into the importance of continuing to ambulate with the walker. At discharge from therapy, the resident was able to ambulate up to 128 feet with the fww, but we recommended an average of 60-100 ft. and the resident could easily walk that. It should be out in the hallway and not just to the bathroom and back. We had R63 on a schedule when R63 did have therapy, but the resident would never be ready or had an excuse of why he wouldn't do it. Needed much encouragement." R63's care plan with problem start date of 4/24/12 was reviewed. The care plan indicated the resident would often refuse assist for ambulation by staff. "Uses walker and can walk in room. Usually does not walk in hallway." Interventions included: "One staff to walk with resident using a walker if resident requests. Usually walks independently in room but has had falls." The care plan was not updated after the resident was seen by physical therapy and was recommended to ambulate 3 x day.	F 311			

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F 311	Continued From page 34 On 1/30/13 at 1:07 p.m., nursing assistant (NA)-D was interviewed and indicated the resident was transferred from the bed to the wheelchair by using the walker and only walked a few steps because R63 was so unsteady. On 1/30/13 at 5:00 p.m., R63's family member stated the Step down program was canceled in the facility. The family member stated R63 had been walking and standing with staff, but now was not doing it. The family member indicated the resident was not walking at all and stated the resident was walking a lot further before than he did now. As for the rehab program, the family member stated, "It stopped a few months ago and so (the resident) has declined. During this conversation the resident stated, "I am much worse than I was." The family member did acknowledge that the resident still refused at times. On 1/31/13 at 7:00 a.m., NA-A was interviewed. NA-A stated that during personal cares for the morning, the resident stood at the walker and did take 4 steps with the walker and then back to bed. NA-A was not heard to ask the resident to walk in the hall. When interviewed about ambulating the resident in the hallway, NA-A indicated the resident did not walk in the hallway because the resident refused. However, the resident was on the ambulation list. NA-A indicated they try to get R63 to ambulate in the room to and from the bathroom but the resident would not always do that either. NA-A stated the resident was a "little more confused."	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	See Attachment #10	3-12-13

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F 314	Continued From page 35 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services necessary to prevent pressure ulcers, including timely repositioning, for 1 of 3 residents (R64) reviewed for pressure ulcer risk. Findings include: R64, at risk for pressure ulcer development, was not offered or provided repositioning on 1/31/13 from 9:01 a.m. to 1:34 p.m. (4 hours and 33 minutes) according to the assessed needs. R64's diagnoses included Parkinson's disease and dementia. The care plan dated 1/29/13, identified R64 as at risk for pressure ulcers and indicated the resident was supposed to be repositioned every three hours. The quarterly Minimum Data Set dated 11/5/12 indicated R64 had short and long term memory loss and R64 was totally dependent with bed mobility and transfers with two plus staff and was at risk for pressure ulcers. The Braden Scale (a tool for predicting pressure ulcer risk) dated	F 314			

Attachment 10

Regulation 483.25 Tag F314 Pressure Sores

Based on the comprehensive assessment, Stewartville Care Center ensures that residents who enter the facility without pressure sores do not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure areas from developing.

The policies and procedures for comprehensively assessing the residents' skin condition and risk factors were reviewed and found appropriate. Based on the comprehensive skin assessment, care plans are developed that address and minimize risks of skin breakdown. The repositioning schedule is based on an analysis of the skin risk assessment, the results of the Bradens Scale for Predicting Pressure Ulcer Risk, and the tissue tolerance evaluation. The plans of care focus on services that maintain skin integrity and prevent pressure sores. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol.

Resident number 64 – The resident's skin risk factors were reassessed. The resident's weight is stable and skin is currently intact. The tissue tolerance evaluation indicates that the resident can tolerate an every three-hour repositioning schedule. The care plan has been updated to reflect every 2-3 hour repositioning which will correspond with the resident's every 2-3 hour toileting schedule. The resident's skin will continue to be assessed on a weekly basis as part of the bathing protocol. If skin issues are noted, the resident's repositioning schedule will be reassessed and the physician/nurse practitioner notified if appropriate.

Compliance with repositioning intervals will be monitored by the charge nurses through observation of staff cares. Resident care observations will be assigned by the Director of Nurses/designee at least weekly for the next two months and then randomly thereafter. The times the resident was repositioned will be tracked using the *Resident Repositioning* auditing forms. If noncompliance with the plan of care is noted, additional auditing and staff training will be done. Compliance will be reviewed at the March and June 2013 Quality Assessment and Assurance Meetings.

Completion date: March 12, 2013

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F 314	Continued From page 36 12/25/12, identified a total score of 12. The facility's assessment of the residents tissue response to prolonged pressure (Tissue Tolerance) dated 11/23/11, indicated R64 was dependent with positioning self in a sitting and lying position. Under observation report, a check was placed identifying R64 was to be repositioned every three hours sitting. The summary directed staff to use maxi chair with anti-pressure liner and to reposition within two hours. The care plan dated 1/29/13, identified R64 was at risk for pressure ulcers and was to be repositioned every three hours. During observation on 1/31/13 at 9:01 a.m., R64 was transferred from bed to a maxi chair and was wheeled to the dining room. At 09:30 a.m., R64 was wheeled out of the dining room and into the lobby by the bird aviary. R64 was still sitting in the maxi chair and was not repositioned. At 9:56 a.m. R64 remained in the maxi chair in the lobby. At 10:15 a.m. R64 was wheeled to the chapel for activities and had not been repositioned. At 11:09 a.m. R64 was wheeled back to the lobby by the aviary. At 11:25 a.m. R64 remained in the maxi chair in the lobby by the aviary. At 11:38 a.m. R64 was wheeled to the dining room. At 12:20 p.m., R64 remained in dining room sitting in the maxi chair. At 12:38 p.m., R 64 remained sitting in dining room eating lunch. At 12:47 p.m., R64 was wheeled to his room by nursing assistant (NA)-I. R64 remained sitting in the maxi chair and had not been repositioned. At 1:28 p.m., R64 remained sitting in maxi chair in room. At 1:34 p.m., NA-I came into the room with NA-K to assist with the transfer of R64 from the maxi chair into bed (4 hours and 33 minutes since last repositioned).	F 314			

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F 314	Continued From page 37 During interview on 1/31/13 at 1:30 p.m., NA-I confirmed R64 was to be repositioned every two hours. NA-I indicated R64 got up late this morning sometime around 8:30 a.m., NA-I verified R64 should have been repositioned every two hours and had not been repositioned in a timely manner. During interview on 1/31/13 at 12:19 p.m., licensed practical nurse (LPN)-C confirmed an assessment of the resident's tolerance to prolonged pressure (tissue tolerance) indicated R64 was to be repositioned every three hours. However, LPN-C also said she thought R64 was to be repositioned every three hours when lying and two hours when sitting. LPN-C stated she'd completed the last tissue tolerance assessment and indicated she had not gone past the two hour repositioning due to R64 being at a high risk for pressure ulcers. During interview on 2/1/13 at 7:10 a.m., the assistant director of nursing stated all residents are on a two hour repositioning schedule. During interview on 2/1/13 at 11:46 a.m., the director of nursing stated staff should be directed by the tissue tolerance assessment results, and based on the tissue tolerance a care plan was developed. During review of the undated policy titled, Tissue Tolerance Audit Policy and Procedure, the policy directed staff after the audit period was completed, the Tissue Tolerance Audits would be reviewed and an overall individualized turning and repositioning schedule would be determined for	F 314			

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F 314	Continued From page 38 lying and sitting position, care planned, added to the nursing assistant assignment sheets and communicated to the nursing assistants and appropriate staff.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide bladder and bowel services as assessed for 1 of 3 residents (R63) in the sample who had bladder and bowel incontinence. Findings include: R63 was not toileted timely or at a minimum every 2 hours. R63 had not been toileted from 2 hours to 3 hours during observations. R63 was admitted to the facility on 8/11/2010 with diagnoses that included but not limited to: history of urinary tract infection (UTI), pain in joints, diabetes, obesity, heart disease and congestive heart failure.	F 315	See Attachment # 11	3-12-13	

ATTACHMENT 11

Regulation 483.25 (d) Tag 315 Urinary Incontinence

Based on the resident's comprehensive assessment, Stewartville Care Center ensures that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is necessary and that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

The facility ensures that each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible.

The policies and procedures related to bladder function and toileting were reviewed. The *NA Assignment Sheet* has been revised to more clearly track cares related to toileting. During the mandatory educational meetings February 26, 27 and 28, 2013, the licensed nursing staff were reminded of the responsibility to be knowledgeable of and oversee implementation of the residents' individualized toileting plan of care. The certified nursing assistants were reminded that their performance expectation includes being aware of and following the resident's individualized plan of care for toileting.

Resident number 63 was discharged to a long term care facility closer to her family on February 14, 2013.

Compliance with the toileting schedules and plan of care will be monitored by the charge nurses through observation of staff cares. Resident care observations will be assigned by the Director of Nurses/designee at least weekly for the next two months and then randomly thereafter. The times the resident was toileted will be tracked using the *Resident Toileting Schedule* auditing forms. If noncompliance with the plan of care is noted, additional auditing and staff training will be done. Compliance will be reviewed at the March and June 2013 Quality Assessment and Assurance Meetings.

Completion Date: March 12, 2013

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F 315	Continued From page 39 R63's quarterly Minimum Data Set assessment dated 12/20/2012 identified the resident as cognitively alert and oriented. The resident required extensive assist of one staff for mobility, transfer, dressing, bathing, toileting, and ambulation in the corridor. A discharge assessment after hospitalization on 12/27/2012 identified the resident with moderate cognitive impairment, short term memory loss and delirium. On 1/30/2013 at 1:30 p.m., an activities assistant (AA) asked R63 if they wanted to go to BINGO. The resident replied "Yes", but stated, " I have to be changed first." At 1:40 p.m., the resident was changed for urinary incontinence episode and was taken upstairs to BINGO. The resident remained at bingo until 4:20 p.m., when a family (F1) member returned R63 to their room. The family member put on the resident's call light to request assistance for the resident to be toileted. At 5 p.m., the F1 said that R63 " had to poop " and had been waiting since 4:20 p.m. when the call light was put on but not staff help came to the room. F1 then assisted R63 to the toilet without staff assistance. R63 went from 1:40 p.m. until 5:00 p.m. a total of 3 hours and 20 minutes without being assisted or offered to be toileted. R63 was observed to be in the wheelchair from 5:00 p.m. until 7:30 p.m. (a total of 2.5 hours) without any staff offering to assist the resident to toilet. At 7:30 p.m. nurse aide (NA)-F verified the resident had not been offered to use the toilet or checked for incontinence. A Bowel and bladder assessment dated 12/20/12 identified the resident with impaired mobility, dependent transfer with EZ stand, frequently	F 315			

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F 315	Continued From page 40 incontinent of bladder, clothes or incontinence pad wet, had diagnoses that included: CHF(congestive heart failure), CVA (stroke), diabetes, and falls. The resident was on antianxiety, antidepressant, diuretic, and narcotic analgesic medications. The assessment also noted urinary incontinence without sensation of urine loss, scheduled toileting, and will call for assist. R63's care plan dated with problem start date of 4/25/2012 for frequently incontinent of bladder was reviewed. The problem indicated the resident wore Attends (an adult incontinent pad.) The resident was alert and oriented and able to use the call light for assistance to use the toilet. The resident will call for assist as needed and at times may need to be reminded that the Attends needs to be changed related to odor. A note dated 1/3/2013 said that the R63 ' s cognition had changed to more confusion. On 1/31/2013 at 7:00 a.m., NA-A was interviewed regarding R63's urinary and incontinence. She indicated the staff check on the resident every 2 hours. The resident will go to the bathroom some days and other times will allow them to just check and change the incontinent pad if soiled. Also R63 had become more confused lately. On 1/31/2013 at 9:30 a.m., NA-E had been interviewed concerning R63 ' s toileting this a.m. and NA-E said the resident had been checked for incontinence by NA-A last at 7:15 a.m. and no one since then. From 9:30 a.m. to 10:00 a.m. no staff had asked R63 if they needed assistance with toileting or was incontinent of bladder or bowel. At 10:35 a.m. NA-E entered R63 ' s room	F 315			

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F 315	Continued From page 41 and asked if they needed to be toileted or had been soiled. R63 had not been toileted or asked if they needed to be changed of an incontinent episode since 7:15 a.m. or a total of 3 hours and 20 minutes. On 1/31/2013 at 10:35 a.m., NA-E verified she had just been into R63's room, for the first time since NA-A had checked R63 at 7:15 a.m., to check the resident for incontinence. On 2/1/2013 at 1:30 p.m., an assistant director of nursing (ADON) was interviewed regarding R63's F1 assisting the resident to the bathroom when staff weren't available. The ADON indicated the family member shouldn't be doing that and staff should be calling for help if they can't assist a resident to the toilet. The staff should be asking R63 every couple hours if the resident needed to be toileted.	F 315			
F 318 SS=D	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 interview and document review the facility failed to provide range of motion services for 3 of 3 residents (R58, R33, R99) reviewed for range of motion. Findings Include:	F 318	See ATTACHMENT # 12	3-12-13	

Attachment 12

Tag F318 483.25(e)(2) Tag F318 Range of Motion

Stewartville Care Center provides comprehensive care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of all residents. Stewartville Care Center staff ensures that residents who enter the facility without limited range of motion do not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

Based on the initial comprehensive assessment and routine subsequent reassessments, a resident with limited range of motion receives appropriate treatment and services to increase range of motion to the highest possible level and/or to prevent further limitation in range of motion.

The policies and procedures for providing nursing restorative range of motion (ROM) exercised were reviewed and revised. The ROM plan of care is based on physical/occupational therapist recommendations and a nursing assessment of the resident's function status. Restorative ROM exercises are provided by the licensed staff and are documented and tracked on the treatment administration record. Appropriate referrals to the physician and/or therapist are made if there is a decline in function.

During the mandatory training meetings February 26, 27, and 28, 2013, the licensed nursing staff were instructed that the restorative plans of care must be followed and that job performance expectations include being aware of and following the resident's plan of care. The policies and procedures for 1) assessing the resident's need for restorative services including range of motion exercises and 2) documenting the services provided were reviewed. Retraining of the licensed nurses on range of motion exercises with return demonstrations is in process.

Resident number 99 - The resident's need for restorative services has been reassessed. The licensed nurses will provide right upper extremity range of motion exercises and document the services on the treatment administration record. The care plan has been reviewed and revised accordingly.

Resident number 33 - The resident's restorative needs were reassessed; the licensed nurses were providing daily range of motion exercised until the resident was hospitalized February 22, 2013. Upon return from the hospital, the resident restorative needs will be reassessed and the care plan will be revised accordingly.

Resident number 58 – The resident's restorative care needs were reassessed; the licensed nurses will continue to provide range of motion exercises. The care plan was reviewed and updated accordingly.

Range of motion exercises will be monitored by the Assistant Director of Nursing through routine review of the treatment administration records. If noncompliance with the plan of care is noted, additional auditing and staff training will be done. Compliance will be reviewed at the March and June 2013 Quality Assessment and Assurance Meetings.

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F 318	Continued From page 42 Resident (R99) lacked development of restorative nursing/range of motion and ambulation program per physical and occupational therapy recommendation. R99 was admitted on 9/12/2012, with diagnoses that included but are not limited to stroke with hemiparesis, aphasia, aortic valve disorder, depressive disorder, congestive heart failure and Alzheimer ' s disease. During an observation on 1/30/13 at 4:43 p.m., R99 was observed during a transfer from a sitting position to a standing position. R99 was observed to walk fifteen feet into the bathroom with assist of staff holding on the gait belt. Review of Significant Change Minimum Data Set (MDS) dated 12/15/12, revealed moderately impaired decision making skills for daily living, extensive assist with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. The MDS did not indicate use of restorative nursing programs. The Care plan dated 12/19/1012, lacked care plan interventions for range of motion/restorative nursing. Maintenance/Restorative Programs for Mobility Deficits dated 11/30/12, included ambulation three to four times a day with front wheeled walker, minimal assist of one, length of the hallway. Range of motion (ROM) seated leg kick, marching and side stepping, daily for 10-15 reps [repetitions]. Maintenance/Restorative Programs for Mobility Deficits dated 1/9/12, included ROM to right	F 318			

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F 318	Continued From page 43 shoulder and elbow. Approximate minutes to complete: 5-10. The physical therapist was interviewed on 1/31/13 at 1:21 p.m. and indicated when R99 was discharged from therapy on 11/30/12, recommendations were made for an ambulation and range of motion exercise program. She indicated the procedure was for therapy to hand over the Maintenance/Restorative Programs for Mobility Deficits to the nurses staff to implement for residents. Review of the December 2012 Treatments Flow sheet revealed the treatment sheets did not include the therapy recommended ROM for R99. Review of the January 2013 Treatments Flow sheet revealed the treatment sheet did include an order that indicated, " PT to provide daily ROM exercises of right hand, and both shoulders. X1 month per Dr. ... MD, once a day from 12/21/12 to 1/21/13. The treatment sheet had no initials for this order for the month of January and the order was not included on the December treatment sheet. The daily ambulation schedule was requested for the weeks of 11/30/12 to 1/28/13. For the time frame requested, the first week R99 was on the daily ambulation schedule was the week of 12/24/12. Therapy recommended the ambulation program for R99 on 11/30/12. The RESTORATIVE CARE-GIVING undated policy was reviewed. The procedure revealed staff are to provide each resident with an individual program involving interdisciplinary facility staff with measurable objectives,	F 318			

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F 318	Continued From page 44 interventions, appropriate documentation and periodic evaluation. Provide Skills practice that improves, maintains and prevents further decline. Facilitate and promote staff knowledge, understanding, application and implementation of the restorative care process on a continuous basis at all times with all residents. During an interview on 1/31/13 at 2:20 p.m., nursing assistant (NA)-C stated staff had a sheet that indicated R99 was to be walked every day. NA-C verified R99 was on a walking program and was unaware R99 was to receive ROM exercises. During an interview on 1/31/12 at 2:43 p.m., registered nurse (RN)-C verified the ROM exercises were not consistently being provided to residents in the facility. RN-C stated she, " tried to get to them when I can and the nursing assistants try to get to them when they can. A lot of it depends on the day. They are not getting done daily. If the facility had the number of staff we should have I think we would be able to get it done, but sometimes we have call ins and we need to make adjustments " . RN-C verified the treatment sheets for the month of January 2013 indicated R99 did not receive ROM services. RN-C was unable to locate any documentation on the December 2012 treatment sheet for R99 that indicated she was to receive ROM services. During an interview on 1/31/13 at 4:26 p.m., the director of nursing (DON) confirmed the ROM program with designated rehab nursing assistants had been discontinued. The DON indicated the nurses are responsible to complete the ROM exercises with residents and the nursing assistants are to complete the walking portion.	F 318			

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F 318	Continued From page 45 The DON stated, " The nursing assistants always walk the people, so I did not see a need for training. We provided the nurses with a copy ROM exercise to be done. The nurses on the unit should be monitoring on the unit to make sure the walk list are being completed and they need to track on the treatment sheets the ROM is being completed " . The DON confirmed the Treatments Flowsheets for December 2012 and January 2013 did not indicate R99 received ROM services. During an interview on 2/1/13 at 2:50 p.m. the assistant director of nursing (ADON) verified R99 was not placed onto the walking list to be walked until the week of 12/24/12. The ADON stated, " I am not sure why she wasn't on there before". R58 did not received range of motion (ROM) exercise as indicated by the plan of care. R58's record was reviewed. The resident's diagnoses included Alzheimer's disease and dementia. A quarterly Minimum Data Set (MDS) assessment dated 1/15/13, indicated R58 had short and long term memory deficit, was rarely understood, dependent with two plus staff with bed mobility and transfers, and as no impairment with functional limitation in ROM with upper and lower extremities. R58's current physician orders indicated the resident had ROM exercises daily by nursing. R58's treatment flow sheet identified the resident had a restorative nursing range of motion exercise program six days a week dated 12/12/12. During review of the December 2012 treatment flow sheets, it was identified there were	F 318			

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F 318	Continued From page 46 no directions for ROM to be completed. During review of the January 2013 treatment flow sheet there was a day with no staff initials verifying ROM was completed. R58's care plan identified problem areas including decreased ROM and Alzheimer's disease. The approaches included: to provide range of motion exercises to the affected extremities per physician orders. During stage I interview on 1/28/13 at 10:07 a.m., licensed practical nurse (LPN)-A indicated R58's hands were pretty fixed, but verified the resident had not received ROM exercises. During interview on 1/31/13 at 10:53 a.m., nursing assistant (NA)-I stated she had not been trained to provide range of motion exercises and had not provided range of motion to residents. During interview on 1/31/13 at 11:05 a.m., registered nurse (RN)-C indicated the nursing assistants are responsible to provide the range of motion for residents since the restorative program had been discontinued in December 2012. RN-C indicated the nurse was responsible for overseeing the range of motion. During interview on 1/31/13 at 1:00 p.m., NA-K verified the nursing assistants don't do range of motion with the residents. NA-K stated that since the restorative program had been cut, she was not sure who was responsible for providing range of motion exercises. NA-I indicated nursing assistants don't have time to get the basics done none the less give the residents range of motion.	F 318			

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F 318	Continued From page 47 During interview on 1/31/13 at 2:33 p.m., licensed practical nurse (LPN)-B indicated nursing assistants were responsible for range of motion. LPN-B verified no range of motion had been done with R58 today, because staff had been too busy. During interview on 1/31/13 at 2:46 p.m., the assistant director of nursing (ADON) confirmed the restorative program had been turned over to the nurses in December 2012. The ADON stated the ROM was on the treatment sheets and the nurses were responsible to ensure residents received their range of motion programs. The ADON verified R58 had a current order to receive ROM. During review of the facility's undated policy titled, ROM-PASSIVE, the purpose was identified as: A) to improve resident's joints through as full a range of motion as possible, B) to improve or maintain joint mobility, C) to prevent contracture. R33 did not receive restorative nursing services for range of motion (ROM) and ambulation as indicated. R33 had diagnoses that included contracture of the right hand, lower extremity (LE) cerebral vascular disease, and hemiplegia. During an observation on 1/29/13, at 11:34 a.m., R33 was observed to have a contracture of the right hand. The resident was not observed to utilize a splint or ROM services. R33 was observed to receive cares on 1/29/13, 1/30/13 and 1/31/13, however no ROM service or	F 318			

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F 318	Continued From page 48 ambulation was observed to have been provided. Review of the care plan dated 8/20/12, revealed R33 was at a greater than normal risk for falls secondary to history of cerebral vascular accident resulting in unsteady gait. The care plan indicated R33 was to receive extensive assistance for all mobility related to weakness and gave direction for restorative nursing for walking and ROM per physicians order. The most current physician's orders gave direction for passive range of motion (PROM) to right arm and hand, and active range of motion (AROM) to LE daily. Review of the Restorative Nursing sheets revealed the following information: November 2012, R33 had ambulated 75 feet on 21 of the 30 days, and received ROM on 22 of the 30 days. October 2012, R33 had ambulated 75 feet on 19 of the 31 days, and received ROM on 21 of the 31 days. September 2012, R33 had ambulated 75 feet on 16 of the 30 days, and received ROM on 21 of the 30 days. August 2012, R33 had ambulated 75 feet on 26 of the 31 days, and received ROM on 28 of the 31 days. Daily Ambulation Sheets were reviewed from 12/1/12 to 1/21/13. These sheets revealed the resident was not included on the list directing staff	F 318			

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F 318	Continued From page 49 to ambulate. Review of treatment sheets from 12/1/12 to 1/31/12, identified R33 was to receive PROM to left arm and hand daily with a start date of 1/19/13. The sheets revealed R33 had been provided this on care on only four of the 12 days possible. During interview on 1/30/13, at 1:02 p.m. NA-D verified R33 had not received ROM services or ambulation stating, "we move as fast as possible but can't always get everything done." During interview on 1/30/13, at 2:55 p.m. LPN-A verified R33 had not received ROM services or ambulation. On 2/1/13, at 9:33 a.m. nursing assistant (NA)-E was interviewed. NA-E stated rehab nursing was discontinued in December. NA-E indicated a book was placed at each station with information regarding restorative nursing, however the book did not identify which resident was to receive ROM. NA-E verified R 33 was not on a walk list, and stated " she used to be when we had rehab aids. " NA-E further verified R33 had not received ROM or ambulation services and NA-E was unable to report which residents were to receive ROM. On 2/1/13, at 3:56 p.m. the director of nursing (DON) indicated the floor nurse is responsible for providing ROM. DON verified R33 had not received ROM and stated the NA ' s would require training prior to providing ROM.	F 318			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	See ATTACHMENT # 13		3-12-13

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F 323	Continued From page 50 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident safety, reduce or prevent accidents, and thoroughly investigated all falls for 1 of 3 residents (R63) reviewed in the sample that had falls. Findings include: R63 had four falls between 12/16/2012 and 1/6/2013, the last fall on 1/6/13 R63 received facial and shoulder contusions from the fall, this fall had not been thoroughly investigated as to the root cause of the fall nor was the box alarm and floor mat alarm assessed to determine if it was effective as the resident had removed the box alarm so it would not sound when R63 wanted to move about the room R63's quarterly Minimum Data Set (MDS) assessment dated 12/20/12 was reviewed. It identified the resident's cognitive status as alert and oriented. Had some verbal and other behaviors, and often refused cares, The activities of daily living required extensive assist of one staff for mobility, transfer, dressing, bathing, ambulation in corridor (only did 1-2 times in 7	F 323			

Attachment 13

483.25 (h) Tag F323 Accidents

Stewartville Care Center ensures that the residents' environment remains safe and as free of accident hazards as possible. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues and implements procedures to prevent accidents and incidents.

The use of and need for safety devices for all residents are assessed at admission and reassessed during the quarterly interdisciplinary care conferences and whenever there is a change in the resident's behavior, physical condition, and/or mental function. The resident's care plan is modified as necessary to assure maximum safety and minimal risk of injury.

During the interdisciplinary safety meetings, the circumstances surrounding falls are reviewed, causal factors are investigated (need to toilet, pain, medication side effects, hunger/thirst, acute illnesses, etc.), the appropriateness and effectiveness of current safety interventions are reassessed, and the need for additional interventions is evaluated. Care plans are updated as necessary.

During the February 26, 27, and 28, 2013 mandatory meetings, the nursing staff were reinstructed on 1) the need for comprehensive fall and post-fall assessments 2) evaluating the effectiveness of the alerting safety devices and 3) the need to use of alert/alarm devices as outlined in the resident's safety plan of care.

Resident number 63 was discharged to a long term care facility closer to her family on February 14, 2013. The resident's safety issues have been reviewed and are being addressed as part of the facility's ongoing quality improvement program and staff education activities.

The Assistant Director of Nurses/designee will continue to facilitate investigation of falls and monitor compliance with appropriate alarm use through review of incident reports and resident records. The charge nurses will monitor for appropriate use of alarms by direct observation two times per week for three weeks. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the June Quality Assessment and Assurance Meeting.

Completion date: March 12, 2013

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F 323	Continued From page 51 days), used a walker and wheelchair. A discharge MDS dated 12/27/12 (re-admitted back to facility on 12/29/12) identified the resident as having moderate cognitive impairment, short term memory loss, with delirium. R63's accident incident reports dated 12/16/12, 12/25/12, 1/1/2013, and 1/6/13 were reviewed. The following was noted: On 12/16/12, the resident was found sitting on buttocks on floor beside the bed. The resident indicated slid off the bed and was trying to untangle the walker from the wheelchair. The fall assessment 12/16/2012 indicated no injury, neurological checks were completed, and drug review was done. The evaluation comments included: falls prevention program initiated, care plan updated. Resident was alert and able to use call light. Staff review use of call light and to arrange room and clutter. On 12/25/12, the resident slid self to floor from bed. No injuries. Sat up on edge of bed and slipped to the floor while reaching for something on the table. The fall assessment indicated neuro checks were done, mental status and contributing factors were reviewed, and drug review was completed. On 1/1/2013, the resident was found sitting on buttocks on floor beside bed. The blankets were underneath the resident. The resident told staff, slid off of the bed. The evaluation note read: will use clip and step on alarm to alert staff. Resident does not always used good judgment and wants to be independent. The falls assessment completed noted: severe pain, non-witnessed fall, neuro checks, mental status was identified as anxiety, confusion and restlessness. Recent change in medications and recent decline in activities of daily living abilities. Interventions of	F 323			

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F 323	Continued From page 52 immediate measures: bed alarm, analgesics, first aid and rest. On 1/6/2013, the resident was heard yelling. The resident was on floor; face down, in the area to the right of the foot of her bed. Stated they had been making the bed and became really dizzy and fell. The evaluation comments noted: bruise and nose bleed resolved. Continue to use clip and step alarm. Prefers to be independent, staff continue to encourage to use call light and are here to help the resident. Resident does not always have good safety judgment. The falls assessment noted: pain mild, abrasion, bruising, laceration, range of motion painful in upper extremity, neurological checks, mental status, contributing factors identified as recent change in medications, and drug review. Immediate interventions: chair wheelchair alarm, first aid, and rest. An interdisciplinary progress note dated 1/3/2013 was reviewed. It noted during Care conferences, the care plan was reviewed with no changes. The resident had more. Had floor alarm on in the bed room and clip alarm on while up in the wheelchair. A nurse 's noted dated 1/9/2013, identified the resident laying on edge of bed with legs hanging over the side. Later, clip alarm sounding resident was found standing at doorway asking staff how they can shut off the noise (in reference to the clip alarm.) On 1/12/2013, the note read: floor mat sounding resident stated was going to walk to the bathroom. On 1/28/2013 at 2:00 p.m., during interview with R63, the resident stated they had 2 alarms on. On observation, the floor mat alarm which was not turned on at this time. The second alarm had	F 323			

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F 323	Continued From page 53 been attached to the resident ' s dress and the box was lying on the bed. The resident stated, " I know how to take the alarm off. I haven't taken it off yet, but if I want to I will." On 1/29/2013 at 4:30 p.m., R63 was observed up in the wheelchair with the box alarm clipped to the wheelchair and the resident. The floor alarm mat was not down next to the bed but at the end of the bed. The resident indicated the staff mopped the floor and got the mat wet so it was drying. However, the mat was dry to the touch. On 1/30/2013 at 1:00 p.m., R63 was observed in the room in the wheelchair eating dinner. The alarm box was set on the cabinet next to bed and not connected to the resident. The floor mat was at the end of the bed and out of reach of the resident for use. The resident said they had to rearrange things. On 1/30/2013 at 1:07 p.m., a nurse aide (NA)-A was interviewed regarding the floor mat alarm not on and the alarm box not connected to the resident. NA-A stated the alarms are a new thing. R63 has had quite a few falls and that is when they added them. A NA-D was interviewed and stated the resident was to have them on but NA-D didn't notice it wasn't on when she delivered the resident ' s meal tray in there, or that the mat on the floor was moved to the end of the bed. On 1/30/2013 at 1:20 p.m., a licensed nurse (LPN)-B was interviewed regarding the alarm box not on the resident. LPN-B said it should be on the resident. Both LPN-B and this surveyor went down to the resident's room and found the alarm	F 323			

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F 323	Continued From page 54 on the cabinet. LPN-B then placed the alarm box on the wheelchair and to the residents clothing with it being turned on. LPN-B said they mostly used at night and when the resident was in bed. LPN-B said that he would inform the NA that they need to remember to have the box alarm attached to the resident. R63's care plan with date 4/25/2012 as initiation date for problem identified-the resident had been having staff assist with transfers by lifting legs and will often refuse assist for ambulation by staff. The resident used the walker and can walk in the room. The resident did not usually walk in the hallway. The resident may use a wheelchair for long distances and can wheel self some. R63 had a history of falls. Resident wishes not to have any more therapy. R63 may participate in restorative nursing for walking some days when offered. Interventions: one staff to assist to reposition in bed and in chair every 3 hours if needs help. One staff to assist to transfer into and out of bed and chair using walker, at resident's request. One staff to walk with the resident using a walker if the resident requested. R63 usually walked independently in room but has had falls. No information for use of box alarm or for the mat alarm use. It was noted that a Physician ' s order dated 1/10/13 for clip alarm (box alarm) and floor (mat) alarm. On 1/31/2013 at 1:00 p.m., the licensed social worker (LSW) was interviewed regarding the resident ' s falls. She stated the resident had been very self-reliant in decision making. R63 had significant change recently and was sent to the hospital due to having hallucinations and delusions and was declining in health.	F 323			

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F 323	Continued From page 55 On 2/1/2013 at 8:15 a.m., the assistant director of nursing (ADON) was interviewed regarding the fall prevention program for R63. ADON said the box alarm is to be used when the resident is up out of bed and when in bed the floor mat alarm is to be used at all times. On 2/1/2013 at 2:45 p.m., registered nurse (RN) -A was interviewed regarding the fall incident of 1/6/2013. RN-A stated she heard the resident yell when she was next door helping another resident. On entering R63 's room the box alarm was hanging off of the resident but not alarming and the mat with alarm was turned off and not alarming. Did not know if the resident had turned the alarms off or if the staff had not turned them on. RN-A continued to say the resident was sent to the emergency room due to injuries sustained from the fall. RN-A also verified the resident's care plan had not been updated to reflect current interventions such as the box and mat alarm use.	F 323			
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	See ATTACHMENT # 14		3-12-13

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F 329	Continued From page 56 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure as needed (PRN) pain medication had criteria and parameters for use, lacked documentation of effectiveness and non-pharmacological interventions were not used prior to use of the pain medication for 3 of 10 residents (R119, R105, R79) who received PRN pain medication, in addition the facility failed to monitor mood to determine if the antidepressant was effective for 1 of 10 residents (R105) currently receiving antidepressant medication. Findings include: R119 received Tramadol (pain medication) without clear parameters for dose use according to pain level. Also non-pharmacological interventions were not used prior to the use of Tramadol. R119 was admitted on 1/21/2013 with diagnoses which included: Lumbago (back pain.)	F 329			

Attachment 14

483.25(l) Tag F329 Unnecessary Drugs

Stewartville Care Center staff ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible.

Based on the resident's comprehensive assessment, Stewartville Care Center staff routinely identify target behaviors that justify the use of psychotropic medications. An effort is made to simplify medication regimens and discontinue psychotropic medications whenever possible. Guidelines/parameters are developed when two or more analgesics are prescribed or when psychotropic medications are prescribed on an as needed (PRN) basis. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during routine 30/60 day visits and more often as indicated.

At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licensed nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record continues to reflect adequate indications for use and that the dose tapering attempts are in compliance with regulatory guidelines. A behavior monitoring log is used to identify and quantify target behaviors justifying antipsychotic and antianxiety medication use.

The medication administration records have been modified to include 1) guidelines for administration when more than one analgesic or a variable dose analgesic is ordered and 2) designated space to record the reason for administering the medication/dose and the effectiveness of the medication. When an antidepressant medication dose is increased, behaviors will be tracked for seven days to monitor the effectiveness of the dosage change.

During the mandatory meetings February 26, 27, and 28, 2013, the licensed staff were instructed to 1) offer nonpharmacological interventions to manage pain and 2) check the administration parameters before administering a variable dose analgesic or deciding which medication to administer when more than one PRN analgesic is ordered. The need to monitor mood/behaviors after an increase in an antidepressant medication dosage was discussed.

Resident number 119 – The resident's pain management program was reviewed. Use of the variable dose analgesic will continue; parameters for use have been added to the medication administration record. The dose administered and the result/outcome will be recorded on the reverse side of the administration record. The resident will be offered nonpharmacological interventions for pain relief prior to administration of the analgesic.

Resident number 79 – The resident's pain management program was reviewed. Use of PRN Ultram will continue. The reason for the administering the medication and the result/outcome will be recorded on the reverse side of the medication administration record. The resident will be offered nonpharmacological interventions for pain relief prior to administration of the analgesic.

Resident number 105 – The resident pain management program was reviewed. Use of PRN Tylenol and Vicodin will continue; parameters for use have been added to the medication administration record. The medication administered and the result/outcome will be recorded on the reverse side of the administration record. The resident will be offered nonpharmacological interventions for pain relief prior to administration of the analgesic.

The resident's mood will be monitored on a daily basis for 30 days. The physician/nurse practitioner will be notified if the resident exhibits depressed mood. The social worker will complete a depression screen questionnaire every three months. The physician/nurse practitioner will be notified if symptoms of depression are noted. The consultant pharmacist will review the resident's medication regimen every 30 days

The Director of Nursing/designee will monitor for adequate documentation of parameters/effectiveness of PRN analgesic medication through routine record audits for one month. If noncompliance is noted, additional auditing and staff training will be done. On a monthly basis, the Consultant Pharmacist will monitor compliance with psychotropic medication monitoring and appropriate guidelines/parameters for PRN medications. Compliance will be reviewed during the June 2013 Quality Assessment and Assurance Committee meeting and ongoing.

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F 329	Continued From page 57 The physician orders dated 1/30/13 read: Tramadol 50 mg every a.m. orally and may take 0.5-1 mg tablets orally every 6 hours PRN for Lumbago. The 1/2013 medication sheets were reviewed and noted that Tramadol (Ultram) medication was used 5 times from 1/24/2013 to 1/30/2013 with each entry there was no dose recorded, three times there was no medication effectiveness recorded and on all four days there was no non-pharmacological interventions used prior to the use of the pain medication. Progress notes for those dates were reviewed and the following was noted for pain management: January 24, 2013, 25 mg of Ultram with some relief, no assessment of resident pain level; January 25, 2013, Tramadol given but nothing documented for effectiveness; January 26, 2013, Tramadol given and again no documentation of pain assessment or effectiveness of the medication; January 29, 2013, Tramadol given and documented it was for leg pain but did not include a pain assessment or effectiveness of the pain medication; January 30, 2013 Tramadol was given and no documented effectiveness of the pain medication or a pain assessment completed. On 1/30/2013 at 7:15 p.m., a licensed practical nurse (LPN)-C was interviewed regarding the use of the PRN Tramadol pain medication. LPN-C stated on a standard pain scale from 1-5 rating of resident 's pain , the lower dose was given and for the 6-10 rating the higher dose was given. LPN-C also indicated the physician should be identifying when to give which dose ordered. He indicated he gave the dosage according to his assessment of the resident need. He verified he	F 329			

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F 329	Continued From page 58 did not document the resident's response to pain level and also verified the medication sheet did not identify the dose amount that was given. On 1/31/2013 at 7:45 a.m., LPN-D was interviewed regarding the range of Tramadol pain medication for R119. LPN-D said they would do a pain rating level from the resident and if it was 1-5, the lesser dose would be given and if it was 6-10 on the scale then the larger dose would be given. LPN-D verified the standard criteria for rating pain wasn't on the resident's medication administration record and the parameters were not on the hospital dismissal summary as she had thought. LPN-D said that the physician should have been contacted to find out what parameters for the resident should have been. Dismissal Summary from the hospital dated 1/21/2013 noted Tramadol 50 mg 0.5-1 tab by mouth every 6 hours as needed (use sparingly.) On 2/1/2013 at 9:00 a.m., a registered nurse (RN)-A was interviewed concerning R119 's PRN Tramadol without parameters. RN-A indicated there were no criteria for determining which dose of the PRN pain medication to use. RN-A verified that the staff didn't document the effectiveness of the pain medication consistently but should have each time the pain medication was given. As far as non-pharmacological interventions attempted first, different things are tried but nothing was documented or tracked for any of the residents. R79 was on a PRN pain medication without consistent monitoring for effectiveness of the medication and lacked documentation of use of	F 329			

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F 329	Continued From page 59 non-pharmacological interventions prior to receiving the medication. R79 was admitted on 1/18/2012 with diagnoses which included fracture neck of femur. Physician orders identified R79 on Ultram (Tramadol) 100 mg every 6 hours PRN. Start date on 5/2012. The December 2012 and January 2013 medication sheets were reviewed. The resident was given the PRN Ultram pain medication 16 times in December and 15 times in January. Progress notes for December 2012 and January 2013 were reviewed. The December notes identified the pain medication was used 5 times (although medication sheet stated 16 times). The effectiveness was not always documented and nothing was documented to identify if non-pharmacological interventions were used prior to the administration of the pain medication. January notes identified the resident used the pain medication twice (although medication sheets identified 16 times.) On 2/1/2013 at 9:10 a.m., RN-A was interviewed on the PRN Ultram (Tramadol) use. RN-A reviewed the December 2012 and January 2013 medication sheets and nursing notes. RN-A verified all the times the Ultram medication was given there had not been documentation for effectiveness of the medication nor was there documentation of use of non-pharmacological interventions prior to administering the medication.	F 329			

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F 329	Continued From page 60 R105 was on two PRN pain medications without parameters/criteria for when to use one versus the other, nor was consistent monitoring for effectiveness of the medication recorded no documentation of use of non-pharmacological interventions prior to receiving the medication documented. R105 was admitted on 10/15/2012 with diagnoses which included below the left knee amputation and generalized pain. Physician orders identified R105 on Vicodin 5-500 mg one tab every 4-6 hours for pain and Tylenol extra strength 1000 mg every 6 hours PRN. Both pain medications were ordered on 10/15/2012. January 2013 medication sheets identified the resident was still receiving both of these medications. December 2012 and January 2013 medication sheets were reviewed. R105 received Tylenol 9 times and Vicodin (stronger pain medication) 9 times in December 2012. In January 2013, the resident received Tylenol 10 times and the Vicodin medication 14 times. There were no identified criteria or parameters of when to give which pain medication. January 2013 nursing progress notes were reviewed. Effectiveness of pain medication was not always documented. Non-pharmacological interventions were not documented as being attempted prior to the pain medication use. The documentation lacked assessment of the resident's pain level prior to the administration of the PRN pain medication. The resident went for	F 329			

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F 329	Continued From page 61 days at a time without any kind of pain medication (Tylenol or Vicodin). On some occasions the pain medication was given but nothing was documented regarding the complaint of pain by the resident. On 2/1/2013 at 9:00 a.m., RN-A was interviewed on when staff was to give the PRN Tylenol and when to give the Vicodin pain medication for R105. RN-A indicated when the resident's pain was less than 5 on a scale of 1 to 10 with 10 being the worst pain ever, she would give the tylenol and if it was at a 6 or more than she would give the Vicodin. RN-A checked R105 's 12/12 and 1/13 medication sheets for PRN use of pain medication and stated staff did not document the effectiveness of the pain medications when given. RN-A said they are to try non pharmacological pain relief interventions first but they had not been documented if effective. R105 had made comments about suicidal thoughts and had an increase in an antidepressant however, there had been no monitoring of mood symptoms to determine if the increase of the antidepressant was effective or not. Admitted 10/15/2012 with diagnoses that included: depressive disorder and recent amputation of the left leg below the knee. On 1/9/2013 a psychiatric consultation note from the hospital emergency room (ER) was reviewed. The resident had been reviewed for depression with suicidal ideations at emergency room visit.	F 329			

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F 329	Continued From page 62 Some of the notes of the ER visit noted the resident arrived with suicidal ideations. The resident had been feeling down lately and wanted to be euthanized with husband. Had also stated they wanted to take pills to end their life. R105 was returned to the facility and the doctor ordered an increase in Celexa (antidepressant) which was originally started on 12/21/2012. R105 's care plan with problem start date noted as 1/23/2013 was reviewed. Under cognition and mood, it noted: On 1/9/2013, R105 reported a plan to commit suicide by overdoing on pills. R105 reported having such thoughts for a while and being unable to stop them. Sent to ER for evaluation and returned same day. Celexa was increased at that time. Interventions included: If resident reports suicidal ideations report to the DON, SW and/or physician immediately and place resident on 15 minute checks. Interdisciplinary notes dated 1/10/2013 through 1/31/2013 were reviewed. The resident was monitored for three days with some shifts lacking documentation of suicidal thoughts. However, 15-30 minute checks on the resident were completed on paper. No further documentation regarding the suicidal ideation comments were provided. No other mood symptoms were monitored to determine if the increase of the antidepressant was effective. On 1/13/2013 at 9:30 a.m., RN-A was interviewed regarding the monitoring the resident for suicidal thoughts and mood symptoms. RN-A indicated staff used behavior monitoring sheets that were placed in the medication book. However, none	F 329			

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F 329	Continued From page 63 were found for the time period of 1/13 or beginning 2/13 med sheets.	F 329			
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently provide sufficient nursing staff to meet resident's needs in a timely manner for 11 of 21 residents (R79, R72, R10, R2, R91, R117, R61, R99, R103, 61, R79) in the sample; Ambulation was not provided as ordered for 1 of 3 residents (R63) reviewed for ambulation. In addition, observations on 1/29/13,	F 353	See ATTACHMENT # 15	3-12-13	

Attachment 15

Regulation 483.30(a) Tag F353 Sufficient 24-hour Staff

The goal of Stewartville Care Center is to have sufficient nursing staff available on a 24-hour basis to provide nursing and related services to enhance the residents' quality of life and to attain or maintain their highest practicable physical, mental, and psychosocial well-being as determined by their comprehensive assessments and individualized plans of care. On the Minnesota Department of Health and Human Services Nursing Home Report Card, the facility scores four out of five stars for hours of direct resident care. The state average is three stars.

With guidance from the Director of Nursing, the staff member responsible for scheduling assures that adequate nursing staff are available to meet the residents' care needs as well as the State case-mix requirements. The scheduler and the charge nurse have the authority to call for replacement staff whenever the regularly scheduled employees are unable to work their assigned shift.

The nursing home aggressively advertises to fill open nursing department positions. Additional staff continue to be recruited. The current staff recruitment challenges are reflective of those experienced by area facilities. The county's overall unemployment rate is low (4%) and there is high demand for nurses and nursing assistants due to the large health institutions in the Rochester area.

Staffing patterns were reviewed and revised; staffing patterns will continue to be assessed for maximum efficiency and efficacy in meeting residents' needs. Staff absenteeism will continue to be tracked; staff who consistently fail to work their scheduled hours will be counseled and/or disciplined. The facility is in negotiation with temporary staffing agencies to provide backup when employees are unavailable to fulfill scheduled shifts.

The Social Worker will interview residents number 79, 72, 10, 2, 61, 99, 61 and 79 regarding their satisfaction with cares and services. Concerns will be communicated to the administrator, nursing supervisory staff, and other members of the interdisciplinary care team as appropriate. The Social Workers will also monitor family/resident satisfaction during care conferences, surveys, resident/family council meetings and interviews. The Director of Nurses and supervisory nursing staff will continue to respond to resident/family concerns regarding nursing care and services.

To monitor compliance the Administrator will routinely review staffing levels/scheduling patterns, investigate complaints, and review resident and family council minutes for concerns regarding satisfaction with services.

Stewartville Care Center will continue with corrective actions and compliance monitoring as addressed in the responses to Tag F244 regarding prompt response to call lights, Tag F309 regarding range of motion and repositioning, Tag F311 regarding ambulation, and Tags F314 and F315 regarding repositioning and toileting.

Completion Date: March 12, 2013

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F 353	Continued From page 64 1/30/13 and 1/31/13 indicated insufficient staff available to meet resident care needs with the potential to affect all 77 residents in the facility. Findings include: Family member (F-A) requested not to be identified expressed concerns of insufficient staffing within the facility as evidenced by: During interview on 1/28/13, at 10:55 a.m., F-A stated the facility did not have enough nursing assistants to provide residents with the care and assistance they needed. F-A stated, "Quite often we have one girl [nursing assistant] on this wing, we need two to three on this wing, it is the heaviest wing, when there is only one she is run ragged." F-A indicated at night there had been times the wait for assistance was 15-20 minutes. F-A stated "I have called down to the desk because my husband gets out of bed and I cannot help him back to bed. I call before he has fallen. He has gotten to the bathroom and then I call the front desk." R79's diagnoses included depression, anxiety and cognitive impairment. The quarterly Minimum Data Set (MDS) dated 12/12/12, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated R79 had intact cognition. The MDS further revealed R79 showed no psychosis or behavioral problems, required extensive assist of one staff for dressing and hygiene and total assist of two staff for toileting. During interview on 1/28/13, at 10:12 a.m. R79 stated, "Don't have enough help, I have to wait a long time, I have waited an hour for help to go to	F 353			

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F 353	Continued From page 65 the bathroom, happens mostly during the day. I use a pad [for incontinence] but I can lie in that [soiled pad]for hours. I have had a bowel movement and urine [reference to soiled pad]. I get sores." R72's diagnoses included Parkinson's disease. The annual MDS dated 12/04/12, revealed a BIMS score of 15, which indicated intact cognition. The MDS further revealed R72 showed no psychosis or behavioral problems, required extensive assist of one staff for hygiene, transfers, dressing, and toileting. During interview on 1/29/13, at 10:51 a.m., R72 stated, "Sometimes it gets kinda short, had to wait too long for them to answer a light, sometimes its 20 minutes or more. Usually it's so I can get to the bathroom, I had an accident [reference to incontinence] a couple of times." R10's diagnoses included schizophrenia and generalized pain. The quarterly MDS dated 11/20/12, revealed a BIMS score of 15, which indicated R10 had intact cognition. The MDS further revealed R10 showed no psychosis or behavioral problems, required extensive assist of one staff for dressing, hygiene and toileting. During interview on 1/28/13, at 10:10 a.m., R10 indicated she required the E-Z stand (a mechanical transfer device) for transfers. R10 stated, "Sometimes I have to go to the bathroom so bad but mother nature doesn't understand that I have to wait." R10 reported she had been incontinent of urine and stool "many times" while waiting for staff assistance.	F 353			

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F 353	Continued From page 66 R2's diagnoses included leukemia, and cerebral palsy. The quarterly MDS dated 11/07/12, revealed a BIMS score of 15, which indicated R2 had intact cognition. The MDS further revealed R2 showed no psychosis or behavioral problems, required extensive assist of one staff for dressing, hygiene and toileting and extensive assist of one to two staff for transfers. During interview on 1/28/13, at 1:33 p.m., R2 stated, "Has never been as bad as it is now. I have been here 11 years. Administration is not nice to employees because cutting back too much. We are short. One nurse that helped didn't know how to use the Hoyer lifts and one aide didn't know anything. When you [referring to surveyor] come in we get all kinds of help on all shifts now. Lot of the employees have quit. One morning I put my light on, I had to go to the bathroom. From 20 minutes to 6:00 a.m. until 6:30 a.m. A nurse was outside the door, I hollered and nobody even come in or looked in. I wear a pad [for incontinence] because I take a water pill. There is one staff on for a hall, and nobody in dining room that helps feed. Residents play in the food." R91's diagnoses included hypertension and joint pain. The quarterly MDS dated 11/15/12, revealed a BIMS score of 11, which indicated R91 had moderately impaired cognition. The MDS further revealed R91 showed no psychosis or behavioral problems, required extensive assist of one staff for dressing, hygiene and toileting. During interview on 1/28/13, at 1:04 p.m., R91 stated, "There is not enough [in response to a question about sufficient staff] no, I have to wait	F 353			

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F 353	Continued From page 67 sometimes for staff to come, the longest is 20 minutes. I need help tying my shoes and need help after I am done in the bathroom." R117 was admitted to the facility on 1/15/13, for therapy following a fall at home. The Nursing admission note dated 1/15/13, indicated R117 was alert and oriented, and required moderate assist of 1-2 staff with gait belt, and pivot transfer on right leg. Review of BIMS dated 1/21/13 revealed a score of 15, which indicated R117 had intact cognition. During interview on 1/28/13, at 11:19 a.m., R117 stated, "I think they could use more staff, the ones they have are running their butts off. I have waited 1/2 hour and that is a long time when you have to go [reference to toileting need]." During interview on 1/30/13, at 1:02 p.m., nursing assistant (NA)-D reported range of motion (ROM) services were not provided to residents due to insufficient staffing. NA-D further stated residents did not receive timely assistance with toileting and repositioning. NA-D indicated the facility had been short on staff and stated, "We move as fast as possible but can't always get everything done." NA-D verified residents have been incontinent of both bladder and bowel because there was a delay in residents receiving toileting due to staff shortage. On 1/30/13 at 1:34 p.m., NA-H stated there are times when one NA is being assigned to an entire wing themselves because of staff call ins or just being scheduled for one because of being short.	F 353			

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F 353	Continued From page 68 An example was when a signup sheet was placed for staff to pick up an evening shift on a weekend. NA-H stated two staff members volunteered to pick up the evening shift, then the schedule came out and they had only one person assigned to west wing, when two staff members had offered to work. When asked how they provide assistance to residents who require assist of two staff with the Hoyer lift, NA-H responded the licensed nurses are to help but a lot of the nurses will not help you and you do the best you can even if you have to do it alone. NA-H said it is very stressful to get everything done and done safely for the residents. During interview on 1/30/13, at 1:25 p.m., the scheduling coordinator stated if changes are made to the schedule, such as a call ins, the changes are hand written on the schedule. Scheduling coordinator provided the staff schedules and daily assignment sheets dated October 2012 to 1/30/13. During interview on 1/30/13, at 2:50 p.m., licensed practical nurse (LPN)-F stated she did not feel there was enough staff to properly care for the residents. LPN-F stated, "How the residents are cared for depends on who is working, some staff are tired from working so much and upset so don't move as fast." LPN-F indicated staff had been skipping their breaks to make sure the residents are cared for. LPN-F further indicated the nurses are to help the NA's, however, they have been working short as well and had been required to split their time between two wings. LPN-F indicated ROM services had not been getting done.	F 353			

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F 353	Continued From page 69 During interview on 1/30/13, at 3:33 p.m. the administrator verified a call light audit had not been completed recently. Administrator stated he has not done a call light audit for "6-8 months." The administrator reported he had no access to do one at that time. During interview on 1/31/13, at 6:22 a.m. NA-I verified she felt there was not enough licensed nurses and nursing assistants within the facility to meet resident needs in a timely manner. NA-I stated, "They don't get toileted or repositioned on time, we do get them up thank God we have open breakfast." NA-I further stated, "Sometimes I come in and residents will say they haven't went to the bathroom since supper this is at 9 o'clock at night." NA-I indicated the facility had worked with one NA on evening shift consistently for the last 5 to 6 weeks, NA-I stated "I'm relieving one person when I come in at 9 p.m. one person with one person." NA-I said they usually are scheduled two NAs to a wing. During interview on 1/31/13, at 8:55 a.m., the scheduling coordinator verified frequent call-ins, and difficulty with filling shifts. Scheduling coordinator reported that the facility practice included staff were to fill out a slip when call-in occurred, then attempts were to be made to fill the open shift. Scheduling coordinator reported that the facility's practice for staffing days and evenings had been three nurses on the main floor and 2 in lower level (LL), two NA's on West Wing (WW,) one on North Wing (NW), two on East Wing (EW) and two in the LL. Scheduling coordinator reported the night shift is staffed with two nurses, one on each floor, three NA's on the main floor and one in LL. Scheduling coordinator	F 353			

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F 353	Continued From page 70 verified that some of the staff have been upset since restorative nursing had been cut. The scheduling coordinator stated she felt there had been enough staff if there were no call-ins, "The stuff the restorative aides did like range of motion I'm sure is not getting done." She verified it had been difficult to fill staff hours due to the call-ins and indicated the administrator had discussed using a nursing pool company to fill the open hours. It was verified the administrator had given the direction to contact a nursing pool company after the surveyors entered the building. During interview on 1/31/13, at 12:05 p.m. director of nursing (DON) verified frequent call-ins and verified the facility had cut restorative nursing. DON stated, "It would always be nice to have more help." During interview on 1/31/13, 2:55 p.m. LPN-A verified resident's ROM was not getting done. On 2/1/13, at 9:33 a.m. NA-E was interviewed and stated restorative nursing who was responsible to do ROM and ambulation services was discontinued in December 2012. NA-E indicated a book was placed at each station with information regarding restorative nursing, however, there had been no education regarding ROM and the book did not identify which resident was to receive ROM services. NA-E verified residents had not been walked and ROM had not been provided as they needed. NA-E was unable to report where she had found information directing resident care. NA-E stated, "Residents are transferred with one assist because we use the mechanical stand." NA-E further stated, "It's too busy to wait for help."	F 353			

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F 353	Continued From page 71 During interview on 2/1/13, at 3:37 p.m. the administrator stated the facility had been in the process of making changes regarding resident rooms between the main level and the LL, indicating the change had been difficult for staff and residents. He stated the facility had recently cut the restorative program and was aware staff and residents were unhappy with the decision. He then stated, "I'm trying to think of what to do, we just set the budget in nursing to do what's in place right now." He indicated the plan was to contact a pool nursing company, review, revise if needed, and enforce the absentee policy, review the procedure for two assist lifts, stating, "I'll have to sit down with [DON] to make sure the aides are trained properly." The administrator reported that he had attended a resident council meeting and had a discussion regarding finances and stated, "The perspective is this is their home, and we can't hire more people if you don't have the money." Administrator verified residents had voiced grievances regarding staffing during six of seven resident council meetings reviewed. During interview on 2/1/13, at 3:56 p.m., the DON stated the facility had been going through some staff changes which had been upsetting to residents and staff. DON stated the nurses had been responsible for providing ROM and was unaware the NA's were informed they were responsible. DON stated the NA's would require training prior to providing ROM, and indicated the expectation had been for the nurse to provide ROM. The nursing schedule reports from 1/15/13, through 1/28/13, revealed 13 of the 14 days had	F 353			

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F 353	Continued From page 72 changes to the schedule. Of the 13 days, changes were made on 11 due to nursing assistance absences which had not been replaced resulting in fewer staff to care for residents than had been scheduled. Resident council meeting minutes were reviewed from 6/26/12, to 12/27/12. At 6 of the 7 meetings, residents had voiced concerns related to not enough staff. There was no evidence of follow up to the residents about staffing concerns in the meeting minutes. Review of daily ambulation schedule, dated 12/10/12 to 1/21/13, revealed multiple areas of missing documentation which identified if the resident had walked with staff as well as multiple areas in which staff documented "refused" or "unable" without explanation. The schedule identified residents who required daily walking assist from staff and included day and evening shift for each wing on the main floor and the lower level. R61's call light was on from 10:25 a.m. to 11:10 a.m. on 1/28/13. No staff was observed in hallway during that time. R61 was sitting in wheelchair in room. At 11:00 a.m. a nurse aide walked by but did not stop to check on the residents need. At 11:05, surveyor went in to check with resident what they needed. The resident wanted a piece of gum because mouth was dry. Surveyor approached a licensed practical nurse (LPN)-D about the resident's request. According to LPN-D, the resident could have gum but they have to give it to the resident because otherwise the resident puts a lot in their mouth at one time and could choke. They keep it in the med cart.	F 353			

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F 353	Continued From page 73 The LPN then gave the resident a piece of gum. On 1/29/13, at 4:05 p.m., R99's mat alarm and chair alarm were sounding. No staff was in the area. R99 was observed standing up near the bed and was trying to shut the alarms off. R99 stated, "I can't do it they are noisy." At 4:09 p.m. no staff had responded or was in the vicinity of the resident room. An Activity staff was requested by surveyor to go in to R99's room and then heard the alarms going off. After surveyor intervention, the staff did go in the room and shut the alarms off and sat the resident down on the bed. The activity staff put the light on to get assistance and ten minutes later it was answered by a nursing assistant. A registered nurse (RN) -B was interviewed regarding R99 and stated the resident had a fall and that was why the alarms being used. RN-B indicated the resident was unsteady at times and did not like the alarms. At the time the alarms were sounding, two nurse aides were on the other end of the West hall, the LPN was in a room helping another resident to the bathroom and the registered nurse was busy admitting a resident. On 1/29/13 at 4:00 p.m., R103 requested to use the bathroom. R103 was sitting at the nurse's desk. RN-B asked R103 to wait a minute. R103 asked another nurse aide who also requested the resident to wait a minute. The resident continued to sit in the chair. A family member of another resident informed the staff that R103 needed to use the bathroom. At 4:20 p.m., RN-B assisted the resident to the bathroom after the resident got up from the chair and started ambulating toward the desk saying they needed to use the bathroom. RN-B stated there were 2 aides on the	F 353			

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F 353	Continued From page 74 lower level for wings, one LPN and herself. She was busy with an admission and the nurse practitioner was here. She indicated it was quite busy. R61's call light was on, on 1/29/13, from 4:10 p.m. until 4:35 p.m., when NA-B responded to R61 yelling, "Help! Help! Help me!" At 4:35 p.m., NA-B went in with the mechanical stand lift and took R61 to the bathroom. The resident had waited 25 minutes. R79's call light was turned on at 4:10 p.m. and not answered until 4:30 p.m. on 1/30/13. At 4:30 p.m., NA-B answered the light and R79 requested to get up. NA-B said to R79 it would be just a bit because she needed help with the lift. At 4:55 p.m., R79 received incontinence cares and assistance up into the wheelchair. R79 waited 45 minutes from the time she turned on her call light for assistance to get incontinence cares done and into her wheelchair. R63 was brought to the bedroom by F-A on 1/30/13, at 4:20 p.m. They put the bathroom light on at this time to get help for R63. At 4:40 p.m., F-C was looking for someone to help R63. NA-F was busy with R106 until 4:42 p.m. and NA-B was busy with R61. At 4:43 p.m., when NA-B went in to check on R63, F-A indicated the problem had already taken care of her. At 7:30 p.m., R63 was still up in the wheelchair. The staff had not approached the resident or offered toileting since 4:45 p.m. and it was learned that R63 was to be toileted or offered to be toileted at a minimum of every two hours according to their bladder assessment.	F 353			

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F 353	Continued From page 75 F-A, R63's family member was interviewed on 1/30/13 at 5:00 p.m., and stated the staffing is short. On Christmas day they had only one aide on the lower level for the day with only one nurse. F-A said they had to take R63 to the bathroom tonight because they had to "poop" and the staffing was short again. F-A said that R63 had a history of skin breakdown and doesn't want it to get bad again as it is good now. F-A also said that the walking program had been stopped for the past month or two. On 1/30/13, at 5:00 p.m., NA-B was interviewed and stated evening lunch breaks are at 4-4:30 p.m. and 4:30-5:00 p.m. during the time when everyone needed to be toileted and ready for supper. NA-B said they did not take a supper break as they had too much work to do. NA-B also indicated the nurse aides are called upstairs to help and it is very difficult to get everything done for twenty residents. R63 was ambulated 17 times, refused twice out of 42 opportunities from January 14 to 27, 2013. A therapy recommendation written for rehabilitative nursing by Physical Therapy (PT) dated 1/16/13, noted, "Please walk pt [patient R63] 3xday every day @ fww [front wheel walker], assist x1, w/c [wheelchair] following distance as tolerated (60-100 ft). Pt to walk to/from Bathroom @fww & assist x1." It was signed by the Physical therapist. The daily ambulation schedule for the week of 1/14/13 to 1/20/13, noted R63 walked in room	F 353			

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F 353	Continued From page 76 twice a day in a.m. and p.m. Monday through Friday, not on Saturday in the morning or afternoon and refused Sunday in the morning and afternoon. For the week of 1/21/13 to 1/27/13, on Monday R63 only ambulated once in the afternoon, on Tuesday only once in the afternoon, on Wednesday ambulated twice, on Thursday did not ambulate all day and on Friday ambulated both morning and afternoon. For Saturday, the resident did not ambulate and for Sunday the resident ambulated one time. The schedule did not follow the PT's recommendations of 3 x day. No documentation of how far the resident did ambulate when was ambulated was evident. Did note the resident ambulated to the bathroom, but did not identify when or if the resident was ambulated in the hall.	F 353			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	See ATTACHMENT # 16		3-12-13

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F 356	Continued From page 77 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post required staffing information on a daily basis. This had the potential to affect 77 of 77 residents living in the facility at the time of the initial tour. Findings include: During the initial facility tour on 1/28/13 at 6:45 a.m., the daily staff posting was dated 1/27/13. Registered nurse (RN)-A verified the daily staff posting was for the day before and was not current. RN-A indicated was unsure who was responsible for posting the daily staffing but thought the scheduler but was not in yet today. During interview on 1/28/13 at 9:30 a.m., the director of nursing verified the person responsible for the daily posting was not in the facility at the time of the tour and the new daily staff posting had not been posted. During interview on 1/30/13 at 2:10 p.m., the scheduler verified the daily staff posting was done each morning when came into the facility. On Friday, the scheduler would prepare the weekend postings and staff was responsible to put the	F 356			

Attachment 16

Regulation 483.30(e) Tag F356 Posted Nurse Staffing Information

Stewartville Care Center routinely posts the following information on a daily basis in a prominent location in a clear and readable format:

- (i) Facility name.
- (ii) The current date.
- (iii) The number of registered nurses, licensed practical nurses, and certified nursing assistants directly responsible for resident care per shift.
- (iv) Resident census.

The staff member responsible for providing the staffing data was instructed on the need for timely posting of information.

The Administrator/designee will monitor compliance by random audits of the timeliness of the posted information.

Completion Date: March 12, 2013

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F 356	Continued From page 78	F 356			
F 371 SS=F	posting out for the day. The scheduler discussed with the administrator about having the daily posting now posted by night shift for the day. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the dishwasher and ice machine was free from lime build-up. In addition, the facility failed to ensure employee food items were not stored in the facility cooler observed during the initial kitchen tour. This has the potential to affect all 77 residents in the facility. Findings include: The dishwasher and ice machine had lime build up upon initial tour of the kitchen. During initial tour on 1/28/13, at 7:15 a.m., observed lime build up on sides and front of dishwasher along with green and white build up and pinkish crumbles of unknown build up on top of dishwasher. Upon interview Cook-A confirmed the lime build up on the dishwasher and indicated it was supposed to be wiped down at night.	F 371	See ATTACHMENT # 17		3-12-13

Attachment 17

Regulation 483.35(I) Tag F371 Sanitary Conditions

The goal of Stewartville Care Center is to store, prepare, distribute, and serve food under sanitary conditions. To reduce the risk of food borne illnesses, the dietary and nursing staff are trained on safe food handling practices.

The policies and procedures related to sanitary food storage and equipment maintenance/cleaning were reviewed and revised. During the mandatory meeting February 25, 2013, the dietary department employees were instructed on the policies and procedures for food storage and cleaning of the dishwasher and ice machine. A log sheet has been developed to track cleaning of the dishwasher and ice machine.

The dietary manager will monitor compliance through random audits/observations of the cleaning logs, refrigerator contents, and cleanliness of the dishwasher and ice machine.

Completion Date: March 12, 2013

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F 371	Continued From page 79 Cook-A indicated there was no check off sheet to indicate if and when wiped down last. Noted also the Ice machine in the kitchen had lime build up on front and sides. Cook-A indicated maintenance does a good scrub down once a month and Cook-A indicated she wipes down every other day and the last day cleaned was 1/27/13, yesterday. Cook-A confirmed there was a lot of build up of lime on the ice machine on the front and the sides. During interview on 1/28/13, at 7:25 a.m., maintenance-A indicated the ice machine was cleaned once a month and the dishwasher was cleaned by maintenance every Thursday. Maintenance-A verified the lime build up was "pretty bad" on the top of the dishwasher. Maintenance-A indicated was unsure of who was responsible for cleaning between maintenance schedule of cleaning. and verified the lime builds up quickly. Upon review of maintenance check list exterior cleaning was last done on 1/3/13 and was scheduled every 6 months. During interview on 2/1/13 at 2:33 p.m. the dietary manager verified the ice machine and dishwasher. During review of undated policy titled MECHANICAL DISHWASHING PROCEDURE, the policy directed staff under l. after completion of dishwashing, the water should be emptied from the dish machine, strainers emptied and rinsed out and the inside of the machine should be wiped out. Under section n. dish machine will be delimed monthly by maintenance team, clean machine as for daily cleaning, add recommended amount of delimer, run machine two cycles, drain	F 371			

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F 371	Continued From page 80 machine and scrub as needed while machine is draining, rinse out machine and clean and polish exterior. During policy review of MANITOWOC B 450 ICE MACHINE MAINTENANCE dated 1/1/96, the policy directed staff to clean area around ice machine as often as necessary to maintain cleanliness and efficient operation, sponge dust dirt off outside with mild soap and water, wipe dry with soft clean cloth. An employee had personal non-pasteurized eggs in facility cooler. During the initial tour on 1/28/13, at 7:03 a.m., observed in the cooler what appeared to be a staff lunch box along with a dozen of brown eggs in an egg carton in a plastic bag. During interview with dietary aide-A at 7:05 a.m., it was verified that the lunch box belonged to a dietary staff member and that the dozen of eggs were eggs brought in from home. During interview on 2/1/13, at 2:33 p.m., the dietary manager indicated staff were allowed to keep their lunch coolers in the facility cooler but were not to bring in eggs to store in the facility cooler due to risk of contamination to the rest of the cooler. During review of undated policy titled RESIDENT & STAFF REFRIGERATOR indicated staff refrigerator was provided in the Staff Break room.	F 371			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	See ATTACHMENT # 18	3-12-13	

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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 81 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. (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:	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 82 Based on observation, interview and document review the facility failed to distribute ice water in a sanitary manner during 2 of 2 water pass observed on 2 of 2 floors. This had the potential to affect 77 of 77 residents. Findings include: During observation on 1/29/13, at 9:30 a.m., there was a cart sitting on the east hallway on the main floor by the small nursing station that contained water glasses, a bucket of ice with a lid on and ice scoop sitting on the ice inside of the bucket. During interview on 1/29/13, at 9:34 am, nursing assistant (NA)-I verified the scoop was sitting on the ice and NA-I indicated had always done it that way. NA-I stated that she was trained to keep the scoop in with the ice. The scoop was always in with the ice. During interview on 1/29/13, at 9:36 a.m., licensed practical nurse (LPN)-F verified the ice scoop was in with the ice and maybe should have something separate to put the scoop in but indicated did not pass ice water so not aware of the policy. During interview on 1/29/13, at 9:40 a.m., the director of nursing confirmed there should be a separate container for the scoop and the ice scoop was not to be kept in with the ice. During observation on 2/1/13, at 11 a.m., in lower level noted ice scoop sitting in ice bucket during the ice pass. During interview on 2/1/13, at 11:01 a.m., NA-J indicated probably should have had a cover on the ice and the ice scoop should be separate but verified was not the current practice. NA-J	F 441			

Attachment 18

Regulation 483.65(a) Tag F441 Infection Control

Stewartville Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate infection control procedures that will be implemented and 3) maintains a record of incidences of infections and tracks actions taken related to infection control.

The policies and procedures for distributing ice water to residents was reviewed and revised. All water pitchers are now filled with ice from the ice machine located in the kitchen. In accordance with facility policy, the ice scoop is stored in a container outside the kitchen ice machine. A bulk container is no longer used to transport ice to resident rooms.

The Dietary Manager will monitor filling of the ice water pitchers two times per week for one month. If noncompliance with infection control techniques is observed, additional monitoring and staff training will be done.

Completion Date: March 12, 2013

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

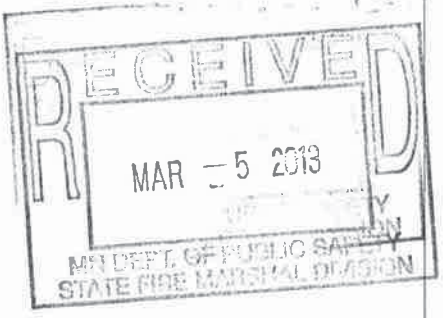
PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
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F 441	Continued From page 83 indicated the ice water pass was for all 23 residents in the lower level. During review of undated policy titled DAILY RESIDENT WATER PASS directed staff to have covered container for ice, ice scoop in a container next to the ice container and scoop needs to be in container between uses.	F 441			

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

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F 5349022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/28/2013
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Stewartville Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	<i>POC ok</i> <i>B 3-8-13</i> 		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Eugene Gustason</i>	<i>Administrator</i>	<i>3-1-13</i>

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

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

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Stewartville Care Center is a 2-story building. The building was constructed at 2 different times. The original building was constructed in 1970 and was determined to be of Type II(111) construction. In 1976, addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000			

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K 000	Continued From page 2 The facility has a capacity of 85 beds and had a census of 76 at the time of the survey.	K 000			
K 054 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2.1. The deficient practice could affect all 76 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 01/28/2013, the review of the annual fire alarm system inspection / test was not completed in a 12 month period. The report from Trans Alarm indicated the 2012 was completed on 08/20/2012 and 2011 was completed on 07/11/2011. This deficient practice was confirmed by the Facility Maintenance Director (DH) at the time of discovery.	K 054	Dan Hanson, the Maintenance Supervisor had the system tested on 8/20/2012. Dan has hired a different fire alarm system company to complete a systems test before 8-20-13, which is the new deadline to complete testing within the 12 month timeframe. Dan will track future testing periods to ensure tests are completed within 12 months of each other.	2-28-13	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9271

February 21, 2013

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

Re: State Nursing Home Licensing Orders - Project Numbers S5349023, H5439018, H5439019

Dear Mr. Gustason:

The above facility was surveyed on January 28, 2013 through February 1, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number S5349023. that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

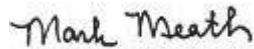
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive South East Rochester, MN 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,



Mark Meath, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

S5349023

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429	RECEIVED (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ 2013		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE MN Dept of Health Rochester 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 28, 29, 30, 31 and February 1, 2013, 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, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6599

LZGD11

If continuation sheet 1 of 85

Eugene Gustafson

Administrative TITLE

3-11-13

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/01/2013
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 28, 29, 30, 31 and February 1, 2013, 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, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000			

Minnesota Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

LZGD11

If continuation sheet 1 of 86

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/01/2013
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2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904. A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5439018 had not been substantiated during this survey. A complaint investigation/s had been completed at the time of the standard recertification survey and licensing survey. Investigation/s of complaint H5349019 had been completed and had been substantiated. Substantiated findings were issued at State Licensing Order/s at: MN Rule 4658.0525 Subp. 6.A, MN Rule 4658.0525 Subp. 5 A & B, and MN Rule 4658.0510 Subp. 1.	2 000			
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 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.	2 555			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/01/2013
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2 555	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was revised to include recent falls and interventions for 3 of 3 residents, (R63, R86 and R106) who had falls, and failed to update the care plan for 1 of 1 resident (R99) reviewed for behavioral and emotional status. Findings include: R106 lacked a revision of the care plan following falls, to identify falls and new interventions to minimize the risk of further falls. R106 was admitted to the facility on 11/30/12, with diagnoses including: osteoporosis, Parkinsonism, secondary, mild cognitive impairment, hallucinations, pain, hypertension and lewy bodies dementia. The last fall assessment was dated 11/30/12, and indicated R106 was a new admission, was at moderate risk for falls, had a fall risk score of 27, and was receiving therapy as ordered. Falls were identified 12/17/12 and 1/20/13. Review of R106's care plan dated 12/18/12, identified problem areas including: "MOBILITY- is usually independent with all mobility, uses a walker and is participating in OT (Occupational) and PT (physical therapy) had a couple of falls prior to admission ". The goal included, R106 will "continue to be independent in all mobility, and will have no falls or injury." The approaches were identified as: "Staff to allow to be independent in bed mobility, repositioning, transfers, and ambulation - assist only if needed. Staff to allow	2 555			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/01/2013
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
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2 555	Continued From page 3 to be independent in walking - using a walker. Staff to allow to transfer independently. Assist only if needed." R106's care plan had not been revised to include dates of fall or fall prevention interventions. On 2/1/13 at 9:16 a.m. registered nurse (RN)-A was interviewed. RN-A confirmed it would be the responsibility of the nurse on duty to update the care plan with the date of the fall, and any new interventions that were put into place to prevent further falls. RN-A verified R106's care plan had not been updated to reflect falls and interventions put into place to prevent further falls. On 2/1/13 at 9:33 a.m. the director of nursing (DON) verified staff should be updating the care plans with dates of falls and new interventions that were put into place following a fall. The DON stated, "I am aware they are not doing that". My expectation is the nurses should be updating the care plan as events occur. The DON confirmed the care plan for R106 had not been updated to include the falls or new interventions that were put into place on 12/17/12 and 1/20/13. R63 had four falls occur between 12/16/12 and 1/6/13, and the resident's care plan was not revised to reflect the falls or the interventions to be implemented for fall prevention. R63 was admitted 8/11/10 with diagnoses which included: restless leg syndrome, joint pain, congestive heart failure, heart disease and obesity. R63's quarterly minimum data set assessment dated 12/20/12 identified the resident as cognitively alert and oriented. The resident required extensive assist of one staff for mobility,	2 555			

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2 555	Continued From page 4 transfer, dressing, bathing, and ambulation in the corridor. A discharge assessment after hospitalization on 12/27/12 identified the resident with moderate cognitive impairment, short term memory loss and delirium. On 1/29/13 at 4:30 p.m., R63 was observed up in the wheelchair with a box alarm clipped to the wheelchair and the resident. A floor alarm mat was not observed to be in place next to the bed. On 1/30/13 at 1:00 p.m., R63 was observed in the bedroom in the wheelchair eating dinner. The alarm box was not on the wheelchair but was setting on the cabinet next to bed. In addition, a floor mat was at the end of the bed. At 1:40 p.m., the resident was observed to have been taken upstairs to bingo. The box alarm was observed to have been placed on the wheelchair. At 3:45 p.m., R63 remained upstairs in the dining room in the wheelchair. The box alarm was in place on the wheelchair. At 6:20 p.m., R63 was observed up in the wheelchair, having supper in the bedroom, with the alarm attached. On 1/31/13 at 7:00 a.m., R63 was observed in bed sleeping. A mat alarm was observed to be in place on the floor next to the bed, and another alarm was observed to be attached to the bed and resident . On 2/1/13 at 2:10 p.m., R63 was in the dining room playing games with 3 other women. The alarm was attached to her blouse and to the wheelchair. A physician's order dated 1/10/13, identified the use of a clip alarm and floor alarm. A nurse's progress note dated 1/3/13, identified	2 555			

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2 555	Continued From page 5 the resident as having more confusion. The note indicated the resident had a floor alarm on in her room, and a clip alarm on while in the wheelchair. R63's care plan with start date 4/25/12 was reviewed While the care plan indicated R63 had had a history of falls, and a fall was identified as having occurred 11/15/12, the care plan had not been revised to address the use of alarms (mat and wheelchair), or the more recent falls the resident had experienced. On 2/1/13 at 8:15 a.m., the assistant director of nursing (ADON) was interviewed regarding the alarms used for R63. She indicated the resident was on a falls prevention program. She stated the program included applying interventions to alert staff when the resident got up, reinforcing the resident to use the call light, reminders to call for help, and also indicated that if the resident was in bed, the floor mat alarm was to be used. The ADON said when the resident was up, the wheelchair alarm should be on at all times. The resident's care plan did not address the resident's most recent falls with interventions or the falls prevention program. On 2/1/13 at 3:10 p.m., the ADON was interviewed. The resident's current care plan was reviewed with the ADON. She verified the care plan had not been revised to address the recent falls or interventions they were using. R86 had a lap belt intervention added for fall precaution, and the care plan had not been revised to include the lap belt. R86 was admitted on 3/21/12, with diagnoses that included: dementia with Lewy Body and Parkinsons disease. During review of fall	2 555			

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2 555	Continued From page 6 interventions in place, it was noted that the use of a lap belt had been initiated on 1/15/13, but had not been added to the care plan. During observation on 1/30/13 at 1:34 p.m., R86 was sitting in the lobby in a wheelchair with a lap belt attached on the wheelchair. At 4:09 p.m., R86 was sitting in lobby having a manicure and the lap belt was present on the wheelchair. During an interview with LPN-G on 2/1/13 at 11:31 a.m., LPN- G stated R86 had frequent falls recently and that they staff had attempted multiple interventions including, moving R86 to a room closer to the nurses' station, mat on floor, alarms and most recently had added the use of a lap belt. LPN-G verified R86 was able to remove the lap belt upon command and that it was only used when R86 was in the wheelchair. LPN-G stated the expectation would be the lap belt would be care planned. During interview on 1/30/13 at 5:51 p.m., the assistant director of nursing (ADON) verified the lap belt had not been care planned and should have been. R99 lacked a revision of the care plan to include behaviors related to refusal of care and physical and verbal abuse towards others. R99 was admitted on 9/12/12, with diagnoses that included: stroke with hemiparesis, aphasia, aortic valve disorder, depressive disorder, congestive heart failure and Alzheimer ' s disease. Review of a significant change Minimum Data Set (MDS) dated 12/15/12, revealed R99 displayed behavior of physical behavioral	2 555			

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2 555	Continued From page 7 symptoms directed towards others, verbal behavioral symptoms directed towards others, rejection of care and other behavioral symptoms not directed towards others. The care plan dated 12/19/12, lacked identification of, and interventions for, these behaviors. R99's plan of care dated 12/19/12, included identification of the resident's use of psychoactive medications and history of depression however, the only approaches included: administer medication as ordered, take soon after meal or snack. DISCUS to be completed every six months. Observe for side/adverse effects. Although the significant change MDS dated 12/15/12, indicated the resident had verbal and physical behaviors and refused care, the care plan had not been revised to include interventions for modifying these behaviors. On 2/1/13 at 2:26 p.m., the licensed social worker (LSW), was interviewed and verified the care plan for R99 had not been revised to include interventions for dealing with the behaviors of rejection of care, physical abuse towards others, or being disruptive to the environment. The LSW confirmed the care plan should have been revised to include R99's behaviors. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could develop a system to educate staff and develop a monitoring system to ensure staff are reviewing and revising the care plan as indicated in order to provide appropriate care and services. The Director of Nursing could develop and implement a random audit tool to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 555			

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2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care for 1 of 3 residents (R99) reviewed for range of motion services. Findings include: R99 lacked development of a care plan for a restorative nursing/range of motion and ambulation program per physical and occupational therapy recommendations. R99 was admitted on 9/12/12, with diagnoses that included: stroke with hemiparesis, aphasia, aortic valve disorder, depressive disorder, congestive heart failure and Alzheimer's disease. During an observation on 1/30/13 at 4:43 p.m., R99 was observed during a transfer from a sitting position to a standing position. R99 was observed to walk fifteen feet into the bathroom with the assist of staff holding onto the gait belt. Review of the significant change Minimum Data	2 560			

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2 560	Continued From page 9 Set (MDS) dated 12/15/12, revealed moderately impaired decision making skills for daily living, extensive assist with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. The MDS did not indicate use of restorative nursing programs. The care plan dated 12/19/12, lacked care plan interventions for range of motion/restorative nursing. A Maintenance/Restorative Program for Mobility Deficits dated 11/30/12, indicated the resident was to have the following: ambulation three to four times a day with front wheeled walker, minimal assist of one, length of the hallway. Range of motion (ROM) seated leg kick, marching and side stepping, daily for 10-15 reps [repetitions]. The Maintenance/Restorative Program for Mobility Deficits dated 1/9/12, indicated the resident was to receive ROM to right shoulder and elbow. Approximate minutes to complete: 5-10. During an interview with nursing assistant (NA)-C on 1/31/13 at 2:20 p.m., NA-C stated staff had a sheet that indicated R99 was to be walked every day. NA-C verified R99 was on a walking program, but was unaware R99 was to receive ROM exercises. During an interview on 1/31/13 at 4:26 p.m., the director of nursing (DON) confirmed the care plan for R99 failed to identify the ROM exercises or ambulation program. The DON verified these programs should have been a part of the care plan for R99. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct	2 560			

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2 560	Continued From page 10 staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. 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 document review and interview, the facility failed to follow the care plan for providing range of motion (ROM) services for 2 of 3 residents (R58, R33) reviewed who required range of motion, and failed to reposition a resident according to the care plan for 1 of 3 residents (R64) reviewed for positioning. Findings include: R58 did not received range of motion exercise as directed by the care plan. R58's record was reviewed. The resident's diagnoses included Alzheimer's disease and dementia. R58's care plan identified problem areas	2 565			

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2 565	Continued From page 11 including decreased ROM and Alzheimer's disease. The approaches included: to provide range of motion exercises to the affected extremities per physician orders. During stage I interview on 1/28/13 at 10:07 a.m., licensed practical nurse (LPN)-A indicated R58's hands were pretty fixed, but verified the resident had not received ROM exercises. During interview on 1/31/13 at 10:53 a.m., nursing assistant (NA)-I stated she had not been trained to provide range of motion exercises and had not provided range of motion to residents. During interview on 1/31/13 at 11:05 a.m., registered nurse (RN)-C indicated the nursing assistants are responsible to provide the range of motion for residents since the restorative program had been discontinued in December 2012. RN-C indicated the nurse was responsible for overseeing the range of motion. During interview on 1/31/13 at 1:00 p.m., NA-K verified the nursing assistants don't do range of motion with the residents. NA-K stated that since the restorative program had been cut, she was not sure who was responsible for providing range of motion exercises. NA-I indicated nursing assistants don't have time to get the basics done none the less give the residents range of motion. During interview on 1/31/13 at 2:33 p.m., licensed practical nurse (LPN)-B indicated nursing assistants were responsible for range of motion. LPN-B verified no range of motion had been done with R58 today, because staff had been too busy. During interview on 1/31/13 at 2:46 p.m., the	2 565			

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2 565	Continued From page 12 assistant director of nursing (ADON) confirmed the restorative program had been turned over to the nurses in December 2012. The ADON stated the ROM was on the treatment sheets and the nurses were responsible to ensure residents received their range of motion programs. The ADON verified R58 had a current order to receive ROM. R64 was not repositioned as the care plan directed. R64's diagnoses included Parkinson's disease and dementia. The care plan dated 1/29/13, identified R64 as at risk for pressure ulcers and indicated the resident was supposed to be repositioned every three hours. During observation on 1/31/13 at 9:01 a.m., R64 was transferred from bed to a maxi chair and was wheeled to the dining room. At 09:30 a.m., R64 was wheeled out of the dining room and into the lobby by the bird aviary. R64 was still sitting in the maxi chair and was not repositioned. At 9:56 a.m. R64 remained in the maxi chair in the lobby. At 10:15 a.m. R64 was wheeled to the chapel for activities and had not been repositioned. At 11:09 a.m. R64 was wheeled back to the lobby by the aviary. At 11:25 a.m. R64 remained in the maxi chair in the lobby by the aviary. At 11:38 a.m. R64 was wheeled to the dining room. At 12:20 p.m., R64 remained in dining room sitting in the maxi chair. At 12:38 p.m., R 64 remained sitting in dining room eating lunch. At 12:47 p.m., R64 was wheeled to his room by nursing assistant (NA)-I. R64 remained sitting in the maxi chair and had not been repositioned. At 1:28 p.m., R64 remained sitting in maxi chair in room. At 1:34 p.m., NA-I came into the room with NA-K to assist with the transfer of R64 from the maxi	2 565			

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2 565	Continued From page 13 chair into bed (4 hours and 33 minutes since last repositioned). During interview on 1/31/13 at 1:30 p.m., NA-I confirmed R64 was to be repositioned every two hours. NA-I indicated R64 got up late this morning sometime around 8:30 a.m., NA-I verified R64 should have been repositioned every two hours and had not been repositioned in a timely manner. During interview on 1/31/13 at 12:19 p.m., licensed practical nurse (LPN)-C confirmed an assessment of the resident's tolerance to prolonged pressure (tissue tolerance) indicated R64 was to be repositioned every three hours. However, LPN-C also said she thought R64 was to be repositioned every three hours when lying and two hours when sitting. LPN-C stated she'd completed the last tissue tolerance assessment and indicated she had not gone past the two hour repositioning due to R64 being at a high risk for pressure ulcers. During interview on 2/1/13 at 7:10 a.m., the assistant director of nursing stated all residents are on a two hour repositioning schedule. During interview on 2/1/13 at 11:46 a.m., the director of nursing stated staff should be directed by the tissue tolerance assessment results, and based on the tissue tolerance a care plan was developed. R33 did not receive restorative nursing services for range of motion (ROM) and ambulation in accordance with the written care plan. R33 had diagnoses that included contracture of the right hand, lower extremity (LE) cerebral	2 565			

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2 565	Continued From page 14 vascular disease, and hemiplegia. Review of the care plan dated 8/20/12, revealed R33 was at a greater than normal risk for falls secondary to history of cerebral vascular accident resulting in unsteady gait. The care plan indicated R33 was to receive extensive assistance for all mobility related to weakness and gave direction for restorative nursing for walking and ROM per physicians order. The most current physician's orders gave direction for passive range of motion (PROM) to right arm and hand, and active range of motion (AROM) to LE daily. R33 was observed to receive cares on 1/29/13, 1/30/13 and 1/31/13, however no ROM service or ambulation was observed to have been provided. Review of the Restorative Nursing sheets revealed the following information: November 2012, R33 had ambulated 75 feet on 21 of the 30 days, and received ROM on 22 of the 30 days. October 2012, R33 had ambulated 75 feet on 19 of the 31 days, and received ROM on 21 of the 31 days. September 2012, R33 had ambulated 75 feet on 16 of the 30 days, and received ROM on 21 of the 30 days. August 2012, R33 had ambulated 75 feet on 26 of the 31 days, and received ROM on 28 of the 31 days. Daily Ambulation Sheets were reviewed from	2 565			

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2 565	Continued From page 15 12/1/12 to 1/21/13. These sheets revealed the resident was not included on the list directing staff to ambulate. Review of treatment sheets from 12/1/12 to 1/31/12, identified R33 was to receive PROM to left arm and hand daily with a start date of 1/19/13. The sheets revealed R33 had been provided this on care on only four of the 12 days possible. During interview on 1/30/13, at 1:02 p.m. NA-D verified R33 had not received ROM services or ambulation stating, "we move as fast as possible but can't always get everything done." During interview on 1/30/13, at 2:55 p.m. LPN-A verified R33 had not received ROM services or ambulation. On 2/1/13, at 9:33 a.m. nursing assistant (NA)-E was interviewed. NA-E stated rehab nursing was discontinued in December. NA-E indicated a book was placed at each station with information regarding restorative nursing, however the book did not identify which resident was to receive ROM. NA-E verified R 33 was not on a walk list, and stated " she used to be when we had rehab aids. " NA-E further verified R33 had not	2 565			

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2 565	Continued From page 16 received ROM or ambulation services and NA-E was unable to report which residents were to receive ROM. On 2/1/13, at 3:56 p.m. the director of nursing (DON) indicated the floor nurse is responsible for providing ROM. DON verified R33 had not received ROM and stated the NA ' s would require training prior to providing ROM. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565			
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements 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, interview and document review, the facility failed to consistently provide sufficient nursing staff to meet resident's needs in a timely manner for 11 of 21 residents (R79,	2 800			

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2 800	Continued From page 17 R72, R10, R2, R91, R117, R61, R99, R103, 61, R79) in the sample; Ambulation was not provided as ordered for 1 of 3 residents (R63) reviewed for ambulation. In addition, observations on 1/29/13, 1/30/13 and 1/31/13 indicated insufficient staff available to meet resident care needs with the potential to affect all 77 residents in the facility. Findings include: Family member (F-A) requested not to be identified expressed concerns of insufficient staffing within the facility as evidenced by: During interview on 1/28/13, at 10:55 a.m., F-A stated the facility did not have enough nursing assistants to provide residents with the care and assistance they needed. F-A stated, "Quite often we have one girl [nursing assistant] on this wing, we need two to three on this wing, it is the heaviest wing, when there is only one she is run ragged." F-A indicated at night there had been times the wait for assistance was 15-20 minutes. F-A stated "I have called down to the desk because my husband gets out of bed and I cannot help him back to bed. I call before he has fallen. He has gotten to the bathroom and then I call the front desk." R79's diagnoses included depression, anxiety and cognitive impairment. The quarterly Minimum Data Set (MDS) dated 12/12/12, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated R79 had intact cognition. The MDS further revealed R79 showed no psychosis or behavioral problems, required extensive assist of one staff for dressing and hygiene and total assist of two staff for toileting. During interview on 1/28/13, at 10:12 a.m. R79	2 800			

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2 800	Continued From page 18 stated, "Don't have enough help, I have to wait a long time, I have waited an hour for help to go to the bathroom, happens mostly during the day. I use a pad [for incontinence] but I can lie in that [soiled pad]for hours. I have had a bowel movement and urine [reference to soiled pad]. I get sores." R72's diagnoses included Parkinson's disease. The annual MDS dated 12/04/12, revealed a BIMS score of 15, which indicated intact cognition. The MDS further revealed R72 showed no psychosis or behavioral problems, required extensive assist of one staff for hygiene, transfers, dressing, and toileting. During interview on 1/29/13, at 10:51 a.m., R72 stated, "Sometimes it gets kinda short, had to wait too long for them to answer a light, sometimes its 20 minutes or more. Usually it's so I can get to the bathroom, I had an accident [reference to incontinence] a couple of times." R10's diagnoses included schizophrenia and generalized pain. The quarterly MDS dated 11/20/12, revealed a BIMS score of 15, which indicated R10 had intact cognition. The MDS further revealed R10 showed no psychosis or behavioral problems, required extensive assist of one staff for dressing, hygiene and toileting. During interview on 1/28/13, at 10:10 a.m., R10 indicated she required the E-Z stand (a mechanical transfer device) for transfers. R10 stated, "Sometimes I have to go to the bathroom so bad but mother nature doesn't understand that I have to wait." R10 reported she had been incontinent of urine and stool "many times" while waiting for staff assistance.	2 800			

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2 800	Continued From page 19 R2's diagnoses included leukemia, and cerebral palsy. The quarterly MDS dated 11/07/12, revealed a BIMS score of 15, which indicated R2 had intact cognition. The MDS further revealed R2 showed no psychosis or behavioral problems, required extensive assist of one staff for dressing, hygiene and toileting and extensive assist of one to two staff for transfers. During interview on 1/28/13, at 1:33 p.m., R2 stated, "Has never been as bad as it is now. I have been here 11 years. Administration is not nice to employees because cutting back too much. We are short. One nurse that helped didn't know how to use the Hoyer lifts and one aide didn't know anything. When you [referring to surveyor] come in we get all kinds of help on all shifts now. Lot of the employees have quit. One morning I put my light on, I had to go to the bathroom. From 20 minutes to 6:00 a.m. until 6:30 a.m. A nurse was outside the door, I hollered and nobody even come in or looked in. I wear a pad [for incontinence] because I take a water pill. There is one staff on for a hall, and nobody in dining room that helps feed. Residents play in the food." R91's diagnoses included hypertension and joint pain. The quarterly MDS dated 11/15/12, revealed a BIMS score of 11, which indicated R91 had moderately impaired cognition. The MDS further revealed R91 showed no psychosis or behavioral problems, required extensive assist of one staff for dressing, hygiene and toileting. During interview on 1/28/13, at 1:04 p.m., R91 stated, "There is not enough [in response to a question about sufficient staff] no, I have to wait sometimes for staff to come, the longest is 20 minutes. I need help tying my shoes and need	2 800			

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2 800	Continued From page 20 help after I am done in the bathroom." R117 was admitted to the facility on 1/15/13, for therapy following a fall at home. The Nursing admission note dated 1/15/13, indicated R117 was alert and oriented, and required moderate assist of 1-2 staff with gait belt, and pivot transfer on right leg. Review of BIMS dated 1/21/13 revealed a score of 15, which indicated R117 had intact cognition. During interview on 1/28/13, at 11:19 a.m., R117 stated, "I think they could use more staff, the ones they have are running their butts off. I have waited 1/2 hour and that is a long time when you have to go [reference to toileting need]." During interview on 1/30/13, at 1:02 p.m., nursing assistant (NA)-D reported range of motion (ROM) services were not provided to residents due to insufficient staffing. NA-D further stated residents did not receive timely assistance with toileting and repositioning. NA-D indicated the facility had been short on staff and stated, "We move as fast as possible but can't always get everything done." NA-D verified residents have been incontinent of both bladder and bowel because there was a delay in residents receiving toileting due to staff shortage. On 1/30/13 at 1:34 p.m., NA-H stated there are times when one NA is being assigned to an entire wing themselves because of staff call ins or just being scheduled for one because of being short. An example was when a signup sheet was placed for staff to pick up an evening shift on a weekend. NA-H stated two staff members volunteered to pick up the evening shift, then the	2 800			

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2 800	Continued From page 21 schedule came out and they had only one person assigned to west wing, when two staff members had offered to work. When asked how they provide assistance to residents who require assist of two staff with the Hoyer lift, NA-H responded the licensed nurses are to help but a lot of the nurses will not help you and you do the best you can even if you have to do it alone. NA-H said it is very stressful to get everything done and done safely for the residents. During interview on 1/30/13, at 1:25 p.m., the scheduling coordinator stated if changes are made to the schedule, such as a call ins, the changes are hand written on the schedule. Scheduling coordinator provided the staff schedules and daily assignment sheets dated October 2012 to 1/30/13. During interview on 1/30/13, at 2:50 p.m., licensed practical nurse (LPN)-F stated she did not feel there was enough staff to properly care for the residents. LPN-F stated, "How the residents are cared for depends on who is working, some staff are tired from working so much and upset so don't move as fast." LPN-F indicated staff had been skipping their breaks to make sure the residents are cared for. LPN-F further indicated the nurses are to help the NA's, however, they have been working short as well and had been required to split their time between two wings. LPN-F indicated ROM services had not been getting done. During interview on 1/30/13, at 3:33 p.m. the administrator verified a call light audit had not been completed recently. Administrator stated he has not done a call light audit for "6-8 months." The administrator reported he had no access to do one at that time.	2 800			

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2 800	Continued From page 22 During interview on 1/31/13, at 6:22 a.m. NA-I verified she felt there was not enough licensed nurses and nursing assistants within the facility to meet resident needs in a timely manner. NA-I stated, "They don't get toileted or repositioned on time, we do get them up thank God we have open breakfast." NA-I further stated, "Sometimes I come in and residents will say they haven't went to the bathroom since supper this is at 9 o'clock at night." NA-I indicated the facility had worked with one NA on evening shift consistently for the last 5 to 6 weeks, NA-I stated "I'm relieving one person when I come in at 9 p.m. one person with one person." NA-I said they usually are scheduled two NAs to a wing. During interview on 1/31/13, at 8:55 a.m., the scheduling coordinator verified frequent call-ins, and difficulty with filling shifts. Scheduling coordinator reported that the facility practice included staff were to fill out a slip when call-in occurred, then attempts were to be made to fill the open shift. Scheduling coordinator reported that the facility's practice for staffing days and evenings had been three nurses on the main floor and 2 in lower level (LL), two NA's on West Wing (WW,) one on North Wing (NW), two on East Wing (EW) and two in the LL. Scheduling coordinator reported the night shift is staffed with two nurses, one on each floor, three NA's on the main floor and one in LL. Scheduling coordinator verified that some of the staff have been upset since restorative nursing had been cut. The scheduling coordinator stated she felt there had been enough staff if there were no call-ins, "The stuff the restorative aides did like range of motion I'm sure is not getting done." She verified it had been difficult to fill staff hours due to the call-ins and indicated the administrator had discussed	2 800			

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2 800	Continued From page 23 using a nursing pool company to fill the open hours. It was verified the administrator had given the direction to contact a nursing pool company after the surveyors entered the building. During interview on 1/31/13, at 12:05 p.m. director of nursing (DON) verified frequent call-ins and verified the facility had cut restorative nursing. DON stated, "It would always be nice to have more help." During interview on 1/31/13, 2:55 p.m. LPN-A verified resident's ROM was not getting done. On 2/1/13, at 9:33 a.m. NA-E was interviewed and stated restorative nursing who was responsible to do ROM and ambulation services was discontinued in December 2012. NA-E indicated a book was placed at each station with information regarding restorative nursing, however, there had been no education regarding ROM and the book did not identify which resident was to receive ROM services. NA-E verified residents had not been walked and ROM had not been provided as they needed. NA-E was unable to report where she had found information directing resident care. NA-E stated, "Residents are transferred with one assist because we use the mechanical stand." NA-E further stated, "It's too busy to wait for help." During interview on 2/1/13, at 3:37 p.m. the administrator stated the facility had been in the process of making changes regarding resident rooms between the main level and the LL, indicating the change had been difficult for staff and residents. He stated the facility had recently cut the restorative program and was aware staff and residents were unhappy with the decision. He then stated, "I'm trying to think of what to do,	2 800			

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2 800	Continued From page 24 we just set the budget in nursing to do what's in place right now." He indicated the plan was to contact a pool nursing company, review, revise if needed, and enforce the absentee policy, review the procedure for two assist lifts, stating, "I'll have to sit down with [DON] to make sure the aides are trained properly." The administrator reported that he had attended a resident council meeting and had a discussion regarding finances and stated, "The perspective is this is their home, and we can't hire more people if you don't have the money." Administrator verified residents had voiced grievances regarding staffing during six of seven resident council meetings reviewed. During interview on 2/1/13, at 3:56 p.m., the DON stated the facility had been going through some staff changes which had been upsetting to residents and staff. DON stated the nurses had been responsible for providing ROM and was unaware the NA's were informed they were responsible. DON stated the NA's would require training prior to providing ROM, and indicated the expectation had been for the nurse to provide ROM. The nursing schedule reports from 1/15/13, through 1/28/13, revealed 13 of the 14 days had changes to the schedule. Of the 13 days, changes were made on 11 due to nursing assistance absences which had not been replaced resulting in fewer staff to care for residents than had been scheduled. Resident council meeting minutes were reviewed from 6/26/12, to 12/27/12. At 6 of the 7 meetings, residents had voiced concerns related to not enough staff. There was no evidence of follow up to the residents about staffing concerns in the meeting minutes.	2 800			

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2 800	Continued From page 25 Review of daily ambulation schedule, dated 12/10/12 to 1/21/13, revealed multiple areas of missing documentation which identified if the resident had walked with staff as well as multiple areas in which staff documented "refused" or "unable" without explanation. The schedule identified residents who required daily walking assist from staff and included day and evening shift for each wing on the main floor and the lower level. R61's call light was on from 10:25 a.m. to 11:10 a.m. on 1/28/13. No staff was observed in hallway during that time. R61 was sitting in wheelchair in room. At 11:00 a.m. a nurse aide walked by but did not stop to check on the residents need. At 11:05, surveyor went in to check with resident what they needed. The resident wanted a piece of gum because mouth was dry. Surveyor approached a licensed practical nurse (LPN)-D about the resident's request. According to LPN-D, the resident could have gum but they have to give it to the resident because otherwise the resident puts a lot in their mouth at one time and could choke. They keep it in the med cart. The LPN then gave the resident a piece of gum. On 1/29/13, at 4:05 p.m., R99's mat alarm and chair alarm were sounding. No staff was in the area. R99 was observed standing up near the bed and was trying to shut the alarms off. R99 stated, "I can't do it they are noisy." At 4:09 p.m. no staff had responded or was in the vicinity of the resident room. An Activity staff was requested by surveyor to go in to R99's room and then heard the alarms going off. After surveyor intervention, the staff did go in the room and shut the alarms off and sat the resident down on the	2 800			

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2 800	Continued From page 26 bed. The activity staff put the light on to get assistance and ten minutes later it was answered by a nursing assistant. A registered nurse (RN) -B was interviewed regarding R99 and stated the resident had a fall and that was why the alarms being used. RN-B indicated the resident was unsteady at times and did not like the alarms. At the time the alarms were sounding, two nurse aides were on the other end of the West hall, the LPN was in a room helping another resident to the bathroom and the registered nurse was busy admitting a resident. On 1/29/13 at 4:00 p.m., R103 requested to use the bathroom. R103 was sitting at the nurse's desk. RN-B asked R103 to wait a minute. R103 asked another nurse aide who also requested the resident to wait a minute. The resident continued to sit in the chair. A family member of another resident informed the staff that R103 needed to use the bathroom. At 4:20 p.m., RN-B assisted the resident to the bathroom after the resident got up from the chair and started ambulating toward the desk saying they needed to use the bathroom. RN-B stated there were 2 aides on the lower level for wings, one LPN and herself. She was busy with an admission and the nurse practitioner was here. She indicated it was quite busy. R61's call light was on, on 1/29/13, from 4:10 p.m. until 4:35 p.m., when NA-B responded to R61 yelling, "Help! Help! Help me!" At 4:35 p.m., NA-B went in with the mechanical stand lift and took R61 to the bathroom. The resident had waited 25 minutes. R79's call light was turned on at 4:10 p.m. and not answered until 4:30 p.m. on 1/30/13. At 4:30	2 800			

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2 800	Continued From page 27 p.m., NA-B answered the light and R79 requested to get up. NA-B said to R79 it would be just a bit because she needed help with the lift. At 4:55 p.m., R79 received incontinence cares and assistance up into the wheelchair. R79 waited 45 minutes from the time she turned on her call light for assistance to get incontinence cares done and into her wheelchair. R63 was brought to the bedroom by F-A on 1/30/13, at 4:20 p.m. They put the bathroom light on at this time to get help for R63. At 4:40 p.m., F-C was looking for someone to help R63. NA-F was busy with R106 until 4:42 p.m. and NA-B was busy with R61. At 4:43 p.m., when NA-B went in to check on R63, F-A indicated the problem had already taken care of her. At 7:30 p.m., R63 was still up in the wheelchair. The staff had not approached the resident or offered toileting since 4:45 p.m. and it was learned that R63 was to be toileted or offered to be toileted at a minimum of every two hours according to their bladder assessment. F-A, R63's family member was interviewed on 1/30/13 at 5:00 p.m., and stated the staffing is short. On Christmas day they had only one aide on the lower level for the day with only one nurse. F-A said they had to take R63 to the bathroom tonight because they had to "poop" and the staffing was short again. F-A said that R63 had a history of skin breakdown and doesn't want it to get bad again as it is good now. F-A also said that the walking program had been stopped for the past month or two. On 1/30/13, at 5:00 p.m., NA-B was interviewed and stated evening lunch breaks are at 4-4:30 p.m. and 4:30-5:00 p.m. during the time when everyone needed to be toileted and ready for	2 800			

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2 800	Continued From page 28 supper. NA-B said they did not take a supper break as they had too much work to do. NA-B also indicated the nurse aides are called upstairs to help and it is very difficult to get everything done for twenty residents. R63 was ambulated 17 times, refused twice out of 42 opportunities from January 14 to 27, 2013. A therapy recommendation written for rehabilitative nursing by Physical Therapy (PT) dated 1/16/13, noted, "Please walk pt [patient R63] 3xday every day @ fww [front wheel walker], assist x1, w/c [wheelchair] following distance as tolerated (60-100 ft). Pt to walk to/from Bathroom @fww & assist x1." It was signed by the Physical therapist. The daily ambulation schedule for the week of 1/14/13 to 1/20/13, noted R63 walked in room twice a day in a.m. and p.m. Monday through Friday, not on Saturday in the morning or afternoon and refused Sunday in the morning and afternoon. For the week of 1/21/13 to 1/27/13, on Monday R63 only ambulated once in the afternoon, on Tuesday only once in the afternoon, on Wednesday ambulated twice, on Thursday did not ambulate all day and on Friday ambulated both morning and afternoon. For Saturday, the resident did not ambulate and for Sunday the resident ambulated one time. The schedule did not follow the PT's recommendations of 3 x day. No documentation of how far the resident did ambulate when was ambulated was evident. Did note the resident ambulated to the bathroom, but did not identify when or if the resident was ambulated in the hall	2 800			

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2 800	Continued From page 29 A SUGGESTED METHOD FOR CORRECTION: (1) Re-evaluate staffing assignments of nursing assistants. (2) Develop and implement a staffing plan which ensures that each resident's individualized needs are addressed and met; educate all staff. (3) Develop and implement a system which ensures appropriate supervision of resident care. (4) Track and trend incidents and resident complaints, which may identify those personnel who need re-education or corrective action. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 800			
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 ensure resident safety, reduce or prevent accidents, and thoroughly investigated all falls for 1 of 3	2 830			

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2 830	Continued From page 30 residents (R63) reviewed in the sample that had falls. Findings include: R63 had four falls between 12/16/2012 and 1/6/2013, the last fall on 1/6/13 R63 received facial and shoulder contusions from the fall, this fall had not been thoroughly investigated as to the root cause of the fall nor was the box alarm and floor mat alarm assessed to determine if it was effective as the resident had removed the box alarm so it would not sound when R63 wanted to move about the room R63's quarterly Minimum Data Set (MDS) assessment dated 12/20/12 was reviewed. It identified the resident 's cognitive status as alert and oriented. Had some verbal and other behaviors, and often refused cares, The activities of daily living required extensive assist of one staff for mobility, transfer, dressing, bathing, ambulation in corridor (only did 1-2 times in 7 days), used a walker and wheelchair. A discharge MDS dated 12/27/12 (re-admitted back to facility on 12/29/12) identified the resident as having moderate cognitive impairment, short term memory loss, with delirium. R63's accident incident reports dated 12/16/12, 12/25/12, 1/1/2013, and 1/6/13 were reviewed. The following was noted: On 12/16/12, the resident was found sitting on buttocks on floor beside the bed. The resident indicated slid off the bed and was trying to untangle the walker from the wheelchair. The fall assessment 12/16/2012 indicated no injury, neurological checks were completed, and drug review was done. The evaluation comments included: falls prevention program initiated, care plan updated.	2 830			

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2 830	Continued From page 31 Resident was alert and able to use call light. Staff review use of call light and to arrange room and clutter. On 12/25/12, the resident slid self to floor from bed. No injuries. Sat up on edge of bed and slipped to the floor while reaching for something on the table. The fall assessment indicated neuro checks were done, mental status and contributing factors were reviewed, and drug review was completed. On 1/1/2013, the resident was found sitting on buttocks on floor beside bed. The blankets were underneath the resident. The resident told staff, slid off of the bed. The evaluation note read: will use clip and step on alarm to alert staff. Resident does not always used good judgment and wants to be independent. The falls assessment completed noted: severe pain, non-witnessed fall, neuro checks, mental status was identified as anxiety, confusion and restlessness. Recent change in medications and recent decline in activities of daily living abilities. Interventions of immediate measures: bed alarm, analgesics, first aid and rest. On 1/6/2013, the resident was heard yelling. The resident was on floor; face down, in the area to the right of the foot of her bed. Stated they had been making the bed and became really dizzy and fell. The evaluation comments noted: bruise and nose bleed resolved. Continue to use clip and step alarm. Prefers to be independent, staff continue to encourage to use call light and are here to help the resident. Resident does not always have good safety judgment. The falls assessment noted: pain mild, abrasion, bruising, laceration, range of motion painful in upper extremity, neurological checks, mental status, contributing factors identified as recent change in medications, and drug review. Immediate interventions: chair wheelchair alarm, first aid,	2 830			

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2 830	Continued From page 32 and rest. An interdisciplinary progress note dated 1/3/2013 was reviewed. It noted during Care conferences, the care plan was reviewed with no changes. The resident had more. Had floor alarm on in the bed room and clip alarm on while up in the wheelchair. A nurse ' s noted dated 1/9/2013, identified the resident laying on edge of bed with legs hanging over the side. Later, clip alarm sounding resident was found standing at doorway asking staff how they can shut off the noise (in reference to the clip alarm.) On 1/12/2013, the note read: floor mat sounding resident stated was going to walk to the bathroom. On 1/28/2013 at 2:00 p.m., during interview with R63, the resident stated they had 2 alarms on. On observation, the floor mat alarm which was not turned on at this time. The second alarm had been attached to the resident ' s dress and the box was lying on the bed. The resident stated, " I know how to take the alarm off. I haven't taken it off yet, but if I want to I will." On 1/29/2013 at 4:30 p.m., R63 was observed up in the wheelchair with the box alarm clipped to the wheelchair and the resident. The floor alarm mat was not down next to the bed but at the end of the bed. The resident indicated the staff mopped the floor and got the mat wet so it was drying. However, the mat was dry to the touch. On 1/30/2013 at 1:00 p.m., R63 was observed in the room in the wheelchair eating dinner. The alarm box was set on the cabinet next to bed and not connected to the resident. The floor mat was at the end of the bed and out of reach of the resident for use. The resident said they had to rearrange things.	2 830			

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2 830	Continued From page 33 On 1/30/2013 at 1:07 p.m., a nurse aide (NA)-A was interviewed regarding the floor mat alarm not on and the alarm box not connected to the resident. NA-A stated the alarms are a new thing. R63 has had quite a few falls and that is when they added them. A NA-D was interviewed and stated the resident was to have them on but NA-D didn't notice it wasn't on when she delivered the resident 's meal tray in there, or that the mat on the floor was moved to the end of the bed. On 1/30/2013 at 1:20 p.m., a licensed nurse (LPN)-B was interviewed regarding the alarm box not on the resident. LPN-B said it should be on the resident. Both LPN-B and this surveyor went down to the resident's room and found the alarm on the cabinet. LPN-B then placed the alarm box on the wheelchair and to the residents clothing with it being turned on. LPN-B said they mostly used at night and when the resident was in bed. LPN-B said that he would inform the NA that they need to remember to have the box alarm attached to the resident. R63's care plan with date 4/25/2012 as initiation date for problem identified-the resident had been having staff assist with transfers by lifting legs and will often refuse assist for ambulation by staff. The resident used the walker and can walk in the room. The resident did not usually walk in the hallway. The resident may use a wheelchair for long distances and can wheel self some. R63 had a history of falls. Resident wishes not to have any more therapy. R63 may participate in restorative nursing for walking some days when offered. Interventions: one staff to assist to reposition in bed and in chair every 3 hours if needs help. One staff to assist to transfer into	2 830			

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2 830	Continued From page 34 and out of bed and chair using walker, at resident's request. One staff to walk with the resident using a walker if the resident requested. R63 usually walked independently in room but has had falls. No information for use of box alarm or for the mat alarm use. It was noted that a Physician 's order dated 1/10/13 for clip alarm (box alarm) and floor (mat) alarm. On 1/31/2013 at 1:00 p.m., the licensed social worker (LSW) was interviewed regarding the resident 's falls. She stated the resident had been very self-reliant in decision making. R63 had significant change recently and was sent to the hospital due to having hallucinations and delusions and was declining in health. On 2/1/2013 at 8:15 a.m., the assistant director of nursing (ADON) was interviewed regarding the fall prevention program for R63. ADON said the box alarm is to be used when the resident is up out of bed and when in bed the floor mat alarm is to be used at all times. On 2/1/2013 at 2:45 p.m., registered nurse (RN) -A was interviewed regarding the fall incident of 1/6/2013. RN-A stated she heard the resident yell when she was next door helping another resident. On entering R63 's room the box alarm was hanging off of the resident but not alarming and the mat with alarm was turned off and not alarming. Did not know if the resident had turned the alarms off or if the staff had not turned them on. RN-A continued to say the resident was sent to the emergency room due to injuries sustained from the fall. RN-A also verified the resident's care plan had not been updated to reflect current interventions such as the box and mat alarm use. SUGGESTED PERIOD OF CORRECTION:	2 830			

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2 830	Continued From page 35 The director of nursing or her designee could develop policies and procedures to ensure residents consistently are provided the appropriate interventions. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830			
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide range of motion services for 3 of 3 residents (R58, R33, R99) reviewed for range of motion. Findings Include:	2 895			

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2 895	Continued From page 36 Resident (R99) lacked development of restorative nursing/range of motion and ambulation program per physical and occupational therapy recommendation. R99 was admitted on 9/12/2012, with diagnoses that included but are not limited to stroke with hemiparesis, aphasia, aortic valve disorder, depressive disorder, congestive heart failure and Alzheimer ' s disease. During an observation on 1/30/13 at 4:43 p.m., R99 was observed during a transfer from a sitting position to a standing position. R99 was observed to walk fifteen feet into the bathroom with assist of staff holding on the gait belt. Review of Significant Change Minimum Data Set (MDS) dated 12/15/12, revealed moderately impaired decision making skills for daily living, extensive assist with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. The MDS did not indicate use of restorative nursing programs. The Care plan dated 12/19/1012, lacked care plan interventions for range of motion/restorative nursing. Maintenance/Restorative Programs for Mobility Deficits dated 11/30/12, included ambulation three to four times a day with front wheeled walker, minimal assist of one, length of the hallway. Range of motion (ROM) seated leg kick, marching and side stepping, daily for 10-15 reps [repetitions]. Maintenance/Restorative Programs for Mobility Deficits dated 1/9/12, included ROM to right shoulder and elbow. Approximate minutes to complete: 5-10.	2 895			

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2 895	Continued From page 37 The physical therapist was interviewed on 1/31/13 at 1:21 p.m. and indicated when R99 was discharged from therapy on 11/30/12, recommendations were made for an ambulation and range of motion exercise program. She indicated the procedure was for therapy to hand over the Maintenance/Restorative Programs for Mobility Deficits to the nurses staff to implement for residents. Review of the December 2012 Treatments Flow sheet revealed the treatment sheets did not include the therapy recommended ROM for R99. Review of the January 2013 Treatments Flow sheet revealed the treatment sheet did include an order that indicated, " PT to provide daily ROM exercises of right hand, and both shoulders x1 month per Dr. ... MD, once a day from 12/21/12 to 1/21/13. The treatment sheet had no initials for this order for the month of January and the order was not included on the December treatment sheet. The daily ambulation schedule was requested for the weeks of 11/30/12 to 1/28/13. For the time frame requested, the first week R99 was on the daily ambulation schedule was the week of 12/24/12. Therapy recommended the ambulation program for R99 on 11/30/12. The RESTORATIVE CARE-GIVING undated policy was reviewed. The procedure revealed staff are to provide each resident with an individual program involving interdisciplinary facility staff with measurable objectives, interventions, appropriate documentation and periodic evaluation. Provide Skills practice that improves, maintains and prevents further decline. Facilitate and promote staff knowledge,	2 895			

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2 895	Continued From page 38 understanding, application and implementation of the restorative care process on a continuous basis at all times with all residents. During an interview on 1/31/13 at 2:20 p.m., nursing assistant (NA)-C stated staff had a sheet that indicated R99 was to be walked every day. NA-C verified R99 was on a walking program and was unaware R99 was to receive ROM exercises. During an interview on 1/31/12 at 2:43 p.m., registered nurse (RN)-C verified the ROM exercises were not consistently being provided to residents in the facility. RN-C stated she, " tried to get to them when I can and the nursing assistants try to get to them when they can. A lot of it depends on the day. They are not getting done daily. If the facility had the number of staff we should have I think we would be able to get it done, but sometimes we have call ins and we need to make adjustments " . RN-C verified the treatment sheets for the month of January 2013 indicated R99 did not receive ROM services. RN-C was unable to locate any documentation on the December 2012 treatment sheet for R99 that indicated she was to receive ROM services. During an interview on 1/31/13 at 4:26 p.m., the director of nursing (DON) confirmed the ROM program with designated rehab nursing assistants had been discontinued. The DON indicated the nurses are responsible to complete the ROM exercises with residents and the nursing assistants are to complete the walking portion. The DON stated, " The nursing assistants always walk the people, so I did not see a need for training. We provided the nurses with a copy ROM exercise to be done. The nurses on the unit should be monitoring on the	2 895			

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2 895	Continued From page 39 unit to make sure the walk list are being completed and they need to track on the treatment sheets the ROM is being completed " . The DON confirmed the Treatments Flowsheets for December 2012 and January 2013 did not indicate R99 received ROM services. During an interview on 2/1/13 at 2:50 p.m. the assistant director of nursing (ADON) verified R99 was not placed onto the walking list to be walked until the week of 12/24/12. The ADON stated, " I am not sure why she wasn't on there before " . R58 did not received range of motion (ROM) exercise as indicated by the plan of care. R58's record was reviewed. The resident's diagnoses included Alzheimer's disease and dementia. A quarterly Minimum Data Set (MDS) assessment dated 1/15/13, indicated R58 had short and long term memory deficit, was rarely understood, dependent with two plus staff with bed mobility and transfers, and as no impairment with functional limitation in ROM with upper and lower extremities. R58's current physician orders indicated the resident had ROM exercises daily by nursing. R58's treatment flow sheet identified the resident had a restorative nursing range of motion exercise program six days a week dated 12/12/12. During review of the December 2012 treatment flow sheets, it was identified there were no directions for ROM to be completed. During review of the January 2013 treatment flow sheet there was a day with no staff initials verifying ROM was completed. R58's care plan identified problem areas including decreased ROM and Alzheimer's	2 895			

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2 895	Continued From page 40 disease. The approaches included: to provide range of motion exercises to the affected extremities per physician orders. During stage I interview on 1/28/13 at 10:07 a.m., licensed practical nurse (LPN)-A indicated R58's hands were pretty fixed, but verified the resident had not received ROM exercises. During interview on 1/31/13 at 10:53 a.m., nursing assistant (NA)-I stated she had not been trained to provide range of motion exercises and had not provided range of motion to residents. During interview on 1/31/13 at 11:05 a.m., registered nurse (RN)-C indicated the nursing assistants are responsible to provide the range of motion for residents since the restorative program had been discontinued in December 2012. RN-C indicated the nurse was responsible for overseeing the range of motion. During interview on 1/31/13 at 1:00 p.m., NA-K verified the nursing assistants don't do range of motion with the residents. NA-K stated that since the restorative program had been cut, she was not sure who was responsible for providing range of motion exercises. NA-I indicated nursing assistants don't have time to get the basics done none the less give the residents range of motion. During interview on 1/31/13 at 2:33 p.m., licensed practical nurse (LPN)-B indicated nursing assistants were responsible for range of motion. LPN-B verified no range of motion had been done with R58 today, because staff had been too busy. During interview on 1/31/13 at 2:46 p.m., the assistant director of nursing (ADON) confirmed	2 895			

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2 895	Continued From page 41 the restorative program had been turned over to the nurses in December 2012. The ADON stated the ROM was on the treatment sheets and the nurses were responsible to ensure residents received their range of motion programs. The ADON verified R58 had a current order to receive ROM. During review of the facility's undated policy titled, ROM-PASSIVE, the purpose was identified as: A) to improve resident's joints through as full a range of motion as possible, B) to improve or maintain joint mobility, C) to prevent contracture. R33 did not receive restorative nursing services for range of motion (ROM) and ambulation as indicated. R33 had diagnoses that included contracture of the right hand, lower extremity (LE) cerebral vascular disease, and hemiplegia. During an observation on 1/29/13, at 11:34 a.m., R33 was observed to have a contracture of the right hand. The resident was not observed to utilize a splint or ROM services. R33 was observed to receive cares on 1/29/13, 1/30/13 and 1/31/13, however no ROM service or ambulation was observed to have been provided. Review of the care plan dated 8/20/12, revealed R33 was at a greater than normal risk for falls secondary to history of cerebral vascular accident resulting in unsteady gait. The care plan indicated R33 was to receive extensive assistance for all mobility related to weakness and gave direction for restorative nursing for walking and ROM per physicians order.	2 895			

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2 895	Continued From page 42 The most current physician's orders gave direction for passive range of motion (PROM) to right arm and hand, and active range of motion (AROM) to LE daily. Review of the Restorative Nursing sheets revealed the following information: November 2012, R33 had ambulated 75 feet on 21 of the 30 days, and received ROM on 22 of the 30 days. October 2012, R33 had ambulated 75 feet on 19 of the 31 days, and received ROM on 21 of the 31 days. September 2012, R33 had ambulated 75 feet on 16 of the 30 days, and received ROM on 21 of the 30 days. August 2012, R33 had ambulated 75 feet on 26 of the 31 days, and received ROM on 28 of the 31 days. Daily Ambulation Sheets were reviewed from 12/1/12 to 1/21/13. These sheets revealed the resident was not included on the list directing staff to ambulate. Review of treatment sheets from 12/1/12 to 1/31/12, identified R33 was to receive PROM to left arm and hand daily with a start date of 1/19/13. The sheets revealed R33 had been provided this on care on only four of the 12 days possible. During interview on 1/30/13, at 1:02 p.m. NA-D verified R33 had not received ROM services or ambulation stating, "we move as fast as possible but can't always get everything done."	2 895			

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2 895	Continued From page 43 During interview on 1/30/13, at 2:55 p.m. LPN-A verified R33 had not received ROM services or ambulation. On 2/1/13, at 9:33 a.m. nursing assistant (NA)-E was interviewed. NA-E stated rehab nursing was discontinued in December. NA-E indicated a book was placed at each station with information regarding restorative nursing, however the book did not identify which resident was to receive ROM. NA-E verified R 33 was not on a walk list, and stated " she used to be when we had rehab aids. " NA-E further verified R33 had not received ROM or ambulation services and NA-E was unable to report which residents were to receive ROM. On 2/1/13, at 3:56 p.m. the director of nursing (DON) indicated the floor nurse is responsible for providing ROM. DON verified R33 had not received ROM and stated the NA ' s would require training prior to providing ROM. SUGGESTED METHOD FOR CORRECTION: The DON, director of therapy or designee(s) could review and revise as necessary the policies and procedures regarding implementing and maintaining proper range of motion care. The DON, director of therapy or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident ' s plan of care. The DON, director of therapy or designee(s) could monitor to assure residents receive proper range of motion treatment. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 895			

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2 900	Continued From page 44	2 900			
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 failed to provide care and services necessary to prevent pressure ulcers, including timely repositioning, for 1 of 3 residents (R64) reviewed for pressure ulcer risk. Findings include: R64, at risk for pressure ulcer development, was not offered or provided repositioning on 1/31/13 from 9:01 a.m. to 1:34 p.m. (4 hours and 33 minutes) according to the assessed needs. R64's diagnoses included Parkinson's disease and dementia. The care plan dated 1/29/13, identified R64 as at risk for pressure ulcers and indicated the resident was supposed to be	2 900			

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2 900	Continued From page 45 repositioned every three hours. The quarterly Minimum Data Set dated 11/5/12 indicated R64 had short and long term memory loss and R64 was totally dependent with bed mobility and transfers with two plus staff and was at risk for pressure ulcers. The Braden Scale (a tool for predicting pressure ulcer risk) dated 12/25/12, identified a total score of 12. The facility's assessment of the residents tissue response to prolonged pressure (Tissue Tolerance) dated 11/23/11, indicated R64 was dependent with positioning self in a sitting and lying position. Under observation report, a check was placed identifying R64 was to be repositioned every three hours sitting. The summary directed staff to use maxi chair with anti-pressure liner and to reposition within two hours. The care plan dated 1/29/13, identified R64 was at risk for pressure ulcers and was to be repositioned every three hours. During observation on 1/31/13 at 9:01 a.m., R64 was transferred from bed to a maxi chair and was wheeled to the dining room. At 09:30 a.m., R64 was wheeled out of the dining room and into the lobby by the bird aviary. R64 was still sitting in the maxi chair and was not repositioned. At 9:56 a.m. R64 remained in the maxi chair in the lobby. At 10:15 a.m. R64 was wheeled to the chapel for activities and had not been repositioned. At 11:09 a.m. R64 was wheeled back to the lobby by the aviary. At 11:25 a.m. R64 remained in the maxi chair in the lobby by the aviary. At 11:38 a.m. R64 was wheeled to the dining room. At 12:20 p.m., R64 remained in dining room sitting in the maxi chair. At 12:38 p.m., R 64 remained sitting in dining room eating lunch. At 12:47 p.m., R64 was wheeled to his room by nursing assistant (NA)-I. R64 remained sitting in the maxi	2 900			

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2 900	Continued From page 46 chair and had not been repositioned. At 1:28 p.m., R64 remained sitting in maxi chair in room. At 1:34 p.m., NA-I came into the room with NA-K to assist with the transfer of R64 from the maxi chair into bed (4 hours and 33 minutes since last repositioned). During interview on 1/31/13 at 1:30 p.m., NA-I confirmed R64 was to be repositioned every two hours. NA-I indicated R64 got up late this morning sometime around 8:30 a.m., NA-I verified R64 should have been repositioned every two hours and had not been repositioned in a timely manner. During interview on 1/31/13 at 12:19 p.m., licensed practical nurse (LPN)-C confirmed an assessment of the resident's tolerance to prolonged pressure (tissue tolerance) indicated R64 was to be repositioned every three hours. However, LPN-C also said she thought R64 was to be repositioned every three hours when lying and two hours when sitting. LPN-C stated she'd completed the last tissue tolerance assessment and indicated she had not gone past the two hour repositioning due to R64 being at a high risk for pressure ulcers. During interview on 2/1/13 at 7:10 a.m., the assistant director of nursing stated all residents are on a two hour repositioning schedule. During interview on 2/1/13 at 11:46 a.m., the director of nursing stated staff should be directed by the tissue tolerance assessment results, and based on the tissue tolerance a care plan was developed. During review of the undated policy titled, Tissue Tolerance Audit Policy and Procedure, the policy	2 900			

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2 900	Continued From page 47 directed staff after the audit period was completed, the Tissue Tolerance Audits would be reviewed and an overall individualized turning and repositioning schedule would be determined for lying and sitting position, care planned, added to the nursing assistant assignment sheets and communicated to the nursing assistants and appropriate staff. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policy and procedures related to providing care to residents at risk or with pressure ulcers. Educate staff on pressure ulcer protocols. Develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 900			
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910			

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2 910	Continued From page 48 This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to provide bladder and bowel services as assessed for 1 of 3 residents (R63) in the sample who had bladder and bowel incontinence. Findings include: R63 was not toileted timely or at a minimum every 2 hours. R63 had not been toileted from 2 hours to 3 hours during observations. R63 was admitted to the facility on 8/11/2010 with diagnoses that included but not limited to: history of urinary tract infection (UTI), pain in joints, diabetes, obesity, heart disease and congestive heart failure. R63's quarterly Minimum Data Set assessment dated 12/20/2012 identified the resident as cognitively alert and oriented. The resident required extensive assist of one staff for mobility, transfer, dressing, bathing, toileting, and ambulation in the corridor. A discharge assessment after hospitalization on 12/27/2012 identified the resident with moderate cognitive impairment, short term memory loss and delirium. On 1/30/2013 at 1:30 p.m., an activities assistant (AA) asked R63 if they wanted to go to BINGO. The resident replied "Yes", but stated, "I have to be changed first." At 1:40 p.m., the resident was changed for urinary incontinence episode and was taken upstairs to BINGO. The resident remained at bingo until 4:20 p.m., when a family (F1) member returned R63 to their room. The	2 910			

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2 910	Continued From page 49 family member put on the resident's call light to request assistance for the resident to be toileted. At 5 p.m., the F1 said that R63 " had to poop " and had been waiting since 4:20 p.m. when the call light was put on but not staff help came to the room. F1 then assisted R63 to the toilet without staff assistance. R63 went from 1:40 p.m. until 5:00 p.m. a total of 3 hours and 20 minutes without being assisted or offered to be toileted. R63 was observed to be in the wheelchair from 5:00 p.m. until 7:30 p.m. (a total of 2.5 hours) without any staff offering to assist the resident to toilet. At 7:30 p.m. nurse aide (NA)-F verified the resident had not been offered to use the toilet or checked for incontinence. A Bowel and bladder assessment dated 12/20/12 identified the resident with impaired mobility, dependent transfer with EZ stand, frequently incontinent of bladder, clothes or incontinence pad wet, had diagnoses that included: CHF(congestive heart failure), CVA (stroke), diabetes, and falls. The resident was on antianxiety, antidepressant, diuretic, and narcotic analgesic medications. The assessment also noted urinary incontinence without sensation of urine loss, scheduled toileting, and will call for assist. R63's care plan dated with problem start date of 4/25/2012 for frequently incontinent of bladder was reviewed. The problem indicated the resident wore Attends (an adult incontinent pad.) The resident was alert and oriented and able to use the call light for assistance to use the toilet. The resident will call for assist as needed and at times may need to be reminded that the Attends needs to be changed related to odor. A note dated 1/3/2013 said that the R63 ' s cognition had changed to more confusion.	2 910			

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2 910	Continued From page 50 On 1/31/2013 at 7:00 a.m., NA-A was interviewed regarding R63's urinary and incontinence. She indicated the staff check on the resident every 2 hours. The resident will go to the bathroom some days and other times will allow them to just check and change the incontinent pad if soiled. Also R63 had become more confused lately. On 1/31/2013 at 9:30 a.m., NA-E had been interviewed concerning R63 ' s toileting this a.m. and NA-E said the resident had been checked for incontinence by NA-A last at 7:15 a.m. and no one since then. From 9:30 a.m. to 10:00 a.m. no staff had asked R63 if they needed assistance with toileting or was incontinent of bladder or bowel. At 10:35 a.m. NA-E entered R63 ' s room and asked if they needed to be toileted or had been soiled. R63 had not been toileted or asked if they needed to be changed of an incontinent episode since 7:15 a.m. or a total of 3 hours and 20 minutes. On 1/31/2013 at 10:35 a.m., NA-E verified she had just been into R63's room, for the first time since NA-A had checked R63 at 7:15 a.m., to check the resident for incontinence. On 2/1/2013 at 1:30 p.m., an assistant director of nursing (ADON) was interviewed regarding R63's F1 assisting the resident to the bathroom when staff weren't available. The ADON indicated the family member shouldn ' t be doing that and staff should be calling for help if they can't assist a resident to the toilet. The staff should be asking R63 every couple hours if the resident needed to be toileted. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents	2 910			

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2 910	Continued From page 51 receive appropriate toileting services based on their assessed needs. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 910			
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 by: Based on observation, interview, and document review, the facility failed to ensure walking programs were consistently implemented for 1 of 3 residents (R63) on a walking program.	2 915			

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2 915	Continued From page 52 Findings include: R63 was not ambulated consistently according to recent therapy recommendations. R63's quarterly minimum data set (MDS) assessment dated 12/20/12 was reviewed. It identified the resident's cognitive status as alert and oriented. The MDS indicated the resident had some verbal and other behaviors, and rejection of care. The activities of daily living data indicated the resident required extensive assist of one staff for mobility, transfer, dressing, bathing, ambulation in corridor (only did 1-2 times in 7 days), used a walker and wheelchair. A therapy to nursing communication written by the physical therapist (PT) dated 1/16/13 was reviewed. It included: "please walk pt (patient) 3x every day with fww (front wheeled walker), assist x1, w/c (wheelchair) following distance as tolerated (60-100 ft). Pt to walk to/from Bathroom with fww & assist x1." The daily ambulation schedule for the week of 1/14 to 1/20/13 indicated R63 had walked in room twice a day (a.m. and p.m.) Monday through Friday, not on Saturday in the morning or afternoon, and that R63 had refused Sunday in the morning and afternoon. For the week of 1/21 to 1/27/13, on Monday the resident only ambulated once in the afternoon, on Tuesday only once in the afternoon, on Wednesday ambulated twice, on Thursday did not ambulate all day, and on Friday ambulated both morning and afternoon. For Saturday, the resident did not ambulate at all and for Sunday the resident had only ambulated one time. The records indicated the ambulation provided did not follow the PT's	2 915			

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2 915	Continued From page 53 recommendations of 3 x day. There was no documentation of how far the resident had ambulated, or when the resident was ambulated. The documentation did indicate the resident had ambulated to the bathroom, but did not identify when or if the resident was ambulated in the hall. On 1/31/13 at 2:35 p.m., the PT was interviewed. The PT indicated R63 had started therapy on 12/31/12 for basic transfer skill development and short distance walking. The resident had refused to go on a program and had therapy on and off related to that. The PT stated R63 had emotional issues when he'd found out he could possibly need an amputation of a leg related to non-healing ulcers. The resident had refused any specific program they'd tried to develop. The resident had subsequently been discontinued to nursing with the recommendation to walk as tolerated 3x/day as documented on 1/16/13. The PT stated if the resident was not participating with nursing, or if nursing sees a decline, R63 should come back to us. The PT indicated she hadn't heard anything since the resident had been discharged from therapy about any issues. The PT stated, "every single session we had with the resident we explained the risks and benefits of not ambulating. The resident did not have insight into the importance of continuing to ambulate with the walker. At discharge from therapy, the resident was able to ambulate up to 128 feet with the fww, but we recommended an average of 60-100 ft. and the resident could easily walk that. It should be out in the hallway and not just to the bathroom and back. We had R63 on a schedule when R63 did have therapy, but the resident would never be ready or had an excuse of why he wouldn't do it. Needed much encouragement."	2 915			

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NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 915	Continued From page 54 R63's care plan with problem start date of 4/24/12 was reviewed. The care plan indicated the resident would often refuse assist for ambulation by staff. "Uses walker and can walk in room. Usually does not walk in hallway." Interventions included: "One staff to walk with resident using a walker if resident requests. Usually walks independently in room but has had falls." The care plan was not updated after the resident was seen by physical therapy and was recommended to ambulate 3 x day. On 1/30/13 at 1:07 p.m., nursing assistant (NA) -D was interviewed and indicated the resident was transferred from the bed to the wheelchair by using the walker and only walked a few steps because R63 was so unsteady. On 1/30/13 at 5:00 p.m.. R63's family member stated the Step down program was canceled in the facility. The family member stated R63 had been walking and standing with staff, but now was not doing it. The family member indicated the resident was not walking at all and stated the resident was walking a lot further before than he did now. As for the rehab program, the family member stated, "It stopped a few months ago and so (the resident) has declined. During this conversation the resident stated, "I am much worse than I was." The family member did acknowledge that the resident still refused at times. On 1/31/13 at 7:00 a.m., NA-A was interviewed. NA-A stated that during personal cares for the morning, the resident stood at the walker and did take 4 steps with the walker and then back to bed. NA-A was not heard to ask the resident to walk in the hall. When interviewed about ambulating the resident in the hallway, NA-A	2 915			

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2 915	Continued From page 55 indicated the resident did not walk in the hallway because the resident refused. However, the resident was on the ambulation list. NA-A indicated they try to get R63 to ambulate in the room to and from the bathroom but the resident would not always do that either. NA-A stated the resident was a "little more confused." SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with ambulation. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 915			
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure the dishwasher and ice machine was free from lime build-up. In addition, the facility failed to ensure employee food items were not stored in the facility cooler observed during the initial kitchen tour. This has the potential to	21015			

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21015	Continued From page 56 affect all 77 residents in the facility. Findings include: The dishwasher and ice machine had lime build up upon initial tour of the kitchen. During initial tour on 1/28/13, at 7:15 a.m., observed lime build up on sides and front of dishwasher along with green and white build up and pinkish crumbles of unknown build up on top of dishwasher. Upon interview Cook-A confirmed the lime build up on the dishwasher and indicated it was supposed to be wiped down at night. Cook-A indicated there was no check off sheet to indicate if and when wiped down last. Noted also the Ice machine in the kitchen had lime build up on front and sides. Cook-A indicated maintenance does a good scrub down once a month and Cook-A indicated she wipes down every other day and the last day cleaned was 1/27/13, yesterday. Cook-A confirmed there was a lot of build up of lime on the ice machine on the front and the sides. During interview on 1/28/13, at 7:25 a.m., maintenance-A indicated the ice machine was cleaned once a month and the dishwasher was cleaned by maintenance every Thursday. Maintenance-A verified the lime build up was "pretty bad" on the top of the dishwasher. Maintenance-A indicated was unsure of who was responsible for cleaning between maintenance schedule of cleaning. and verified the lime builds up quickly. Upon review of maintenance check list exterior cleaning was last done on 1/3/13 and was scheduled every 6 months. During interview on 2/1/13 at 2:33 p.m. the dietary manager verified the ice machine and dishwasher.	21015			

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21015	Continued From page 57 During review of undated policy titled MECHANICAL DISHWASHING PROCEDURE, the policy directed staff under l. after completion of dishwashing, the water should be emptied from the dish machine, strainers emptied and rinsed out and the inside of the machine should be wiped out. Under section n. dish machine will be delimed monthly by maintenance team, clean machine as for daily cleaning, add recommended amount of delimer, run machine two cycles, drain machine and scrub as needed while machine is draining, rinse out machine and clean and polish exterior. During policy review of MANITOWOC B 450 ICE MACHINE MAINTENANCE dated 1/1/96, the policy directed staff to clean area around ice machine as often as necessary to maintain cleanliness and efficient operation, sponge dust dirt off outside with mild soap and water, wipe dry with soft clean cloth. An employee had personal non-pasteurized eggs in facility cooler. During the initial tour on 1/28/13, at 7:03 a.m., observed in the cooler what appeared to be a staff lunch box along with a dozen of brown eggs in an egg carton in a plastic bag. During interview with dietary aide-A at 7:05 a.m., it was verified that the lunch box belonged to a dietary staff member and that the dozen of eggs were eggs brought in from home. During interview on 2/1/13, at 2:33 p.m., the dietary manager indicated staff were allowed to keep their lunch coolers in the facility cooler but were not to bring in eggs to store in the facility cooler due to risk of contamination to the rest of	21015			

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21015	Continued From page 58 the cooler. During review of undated policy titled RESIDENT & STAFF REFRIGERATOR indicated staff refrigerator was provided in the Staff Break room. SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: Fifteen (15 days),	21015			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to distribute ice water in a sanitary manner during 2 of 2 water pass observed on 2 of 2 floors. This had the potential to affect 77 of 77 residents. Findings include: During observation on 1/29/13, at 9:30 a.m., there was a cart sitting on the east hallway on the	21375			

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21375	Continued From page 59 main floor by the small nursing station that contained water glasses, a bucket of ice with a lid on and ice scoop sitting on the ice inside of the bucket. During interview on 1/29/13, at 9:34 am, nursing assistant (NA)-I verified the scoop was sitting on the ice and NA-I indicated had always done it that way. NA-I stated that she was trained to keep the scoop in with the ice. The scoop was always in with the ice. During interview on 1/29/13, at 9:36 a.m., licensed practical nurse (LPN)-F verified the ice scoop was in with the ice and maybe should have something separate to put the scoop in but indicated did not pass ice water so not aware of the policy. During interview on 1/29/13, at 9:40 a.m., the director of nursing confirmed there should be a separate container for the scoop and the ice scoop was not to be kept in with the ice. During observation on 2/1/13, at 11 a.m., in lower level noted ice scoop sitting in ice bucket during the ice pass. During interview on 2/1/13, at 11:01 a.m., NA-J indicated probably should have had a cover on the ice and the ice scoop should be separate but verified was not the current practice. NA-J indicated the ice water pass was for all 23 residents in the lower level. During review of undated policy titled DAILY RESIDENT WATER PASS directed staff to have covered container for ice, ice scoop in a container next to the ice container and scoop needs to be in container between uses.	21375			

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21375	Continued From page 60 Suggested Method of Correction: The administrator or designee could review policy and procedures regarding infection control. Facility could educate staff on policy and procedures and develop a monitoring system to ensure compliance. Time Period for Correction: Twenty one (21) days.	21375			
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced	21535			

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21535	Continued From page 61 by: Based on interview and record review, the facility failed to ensure as needed (PRN) pain medication had criteria and parameters for use, lacked documentation of effectiveness and non-pharmacological interventions were not used prior to use of the pain medication for 3 of 10 residents (R119, R105, R79) who received PRN pain medication, in addition the facility failed to monitor mood to determine if the antidepressant was effective for 1 of 10 residents (R105) currently receiving antidepressant medication. Findings include: R119 received Tramadol (pain medication) without clear parameters for dose use according to pain level. Also non-pharmacological interventions were not used prior to the use of Tramadol. R119 was admitted on 1/21/2013 with diagnoses which included: Lumbago (back pain.) The physician orders dated 1/30/13 read: Tramadol 50 mg every a.m. orally and may take 0.5-1 mg tablets orally every 6 hours PRN for Lumbago. The 1/2013 medication sheets were reviewed and noted that Tramadol (Ultram) medication was used 5 times from 1/24/2013 to 1/30/2013 with each entry there was no dose recorded, three times there was no medication effectiveness recorded and on all four days there was no non-pharmacological interventions used prior to the use of the pain medication. Progress notes for those dates were reviewed and the following was noted for pain management: January 24, 2013, 25 mg of Ultram with some	21535			

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21535	Continued From page 62 relief, no assessment of resident pain level; January 25, 2013, Tramadol given but nothing documented for effectiveness; January 26, 2013, Tramadol given and again no documentation of pain assessment or effectiveness of the medication; January 29, 2013, Tramadol given and documented it was for leg pain but did not include a pain assessment or effectiveness of the pain medication; January 30, 2013 Tramadol was given and no documented effectiveness of the pain medication or a pain assessment completed. On 1/30/2013 at 7:15 p.m., a licensed practical nurse (LPN)-C was interviewed regarding the use of the PRN Tramadol pain medication. LPN-C stated on a standard pain scale from 1-5 rating of resident's pain, the lower dose was given and for the 6-10 rating the higher dose was given. LPN-C also indicated the physician should be identifying when to give which dose ordered. He indicated he gave the dosage according to his assessment of the resident need. He verified he did not document the resident's response to pain level and also verified the medication sheet did not identify the dose amount that was given. On 1/31/2013 at 7:45 a.m., LPN-D was interviewed regarding the range of Tramadol pain medication for R119. LPN-D said they would do a pain rating level from the resident and if it was 1-5, the lesser dose would be given and if it was 6-10 on the scale then the larger dose would be given. LPN-D verified the standard criteria for rating pain wasn't on the resident's medication administration record and the parameters were not on the hospital dismissal summary as she had thought. LPN-D said that the physician should have been contacted to find out what	21535			

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21535	Continued From page 63 parameters for the resident should have been. Dismissal Summary from the hospital dated 1/21/2013 noted Tramadol 50 mg 0.5-1 tab by mouth every 6 hours as needed (use sparingly.) On 2/1/2013 at 9:00 a.m., a registered nurse (RN)-A was interviewed concerning R119 's PRN Tramadol without parameters. RN-A indicated there were no criteria for determining which dose of the PRN pain medication to use. RN-A verified that the staff didn't document the effectiveness of the pain medication consistently but should have each time the pain medication was given. As far as non-pharmacological interventions attempted first, different things are tried but nothing was documented or tracked for any of the residents. R79 was on a PRN pain medication without consistent monitoring for effectiveness of the medication and lacked documentation of use of non-pharmacological interventions prior to receiving the medication. R79 was admitted on 1/18/2012 with diagnoses which included fracture neck of femur. Physician orders identified R79 on Ultram (Tramadol) 100 mg every 6 hours PRN. Start date on 5/2012. The December 2012 and January 2013 medication sheets were reviewed. The resident was given the PRN Ultram pain medication 16 times in December and 15 times in January. Progress notes for December 2012 and January 2013 were reviewed. The December notes identified the pain medication was used 5 times	21535			

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21535	Continued From page 64 (although medication sheet stated 16 times). The effectiveness was not always documented and nothing was documented to identify if non-pharmacological interventions were used prior to the administration of the pain medication. January notes identified the resident used the pain medication twice (although medication sheets identified 16 times.) On 2/1/2013 at 9:10 a.m., RN-A was interviewed on the PRN Ultram (Tramadol) use. RN-A reviewed the December 2012 and January 2013 medication sheets and nursing notes. RN-A verified all the times the Ultram medication was given there had not been documentation for effectiveness of the medication nor was there documentation of use of non-pharmacological interventions prior to administering the medication. R105 was on two PRN pain medications without parameters/criteria for when to use one versus the other, nor was consistent monitoring for effectiveness of the medication recorded no documentation of use of non-pharmacological interventions prior to receiving the medication documented. R105 was admitted on 10/15/2012 with diagnoses which included below the left knee amputation and generalized pain. Physician orders identified R105 on Vicodin 5-500 mg one tab every 4-6 hours for pain and Tylenol extra strength 1000 mg every 6 hours PRN. Both pain medications were ordered on 10/15/2012. January 2013 medication sheets identified the resident was still receiving both of	21535			

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21535	Continued From page 65 these medications. December 2012 and January 2013 medication sheets were reviewed. R105 received Tylenol 9 times and Vicodin (stronger pain medication) 9 times in December 2012. In January 2013, the resident received Tylenol 10 times and the Vicodin medication 14 times. There were no identified criteria or parameters of when to give which pain medication. January 2013 nursing progress notes were reviewed. Effectiveness of pain medication was not always documented. Non-pharmacological interventions were not documented as being attempted prior to the pain medication use. The documentation lacked assessment of the resident's pain level prior to the administration of the PRN pain medication. The resident went for days at a time without any kind of pain medication (Tylenol or Vicodin). On some occasions the pain medication was given but nothing was documented regarding the complaint of pain by the resident. On 2/1/2013 at 9:00 a.m., RN-A was interviewed on when staff was to give the PRN Tylenol and when to give the Vicodin pain medication for R105. RN-A indicated when the resident's pain was less than 5 on a scale of 1 to 10 with 10 being the worst pain ever, she would give the tylenol and if it was at a 6 or more than she would give the Vicodin. RN-A checked R105 's 12/12 and 1/13 medication sheets for PRN use of pain medication and stated staff did not document the effectiveness of the pain medications when given. RN-A said they are to try non pharmacological pain relief interventions first but they had not been documented if effective.	21535			

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21535	Continued From page 66 R105 had made comments about suicidal thoughts and had an increase in an antidepressant however, there had been no monitoring of mood symptoms to determine if the increase of the antidepressant was effective or not. Admitted 10/15/2012 with diagnoses that included: depressive disorder and recent amputation of the left leg below the knee. On 1/9/2013 a psychiatric consultation note from the hospital emergency room (ER) was reviewed. The resident had been reviewed for depression with suicidal ideations at emergency room visit. Some of the notes of the ER visit noted the resident arrived with suicidal ideations. The resident had been feeling down lately and wanted to be euthanized with husband. Had also stated they wanted to take pills to end their life. R105 was returned to the facility and the doctor ordered an increase in Celexa (antidepressant) which was originally started on 12/21/2012. R105 ' s care plan with problem start date noted as 1/23/2013 was reviewed. Under cognition and mood, it noted: On 1/9/2013, R105 reported a plan to commit suicide by overdoing on pills. R105 reported having such thoughts for a while and being unable to stop them. Sent to ER for evaluation and returned same day. Celexa was increased at that time. Interventions included: If resident reports suicidal ideations report to the DON, SW and/or physician immediately and place resident on 15 minute checks. Interdisciplinary notes dated 1/10/2013 through	21535			

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21535	Continued From page 67 1/31/2013 were reviewed. The resident was monitored for three days with some shifts lacking documentation of suicidal thoughts. However, 15-30 minute checks on the resident were completed on paper. No further documentation regarding the suicidal ideation comments were provided. No other mood symptoms were monitored to determine if the increase of the antidepressant was effective. On 1/13/2013 at 9:30 a.m., RN-A was interviewed regarding the monitoring the resident for suicidal thoughts and mood symptoms. RN-A indicated staff used behavior monitoring sheets that were placed in the medication book. However, none were found for the time period of 1/13 or beginning 2/13 med sheets. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced	21565			

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21565	Continued From page 68 by: Based on observation, interview and document review, the facility failed to determine if the practice of self-administration of a nebulizer medication utilizing a nebulizer machine was safe for 1 of 1 resident (R19) in the sample observed during medication pass. Findings include: R19 was left unattended in her room while receiving a nebulizer (inhalation) treatment. R19 did not have an order for self-administration of a nebulizer treatment and did not have an assessment to indicate if R19 was safe for self-administration of an inhaled medications. R19's diagnoses included: chronic obstructive pulmonary disease (COPD,) chronic cough, possible asthma, arthritis and joint pain. A physician order dated 12/13/12, directed staff to administer albuterol sulfate solution via a nebulizer four times a day. R19's care plan dated 12/11/12, indicated R19 had hearing and vision deficits, chronic joint pain involving shoulders, and restricted mobility and pain due to arthritis. R19's care plan indicated she required limited to extensive assistance of one staff with dressing, grooming and bathing. The care plan did not identify R19's ability or inability to safely self-administer medications. The significant change Minimum Data Set (MDS) dated 11/28/12, identified R19 as having hearing and vision impairment, and upper extremity impairment on both sides. On 1/28/13, at 11:15 a.m. licensed practical nurse (LPN)-A was observed to enter R19's room and set up a nebulizer treatment. LPN-A handed	21565			

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21565	Continued From page 69 R19 the prepared nebulizer and stated "I'll be back" and left the room. LPN-A was not present at any time during the treatment. During interview on 1/28/13, at 1:55 p.m. LPN-A verified R19 did not have an order for self-administration of a nebulizer treatment, and did not have an assessment to indicate if R19 was safe for self-administration. LPN-A stated "we usually put it on [nebulizer] and leave, there's no way we have time to stay in their room for 7 minutes." When interviewed on 1/28/13, at 2:10 p.m. the director of nursing (DON) indicated the expectation was that an assessment for self-administration of medication be completed when residents were left alone with a nebulizer treatment. DON verified R19 should have an assessment prior to self-administration of the nebulizer. Review of undated policy titled, Self-Administration of Medications, revealed the policy directed social services to inform each resident of their right to self-administer medications during the admission process. The policy further directed nursing staff to complete an initial assessment on self-administration of medications; the interdisciplinary team was then directed to evaluate the residents ability and judgment to self-administer medications. The policy further directed to obtain a physician's signature and inform the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents have an opportunity to self administer medications and are safe to do so. The director of nursing or her	21565			

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21565	Continued From page 70 designee could educate all appropriate staff members on the processes. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days	21565			
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accommodate preferences of early rising for 1 of 1 resident (R72) who preferred to get up early in the mornings. Findings include: R72 was not given a choice of when to get up in the morning. R72's annual minimum data set assessment (MDS) dated 12/4/12, identified the resident's cognitive status was alert and oriented with no impairment; activities of daily living required extensive assist of one staff for all of them except	21810			

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21810	Continued From page 71 eating, and the resident had a diagnoses of Parkinson's Disease. The MDS did not address a question regarding what time a resident may want to get up in the morning. Resident council notes were reviewed and did not identify any complaints from R72 although the resident had indicated it was brought up in resident council meetings. The social service notes dated 7/2, 8/23,11/16 and 12/18/12 were reviewed. None of the notes identified concerns regarding the resident's preference about getting up in the morning. R72's care plan dated 12/18/12, was reviewed. The care plan indicated the resident had a strong identification with past roles as a farmer and community member. R72 has lived at the care center for two years but continues to long for independence back at the farm, where the resident enjoyed spending time alone with the land and the animals. The notes indicated that R72 understands that Parkinsons disease is a progressive disease and felt at times there was not much to look forward to. The care plan did not address customary routine preferences for getting up early in the morning. On 1/29/13 at 10:43 a.m., R72 was interviewed. During the interview, when questioned about choice of time to get up in the mornings, R72 stated, the "Don't get me up early enough. When I ask they refuse to do it. I want to get up at 4:30 a.m. I was a farmer all my life and got up to milk cows. They get me up between 6 and 7 a.m. I prefer to get up at 4:30 a.m. I could take a nap at noon then if I got tired. In my recliner." On 1/31/13 at 7:00 a.m., nurse aide (NA)-A was	21810			

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21810	Continued From page 72 interviewed about getting R72 up in the mornings. She stated that sometimes they get R72 up right when they get there at 5:30 a.m.. The aide stated she knew R72 had requested the night staff to get up at 4:30 a.m. but they couldn't because it was "too early". She also stated R72 could put the light on when ready to get up. On 1/31/13 at 12:40 PM, the licensed social worker (LSW) was interviewed regarding the resident's choice of getting up in the mornings. The LSW stated the activity director (AD) completed the initial customary routine section of the assessment which would identify that. The LSW said she didn't recall the resident saying anything about getting up early in the morning during resident council, but said R72 had only come once or twice this past year. The LSW stated she wasn't aware of this being an issue. She indicated there was no reason why they couldn't get R72 up when the resident wanted to get up. In addition, the LSW stated that R72 would usually let her know when there is an issue but hadn't said anything. On 1/31/13 at 4:20 p.m, the AD was interviewed regarding resident preferences for arising in the a.m. She indicated she just asked the residents what time they want to go to bed and stated, "after a while you just know who wants to get up and who wants to stay in bed." The AD said the nurse aides should probably be telling the nurses. On 1/31/13 at 4:30 p.m., licensed practical nurse (LPN)-A stated,"Residents can get up as early as they like. No restrictions on how early they can get up. Initially ask them on admission. If nurse aides find out they tell their charge nurse and the nurses put it on the care plan and let everyone	21810			

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21810	Continued From page 73 know." On 1/31/13 at 4:44 p.m., the director of nursing (DON) was interviewed regarding resident preferences for getting up in the mornings. He stated it was by resident choice, and that they try to keep staff on the same units so they know the residents. He stated he would expect staff to get residents up when they would like to get up and he would have no problems with that. The DON stated the residents should be allowed to get up per their customary routine. He said they try to assess routines within the first couple of days to learn what the preferences are and what works for that resident. SUGGESTED METHOD FOR CORRECTION: The DON or designee could establish procedures, educate staff regarding residents preference to customary routine of getting up in the morning. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21810			
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 prompt responses related to grievances of staffing concerns for 6 of 7	21870			

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21870	Continued From page 74 monthly resident council meeting minutes reviewed for resident council. Findings include: The facility did not respond appropriately to resident concerns related to sufficient staffing, as evidenced by resident council meeting minutes and interview with a resident council member. Resident council meeting minutes from meeting held between 6/26 and 12/27/12, were reviewed and revealed the following: The 6/26/12 resident council minutes indicated residents had voiced concerns regarding care not being as good as it used to be for both morning and evening shifts. The minutes did not reflect whether the facility had responded to the concern or discussed a plan for addressing this issue. The 7/31/12 resident council minutes indicated residents had voiced concerns regarding staff failure to answer call lights. The minutes did not address the previous month's concern regarding care nor did they reflect whether the facility had responded to the concern, or discussed a plan for addressing this issue. The 8/28/12 resident council minutes did not address the previous months's concerns nor did they reflect if the facility had discussed a plan for addressing this issue. The 9/25/12 resident council minutes reflected residents had voiced concerns regarding care being worse on the weekends, and on the East wing depending on which staff person was working. The minutes indicated a resident stated, "I sit all a.m. in wet clothes, don't get my bath till	21870			

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21870	Continued From page 75 later." The minutes further indicated the director of nursing (DON) was to check assignment sheets to identify which staff person was responsible when the resident was left in wet clothing, and the DON directed residents to inform him if they were left to sit in wet clothing. The minutes did not reflect whether the facility had discussed a plan for addressing concerns regarding care being worse on the weekends. The 10/30/12 resident council minutes reflected residents continued to voice concerns regarding care including staff answering call lights, and assisting residents with going to bed timely. Residents reported when staff responded to call lights they [staff] had turned the call lights off, telling residents they would be right back, and then would not return for one hour or longer. The minutes indicated the DON agreed East wing was heavy at that time, and the DON had reported the staff to resident ratio was one aide to 8-10 residents. The DON further reported that care level changed often on each wing, stating "if we have 80 residents and 8-9 staff they [staff] can't get you all up at a certain time." The minutes indicated the DON was to request the administrator to check call light times to identify concerns, and a discussion would be held with staff. The 11/27/12 resident council minutes reflected the administrator was present at this meeting during which time a discussion was held between the administrator and residents regarding staffing concerns which resulted in unsatisfactory care. The minutes indicated the administrator had stated, "this summer our census went down to 72-73. We did not cut staff hours [the] but need to now. They will try to maintain 2 aides per wing except north. If any issues arise because of that,	21870			

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21870	Continued From page 76 talk to brad or Nicole." The administrator reported the rehab program had been cut, however nursing was to help with walking residents. The administrator further reported that therapy may become involved if a decline in condition was identified. The administrator had stated, "we try to keep 1 to 10 for aides and 1-20 for nurses but call ins affect that." The minutes indicated a resident had stated, "sometimes on p.m.'s there is only 1 girl working it. The care is not good. Some are here for a paycheck. Some are good but more are not." The administrator had responded by stating, "it's just like your own checkbook, if there is not enough money, you have to make adjustments." Another resident stated, "we have to wait so long in the dining room, to be served." The administrator responded by stating, "we are raising money right now for a new van, ours has over 250,000 miles on it." The minutes reflected the DON asked if there were questions related to rehab, at which time a resident had stated, "why do we wait so for meals." The DON had responded, "they are served at these times: Breakfast 7 a.m., lunch 11:30 a.m., supper 5:00 p.m." The minutes did not reflect whether the facility had discussed a plan for addressing this issue. The resident council minutes from 12/27/12, indicated residents continued to voice concerns regarding care including having to wait in the dining room, not receiving their snacks, and not recieving their medications. The minutes indicated residents had stated, "care was bad, then worse now it has hit rock bottom!" and "they dress me, they throw my dirty clothes on the ground then run over them with my easy up." The DON had reported he would talk one on one to the resident who had reported cares as being rock bottom, not receiving snacks or medication	21870			

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21870	Continued From page 77 when needed. The minutes did not reflect whether the facility had discussed a plan for addressing these issues. R10, who had attended six of the seven resident council meetings was interviewed on 1/29/13, at 10:45 a.m. R10 was unable to recall whether the facility had responded to grievances regarding staffing concerns, stating "I think they talk to everyone separately." R10 verified the facility had not discussed at the council meetings what actions had been taken related staffing concerns. During interview with the activities director (AD) on 1/30/13, at 1:00 p.m. the AD was unable to report what the formal grievance process was. The AD indicated hand written notes were taken during the meetings and then typed. The AD indicated concerns were highlighted and given to each department. The AD was unable to report how each department handles grievances. During interview on 1/30/13, at 1:15 p.m. the DON stated there was no formal process for following up on grievances. The DON stated that if a concern is related to the nursing department he would talk to the resident who had the concern individually. The DON indicated he did not recall the concern voiced at the 12/27/12, meeting regarding the resident who had voiced specific concerns regarding snacks, Tylenol and clothing being thrown on the floor. During interview on 1/30/13, at 3:33 p.m. the administrator verified a call light audit had not been completed. The administrator stated he has not done a call light audit for "6-8 months." The administrator reported he had no access to do one at this time.	21870			

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21870	Continued From page 78 During interview on 1/31/13, at 9:20 a.m. R10 stated, "if something needs to be fixed they talk to you and say they fixed it but I don't know if it gets fixed." R10 further stated, "I don't know if things get done or not." During interview on 1/31/13, at 12:05 p.m. the DON stated he had not received a resident council concern form recently. The DON stated, "so I have not filled one out." During interview on 2/01/13, at 3:24 p.m. the administrator stated the AD was responsible for recording minutes at resident council meetings. He stated if residents voiced grievances, the AD was to write the grievances out and pass them to the administrator as well as to each department involved. The administrator stated the DON would then address the grievances. The administrator also verified the accuracy of the resident council meeting minutes from 6/26/12 to 12/27/12, and further verified he did not know whether or not the grievances were addressed. Review of the Resident Council Concern Policy, dated 6/2009, revealed when writing minutes a Resident Council action form will be written for each concern or problem and directed to the department involved. The policy indicated there would be a time frame to allow each department to follow through with the concerns then the form was to be returned to activities before the next council meeting. The form and response will be shared at the next resident council meeting. The facility was unable to produce documentation that would identify whether the above grievances had been addressed. A SUGGESTD METHOD FOR CORRECTION:	21870			

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21870	Continued From page 79 The Administrator could develop and implement a system which ensures that resident council concerns are addressed timely and thoroughly, with follow up response to the residents; educate staff accordingly. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21870			
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	21980			

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21980	Continued From page 80 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of abuse/neglect immediately for 1 of 4 residents (R79) reviewed for allegation of abuse/neglect in care. Findings include: R79 experienced neglect of care without immediate reporting of the incident to the administrator and state agency (SA) - the Office of Health Facility Complaints (OHFC). An allegation of abuse/neglect report dated 8/4/12, was reviewed for R79. The report indicated R79 had requested to be toileted	21980			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/01/2013
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21980	Continued From page 81 several times and had not been toileted in a timely manner. This had resulted in the resident sitting in urine soaked clothes, on a urine soaked mechanical lift sling, with urine dripping onto the floor. According to the report, a nurse aide who witnessed the incident, had not reported the incident until 3 days later on 8/7/12. At that time, the nurse aide had reported it to the licensed social worker. The report identified the administrator, director of nursing, licensed social worker, and the State agency (OHFC) were notified on 8/7/12 (3 days after the incident). On 2/1/13 at 12:00 p.m., a licensed social worker (LSW) was interviewed regarding the vulnerable adult report of 8/4/12. The LSW verified the aide had not reported the incident for 3 days but should have according to the facility policy. At that same time, the director of nursing was also interviewed. She stated the aide involved had not been retrained about timely reporting. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980			

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22000	Continued From page 82	22000			
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if	22000			

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22000	Continued From page 83 unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their Vulnerable Adult/Abuse Prevention Policies for immediate reporting of allegations of resident abuse/neglect to the administrator and the State designated agency, for 1 of 4 residents (R79) in the sample reviewed for allegations of abuse/neglect. Findings include: A an allegation of abuse/neglect dated 8/4/12, was reviewed for R79. The allegation indicated R79 had requested to be toileted several times and had not been toileted in a timely manner. This had allegedly resulted in the resident sitting in urine soaked clothes, on a urine soaked mechanical lift sling, with urine dripping onto the floor. The report identified the administrator, director of nursing, and the State agency (office of health facility complaints- OHFC) were not notified until 8/7/12 (3 days after the incident). The facility's Vulnerable Adult Policies undated, were reviewed. The policies included: TABLE OF CONTENTS: A. SCREENING B.	22000			

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22000	Continued From page 84 TRAINING C. PREVENTION D. IDENTIFICATION E. REPORTING AND RESPONSE F. INVESTIGATIONS G. PROTECTION H. REPORTING ABUSE TO STATE AGENCIES & OTHER ENTITIES/INDIVIDUALS I. REPORTING SUSPECTED CASES AND /OR INCIDENTS OF RAPE J. INVESTIGATING UNEXPLAINED INJURIES K. VULNERABLE ADULT REPORTING OF ALLEGED MISAPPROPRIATION OF RESIDENT ' S PERSONAL PROPERTY L. RESIDENT-TO-RESIDENT ABUSE M. VISITATION. Under the headings B. TRAINING I. POLICY: IN-SERVICE TRAINING II. PURPOSE: All employees receive periodic in-service training relative to resident rights and our facility's abuse prevention program policies and procedures. E: I. POLICY: REPORTING/INVESTIGATING RESIDENT ACCIDENTS/INCIDENTS; PURPOSE: All accidents/incidents involving residents must be reported to the director of nursing services and immediately to the administrator. H. I. POLICY: REPORTING ABUSE TO STATE AGENCIES AND OTHER ENTITIES/INDIVIDUALS ; II. PURPOSE: All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies. On 2/1/13 at 12:00 p.m. a licensed social worker (LSW) was interviewed regarding the vulnerable adult report from 8/4/12. The LSW verified the aide had not reported the incident for 3 days and should have according to their facility policy. The director of nursing was interviewed at that same time, she stated their had been no retraining done for the aide regarding timely reporting of allegations as indicated in their	22000			

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22000	Continued From page 85 policy. SUGGESTED METHOD FOR CORRECTION: The Director of Nurses and the Social Worker could provide additional education to all staff regarding reporting responsibilities and immediate investigation to ensure implementation of the procedures of the facility's Abuse Prevention Policy. The quality assurance program could randomly audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty- one (21) days.	22000			