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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M2K4

Facility ID: 00943

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245148**

2.STATE VENDOR OR MEDICAID NO.
(L2) **428658800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA**
(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **06/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **208** (L18)

13.Total Certified Beds **208** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	208			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, Health Program Rep Senior 07/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/18/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245148

July 6, 2015

Mr. Timothy Johnson, Administrator
Golden Livingcenter - St Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, Minnesota 55426

Dear Mr. Johnson:

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 June 17, 2015 the above facility is certified for:

208 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 208 skilled nursing facility bed.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 6, 2015

Mr. Timothy Johnson, Administrator
Golden Livingcenter - St Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, Minnesota 55426

RE: Project Number S5148024 and H5148150

Dear Mr. Johnson:

On May 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 8, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 25, 2015 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 May 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 17, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 8, 2015, effective June 17, 2015 and therefore remedies outlined in our letter to you dated May 29, 2015, will not be imposed. In addition, at the time of the June 30, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5148150 that was found to be unsubstantiated.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245148	A. Building B. Wing	6/30/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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 **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **06/17/2015**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0275** Reg. # **483.20(b)(2)(iii)** LSC	Correction Completed **06/17/2015**
ID Prefix **F0278** Reg. # **483.20(q) - (i)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/17/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/17/2015**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0406** Reg. # **483.45(a)** LSC	Correction Completed **06/17/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	07/06/2015	30923	06/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245148	A. Building B. Wing	6/30/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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 **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **06/17/2015**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **06/17/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	07/06/2015	30923	06/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/8/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245148	A. Building B. Wing **01 - MAIN BUILDING 01**	6/25/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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	Correction Completed **06/17/2015**	ID Prefix	Correction Completed **06/17/2015**	ID Prefix	Correction Completed **06/17/2015**
Reg. # **NFPA 101** LSC K0020		Reg. # **NFPA 101** LSC K0021		Reg. # **NFPA 101** LSC K0043	
ID Prefix	Correction Completed **06/17/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0069		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	07/06/2015	28120	06/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/6/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: M2K4

Facility ID: 00943

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245148**
2.STATE VENDOR OR MEDICAID NO.
(L2) **428658800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA**
(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **05/08/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **208** (L18)

13.Total Certified Beds **208** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	208			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NE II 06/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/16/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS
Posted 06/18/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2015

Mr. Timothy Johnson, Administrator
Golden Livingcenter - St Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, Minnesota 55426

RE: Project Number S5148024

Dear Mr. Johnson:

On May 8, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 17, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 17, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will

recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 8, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 8, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	05/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure unresolved grievances were acted on for 5 of 15 residents (R55, R41, R118, R200, R154) reviewed who had voiced concerns with the facility staff. Findings include: The residents repeatedly complained about call lights not being answered and the facility did not resolve their concern. R55's quarterly Minimum Data Set (MDS) dated	F 166	Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continously improve the quality of care and to comply with all applicable state and federal regulatory requirements. a. Facility staff will be designated to meet with each resident who expressed unresolved concerns at the time of the	6/17/15

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

Electronically Signed | 06/05/2015

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F 166	Continued From page 1 2/16/15, indicated R55 had intact cognition and was independent with activities of daily living (ADL's). On 5/5/15, at 3:10 p.m. when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R55 stated "you hit the light and can take forty five minutes to one hour before they show up....I wanted some pain pills, was last week, evening shift about 7, can't remember the day, if you ask the nurses for something they forget about you. Last night I asked for the telephone, forty five minutes later you asked again and finally went down and used another resident phone." R41's quarterly MDS dated 1/26/15, indicated cognition was intact and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. On 5/5/15, at 9:54 a.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R41 stated "there are times I had to wait, some come in and turn off my light and say they are getting help and then don't come back....when I have to go I have to go and that isn't right, mostly weekends." R118's annual MDS dated 4/9/15, indicated R8 had intact cognition and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used	F 166	survey, R55, R41, R118, R200 and R154 and will interview each of them regarding their concerns with recieving care without having to wait a long time. Facility staff will provide timely resolution for the residents concerns according to the Grievance Guideline. b. All residents are informed of facility Grievance Guideline and process for filing concerns. Residents will be reeducated by Social Services Director or designee on the Grievance Guideline at the next resident council meeting. Residents will be educated that facility staff will not retaliate for expressing concerns. c. All staff will be reeducated on the facility Grievance Guideline and ensuring that residents concerns are resolved in a timely manner. Facility staff will be reeducated on call light policy and providing timely response to resident care needs. Staff will be educated to notify management of any issues that may prevent them from providing timely care to the residents. d. Social Services Director or designee will audit grievances 1x weekly for trends and patterns relating to resident complaints about recieving care without having to wait a long time. All residents with grievances relating to recieving care in a timely manner will be followed up with to ensure continued satisfaction with resolutions provided. Facility developed audit form for call lights	

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F 166	Continued From page 2 a walker for mobility. On 5/5/15, at 2:45 p.m. when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R8 stated she had to waited for a long time in the afternoon to have call light answered. R200's MDS dated 2/19/15, indicated R200 had moderately impaired cognition and required extensive assistance of one to staff with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. On 5/4/15, at 5:54 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R200 Stated has to wait for an "Hour" or "Two hours" and "they come in here all pissed at me!" as he described being incontinent of bowel and bladder and waiting to be changed and denied being able to use toilet, urinal, or bed pan. R200 further stated he felt "dirty" and grew teary eyed and began to cry. R154's quarterly MDS dated 2/3/15 indicated cognition was intact, required extensive physical assistance of one staff with bed mobility, dressing, toilet use and supervision oversight of one staff with personal hygiene and used walker and wheelchair for mobility. On 5/5/15, at 3:05 p.m. when asked if she felt there was enough staff available to make sure she got the care and assistance she needed	F 166	to ensure consistent information. DNS or designee will complete call light audits 5 days per week for at least 5 call lights on varying shifts and days and times, including evenings and weekends. DNS or designee will interview 5 nursing staff 1x weekly for potential concerns with providing care to residents without having to wait a long time. Audit results will be reviewed at monthly QAPI meeting and the frequency of the audits will be changed depending on the results.	

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without having to wait for a long time R154 stated "I have waited for hours and even had accidents when waiting for them to come. I use my call light and they don't come at all. Someone said they were going to have three aides and they have had only to and I have to wait until the second shift comes to be changed I should not wait to go the bathroom. I have had UTI's [urinary tract infections] twice and been put on antibiotics and now on cranberry juice. They say I refuse cares but when I am alert, am able to tell them my needs and I have the right to refuse cares but when I need the help and I put the call light I need them to help me." R154 was crying the whole time when explaining to surveyor with tears rolling down her checks as her body was shaking.

On 5/7/15, at 3:57 p.m. when approached R154 indicated some of the staff were indicating she was refusing cares, yet on some nights she was not able to sleep well or had little sleep due to the noise and during the day that was when she was finally falling asleep. R154 further indicated in the last two days during the evening and night shifts the staff had taken over one hour to answer her call light and she had bladder/bowel accidents as a result of waiting for the staff to answer the call light which was a problem and the staff knew about it. When asked how it made her feel when she soiled herself she indicated it made her feel helpless as tears rolling down her cheeks as she stated "I want to go to a different place."

Review of Responding to Resident needs and Call Light Audit forms dated 3/6/15, 3/16/15, 3/18/15, 4/17/15, 4/28/15, 4/29/15, 5/1/15, 5/4/15, 5/5/15, and 5/6/15, revealed the call light audit forms did not consistently provide follow up or indicated resident had confirmed needs were

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met, the audits were mostly completed at the start to mid-week, no Thursdays, Saturdays and Sundays. The audits provided none had been done for 2 South which was one of the units where call light concerns brought up by both residents and staff concerns for adequate care. In addition the facility was using two different kinds of forms for auditing which did not contain consistent information and did not consistently provide follow up and if need had been met. The facility lacked a consistent call light audit system in spite of the many call light complaint grievance's filed by 15 different residents of which some had filed multiple complaints of call light concerns dated from 11/11/14, through 4/27/15, provided.

When interviewed on 5/8/14, at 8:48 a.m. anonymous nurse approached surveyor and provided a note that read "Please ask how is it possible to work on 2 South and 2 North with about 60 residents with lots of behaviors and about 30 people with blood sugars and only four nursing assistants. There is five people on 15 minute checks on 2 South. How is that possible with all other things going on. Please check [R156], check [R54], no enough time to care for this people and other obese residents like they deserve due to no enough staff. Please look into it."
-At 8:53 a.m. when approached staff indicated she was fearful and indicated a lot of time the staff were asked to work a lot and yet the work load was a lot because they were short staffed and with some of the residents needs it was near impossible to finish the work on time and had to work overtime to complete documentation at time.

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F 166	Continued From page 5 On 5/8/15, at 11:56 a.m. when asked what the facility did when residents complained about call lights, the director of nursing (DON) stated they completed grievance forms on call lights. Surveyor indicated to DON after reviewing all grievance forms if there was anything else done other than education DON stated "We are talking about customer service training, how residents are feeling and how we are treating residents." DON indicated another staff person was working on customer service training, also the facility was working on holding the staff accountable and call light audits were being done to ensure they are answered timely. DON also stated currently on 2 East a process improvement plan was being worked on in a weekly basis and staffing numbers were being looked at for example on 2 East had five NAs on day shift, which had increased to six NA's.	F 166		
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure individual resident dignity was maintained for 7 of 31 residents (R154, R257, R1, R55, R96, R193, R135) interviewed regarding dignified treatment. This deficient practice resulted in harm for R154 and R257 who experienced harm and felt disrepected due to lack of provision of	F 241	a. Facility staff will be designated to meet with each resident who expressed unresolved concerns at the time of the survey, R154, R257, R1, R55, R96, R193, and R135 and will interview each of them regarding their concerns with recieving care without having to wait a long time, staff treating them respectfully, identifying	6/17/15

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F 241	Continued From page 6 incontinence cares and privacy. Findings include: R154's quarterly Minimum Data Set (MDS) dated 2/3/15, indicated cognition was intact, required extensive physical assistance of one staff with bed mobility, dressing, toilet use and supervision oversight of one staff with personal hygiene and used walker and wheelchair for mobility. On 5/5/15, at 3:05 p.m. when asked if she felt there was enough staff available to make sure she got the care and assistance she needed without having to wait for a long time R154 stated "I have waited for hours and even had accidents when waiting for them to come. I use my call light and they don't come at all. Someone said they were going to have three aides and they have had only two and I have to wait until the second shift comes to be changed I should not wait to go the bathroom. I have had UTI's [urinary tract infections] twice and been put on antibiotics and now on cranberry juice. They say I refuse cares but when I am alert, am able to tell them my needs and I have the right to refuse cares but when I need the help and I put the call light I need them to help me." When asked if staff treated her with respect and dignity R154 stated "Some don't you tell them to slow down or be soft when providing cares and they just don't." R154 was crying the whole time when explaining to surveyor with tears rolling down her checks as her body was shaking. On 5/7/15, at 3:57 p.m. when approached R154 indicated some of the staff were indicating she was refusing cares, yet on some nights she was not able to sleep well or had little sleep due to the	F 241	themselves, explaining care, providing privacy, and provision of incontinence care. Facility staff will provide timely resolution to their concerns. b. ED or designee is responsible to ensure all residents are treated in a dignified manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Each resident or their responsible party can express potential corcnerns regarding dignified treatment at next care conference or anytime through the facility grievance process. c. All staff will be reeducated on facility policy for residents rights - Dignity, and call light. All staff will be educated on customer service including identifying themselves, expaining care provided, providing privacy. All nursing staff will be educated on provision of incontinence cares. d. A call light audit form was created for consistent information. DNS or designee will complete call light audit 5 days weekly for at least 5 call lights on varying units, and varying days, shifts and times. DNS or designee will audit 5 residents weekly for respectful, dignified treatment, and provision of incontinence cares. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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noise and during the day that was when she was finally falling asleep. As R154 was talking to surveyor she broke down looked to the other side of the room facing the window crying and tears were observed rolling down her cheeks. R154 further indicated in the last two days during the evening and night shifts the staff had taken over one hour to answer her call light and she had accidents as a result of waiting for the staff to answer the call light which is a problem and the staff knows about it. When asked how it made her feel when she soiled herself she indicated it made her feel helpless as tears rolling down her cheeks as she stated "I want to go to a different place."

R154's diagnoses included morbid obesity, bipolar, edema, malaise and fatigue and unspecified urinary incontinence obtained from MDS. The MDS also indicated R154 had rejected cares one to three days during the assessment period, was occasionally incontinent of urine, had no urinary program and was always continent bowel.

During review of the Progress Notes dated 4/1/15, through 5/8/15, it had been documented mostly at the end of the shifts 13 times R154 had refused cares and getting out of bed. Although refusal of care was documented R154 had expressed to staff she did not want to get up and would let staff know but this was considered refusal of care. In addition the Progress Notes revealed R154 had complained of burning with urination and upon a urinary analysis and culture R154 was found to have urinary tract infection which she was treated for with an antibiotic. R154 was not treated in a dignified manner.
R257 was interviewed on 5/6/15, at 8:06 a.m.

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R257, who was assessed as cognitively intact according to the CAA dated 11/17/14, expressed concern and stated, "Some of the staff here don't listen and they just don't care enough to do the job right. I will refuse cares from the staff who do not perform my cares the right way. They don't understand my arthritis and some of them don't have the patience and they push me. Some of the staff are nasty and I have said to them, I don't know what your problem is but you need to leave it outside this door, don't come in to help." Furthermore, R257 expressed sometimes she felt like they are against her that she complains, but they do not understand the arthritis and the problems developing from the arthritis. R257 validated she had refused cares and transfers because the staff are hurting her and they are not listening to what was best for her condition. R257 said staff have told her so many times to just urinate in her brief so that she does. R257 said when she lived on first floor they used the bedpan. R257 boldly stated' "I am not incontinent, I have never been incontinent." R257 did not know why a commode or toilet had not been an option. R257 expressed "feeling sad" that the staff do not understand her pain and condition and was "afraid" they would retaliate against her for complaining and move her to third floor. R257 felt like the staff treat her as if she had a "mental" condition/problem so they do not listen to her. R257 stated, "I am not treated with dignity and respect, the staff listen in on my personal conversations and turn everything against me, I feel like I am worth nothing."

During our interview an activity person came into the room without waiting for permission and preceded to sit on the roommates bed when the roommate was not there. Surveyor asked the

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activity person for privacy so they left the room. R257 said, "See, they were coming in to find out what was being said so they could hold it against me. Watch the bathroom next, they will be in there trying to listen to our conversation."

According to a care area assessment dated 11/11/14, R1 had been assessed as cognitively intact. R1 was interviewed on 5/8/15, at 7:19 a.m. R1 expressed concerns regarding dignity and respect. He said some of the staff come into his room without knocking on the door or waiting for a response. R1 also stated the majority of staff do not say who they are or what they are going to do for you. R1 stated sometimes the staff do not speak in English and expressed "frustration" with not knowing what was being said. R1 said sometimes he would get "angry" because the nursing assistants (NA) would tell the nurse he refused to do something, like get up when they wanted him to. R1 said it wasn't true and that he thought the staff were saying more to the nurses about him refusing so they would not have to do the work of getting him up or taking him to the bathroom when he requested. R1 expressed not knowing who the staff are, even the regulars, and said he sometimes forgot who they were and wished out of dignity and respect, they would tell him who they were each time they entered his room. R1 talked about several of the residents talking about dignity at the facility when cares were not provided according to their (resident) wishes. R1 stated, "I am not important enough for them to care about me. I just want to give up, but I think of the people who can't speak up for themselves. I am afraid of retaliation by them telling me to move out." R1 said he had told "several in management" about his concerns without a resolution to his satisfaction.

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During the interview at about 7:30 a.m. 5/8/15, licensed practical nurse (LPN)-D was observed to enter R1's room without knocking and/or waiting for an invitation to come in. LPN-D did not tell R1 who they were and donning a pair of gloves preceded to do a blood glucose check without informing R1 what they were going to do. The surveyor asked the LPN-D what they were going to do for R1. During the observation another staff member, nursing assistant (NA)-G, also entered the room without knocking or seeking R1's permission.

R55 was interviewed on 5/5/15, at 2:57 p.m. R55, who was assessed as cognitively intact according to the CAA dated 11/21/14, reported the majority of the NAs are very disrespectful and implied they think they have rights above and beyond what we the residents have. An example according to R55 would be while talking to a nurse, the NAs would interrupt and actually talk above what R55 was reporting. According to R55 meals are sometimes missed because the staff forget about [R1] because he was out and about in the facility. R55 feels not getting the meals may be retaliation for concerns expressed to management but has no proof of retaliation. R55 expressed staff have actually walked away from him when they have been asked to do something regarding cares. R55 said the staff have told him to urinate in his brief rather than taking him to the bathroom or offering a urinal. R55 said "It seems petty, but the aides don't introduce themselves or let me know who is my aide for the shift, I think when they come in my room they should tell me who they are." R55 had a note posted on the door of the room informing staff and visitors to knock and wait for permission before entering the room. R55

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expressed fear of retaliation because he speaks up about concerns in the facility, R55 stated, "I am afraid I will lose my room and they will make me move."

R96 was interviewed on 5/7/15, at 7:53 a.m. R96, who was assessed as cognitively intact according to the Care Area Assessment (CAA) dated 3/7/15, complained that staff do not wait for her response before coming into the room and thought that was a dignity concern. R96 expressed relaying concerns to the nurses regarding concerns "many times." R96 said LPN-E barged into the room all the time and when she was told "No, she barges in anyway, looks at me, laughs at me and proceeds to tell the nursing assistants about someone else that needs help. That's a breach of confidentiality." R96 expressed getting "angry and frustrated" that all the interruptions distract the staff who are taking care of her at the time. R96 talked about NA-L and stated, "She is rude, she just comes in without knocking, and doesn't talk to you, doesn't say anything to you, pushes you around like a piece of meat, you ask her to do something and she just looks at you. Everybody know that she is that way and no one gets her straightened out to not be rude." Furthermore R96 talked about dignity and staff telling her to urinate in her brief rather than use the bedpan or commode or toilet. R96 stated, "I demanded to be toileted after lunch, before supper and before bed, I wasn't going to tolerate them telling me to just go in my brief."

During the interview on 5/7/15, about 8:00 a.m., NA-B opened the door without knocking to see who was in the room. R96 validated and stated, "That happens all the time, no knocking and no saying who they are. I once heard that nursing

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F 241	Continued From page 12 assistant tell a resident she was too busy to take care of them." R193 was interviewed on 5/7/15, at 9:55 a.m. R193, who was assessed as cognitively intact according to the CAA dated 5/20/14, expressed dissatisfaction with the "room needing paint and the registers falling apart." R193 stated, "Does that look like they care about me, that is not respect to have my room be like this for so long, they know it is like this." R193 said he had spoken to the ombudsman because of staff coming into his room without knocking and he did not know who they are. R193 expressed concern because staff would say he was sleeping and then they would skip his shower which frustrated him because then they say he was argumentative when the staff are the ones who frustrate him. During the interview on 5/7/15, at 9:55 a.m. the oxygen person knocked on the door and came through the door without waiting for R193 to say come in. The oxygen person did not say their name, did not smile and preceded to move to the oxygen tank. R193 told the oxygen person you did not wait for my response. The oxygen person started to become defensive with the resident. The surveyor intervened and reported the incident to the director of social services. When interviewed on 5/8/15, at 9:18 a.m. the administrator validated the facility had meetings with the residents, but due to the changing of the social services department they have not had an advocate and have lost the trust which needed to be regained with the resident's. The administrator verified the facility did not have a specific policy for dignity, but staff are educated with the Residents Rights information.	F 241		

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R135 was interviewed on 5/7/15, at 10:12 a.m. resident stated "sometimes it takes an hour for aides to come to my room." The most recent happened on 5/5/15, before lunch when R135 turned on the call light. R135 was sitting in her wheelchair at that time and was waiting to go to lunch. R135 verbalized she waited an hour before staff came to get her for lunch.

On 5/7/15, at 1:01 p.m. R135 was interviewed again and further stated she had turned on her call light because she had to use the bathroom [referring back to 5/5/15]. At that time, her incontinent pad was not wet. She stated her pad was wet of urine, when staff came into the room to answer the call light (which was one hour later). When R135 retold the surveyor the information, R135's tone of voice was slightly high pitched and R135's shoulders were slumped in a downward position as if R135 was disgusted.

R135 was admitted to the facility on 1/27/10, per the Admission Record. R135's diagnoses included: cerebrovascular disease, urinary tract infection, diabetes Type II, anxiety, and depressive disorder.

Care plan dated 6/23/14, indicated: "alteration in elimination of bowel and bladder function, functional incontinence of bowel and bladder related to bilateral cerebral infarction, diabetic ketoacidosis, bipolar disorder with personality disorder and history of UTI's. Refused to be checked and changed every two hours, with goal to be free of UTI. Intervention was to check, change or toilet every two hours and as needed (prn). Monitor and report signs and symptoms of UTI. Risks/benefits had been explained of not following toileting plan. Used briefs/pads for

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F 241	Continued From page 14 incontinence protection." The quarterly MDS dated 4/10/15, indicated R135 was cognitively intact, and the MDS indicated moderate depression. Bowel and bladder assessment indicated frequently incontinent of urine, always incontinent of bowels, and was not on a toileting program. Functional status indicated bed mobility was one person assist; transfers were two person assist, dressing was one person assist, toileting was two person assist and hygiene was one person assist. R137 used a wheelchair for mobility. On 5/7/15, at 1:10 p.m. registered nurse (RN)-B stated sometimes residents think time has gone by longer than they realize when they wait for a call light to be answered. She provided a copy of call light log from 3/18/15, and indicated they do not do call light logs daily. RN-B further stated if a resident has a call light concern they will then do a random audit. She did not have a call light audit for 5/5/15. On 5/8/15, at 8:34 a.m. R135 was eating breakfast. When asked if she had concerns with her call light not being answered today, stated "no." Facility did not provide call light or a dignity policy.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices	F 242		6/17/15

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F 242	Continued From page 15 about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure choices were honored for 1 of 3 residents (R107) who requested a shower. Findings include: On 5/4/15, at 5:28 p.m. R107 was asked if she had a choice of how many times she wanted a bath. R107 replied, "I have not had a shower in six weeks. I was on the East side before coming to 2 North. I have been here a month now." R107 indicated she did not want a male nursing assistant [NA] to provide her with showering. R107 added, "I asked last Thursday again and was told she [nursing assistant] would help on Friday." However, R107 stated she did not receive a shower on Friday, and had not asked the nurses because they would not help with showering. R107's quarterly Minimum Data Set (MDS) dated 2/11/15, indicated R107 had been admitted to the facility on 9/29/14, and was cognitively intact. In addition, the MDS assessment indicated R107 needed one person for assistance with bed mobility, transfers, walking in room, dressing, toilet use and personal hygiene. R107's care plan indicated: "physical functioning deficit related to self-care impairment, mobility impairment, with goal to improve current level of physical functioning." Interventions included:	F 242	a. R107 plan of care relating to shower preference was updated at the time of the survey to include preference for female caregiver and 2 showers per week. b. Residents are interviewed regarding their choices and preferences at care conferences and this is care planned. c. CNA care sheets are reviewed and revised to reflect residents choices and preferences for showers. Education to all staff on residents right to make choices about their care. Facility process for notifying changes and updates to CNA care sheets will be communicated. d. DNS or designee will audit 5 residents weekly for residents shower preferences followed. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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assistive devices-wheelchair for mobility, dressing assist of 1-2 depending on needs, personal hygiene assist of 1-2 if incontinent or if needed to shower, prefers female caregivers for showers, and would like to shower once a week, toilet assist of 1, transfer assist 1-2 depending on lower limb weakness, walking assist."

Quarterly MDS behavioral care area assessment dated 4/16/15, indicated "verbal behavioral symptoms directed towards others (e.g. threatening others, screaming at others, cursing at others) behavior of this type occurred 1 to 3 days." The rejection of care did not happen within the last seven days.

On 5/6/15, at 10:55 a.m. when asked about R107's care, NA-I stated she was independent and would ask for help when she needed it.

On 5/6/15, at 10:59 a.m. registered nurse (RN)-B stated R107's shower was scheduled for Friday evening. When asked when R107's last shower was, RN-B stated she would look for the date.

On 5/6/15, at 12:29 p.m. R107 again reiterated she had last had a shower six weeks ago, but verified she would be getting a shower that afternoon.

On 5/6/15, at 2:08 p.m. RN-B stated NAs have told her R107 had refused her showers in the past, and stated she would take it later. RN-B said she was aware R107 did not want a male caregiver to assist with her shower. RN-B then put resident on a shower schedule for showers twice a week.

On 5/6/15, at 2:23 p.m. R107 was observed

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F 242	Continued From page 17 sitting outside in her wheelchair. When asked if she had been given a shower, R107 stated "yes" said she felt "great". On 5/7/15, at 10:15 a.m. RN-B stated the first Friday R107 had arrived on the unit was 4/10/15 and RN-B stated R107 had declined a shower. RN-B said another time a shower was offered by a female R107 said "later." However, R107 never came back to get a shower from the NA. RN-A indicated she could not determine whether the NA had ever re-approached R107 regarding the shower.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure activities were offered to 2 of 3 residents (R90, R56) who were at risk for social isolation and reviewed for activities. Findings include: On 5/4/15, at 7:21 p.m. R90 was observed to be in bed. The bed was observed to be against the wall under the only window in the room. The television (TV) was observed to be located on a built in dresser at the foot of the bed. Although	F 248	a. R56 passed away. R90 reassessed leisure interests survey, reassessed risk of isolation, updated plan of care based on reassessment. R90 added additional cds, books on cd. Posted signs in R90 room for staff to ensure volume of music and tv exceeds external noises. R90 increased in room visits from 2 to 3 per week. b. All resident are assessed for leisure interests and risk of isolation with scheduled assessments. Plan of care	6/17/15

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F 248	Continued From page 18 the TV was turned on at the time of the observation, R90 was not facing the TV so would not have been able to see the picture. The TV screen faced the door and not R90's bed. The volume was observed to be on low and could not be heard over the sound of an oxygen concentrator running in the room. At the time of the observation, R90's eyes were fixed and the resident did not rouse to voice. On 5/5/15, at 9:27 a.m. R90 was observed to be in bed in the room. R90 was again positioned in a manner so she was unable to see the TV screen. In addition, the TV volume was adjusted so low R90 would not be able to hear the TV over the sound of the oxygen machine. On 5/6/15, at 7:21 a.m., two nursing students (NS)-A and NS-B, were observed in the room with R90. Both students were observed to gather supplies for cares in and out of the room. R90's TV was turned off. - At 7:46 a.m. R90's door was observed to be open to room. R90 was observed to be laying on her right side facing the door. The over bed light was turned on, the drapes were partially opened over the bed. The TV was turned off; although a radio and compact disc (CD) player were observed in the room, they were turned off. - From 9:16 a.m. to 10:00 a.m. no staff were observed to enter R90's room, and neither the TV, radio or CD player were on.. - At 10:07 a.m. the door was closed. After knocking and slowly opening the door, it was observed the over bed light was turned on and R90 was observed to be laying on her left side. The TV, CD player, and radio, and hot been turned on and no staff were in the room. The curtains to the only window were observed to be	F 248	updated to reflect assessment. c. TR reviews weekly any change in resident participation with activities and reassesses need for in room activites and changes plan of care based on assessment. Education provided to recreation therapy staff on completing leisure assessments and risk of isolation and updating plan of care and providing activities according to the plan of care. d. TR Director or designee to audit 5 residents 1x week who are at risk of isolation. Audit results will be reviewed at monthly QAPI meeting and the frequency of the audits will be changed depending on the results.	

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closed.
- At 10:40 a.m. registered nurse (RN)-C explained R90 sometimes able to communicate by blinking to yes/no questions. Surveyor and RN-C engaged R90, but the resident did not blink or respond. RN-C further explained the increased activity level in the room was "not normal" for R90 and she was "agitated" from the different people in the room.
- At 2:31 p.m. R90 was observed to be laying on her right side. The TV, CD player and radio were turned off, the room was dark and the curtains to the only window were partially closed. At the time of the observation the therapeutic recreation staff (TR) was observed to wheel a cart into the room. The cart contained a guitar and various music items. At 2:34 p.m. TR was observed to play gospel music on the guitar and sing to R90. TR talked to R90 about going to church with her sister.

The quarterly Minimum Data Set (MDS) dated 3/5/15, indicated R90 was not in a coma, could sometimes understand others, but was rarely/never understood; R90's vision and hearing were identified as adequate; the MDS indicated R90 had severely impaired cognition, but had no behavior or mood problems. R90 required total dependence with activities of daily living, did not ambulate, transfer or leave the unit. The quarterly assessment did not include review of activity (therapeutic recreation) preferences.

A TR Quarterly Review Note dated 3/16/15, identified R90 received 1:1s, music therapy weekly along with "listening to TV and CD [compact disc] player." The note identified R90's vision was "poor," that R90 was unable to vocalize; and could "use eyes to communicate

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yes or no answers." The note identified R90 would receive weekly 1:1 visits, listen to TV, listen to music and listen to books on CD.

The Annual MDS dated 4/18/14, indicated R90 could sometimes understand and be understood, had severely impaired cognition, no mood or behavior problems, total dependence for transfer and all other ADLs, did not walk (did leave the unit); R90 was at risk for pressure ulcers and had no pressure ulcers. The MDS indicated R90 could not be interviewed for activity preferences, the MDS indicated staff identified R90 cared for her personal belongings, receiving shower, family involvement, listening to music, spending time outdoors and participating in religious activities.

The Care Area Assessment (CAA) for Activities dated 4/18/14, identified, "[R90] is unable to participate in in most activities d/t [due to] diagnosis. Writer does 1:1's 1-2x/wk [one to one visits one to two times per week]. [R90] watches TV, listens to music and books on CD, and occasionally watches a movie in the dayroom." "Resident's family has asked for books on tape." "Resident needs sensory stimulation."

The Recreation Services Assessment dated 4/25/14, indicated R90 had sisters who were involved in her care, spoke English and had an education of a Bachelor's Degree. The assessment indicated R90's vision was impaired, hearing was intact, that R90 was non-verbal and communicated in gestures, with "Fair" short and long-term recall and no decision making ability. R90 was identified as having a delayed response, limited and weak motor abilities all extremities, was dependent for mobility and assisted from bed. The Activity Adaptations (Equipment,

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Techniques, Cautions) section consisted of a check mark for "Talking books" and identified R90 was "NPO [nothing by mouth]." R90's interests were identified as: Games/Cards - past; television, musicals, movies; music - sacred, blues, jazz; "Books on tape," "Sit outside," Religious - "sacred songs, the Our Father, Christian, "family visits often." The program preferences section consisted of a check list which checked: 1:1, With Friends/Family, In-Room; no preferred activity times were identified; the information source for the assessment was "staff."

On 5/7/15, at 1:48 p.m. TR and surveyor reviewed the Attendance Records (Individual) for 2015. The documentation consisted of letter codes identifying R90's activity attendance. TR stated a U = watching TV; JZ=1:1, J=social visit; LI=audio book, when asked if books on CD were in the room, TR stated she "would stop in and play a chapter" of a book and stated "at times the aides" turned the book on CD on for R90. TR stated the rest of the codes were as follows MZ=music therapy, and X=family visits. Review of the attendance indicated the following:
- January 2015, out of 31 opportunities, R90 had an activity documented 16 times during the month. All identified activities were in room.
- February 2015, out of 28 opportunities, R90 had in room activities coded 22 times.
- March 2015, out of 31 opportunities, R90 had 10 in room activities coded.
- April 2015, out of 30 opportunities, R90 had 7 in room activities coded.
- May 2015, R90 had no activities coded for the month of May at the time of the review on 5/7/15.
During the review, the TR verified R90's activity attendance had decreased since February and

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only included in room activities. TR stated R90 had not left the room for activities, but was unclear for how long. TR stated R90 was at risk for isolation in her room. TR verified R90 attended less than two activities, determined R90 went for long periods of unstructured time in the room, and stated she determined R90 had severe physical limitations. TR explained the 1:1s were being done 1-2x/week; TR stated when staff were not in the room, or if TR was not doing a 1:1 or music therapy, TR stated staff should have turned the TV on for R90 to watch or listen to radio. TR stated she usually asked the resident if she wanted to "watch TV" and R90 would indicate she wanted TV with her "eyes." When asked if TR was supposed to be able to see the TV from the bed, TR stated R90 "listened" to the TV, more than watched it. When asked if the radio should have been turned on, or when the TV was observed to have the sound off, TR stated the sound should have been turned up. TR stated there were books/CD's in R90's room for staff to put in the player for R90. TR was unclear how long it had been since R90 had been out of her room, or why R90 no longer transferred out of bed. TR stated, "I'm not a medical person, so I'm not sure why [R90] doesn't come out anymore."

R90's 1:1 Risk of Isolation Assessments dated 10/6/14, and 3/16/15, both indicated R90 attended less than two activities per week, and also identified R90 had a low ability to engage in meaningful conversations, programs, or interests. The 10/6/14, assessment identified R90 had "severe physical limitations." The 10/6/14, assessment directed R90 needed 1:1 interventions twice per week, recommended "Books on Tape, Music CD, Music Therapy, Religious Visit" and indicated, "[R90] needs

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stimulation d/t [due to] not leaving her room." The 3/16/15, assessment also indicated R90 had "long periods of unstructured time (staring into space, sitting in dayroom etc)," and indicated R90 had "severe physical limitations." The assessment recapitulated the same interventions, frequency of 1:1 visits and need for socialization and mental stimulation.

The current care plan for activity for R90 dated as initiated on 9/9/13, identified R90 required assistance participating in activities. Interventions regarding family visits on Sundays, listing to music and TV when not sleeping, using the CD/radio, a sign in the room reminding staff to turn on the TV or music including audible volume were dated as initiated on 5/7/15.

On 5/7/15, at 2:17 the director of therapeutic recreation (DTR) and surveyor observed R90 in the room. During the observation, R90's TV was observed to be turned on with volume too low to be heard over the sound of the oxygen. DTR confirmed the sound was too low to be heard by R90 and R90 could not see the TV from the bed. DTR confirmed the CD/Radio were available but turned off; DTR verified there were music CD's and a Book on CD directly under the radio for R90 to listen to. DTR stated she was not clear on the plan for R90's in room activities and did not know R90 did not leave the room. DTR stated R90 was at risk for isolation.

On 5/7/15, at 2:50 p.m. DTR verified R90 had not left her room to attend activities. DTR further stated if R90's activity attendance changed, such as no longer attending scheduled activities outside the room, R90 should have been reassessed for activities. AD stated staff should

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have turned the music or TV on for R90 after leaving the room. DTR stated if R90 was assessed to be able to tolerate "one hour" up in a chair, R90 would be able to attend a scheduled activity within that hour.

The policy and procedures for Recreation Assessments dated as effective 2/19/15, for Recreation Care Plan and for Family Involvement both dated as effective 2/24/15, were reviewed. None of the policies addressed ensuring residents at risk were provided with appropriate in room activities, such as but not limited to, strategies to ensure the assessed interventions on the care plan were followed.

The policy and procedure for Individual Programming dated as effective 2/24/15, indicated resident who do not participate in group activities would be identified through the assessment process. The policy directed structured individual interventions would be developed based on each resident's history and assessed needs and preferences. The policy identified the activities "should be adapted in various ways to accommodate the resident's change in functioning due to physical or cognitive limitations."

R56 was observed on 5/4/15, at 2:00 p.m. seated in his wheelchair (w/c) in his room when approached and spoken too R56 stared at surveyor, did not respond and was noted to be sleepy. At the time no music or television was noted in the room, the privacy curtain was pulled.

On 5/5/15, at 8:30 a.m. to 3:00 p.m. R56 was not observed to attend and was not observed to be offered any activities outside or in the room.

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F 248	Continued From page 25 On 5/6/15, at 7:34 a.m. R56 was seated in front of the lounge connected to the dining room asleep in front of the TV. -At 7:45 a.m. to 8:39 a.m. R56 was seated at the table being assisted with his breakfast eyes closed during the entire time. -At 8:40 a.m. licensed practical nurse (LPN)-F wheeled R56 down to his room and transferred R56 to bed. -At 8:45 a.m. to 11:15 p.m. R56 remained in his room lying in bed sleeping no activity was offered no radio or TV on in room and none available. -At 11:45 a.m. R56 was observed seated in his wheelchair asleep in the dining room. - At 1:30 p.m. to 3:15 p.m. R56 was again back in bed lying in his bed eyes open looking outside the hallway no TV or radio in room. Privacy curtain pulled lights out in room. On 5/7/15, at 7:55 a.m. to 10:00 a.m. R56 was lying in bed asleep hard to arouse the privacy curtain was pulled room was dark still wearing a hospital gown no TV or radio in the room. - At 10:00 a.m. to 11:12 a.m. R56 remained in bed lying in bed looking around. The room was noted to be dark and the privacy curtains were pulled partially door open when approached and asked what he liked to do R56 stated "I like TV, games and music but I don't have a TV." When surveyor pulled the curtain on the other side of the bed a TV set was observed on the stand not plugged and was facing away from R56. - At 1:22 p.m. during the environmental tour with the administrator and the maintenance director R56 was observed still lying in bed at the time LPN-F was repositioning R56. R56's activities care plan dated 4/5/11, identified	F 248		

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R56 had potential of alteration in psychosocial well-being as demonstrated by history of withdrawal from social and individual activities. The care plan indicated "I spend majority of time in my room per choice." The care plan directed staff to "Assist me with problem solving, encourage involvement in activities and therapeutic recreation programming, encourage me to come out of my room for activities of interest and socialization, encourage me to eat in the craft room for all meals by assisting me there in my wheelchair and provide emotional support as needed [PRN]."

R56's diagnoses included dementia, diabetes and chronic obstructive pulmonary disease obtained from the significant change MDS dated 3/16/15. In addition MDS section for Preference for Customary Routine and Activities indicated it was "Very Important" to have books, newspapers and magazines to read, participate in religious services or practices, listen to music, and it was "Somewhat Important" to do things with groups of people and keep up with the news. R56 did not have the Activities CAA trigger and no recreation service assessment could be located in the medical record even though R56 had been identified with potential of psychosocial well-being with history of withdrawal from social and individual activities.

R56's Therapeutic Recreation Attendance Record dated January 2015, through 5/7/15, indicated R56 had attended 60 activities out of 158 days of which 39 coded as "S=Sleeping", 17 coded as "A=active", one coded as "P=passive", two coded as "R=refused and one coded as "I". The attendance record also revealed since R56 had been moved to the unit on 4/17/15, it had been

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documented only two times activity had been offered.

R56's Comprehensive Assessment Note dated 3/14/15, indicated "Resident prefers to stay in his room and watch television and/or rest most of the day."

The Resident/Patient and Family/Representative Participation in Care Planning form dated 3/25/15, identified, "[R90] Does music, CD's & books on CD w/res [with resident]. Res not doing as many eye movements for yes or no as prior." The form further indicated, "Court apt [appointment] to appoint new guardian r/t [related to] current one having a stroke."

A Progress Note dated 5/4/15, by TR staff indicated "Res. [resident] transferred from RM [room] 381 d/t [due to] medical condition. He attended Crosswords on 4/21/15. He has refused all activities invites. Care plan changed. 1:1 Risk Assessment Complete. Res. will receive 1:1's 1x/wkly [weekly] by TR." Although the 1:1 Risk of Isolation Assessment was completed on 5/4/15, the care plan was not revised until 5/7/15, after the concern of lack of activity participation which was collaborated with no TV or radio was in the room when R56 was in the room during all the observations.

On 5/7/15, at 9:30 a.m. the unit TR stated R56 refused all activities at times and now staff was doing 1:1's with him which he was benefiting from and the staff would do it once a week but would still offer other activities and he would come to those he wanted to attend. She went on to state R56 had just moved to the unit on 4/17/15, and during that time had only had two times he had

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attended an activity as per the activity log. When asked where the documentation would be for R56's activities refusal she provided only one sheet dated 5/4/15, which had indicated R56 had refused and that was all the documentation she had.

On 5/8/15, at 8:27 p.m. when asked if an assessment had been completed for R56's the director for DTR stated R56 had resided on third floor prior to being moved to second floor and thought for resident's on the third floor "I don't think they do the assessment that is attached in Point Click Care like the one we do on this floor. Am not sure and would look and get back to you."
-At 8:30 a.m. TR stated on Monday 5/4/15, at 10:30 a.m. she had a ball tossing activity which R56 had attended but he had not been able to participate but when music was played she thought R56 was listening and thought R56 was singing but was not sure if it was him. DTR added R56 had extensive history of not wanting to participate in group activities and thought it was because of his mental health history. TR also stated she had and continues to make several attempts to initiate activities with R56 but was not successful. When asked for documentation of the attempts made she acknowledged she never documented and only documented when R56 had a "firm refusal."
-At 8:32 a.m. TR indicated the previous week she had reported to the nurse manager about making sure a television was in R56's room. TR further indicated she had approached R56 on 5/7/15, around 12:30 p.m. to attempt a 1:1 activity but found staff was assisting R56 with eating which was after the activity concern had been brought to the departments' attention.
-At 8:34 a.m. both the DTR director and TR both

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F 248	Continued From page 29 verified R56 did not have a TV in his side of the room and the TV on the other side was unplugged and also verified there was no radio in the room. On 5/8/15, at 9:05 a.m. the DTR director and TR both verified the significant change MDS dated 3/16/15, indicated it was "Very Important" to have books, newspapers and magazines to read, do favorite activities, participate in religious services or practices, listen to music, and it was "Somewhat Important" to do things with groups of people and keep up with the news. Which was contrary was what both were indicating about R56's activity preferences. -At 9:06 a.m. when asked what her expectation was regarding staff documentation on resident attendance or refusals DTR stated "they should document in the medical record or the activity attendance sheets." When asked about the care plan DTR stated it should have been updated as indicated. - At 10:34 a.m. the DTR approached surveyor stated she had talked to the nursing manager who had stated R56 was not feeling well that week and that would explain his low interest in activities. When asked about other weeks since he had moved to the unit DTR director was not able to answer to it. DTR further stated she had completed a recreation services assessment after the concern had been brought to her attention and was initiating other activities for R56.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		6/17/15

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F 253	Continued From page 30 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R90) tube feeding pole was maintained in a clean and sanitary manner. In addition, the facility failed to ensure 1 of 1 resident (R41) wheelchair was maintained in a clean manner reviewed for environmental concerns. Findings include: On 5/4/15, at 7:21 p.m. R90's tube feeding was observed to be on and running. The floor directly under the tube feeding pump/pole base was observed to have dried tan colored spills (the same color as the formula). The area of the floor to the right of the head of R90's bed was observed to have many black colored spatter shapes directly under and around the tube feeding pole base. The bathroom wall and ceiling were observed to be heavily patched; the exhaust vent cover was observed to be off and lying on the floor. A thin film of dust covered all surfaces and items in the room. On 5/5/15, at 9:32 a.m. the same formula spills remained unchanged on the floor around the tube feeding pole. The room remained unchanged, the tube feeding was on and running, R90 remained in bed. On 5/6/15, at 7:21 a.m. during observation R90 was in bed the tube feeding pole and base surfaces were observed to be covered with splatters of a tan colored liquid. The floor directly	F 253	a. R90 tube feeding pole was cleaned at the time of the enviornmental tour. R41 electric w/c was cleaned following survey exit. b. ED or designee is responsible to complete regular enviornmental rounds and observe for sanitary, orderly, and comfortable interior. c. Facility staff will be educated on cleaning up spills as they occur on iv poles and wheelchairs, facility schedule for routine housekeeping and maintenance services, and process for notifying housekeeping and maintenance for needed cleaning and repairs. Cleaning of medical equipment was added to the night shift duty schedule. Housekeeping is resposible to clean wheelchairs routinely. d. ED or designee will audit all IV poles weekly, and 5 wheelchairs per unit weekly for cleanliness. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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to the right of the head of R90's bed was observed to have the same numerous dried and sticky spills and spatters of tan colored liquid, blackish colored dried spills and spatters under and around the tube feeding pole. The floor under R90's bed was observed to have a buildup of dust and debris. Room surfaces remained dusty. The tube feeding was observed to be turned on, connected and running. A housekeeping cart was observed outside of the room, a housekeeping staff was observed to clean the opposite side of the hallway.
- At 7:36 a.m. a housekeeping staff was observed in resident room 255 cleaning and mopping the floor. The housekeeper (H)-A stated floors in resident rooms were mopped every morning and scheduled to be deep cleaned once a month. H-A stated housekeepers were assigned to different rooms to clean daily. H-A pointed to the side of the hallway across from R90's room and stated she was only to clean the "odd sided" rooms (not R90's room).

On 5/7/15, at 12:36 p.m. to 1:32 p.m. the environmental tour was conducted with the maintenance director (MD) and the administrator. During the tour MD verified the entire tube feeding pole and ball bearing caster were soiled/covered with dried white/brown matter. In addition MD verified there was dried matter all over the floor. During the tour the administrator stated "spills should be cleaned immediately" he further stated general room cleaning was done daily and deep cleaning was done every month.

On 5/7/15, at 1:40 p.m. the house keeping director verified under R90's bed was a lot of debris and dried matter and stated he was going to have it all cleaned.

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R90's diagnoses included aphasia and respiratory failure obtained from quarterly Minimum Data Set (MDS) dated 3/5/15. In addition the MDS indicated R90 received tube feeding and had severely impaired cognitive skills.

Review of the Deep Clean Schedule Housekeeping logs for February 2015, through April 2015, revealed R90's room had not been deep cleaned per the facility policy/protocol monthly as indicated by MD, housekeeping director and the administrator during the tour.

Wheelchair
R41's electric wheelchair on 5/5/15, at 11:27 a.m. during interview was noted to have heavy white dust on the entire bottom carriage area and with food spills underneath carriage area and foot rest.

On 5/6/15, at 10:10 a.m. the electric wheelchair was still observed to have visible heavy white dust on the frame, carriage area and foot rest had food debris/spills. When asked who was responsible for cleaning his wheelchair R41 stated the facility was supposed to help him but no one had offered to clean it.

During the tour the administrator verified the electric wheelchair was covered with heavy powder debris which was even visible from a distance. When asked who was responsible to assisting and ensuring resident's wheelchairs were clean the administrator stated housekeeping and had a schedule. The administrator further stated R41 was in the community a lot and was not able to respond when asked who was responsible for ensuring the wheelchair was

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F 253	Continued From page 33 clean even though R41 was out a lot causing the wheelchair to be dirty. On 5/7/15, at 2:26 p.m. the housekeeping director stated regarding wheelchair cleaning Healthcare Service group (HSG) had taken over wheelchair cleaning starting May 1st and was going to clean the wheelchairs on one floor each week and prior to that the facility was responsible. R41's diagnoses included muscular dystrophy, chronic pain, history of non-weight bearing and muscle weakness obtained from the admission record dated 5/8/15. R41's quarterly MDS dated 1/26/15, identified R41 had a functional limitation to both lower extremities, required total physical dependence of two staff with transfers and used a wheelchair for mobility. On 5/7/15, at 1:40 p.m. resident care equipment cleaning and maintenance was requested but was not provided.	F 253		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not comprehensively assess 1 of 1 resident (R90) who required a comprehensive assessment at 366 days and who was reviewed	F 275	a. R90 comprehensive assessment was completed. b. All residents will have a	6/17/15

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F 275	Continued From page 34 for current pressure ulcers. Findings include: R90's annual Minimum Data Set (MDS) dated 4/18/14, identified R90 was not in a coma, could sometimes understand and be understood, had severely impaired cognition, and R90 had no mood or behavior problems. The annual MDS indicated R90 was totally dependent on staff for all activities of daily living, including transfers, bed mobility, eating and toilet use; R90 did not walk and was identified as at risk for pressure ulcers. The Care Area Assessment (CAA) for Nutrition and Annual Nutritional Assessment dated 4/18/14, identified R90 had diagnoses to include Locked-In Syndrome, stroke and dysphagia (difficulty swallowing) and received nothing by mouth (NPO). The assessment identified all R90's nutrition was provided with Promote with Fiber at 60 cubic centimeters (cc)/hour. The assessment identified the tube feeding formula was high in protein and remained "appropriate" due to R90's history of "skin breakdown." The assessment identified R90 had no pressure areas noted at the time. The CAA for pressure ulcers dated 4/21/14, indicated, "Resident currently has no pressure ulcer as evident by body audit 4/1/14, and clinical assessment 4/11/14. Resident is at risk for pressure ulcers r/t [related to] need for assist with all mobility, contracture, and incontinence of both bowel and bladder. Resident is at risk for pressure ulcers with potential for infection, discomfort, and further debilitation. Will continue to care plan in order to maintain skin integrity."	F 275	comprehensive assessment completed not less than once every 12 months. c. Education provided to nursing staff on completion of comprehensive assessment not less than every 12 months. All comprehsive assessments will be reviewed with next scheduled MDS. d. DNS or designee to audit 5 MDS weekly for comprehensive assessment completed not less than once every 12 months. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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	245148	A. BUILDING _____ B. WING _____	05/08/2015

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F 275	Continued From page 35	F 275		

The MDS data indicated quarterlies were completed on 7/12/14, on 10/6/14, on 12/31/14, and a fourth quarterly was completed on 3/5/15. The fourth quarterly MDS should have been either a significant change or annual MDS.

The quarterly MDS dated 3/5/15, indicated R90 sustained no change in cognitive, mood or behavioral status. R90 was identified as rarely/never understood and to have declined in ability to communicate. The MDS indicated R90 did not transfer during the assessment period. The MDS identified R90 was always incontinent of bladder and bowel. The quarterly MDS identified R90 had "2 [two] unhealed" unstageable pressure ulcers (full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] and/or eschar [tan, brown or black] in the wound bed) and one Stage 2 (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) which had worsened. The MDS identified R90 used a pressure reduction chair, device for bed and was on a nutrition/hydration program. Although R90 was identified to have multiple pressure ulcers and as having worsening pressure ulcers, the MDS indicated R90 was not on a turning/repositioning program.

On 5/5/15, at 10:47 a.m. during the stage one interview, the licensed practical nurse (LPN)-B was asked if R90 currently had one or more pressure ulcers? LPN-B stated R90 had an unstageable pressure ulcer located at R90's gluteal cleft on both the right and left side of the cleft. LPN-B stated R90's unstageable pressure ulcer started as a "stage two" ulcer on the "left [of the gluteal cleft]." LPN-B stated the Stage 2 on

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F 275	Continued From page 36 the left had "healed," then stated the wound became "one wound" and "became unstageable." LPN-B stated the current unstageable wound was located in R90's coccyx region. On 5/7/15, 10:56 a.m. RN-C and director of resident assessment (DRA) reviewed the MDS data and stated the quarterly MDS dated 3/5/15, should have been an annual (comprehensive) MDS. Both staff verified R90 was not comprehensively assessed on 3/5/15. On 5/7/15, at 12:18 p.m. LPN-B stated R90 had a Stage 2 pressure ulcer to left and right buttock and was notified of the pressure ulcers on 1/28/15. On 5/7/15, at 2:18 p.m. the director of nursing (DON) verified R90 was not comprehensively assessed when the coccyx pressure ulcers returned on 1/28/15. DON verified the MDS dated 3/5/15, should have been an annual comprehensive MDS.	F 275		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		6/17/15

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F 278	Continued From page 37 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 1 of 3 residents (R90) reviewed for pressure ulcers. Findings include: R90's annual MDS dated 4/18/14, identified R90 was not in a coma, could sometimes understand and be understood, had severely impaired cognition, and R90 had no mood or behavior problems. The annual MDS indicated R90 was totally dependent on staff for all activities of daily living, including transfers, bed mobility, eating and toilet use; R90 did not walk and was identified as at risk for pressure ulcers. The quarterly MDS dated 12/31/14, identified R90 was at risk for pressure ulcers, had no pressure ulcers and identified no changes in condition.	F 278	a. R90 had revision of quarterly MDS. b. All residents MDS will accurately reflect teh resident's status. c. Education provided to nursing staff on assessment accurately reflect resident status. d. DNS or designee will audit 5 MDS weekly for accurately reflect resident's status. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 278	Continued From page 38 The quarterly MDS dated 3/5/15, indicated R90 sustained no change in cognitive, mood or behavioral status. R90 was identified as rarely/never understood and to have declined in ability to communicate. The MDS indicated R90 did not transfer during the assessment period. The MDS identified R90 was always incontinent of bladder and bowel. The quarterly MDS identified R90 had "2 [two] unhealed" unstageable pressure ulcers (full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] and/or eschar [tan, brown or black] in the wound bed) and one Stage 2 (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) which had worsened. The MDS identified R90 used a pressure reduction chair, device for bed and was on a nutrition/hydration program. Although R90 was identified to have multiple pressure ulcers and as having worsening pressure ulcers, the MDS indicated R90 was not on a turning/repositioning program. On 5/7/15 10:56 a.m. registered nurse (RN)-C and director of resident assessment (DRA) reviewed the above MDS data and stated the quarterly MDS dated 3/5/15, should have been an annual (comprehensive) MDS. When asked why an annual MDS was not completed, DRA stated the MDS was incorrect because DRA was "new" to the position.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		6/17/15

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F 280	Continued From page 39 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 for 1 of 3 residents (R56) who had declined in activity participation was revised for activities. In addition, the facility failed to update the care plan to reflect bed bound status for 1 of 1 resident (R90) identified to no longer transfer during the assessment period on the quarterly Minimum Data Set (MDS). Findings include: R56: On 5/4/15, at 2:00 p.m. to 7:00 p.m. and consecutive days of the survey 5/5/15, at 8:30 a.m. to 3:00 p.m., 5/6/15, at 7:34 a.m. to 3:15 p.m. and 5/7/15, at 7:55 a.m. to 11:12 a.m. R56	F 280	a. R56 passed away. R90 lift reassessment completed and plan of care updated to reflect current transfer status. b. All residents are assessed for leisure interests and risk of isolation with scheduled assessments. Plan of care updated to reflect assessment. Activities are documented in the resident medical record and/or the activities attendance records. All residents lift assessments were reviewed for current transfer status. c. TR reviews weekly any change in resident participation with activities and reassesses need for in room activites and changes plan of care based on	

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F 280	Continued From page 40 was not observed attending/participating in any activity and was observed in his room during observations lying in bed either asleep of awake with no television or radio in room. R56's activities care plan dated 4/5/11, identified R56 had potential of alteration in psychosocial well-being as demonstrated by history of withdrawal from social and individual activities. The care plan indicated "I spend majority of time in my room per choice." The care plan directed staff to "Assist me with problem solving, encourage involvement in activities and therapeutic recreation [TR] programming, encourage me to come out of my room for activities of interest and socialization, encourage me to eat in the craft room for all meals by assisting me there in my wheelchair [w/c] and provide emotional support as needed [PRN]." Although an assessment had been completed which had identified R56 refused all or most of activity invitations, displayed socially isolative behaviors, had a significant change in physical and mental status and attended less than two activities per week the facility failed to revise R56's care plan to reflect the appropriate interventions to accommodate for his current status change. R56's Therapeutic Recreation Attendance Record dated January 2015, through 5/7/15, indicated R56 had attended 60 activities out of 158 days of which 39 coded as "S=Sleeping", 17 coded as "A=active", one coded as "P=passive", two coded as "R=refused and one coded as "I". The attendance record also revealed since R56 had been moved to the unit on 4/17/15, it had been documented only two times activity had been offered.	F 280	assessment. Education provided to recreation therapy staff on completing leisure assessments and risk of isolation and updating plan of care and providing activities according to the plan of care. Education provided to TR staff on documenting attendance in the activities CNA care sheet. d. TR Director or designee to audit 5 residents 1x week who are at risk of isolation. TR director to audit 5 residents weekly for complete attendance records. DNS or designee will audit 5 residents weekly for lift assessment and plan of care matches current transfer status. Audit results are reviewed at QAPI meeting monthly. Frequency of audits is adjusted based on results of audits.	

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F 280	Continued From page 41 R56's Comprehensive Assessment Note dated 3/14/15, indicated "Resident prefers to stay in his room and watch television and/or rest most of the day." R56's diagnoses included dementia, diabetes and chronic obstructive pulmonary disease obtained from the significant change MDS dated 3/16/15. In addition MDS section for Preference for Customary Routine and Activities indicated it was "Very Important" to have books, newspapers and magazines to read, participate in religious services or practices, listen to music, and it was "Somewhat Important" to do things with groups of people and keep up with the news. R56 did not have activities Care Area Assessment (CAA) and no recreation service assessment even though R56 had been identified with potential of psychosocial well-being with history of withdrawal from social and individual activities. Progress Note dated 5/4/15, by TR staff indicated "Res. [resident] transferred from RM [room] 381 d/t [due to] medical condition. He attended Crosswords on 4/21/15. He has refused all activities invites. Care plan changed. 1:1 Risk Assessment Complete. Res. will receive 1:1's 1x/wkly [weekly] by TR." Although the 1:1 Risk of Isolation Assessment was completed on 5/4/15, the care plan was not revised until 5/7/15, after the concern of lack of activity participation collaborated with all the observations and lack of documentation. On 5/7/15, at 9:30 a.m. the unit TR stated R56 refused all activities at times and now staff was doing 1:1's with him which he was benefiting from and the staff would do it once a week but would	F 280		

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still offer other activities and he would come to those he wanted to attend. She went on to state R56 had just moved to the unit on 4/17/15 and during that time had only had two times he had attended an activity as per the activity log. When asked where the documentation would be for R56's activities refusal she provided only one sheet dated 5/4/15, which had indicated R56 had refused and this was all the documentation she had.

On 5/8/15, at 8:27 p.m. when asked if an assessment had been completed for R56's the director for therapeutic recreation (DTR) stated R56 had resided on third floor prior to being moved to second floor and thought for resident's on the third floor "I don't think they do the assessment that is attached in Point Click Care [PCC] like the one we do on this floor. Am not sure and would look and get back to you."
-At 8:30 a.m. TR stated on Monday 5/4/15, at 10:30 a.m. she had a ball tossing activity which R56 had attended but he had not been able to participate but when music was played she thought R56 was listening and thought R56 was singing but was not sure if it was him. DTR added R56 had extensive history of not wanting to participate in group activities and thought it was because of his mental health history. TR also stated she had and continues to make several attempts to initiate activities with R56 but was not successful. When asked for documentation of the attempts made she acknowledged she never documented and only documented when R56 had a "firm refusal."
-At 8:32 a.m. TR indicated the previous week she had reported to the nurse manager about making sure a television was in R56's room. TR further indicated she had approached R56 on 5/7/15,

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around 12:30 p.m. to attempt a 1:1 activity but found staff was assisting R56 with eating which was after the activity concern had been brought to the departments' attention.
-At 8:34 a.m. both the DTR director and TR both verified R56 did not have a TV in his side of the room and the TV on the other side was unplugged and also verified there was no radio in the room.

On 5/8/15, at 9:05 a.m. the DTR director and TR both verified the significant change MDS dated 3/16/15, indicated it was "Very Important" to have books, newspapers and magazines to read, do favorite activities, participate in religious services or practices, listen to music, and it was "Somewhat Important" to do things with groups of people and keep up with the news. Which was contrary was what both were indicating about R56's activity preferences.
-At 9:06 a.m. when asked what her expectation was regarding staff documentation on resident attendance or refusals DTR stated "they should document in the medical record or the activity attendance sheets." When asked about the care plan DTR stated it should have been updated as indicated.

On 5/8/15, at 10:34 a.m. the DTR approached surveyor stated she had talked to the nursing manager who had stated R56 was not feeling well that week and this would explain his low interest in activities. When asked about other weeks since he had moved to the unit DTR was not able to answer to it. DTR further stated she had completed a recreation services assessment after the concern had been brought to her attention and was initiating other activities for R56.

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R90:
The Lift Mobility Status form dated 3/5/15, identified R90 could not bear weight on legs. The form identified "any" of the identified full body lifts could be used, to use a "med [medium sized] sling with a "hoyer lift & 2 staff."

Although the form identified R90 could be transferred with a mechanical lift, the quarterly MDS dated 3/5/15, indicated R90 did not transfer during the assessment period from 2/27/15, through 3/5/15.

Review of the data collection documentation from 2/27/15, through 3/5/15, indicated R90 did not transfer during the seven day look back period. A hand written note at the bottom indicated, "see IPN [interdisciplinary progress] note dated 3/09/15 for clarification."

The GL-St Louis Park [00887] Progress Note (IPN) written by the registered nurse/MDS nurse (RN)-C dated 3/9/15, indicated, "MDS for ARd [sic] 3/5/15 ADL [activities of daily living] coding correction for bed mobility, dressing, toilet use hygiene 4/3 [total/extensive assistance]. MDS scored to reflect accurate status. That was confirmed through staff interview and documentation review."

On 5/4/15, at 7:00 p.m. R90 was initially observed to be in bed in the room. A wheelchair was observed to in the room directly to the left of the door.

On 5/5/15, at 9:26 a.m. R90 was observed to be in bed. At 7:10 p.m. the licensed practical nurse (LPN)-E verified R90 did not use the call light and

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F 280	Continued From page 45 staff anticipated all the resident's care needs. The wheelchair had not moved. During continuous observations on 5/6/15, from 7:21 a.m. to 10:55 a.m. R90 was not observed to leave the bed or the bed room. The wheelchair was observed to be unmoved throughout the observations. At approximately 7:46 a.m. the nursing assistant (NA)-E verified assignment to R90 and stated R90 did not transfer out of bed. NA-E was unclear when R90 was last transferred out of bed. R90's care plan dated as initiated 8/18/10, identified deficits in physical mobility, and identified R90 was totally dependent on staff for bed mobility, eating, "toileting assistance", and transfers. The care plan did not reflect R90's bed bound status, including but not limited to, risks associated with not transferring out of bed. On 5/7/15, at 12:37 p.m. the director of resident assessment (DRA) stated R90 did not transfer during the quarterly MDS dated 3/5/15, DRA verified changes to the MDS should be included on the care plan. On 5/7/15, at 2:18 p.m. the director of nursing (DON) confirmed the care plan should have been updated to include R90's identified bed bound status. DON stated she was unaware R90 had not transferred out of bed during the survey or during the look back period of the MDS dated 3/5/15.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		6/17/15

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F 282	Continued From page 46 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the written plan of care for 3 of 3 residents (R28, R50, R257) in the sample who required physical therapy services, and for 1 of 1 resident R257 in the sample reviewed for a change in toileting. Findings include: R28, R50 and R257 did not receive physical therapy according to a set schedule of five to six treatment days per week and R257 did not receive toileting care every two hours according to the plan of care. On 5/7/15, from 7:53 a.m. to 9:00 a.m. the medical record was reviewed and the following was noted: R28 received physical therapy three times in the seven day period, and missed two treatments during review of the form titled, "Physical Therapy Log" for the month of May 2015. A review of the April 2015 therapy log indicated R28 received 15 physical therapy treatments when R28 should have had 24 days of physical therapy treatments according to the individualized plan of care. R50 received physical therapy three times out of the seven day period and missed three treatments during review of the form titled, "Physical Therapy Log" for the month of May 2015. A review of the April 2015 therapy log indicated R50 received 14 physical therapy	F 282	a. The plan of care for R28, R50, R257 are reviewed and revised to ensure services provided by qualified persons. R257 reassessed for bowel and bladder status, and care plan update to reflect status. b. All residents will recieve services by qualified persons according to each resident's written plan of care. Each plan of care is reviewed and revised by therapy staff according to residents status. All residents will be assessed for bowel and bladder status and care plan revised to reflect status with next scheduled assessment. c. All therapy staff is educated on services provided by qualified persons according to residents plan of care. All nursing staff educated on bowel and bladder assessment and care planning, and services provdied by qualified persons according to plan of care. CNA care sheets updated to reflect current plan of care. d. Director of Therapy or designee will audit 5 residents on therapy caseload weekly for therapy services provided according to plan of care. Plan of care will be revised according to residents	

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F 282	Continued From page 47 treatments when R50 should have had 19 physical therapy treatment days in the month of April 2015 according to the individualized plan of care. R257 received physical therapy once out of the seven day period, and missed four treatments during review of the form titled, "Physical Therapy Log" for the month of May 2015. A review of the April 2015 therapy log indicated R257 received 17 physical therapy treatments when R257 should have had 20 physical therapy treatment days in the month of April 2015 according to the individualized plan of care. The director of rehabilitation therapy (DRT) was interviewed on 5/6/15, at 1:11 p.m. and verified R28, R50, and R257 did not receive the frequency for physical therapy due to staff therapist call ins, vacations, and furthermore stated, "We overbook people for therapy and there are people who are not going to be seen." According to the DRT, the facility does not have a policy or procedure for canceling/selection of residents from therapy for the day and the facility does not call the physician to report the order was not followed for physical therapy, occupational therapy or speech therapy when a therapist is not available to treat the resident according to the individual plan of care.. Toileting: During observation on 5/6/15 and 5/7/15, throughout various times of the day from 8:00 a.m. until 2:00 p.m., R257 was not offered a bedpan or a commode and the staff revealed they did not know R257 was to be offered toileting assistance. The nursing assistant assignment	F 282	status. DNS or designee will audit 5 residents weekly for care needs relating to toileting. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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sheet directed staff, "incontinent check and change every 2 hours and prn (whenever necessary)."

R257 was interviewed on 5/6/15, at 8:06 a.m. R257, who was assessed as cognitively intact according to the CAA dated 11/17/14, expressed concern and stated, "The only reason I have briefs on is because I cannot get up and go to the bathroom, it is for staff convenience. I am not incontinent of urine but have been told to just go in my brief. I wait until I can get the staff to help me and then I go in my brief because it is easier for the staff." Furthermore R257 expressed there were not enough staff to get her up because a mechanical lift was used for transfers because of her weight and arthritis and the process takes too long so it was easier to "just go" in the brief. R257 said staff had told her so many times to just urinate in her brief so that she does so without asking to be toileted. R257 said when she lived on first floor they used the bedpan. R257 boldly stated "I am not incontinent, I have never been incontinent." R257 did not know why a commode or toilet had not been an option. R257 talked about when she was on first floor the staff offered to toilet her but since moving up to second floor there were no more offers. R257 became teary eyed when talking about arthritis pain and being a "bother" to the staff.

The undated aide assignment sheet directed staff, incontinent of urine. Check and change every two hours. The plan of care dated 11/10/14, read, "Toileting assistance of 1-2 staff. "

When interviewed on 5/6/15, at 1:46 p.m. the full time licensed practical nurse (LPN)-D did not know about any toileting plan for R257 and

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implied R257 was always incontinent and wore a brief. LPN-D was not aware of offering a bedpan or commode for R257.

When interviewed on 5/7/15, at 1:54 p.m. the full time NA-A referred to R257 as continent sometimes and sometimes used the bedpan and stated, "We are to offer the bedpan."

When interviewed on 5/7/15, at 1:55 p.m. NA-D stated, "I have never offered to toilet [R257] because [R257] just uses the brief, I never knew about offering a bedpan or commode."

When interviewed on 5/7/15, at 2:03 p.m. NA-K who worked full-time on the evening shift verified NA-K had never offered a bedpan or commode to R257 and stated, "We just change her brief. "

When interviewed on 5/7/15, at 2:46 p.m. nurse manager RN-A referred to R257 as someone who just stopped doing everything because of her arthritis and many times she would not talk to staff and would just pull the covers up over her head. RN-A verified efforts were not pursued to restore or improve R257 bladder continence.

A policy to re-approach residents after refusal of care was asked for but not received at the time of the exit.

A review of the facility policy titled, Bowel and Bladder Review, dated 12/2/14, read, "To ensure that the Medical Record includes documentation that incontinent Residents are receiving care and services to restore or improve bowel and bladder functioning." R257 did not receive toileting assistance of one to two staff assist according to the plan of care.

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores 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 comprehensively reassess a recurrent pressure ulcer in order to develop interventions for appropriate treatment for 1 of 3 residents (R90) reviewed for pressure ulcers. Findings include: According to the face sheet in the record, R90 had originally been admitted to the facility 7/4/10, with numerous complicated health issues including: chronic respiratory failure with tracheostomy, quadriplegia with required tube feeding, aphasia (communication disorder), cardiovascular disease, and acute kidney injury. R90's initial care plan dated 8/18/10, identified R90 had problems with physical mobility including total dependence on staff for bed mobility, eating, meeting toilet needs, and transfers; impaired skin integrity related to required assistance with bed mobility, history of open areas, incontinence, and history of pressure ulcer to buttocks, right hip and	F 314	a. R90 plan of care relating to pressure ulcer was updated. b. All residents with current pressure ulcers will be reviewed for appropriate plan of care and interventions. c. Education provided to nursing staff on facility skin integrity guideline which addresses prevention and treatment of pressure sores. Facility holds monthly pressure ulcer committee including interdisciplinary members to review facility system relating to treatment and prevention of pressure sores. d. DNS or designee will audit 5 residents weekly for appropriate plan of care to prevent and heal pressure sores. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	6/17/15

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left foot 2nd toe due to overall disease process. The care plan approaches included inspection of R90's skin with cares, turn and position every two hours, report reddened areas, use of an air mattress in bed, and pressure reducing wheelchair cushion. A care plan revision 9/23/10, had identified the resident had a wound to the buttocks and required nutritional support. A care plan intervention initiated on 9/23/10, directed enteral formula and feedings as ordered and identified the formula as high protein "for skin integrity/wound healing." The care plan lacked identification of R90's current unstageable coccyx pressure ulcer, lacked resident specific intervention to address the unstageable pressure ulcer and was contradictory to R90's assessed offloading scheduled (turning and repositioning program). Although LPN-B identified R90 had an unstageable pressure ulcer of the coccyx, the care plan lacked clear identification of R90's current or past pressure ulcer location(s).

During observations of R90's care on 5/6/15 from 7:21 a.m. through 10:55 a.m.:
R90 was observed on 5/6/15, from 7:21 a.m. to 12:30 p.m. R90 was observed to be lying in bed on her left side. The bed was observed to have an alternating pressure air mattress (a pressure relieving device) on the bed and inflated. The head of the bed (HOB) was observed to be raised approximately 30 degrees. A pole with a running tube feeding pump and hanging formula was observed directly to the right of the bed. Humidified oxygen was observed to be applied at two liters per minutes, under positive pressure and administered via tracheostomy collar to R90. Both of R90's arms and legs were observed to be severely contracted with only spastic type movements observed. A large wheelchair with

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pressure relieving cushion was observed to be stored in the room near the dresser. When greeted by the surveyor, R90 did not respond to voice and did not make eye contact. Two nursing students (NS-A, NS-B) were also observed in the room at the time, the students gathered care supplies on an over bed table. NS-A and NS-B stated they were assigned to R90 and would complete all cares until "11:30 [a.m.] or 12:00 [p.m.]" Both students stated they were usually assigned to R90 on Wednesdays. The students stated R90 had a pressure ulcer on the coccyx and stated they would be assisting with changing the dressing. At 7:46 a.m. a nursing assistant (NA)-E entered the room. NA-E stated in addition to the two students, he also was assigned to care for R90. NA-E stated he was responsible for repositioning R90 "every two hours." NA-E stated he was "checking on" NS-A and NS-B to ensure R90's grooming tasks were being completed. NA-E left the room, the nursing students remained in the room with R90. At 7:53 a.m. licensed practical nurse (LPN)-A and the nursing instructor stated R90's cares and dressing changes would be completed by the nursing students. The nursing instructor stated she and the facility nurse would supervise the dressing change. At 7:56 a.m. the door to the room was opened and both students left the unit. R90 was observed to be laying on her right side. The HOB remained up approximately 30 degrees. From 7:56 a.m. to 9:09 a.m. no staff entered R90's room, and R90 remained in the same position. At 9:22 a.m. NS-A and NS-B entered R90's room, raised the bed to a high position and prepared supplies at bedside. NS-C entered the room carrying linens and NA-E and LPN-B also entered the room. LPN-B discussed with NS-A and NS-B when R90 was "last turned," and directed the

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students to offload pressure and turn R90 onto the left side in bed. R90 was repositioned/offloaded [repositioned one hour and twenty-six minutes]. NS-C left the room. R90 was observed to be wearing blue pressure relief booties on both feet. R90's legs were observed to be severely contracted in a bent position at an approximate 45 degree angle. R90 was observed to be unable to assist with bed positioning. From 9:22 a.m. to 10:47 a.m. the nursing instructor, NA-F, NA-E, NS-A, NS-B, LPN-B, registered nurse (RN)-C, and LPN-A were in and out of R90's room providing a variety of cares for R90. When NA-E removed R90's incontinent product during that time, the incontinent pad was observed to be urine soaked. R90's dressing was observed to be loose and pulling away from R90's coccyx. The dressing was observed to be a white square shaped dressing affixed with tape; wound packing was visible directly under the covering. At 10:47 a.m. LPN-A was observed to gently remove the dressing. The dressing was observed to be saturated with serous and somewhat purulent drainage. A saturated packing was observed to be intact in the wound. A slight odor was noted upon removal of the cover dressing. The wound was observed to be circular shaped full thickness and located over R90's coccyx region. LPN-A gently removed approximately 6 to 7 inches of rope shaped wound packing gauze. The packing was observed to be fully saturated with brownish colored slough and serous colored drainage. The wound was observed to be full thickness; the wound base was covered with a brownish blackish colored slough and could not be visualized. The outer wound edges appeared pink and granulated. LPN-A lightly covered the coccyx wound with a dry ABD pad (a multi-layered

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absorbant dressing) and lightly taped into place. At 10:49 a.m. LPN-A came with new supplies for the dressing change. LPN-A held up a large dressing labeled Silicone Foam and stated to RN-C it was to cover the coccyx wound. LPN-A verified the dressing she had removed was different than the one silicone dressing and stated an "order" was being obtained for the Silicone dressing. At 10:54 a.m. LPN-B reminded LPN-A to provide pain medication for R90 prior to the dressing change. At 10:55 a.m. LPN-A was observed to review the medication administration record (MAR) and stated R90 would be administered Tylenol extra strength via "G-tube [gastrostomy tube]." At 12:18 p.m. LPN-B was observed to change R90's dressing with assist from LPN-A and LPN-C. R90's coccyx pressure ulcer was measured at that time:

- top to bottom 3.5 centimeters (cm);
- side to side 3.1 cm;
- depth at deepest point 3.7 cm;
- tunnel depth at 12 o'clock 3.3 cm.

LPN-B described the wound has having necrotic tissue and an odor. LPN-B assessed the wound with a sterile Q-tip and verified the edges had no undermining. The edge to the right aspect of the wound was observed to be granulated. LPN-B verified the wound was deepest on the left aspect and stated the tunnel diameter was "about Q-tip size." LPN-B described the wound as having scar tissue around the edges and as having no maceration. LPN-B visualized the base of the wound with a flashlight and stated the base of the wound had necrosis and could not be staged (unstageable). LPN-B stated R90 was scheduled to see the physician during wound rounds "tomorrow." LPN-B stated the wound "will require sharps debridement." LPN-B further explained Santyl (prescription ointment that cleans wounds

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to clear the way for healthy tissue) had been used to chemically debride the wound without success. LPN-B irrigated the wound with NS, LPN-B packed the wound wet to moist with Daken (used to kill germs and prevent germ growth in wounds) soaked gauze, applied Skin Prep (a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films) to the skin surrounding the wound and applied the Silicone Foam to cover. LPN-B stated the order was changed to reflect the new dressing. R90 appeared relaxed and appeared to sleep throughout the procedure.

Additional record review revealed a Comprehensive Assessment dated 7/11/14, which identified R90 was at risk for impaired skin integrity and identified a history of "pressure ulcer to buttocks" and a history of pressure ulcers on the left foot. The assessment identified R90's skin was "CDI [clean dry and intact] at time of assessment." The assessment directed to assess R90's skin "per facility policy." Although R90's care plan lacked a clear offloading schedule (such as clearly idenifying a one or two hour offloading schedule), the assessment directed to refer to R90's care plan for "offloading schedule" and pressure relief/reduction devices in place.

A form entitled, Medicine Admission History and Physical dated 9/14/14, indicated R90 had been hospitalized on 9/13/14, with "sepsis [the presence in tissues of harmful bacteria and their toxins, typically through infection of a wound] and concern for clogged G tube [medical device used to provide nutrition to patients who cannot obtain nutrition by mouth]." The section of the form titled "3. Pressure ulcers, present on admission:"

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indicated R90 had a "Stage 1 ulcer [Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue] on sacrum and R [right] ischium [the curved bone forming the base of each half of the pelvis]." The form identified R90 received daily dressing changes for the wound and indicated R90 resided in a nursing home at the time of hospital admission.

A Clinical Health Status form completed after readmission from the hospital dated 9/17/14, included a body map of R90's skin which identified a "Scab" on R90's coccyx and indicated R90 was at high risk for skin breakdown. The Clinical Health Status form also indicated the facility was aware R90 had sustained a pressure ulcer to the coccyx area.

Review of the facility's Comprehensive Weekly Skin Assessment forms identified R90's Stage 1 pressure area had been healed until 12/13/14, then an "O/A [open area]" was observed. The recurrent pressure ulcer was identified as "healed" again on 1/13/15. On 2/1/15, the assessment forms identified R90 had another pressure ulcer occurring on the coccyx area which remained open through 4/21/15. The directions written at the top of the Comprehensive Weekly Skin Assessment forms directed, "If any alteration in skin integrity is observed, document and initiate the appropriate skin care interventions."

Review of the facility's Comprehensive Weekly

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Skin Assessment forms was conducted for the time period of 10/7/14, through 4/28/15. The assessment identified "intact" for R90's Head/Scalp, Thorax-anterior and posterior [front and back of chest area], Buttocks & Perineum [sacrum/coccyx and genitalia area], and Lower extremities until identification of an open area on 12/13/14 identified on the buttocks and perineal area.

The forms included:
-12/17/14, through 12/23/14, "alteration" was circled and R90 was identified as having "O/A healing" on the Buttocks & Perineum area.
- On 12/27/14, and 12/30/14, the form had "intact' circled but also identified an "open area on coccyx" for R90's Buttocks & Perineum area.
- On 1/6/15, R90 to had "O/A healing" documented thru 1/13/15. However, the area on the form indicating 'Intact' was circled for R90's Buttock & Perineum.
- On 1/13/15, the form 'Intact' was again circled and "Healed" was written after Buttocks & Perineum, indicating R90's open area on the coccyx had healed.

There were no weekly skin assessments completed for the weeks of 1/20 or 1/27/15.

- On 2/1/15, the form indicated R90 had developed a recurrent ulcer and directed, "Monitor wound on coccyx area."
- On 2/3/15 and 2/7/15, the forms had "alteration" circled and "Tx [treatment] per order" documented for Buttocks & Perineum.
- On 2/18/15, "Buttocks" was circled and "O/A Tx per order" was documented.

- From 3/3/15, through 3/31/15, the forms

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included: "Tx Wound QD [daily]." The forms identified R90 received a treatment of a "Red Cream Applied" to the "Coccyx area."

- From 4/14/15, through 4/21/15, R90 was identified as having a daily dressing to a coccyx wound.

Review of Wound Evaluation Flow Sheets from 1/28/15, through 4/30/15, for the right buttock area, identified R90 had a 3 centimeter (cm) long x 2.5 cm wide x less than (<) 0.1 cm deep area of irregular and undefined wound with "peeling moist skin" surrounding a coccyx wound. The form indicated skin prep was applied and a foam dressing. The form indicated the ulcer was identified on 1/28/15, and a body map identified the wound was located on R90's coccyx region of the body. The documentation of the ulcer size indicated the ulcer had increased to 4 cm x 4.7 cm x 2 cm on 3/10/15. The wound was identified to have an "odor [a potential symptom of infection]" and was debrided chemically with "Santyl" and covered with calcium arginate foam dressing.
- A flow sheet for the left upper coccyx-sacral region identified R90 had a pressure ulcer on 1/18/15, which measured 0.8 cm x 05 cm x < 0.1 cm. On 2/9/15, the documentation indicated "all wounds run together [formed into one pressure ulcer]." On 3/17/15, both the right and left buttocks were monitored with measurements of 3 cm x 4.4 cm x 1 cm. The wound was described as having "purulent [Pertaining to pus. Containing or composed of pus. The term "purulent" is often used in regard to drainage.]" drainage, with dark tissue covering half the wound. The dressing was changed to silver nitrate on 3/13/15. On 4/3/15, the wound was sharp debrided. On 4/30/15, the

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wound measurements were 3.1 cm x 2.3 cm x 4.5 cm, the wound had moderate amounts of serosanguineous (means containing or relating to both blood and the liquid part of blood [serum]. It usually refers to fluids collected from or leaving the body. For example, fluid exiting a wound that is serosanguineous is yellowish with small amounts of blood.) purulent drainage, a slight odor, and had darker granulation. The edges were descrobed as remaining irregular and undefined. The treatment was changed to Darken solution wet to moist gauze with foam dressing change.

R90's clinical record lacked evidence the recurrent pressure areas were reassessed in order for the staff to develop resident specific interventions to promote healing and prevent return of the coccyx pressure ulcer, and to prevent development of new pressure ulcers. The clinical record lacked evidence R90 was comprehensively assessed for these changes upon re-emergence of the pressure ulcer on 12/13/14, and again on or around 2/1/15.

R90's current Physician's Orders and Order Summary Report dated 4/20/15, included R90's current enteral and wound treatment orders. The orders directed to keep R90's head of bed (HOB) elevated greater than (>) 30 degrees at all times, except during cares due to a risk for aspiration from her secretions and directed, "Monitor drg [dressing] on coccyx area Q [every] shift." The Physician's Orders did not include orders for R90 to be on bedrest and did not identify orders for offloading frequency.

Review of the Treatment Administration Records (TARs) from January 2015 through May 2015

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F 314	Continued From page 60 directed wound dressing change treatments and monitoring of the coccyx wounds. However did not include other interventions to promote healing/prevent development of new pressure areas. On 5/7/15, 10:56 a.m. RN-C and the director of resident assessment (DRA) acknowledged a lack of a current turning/offloading/repositioning schedule for R90. They also verified R90 had not been comprehensively reassessed following the recurrence of the pressure ulcers. A copy of the pressure ulcer policy and procedure(s), including procedure for pressure ulcer assessment was requested, but was not provided by the facility.	F 314		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R257, R200) identified as incontinent of urine, received the necessary care and services to meet	F 315	a. R257 and R200 were reassessed for bowel and bladder status, and plan of care updated to reflect current status. Facility staff will be designated to check in	6/17/15

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F 315	Continued From page 61 their toileting needs. This deficient practice resulted in harm for R257 who experienced an increase in urinary incontinence. Findings include: R257 was interviewed on 5/6/15, at 8:06 a.m. R257, who was assessed as cognitively intact according to the care area assessment (CAA) dated 11/17/14, expressed concern and stated, "Some of the staff here don't listen and they just don't care enough to do the job right. I will refuse cares from the staff who do not perform my cares the right way. They don't understand my arthritis and some of them don't have the patience and they push me. "The only reason I have briefs on is because I cannot get up and go to the bathroom, it is for staff convenience. I am not incontinent of urine but have been told to just go in my brief. I wait until I can get the staff to help me and then I go in my brief because it is easier for the staff." Furthermore R257 expressed there were not enough staff to get her up because a mechanical lift was used for transfers because of her weight and arthritis and the process takes too long so it was easier to "just go" in the brief. R257 said staff had told her so many times to just urinate in her brief so that she does so without asking to be toileted. R257 said when she lived on first floor they used the bedpan. R257 boldly stated "I am not incontinent, I have never been incontinent." R257 did not know why a commode or toilet had not been an option. R257 expressed "feeling sad" that the staff do not understand her pain and condition and was "afraid" they would retaliate against her for complaining and move her to third floor. R257 talked about when she was on first floor the staff offered to toilet her but since moving up to second floor there were no	F 315	and interview R257 and R200 regarding provision of urinary incontinence care. Any identified concerns will be addressed. b. All residents will be reviewed for bowel and bladder status and plan of care updated with next scheduled assessment. c. All nursing staff will be educated on facility Bowel and Bladder Review and appropriate provision of urinary incontinence care according to the residents plan of care. CNA care sheets will be updated to reflect current bowel and bladder status and plan of care. d. DNS or designee will audit 5 residents 1x weekly for appropriate provision of urinary incontince care. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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more offers. R257 felt like the staff treat her as if she had a "mental" condition/problem so they don't listen to her. R257 stated, "I am not treated with dignity and respect, the staff listen in on my personal conversations and turn everything against me, I feel like I am worth nothing." R257 became teary eyed when talking about arthritis pain and being a "bother" to the staff.

During observation on 5/6/15 and 5/7/15, throughout various times of the day from 8:00 a.m. until 2:00 p.m., R257 was not offered a bedpan or a commode and the staff revealed they did not know R257 was to be offered toileting assistance.

R257's 14 day scheduled Minimum Data Set (MDS) dated 11/24/14, indicated R257 was occasionally incontinent of urine, less than seven episodes of incontinence in the week of observation. R257's MDS noted R257 was not on a toileting program.

The quarterly MDS dated 2/10/15, indicated R257 was cognitively intact and was always incontinent of urine with no episodes of continent voiding in the one week observation period. R257 had a decline in bladder function in the last three months and was not on any toileting program to potentially restore bladder function as much as possible.

R257's plan of care dated 11/10/14, directed staff, "Toileting assistance of 1-2 staff." In addition care plan dated 11/14/14, indicated "I sometimes have behaviors which include crying stating I am not crazy." The care plan did not indicate R257 had behaviors with care refusal. Although the MDS dated 2/10/15, had indicated R257 had rejection

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of care for one to three days during the assessment period the care plan did not have the care rejection.

The undated aide assignment sheet directed staff, incontinent of urine and "Check and change every 2 hours."

On 5/6/15, at 1:46 p.m. the full time licensed practical nurse (LPN)-D did not know about any toileting plan for R257 and implied R257 was always incontinent and wore a brief. LPN-D was not aware of offering a bedpan or commode for R257.

When interviewed on 5/7/15, at 1:54 p.m. the full time nursing assistant (NA)-A referred to R257 as continent sometimes and sometimes used the bedpan and stated, "We are to offer the bedpan."

When interviewed on 5/7/15, at 1:55 p.m. NA-D stated, "I have never offered to toilet [R257] because [R257] just uses the brief, I never knew about offering a bedpan or commode."

When interviewed on 5/7/15, at 2:03 p.m. NA-K who worked full-time on the evening shift verified NA-K had never offered a bedpan or commode to R257 and stated, "We just change her brief. "

When interviewed on 5/7/15, at 2:46 p.m. nurse manager RN-A referred to R257 as someone who just stopped doing everything because of her arthritis and many times she would not talk to staff and would just pull the covers up over her head. RN-A verified efforts were not pursued to restore or improve R257 bladder continence.

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R200 was observed on 5/6/15, at 7:28 a.m. in the wheelchair dressed and watching television (TV). Stated he got ready that morning.
- At 2:14 p.m. R200 returned from therapy.

R200 was observed on 5/8/15, at 7:26 a.m. and was groomed and dressed in clean clothing. Toileting was not observed as the resident was up already.

The Minimum Data Set (MDS) dated 10/14/14, identified R200 had moderate cognitive impairment, no mood indicators, no behaviors, and identified R200's behaviors had "improved;" MDS identified R200 required extensive assistance with bed mobility, transferring, dressing, personal hygiene and toilet use; and was non-ambulatory. The MDS identified used a wheelchair and had a limb prosthesis. The MDS identified R200 was "frequently" incontinent of urine.

The Cognitive Loss Care Area Assessment (CAA) dated 10/24/14, indicated, "CAA triggered for cognitive Loss/Dementia. Resident appears to be alert and oriented to self, place and time. He does however have a lot [sic] of anxiety and that seems to affect his judgement/insight. Has Dx [diagnoses]: Vascular Dementia, Mild Cognitive impairment, Cognitive and neurobehavioral dysfunction. At risk for neglect, falls, behaviors and mood changes secondary to safety deficits and cognitive deficits. Currently working with PT [physical therapy]. Proceed to care plan."

The CAA for ADL Functional/Rehabilitation Potential dated 10/24/14, indicated, "CAA triggered for ADLs [Activities of Daily Living] secondary to patient requiring assist with bed

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mobility, transfers, dressing, toilet use, personal hygiene and bathing. Has a right BKA [below the knee amputation] and uses w/c [wheelchair] as primary mode of locomotion." The CAA identified R200 was, "At risk for isolation, falls, and behaviors causing further debilitation and discomfort."

R200's MDS dated 12/17/14, depicted R200 as being frequently incontinent of urine (bladder). The MDS noted R200 was not on a toileting program to potentially restore bladder and/or bowel function.

The MDS dated 2/19/15, depicted R200 as being frequently incontinent of urine and always incontinent of bowel. The MDS identified R200 had a decline in bladder function as R200 went from being frequently incontinent of bladder to always incontinent of bladder; the MDS identified R200 was not on toileting program to restore function.

The Comprehensive Assessment (narrative summary) dated 2/19/15, identified R200 required extensive assist of one with transfers and assist of two with bed mobility. Did not ambulate and was working with physical therapy for to work towards being independent to limited assist of one off unit for locomotion, was frequently incontinence of bladder. The assessment did not identify if R200 was on a toileting program, lacked identification if R200 was a candidate for bladder retraining.

R200's MDS dated 4/24/15, depicted R200 had no behaviors, had one mood indicator of feeling tired/having little energy; the MDS depicted R200 as "always" incontinent of urine. Although the

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assessment on 2/19/15, identified R200 was "frequently" incontinent of bowel, the care plan identified R200 was "always" incontinent of bowel. The MDS indicated R200 needed assistance from two staff for dressing, grooming, transfers, bed mobility, toileting. Although R200 had a below the knee amputation, the MDS identified R200 had no functional limitations with range of motion (ROM). The MDS noted R200 was able to speak clearly, had no hearing difficulties, was able to make needs known, and was able to comprehend others. The MDS noted R200 had moderately impaired cognition as he did not know the year or month. The MDS indicated R200 sustained a decline in bladder function, as R200 went from being frequently incontinent of bladder to always incontinent of bladder. R200 sustained a decline in bladder and bowel function in the last six months and was not on toileting program to potentially restore bladder and bowel function as much as possible. The care plan did not identify a toileting program to potentially address R200's change in bladder continence status. The care plan did not identify R200 was not a candidate for bladder retraining.

The plan of care dated as reviewed on 7/24/15, identified the facility had identified R200 was at risk for abuse due to a diagnosis of schizophrenia, a history of hallucinations, a history of delusions and identified R200 required assistance with ADLs. The care plan identified the facility was aware R200 had a history of "calling the police" when in need of help and when staff "are not immediately available." The care plan indicated the facility had identified R200 made statements of "they hurt me," of being witnessed to have a "Hx [History] of lacking impulse control as evidenced by nursing watching [R200's name]

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lower self to floor to meet immediate need, i e [in example] bathroom, eating." The care plan identified the facility was aware of R200's making statements of feeling "Balled out" when staff explained safety concerns/redirection to R200. Although the care plan directed, "Let my physician know if I [sic] my behaviors are interfering with my daily living [such as bladder and/or bowel continence changes, or changes in toileting function]." The clinical record lacked evidence R200's behaviors interfered with continence or toileting function. The care plan further revealed R200 had a physical functioning deficit related to self-care impairment, mobility impairment, ROM (range of motion) limitations secondary to right below the knee amputee. The care plan also noted R200 needed toileting and transferring assistance of "1 to 2 persons as needed."

On 5/4/15, at 5:54 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R200 Stated had to wait for an "Hour" or "Two hours" and "they come in here all pissed at me!" as he described being incontinent of bowel and bladder and waiting to be changed and denied being able to use toilet, urinal, or bed pan; R200 further stated he felt "dirty" and grew teary eyed and began to cry.

A policy to re-approach residents after refusal of care was asked for, but not received at the time of the exit.

A review of the facility policy titled, Bowel and Bladder Review dated 12/2/14, read, "To ensure that the Medical Record includes documentation

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F 315	Continued From page 68 that incontinent Residents are receiving care and services to restore or improve bowel and bladder functioning."	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure side rail on resident bed, used for bed mobility/transfers was maintained to assure stability for 1 of 3 residents (R41) reviewed for accidents Findings include: R41's left side bed rail was observed in the up position on 5/5/15, at 11:00 a.m. The side rail appeared to be loose and sway approximately two to three inches either way. At that time the side rail was manipulated by the surveyor and determined to flex from the bed to the mattress. On 5/6/15, at 9:18 a.m. R41's room door was observed being opened nursing assistant (NA) came out of room with a transfer lift and parked it outside the room. In the room, R41 was observed seated on his wheelchair and another staff was in the room adjusting clothing and cleaning the	F 323	a. R41 side rail was stabilized at the time of the survey. b. Side rails are provided to residents according to the the Side Rail Guideline. c. All staff will be educated on side rail guideline and identifying and reporting needed repairs to side rails. d. ED or designee will audit 5 side rails 1x weekly for stability. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	6/17/15

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room.

R41's Side Rail Evaluation Screen completed 9/8/13, and reviewed 5/14/14, and 4/20/15, indicated R41 utilized the rails to assist with mobility and promote independence. Although the assessment indicated the side rails met safety guidelines, the assessment lacked to indicate the rails had been checked to ensure a secure fit.

R41's quarterly Minimum Data Set (MDS) dated 1/26/15, identified R41 had a functional limitation to both lower extremities, required total physical dependence of two with transfers, extensive physical assist of two with bed mobility and extensive physical assist of one with dressing and personal hygiene. Fall Care Area Assessment (CAA) dated 8/13/14, indicated R41 had history of falls, had muscular dystrophy and chronic pain syndrome. CAA indicated R41 required Hoyer transfer and with assist of two staff. CAA did not indicate R41 used side rails.

R41's care plan dated 5/4/15, indicated "I have a physical functioning deficit related to: Self-care impairment, mobility impairment. 1/2 side rails for bed mobility." The care plan directed staff R41 required assistance one to two staff with bed mobility.

R41's diagnoses included muscular dystrophy, chronic pain, history of non-weight bearing and muscle weakness obtained from the Admission Record printed on 5/8/15.

On 5/6/15, at 9:23 a.m. when asked where staff entered any resident equipment concerns for maintenance, licensed practical nurse (LPN)-B stated the staff would put all the concerns in the

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F 323	Continued From page 70 computer "building engines." On 5/6/15, at 9:30 a.m. when asked what staff assisted cares were needed for R41 NA-A indicated R41 required extensive assist with all activities of daily living and would assist a little with cues. NA-A stated he had assisted to get R41 ready that morning because other staff was fairly new and to prevent R41 from being agitated he assisted her to get him ready as staff may not know R41's routine. On 5/6/15, at 9:56 a.m. NA-A verified the side rail was loose and when asked if R41 used the side rails NA-A indicated R41 was able to grab onto the side rails after he was given a boost and turned side to side. NA-A further stated he had not really noticed the left side rail was loose when assisting R41 with cares as he was leaning really close to the side rail. When asked where all the maintenance repair issues were documented he indicated in the computer. On 5/6/15, at 9:57 a.m. maintenance director (MD) verified the left half side rail was loose after comparing with the right one "I get that." When asked who was responsible for ensuring the side rails were appropriately fitting he indicated "This is his own bed and the side rails I don't have any of this side rails in the building." MD further stated he would find out. When conversing with MD, LPN-B came to room also indicated the bed was R41's and when asked who was responsible for ensuring the side rails were properly fitting to bed she stated she would ask the director of nursing and would get back to surveyor. On 5/7/15, at 9:14 a.m. the director of nursing (DON) stated she expected the staff to report all	F 323		

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F 323	Continued From page 71 resident care equipment concerns in the computer "building engines" or report to their supervisor. When asked if the facility had a system of checking side rails DON directed surveyor to maintenance. Side Rails Guideline policy revised 2013, directed "The assessment and documentation also includes: measuring the gaps between the rails(s) themselves and the gaps between the side- rail and the mattress. A visual review is performed to assess that the mattress does not shift/slide allowing for an increased gap between the bed and the side rail." The policy did not indicate who was responsible for ensuring and overseeing on going side rail checks was completed.	F 323		
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	F 353		6/17/15

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F 353	Continued From page 72 nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient staffing to meet the needs of the residents in accordance with their plan of care for 9 of 9 residents (R1, R96, R55, R41, R118, R200, R154, R90, R257) reviewed for toileting, transferring and position changes. Findings include: R1 was assessed as cognitively intact, had diagnoses that included obesity, bilateral lower extremity amputations and blindness according to the Care Area Assessment (CAA) dated, 11/11/14. R1 remained in bed without an offer to get out of bed on 5/8/15, at 7:30 a.m. per observation. R1 said he did not know who his nursing assistant (NA) was for the day and was feeling frustrated because he wants to be up for the day at 7:00 a.m. but not later than 7:15 a.m. When interviewed on 5/8/15, at 7:35 a.m. R1 said he reported to registered nurse (RN)-A at the last care conference he wanted to be up at 7:00 a.m. and stated, "As you can see that is not happening." R1 continued to say he was "frustrated" because stated, "They always send someone different and they turn the story around and say I refuse when I do not refuse, Yesterday I waited for an hour after the aide came in and I told her I wanted to get up, it was 9:45 a.m." R1 said for toileting, he has been told on numerous	F 353	a. Facility staff will be designated to check in with R1, R96, R55, R41, R118, R200, R154, R90, and R257 to interview them regarding recieving care without having to wait a long time. Identified issues will be addressed. b. Facility will provide sufficient nursing staffing to provide nursing and related services to attain or maintain the highest practicable well-being of residents. c. Education provided to all staff relating to provision of sufficient nursing staffing to meet the residents needs. All staff educated on call light policy. All staff will be educated to report resident concerns or staff concerns with nursing staffing and will be educated that facility management will not retaliate for reporting issues. d. Call light audit form created to provide consistent information. DNS or designee completes 5 call light audit 5 days/ wk. for at least 5 call lights on varying times, days, and shifts. DNS or designee will interview 5 nursing staff weekly regarding resident concerns of reciveing cares without having to wait a long time, and to ensure they are educated to report concerns to management.	

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F 353	Continued From page 73 occasions to "go in the brief" as the staff did not have "time" to wait for him to use the urinal. R1 stated, "The staff do not understand the male prostate, sometimes it takes longer to go." R1 stated he was "sad", that the facility did not have enough staff to get him up on time when he requested and that he would not be incontinent of bowel or bladder if there were enough staff available to use the mechanical lift for transfers so that he was not incontinent. R96, who was assessed as cognitively intact, had diagnoses that included obesity and joint replacement according to the CAA dated 3/7/15. During an interview on 5/7/15, at 7:53 a.m. R96 expressed "irritation" with having to wait for the mechanical lift for transfers. R96 said she used to have a catheter and when that was removed the staff said come to me when you want to be changed. R96 stated, "They don't have enough staff to take you to the bathroom when you need to go, I have heard them tell other people to just go in the brief." Furthermore R96 talked of staff telling her to go in her brief because they did not have enough help. R96 does not think there are enough staff to deal with all the mechanical lifts and resident transfers without having to wait often up to an hour to get help." Stage 1 Resident Interviews: R55's quarterly Minimum Data Set (MDS) dated 2/16/15, indicated R55 had intact cognition and was independent with activities of daily living (ADL's). On 5/5/15, at 3:10 p.m. when asked if he felt there was enough staff available to make sure	F 353	DNS or designee will interview 5 residents weekly for concerns relating to recieving cares without having to wait a long time. All staff will be educated to report resident concerns or staff concerns with staffing and will be educated that facility management will not retaliate for reporting issues.	

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F 353	Continued From page 74 you get the care and assistance you need without having to wait a long time R55 stated "you hit the light and can take forty five minutes to one hour before they show up....I wanted some pain pills, was last week, evening shift about 7, can't remember the day, if you ask the nurses for something they forget about you. Last night I asked for the telephone, forty five minutes later you asked again and finally went down and used another resident phone." R41's quarterly MDS dated 1/26/15, indicated cognition was intact and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. On 5/5/15, at 9:54 a.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R41 stated "there are times I had to wait, some come in and turn off my light and say they are getting help and then don't come back....when I have to go I have to go and that isn't right, mostly weekends." R118's annual MDS dated 4/9/15, indicated R8 had intact cognition and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used a walker for mobility. On 5/5/15, at 2:45 p.m. when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R8 stated she had to	F 353		

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F 353	Continued From page 75 waited for a long time in the afternoon to have call light answered. R200's MDS dated 2/19/15, indicated R200 had moderately impaired cognition and required extensive assistance of one to staff with toileting, transferring, bed mobility, dressing and personal hygiene and used a wheelchair for mobility. On 5/4/15, at 5:54 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R200 Stated has to wait for an "Hour" or "Two hours" and "they come in here all pissed at me!" as he described being incontinent of bowel and bladder and waiting to be changed and denied being able to use toilet, urinal, or bed pan. R200 further stated he felt "dirty" and grew teary eyed and began to cry. R154's quarterly MDS dated 2/3/15 indicated cognition was intact, required extensive physical assistance of one staff with bed mobility, dressing, toilet use and supervision oversight of one staff with personal hygiene and used walker and wheelchair for mobility. On 5/5/15, at 3:05 p.m. when asked if she felt there was enough staff available to make sure she got the care and assistance she needed without having to wait for a long time R154 stated "I have waited for hours and even had accidents when waiting for them to come. I use my call light and they don't come at all. Someone said they were going to have three aides and they have had only to and I have to wait until the second	F 353		

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shift comes to be changed I should not wait to go the bathroom. I have had UTI's [urinary tract infections] twice and been put on antibiotics and now on cranberry juice. They say I refuse cares but when I am alert, am able to tell them my needs and I have the right to refuse cares but when I need the help and I put the call light I need them to help me." R154 was crying the whole time when explaining to surveyor with tears rolling down her checks as her body was shaking.

On 5/7/15, at 3:57 p.m. when approached R154 indicated some of the staff were indicating she was refusing cares, yet on some nights she was not able to sleep well or had little sleep due to the noise and during the day that was when she was finally falling asleep. R154 further indicated in the last two days during the evening and night shifts the staff had taken over one hour to answer her call light and she had bladder/bowel accidents as a result of waiting for the staff to answer the call light which was a problem and the staff knew about it. When asked how it made her feel when she soiled herself she indicated it made her feel helpless as tears rolling down her cheeks as she stated "I want to go to a different place."

Staff Interviews:
When interviewed on 5/8/14, at 8:48 a.m. anonymous nurse approached surveyor and provided a note that read "Please ask how is it possible to work on 2 South and 2 North with about 60 residents with lots of behaviors and about 30 people with blood sugars and only four nursing assistants. There is five people on 15 minute checks on 2 South. How is that possible with all other things going on. Please check [R156], check [R54], no enough time to care for this people and other obese residents like they

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F 353	Continued From page 77 deserve due to no enough staff. Please look into it." -At 8:53 a.m. when approached staff indicated she was fearful and indicated a lot of time the staff were asked to work a lot and yet the work load was a lot because they were short staffed and with some of the residents needs it was near impossible to finish the work on time and had to work overtime to complete documentation at time. On 5/8/15, at 11:56 a.m. when asked what the facility did when residents complained about call lights, the director of nursing (DON) stated they completed grievance forms on call lights. Surveyor indicated to DON after reviewing all grievance forms if there was anything else done other than education DON stated "We are talking about customer service training, how residents are feeling and how we are treating residents." DON indicated another staff person was working on customer service training, also the facility was working on holding the staff accountable and call light audits were being done to ensure they are answered timely. DON also stated currently on 2 East a process improvement plan was being worked on in a weekly basis and staffing numbers were being looked at for example on 2 East had five NAs on day shift, which had increased to six NA's. When asked how the facility determined the staffing patterns for the units DON stated "We staff according to acuity and census. We have overall PPS [Prospective Payment System] and in addition we look at CMI [Case Mix Index] numbers and if high or trending down we pull from that." When asked how the facility determined staffing patterns for units with bariatric residents 2 North and 2 South DON stated both units had low CMI and had four NAs,	F 353		

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one trained medication aide (TMA) and one nurse. DON added the facility was looking to ensure behaviors were being captured.

When asked how was it manageable for four NAs, one TMA and one nurse to do cares for 60 residents, with five residents on 15 minute checks at the time and all other cares including medication passes, two resident cares, behavior's and blood sugar checks the DON stated "We have nurse manager and nurse supervisor. On evening shift, have a supervisor who is on unit, helps out with behaviors and night shift has a supervisor also." DON was not able to answer when asked what if another unit needed the supervisor at the same time.

On 5/8/15, at 12:08 p.m. when asked what her expectation was when staff told residents to go on their briefs or incontinent product DON stated her expectation was to not have residents go in their briefs. When asked if residents were being moved around the facility for the facility house convenience DON stated the facility looked at various reasons including room appropriateness, staff and equipment required to provide care. When told about reports of staff being fearful of management retaliation and staff was not comfortable being seen talk to surveyors and staff was worried about care residents are getting DON stated "I can't fix it if I don't know about it" and indicated she was disheartened staff was not comfortable talking to her about staffing concerns.

Review of Responding to Resident needs and Call Light Audit forms dated 3/6/15, 3/16/15, 3/18/15, 4/17/15, 4/28/15, 4/29/15, 5/1/15, 5/4/15, 5/5/15, and 5/6/15, revealed the call light audit

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forms did not consistently provide follow up or indicated resident had confirmed needs were met, the audits were mostly completed at the start to mid-week, no Thursdays, Saturdays and Sundays. The audits provided none had been done for 2 South which was one of the units where call light concerns brought up by both residents and staff concerns for adequate care. In addition the facility was using two different kinds of forms for auditing which did not contain consistent information and did not consistently provide follow up and if need had been met. The facility lacked a consistent call light audit system in spite of the many call light complaint grievance's filed by 15 different residents of which some had filed multiple complaints of call light concerns dated from 11/11/14, through 4/27/15, provided.

Refer to 314: the facility failed to institute interventions based on a comprehensive assessment to treat a facility acquired recurrent pressure ulcer. The pressure ulcer was documented as healed on 1/13/15, and returned 1/28/15, on the sacrum/coccyx area [The triangular segment of the spinal column that forms part of the pelvis made up of five originally separate sacral vertebrae, the last lumbar vertebra, the coccyx, and the hipbone on either side] for 1 of 3 residents (R90) in the sample reviewed for pressure ulcers. This resulted in actual harm to R90, whose pressure ulcer worsened and became unstageable (Full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed).

Refer to 315: the facility failed to ensure 1 of 3

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F 353	Continued From page 80 residents (R257) identified as incontinent of urine received the necessary care and services to prevent incontinence.	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness. This had the potential to affect 181 of 182 residents who ate out of the kitchen. Findings include: During the kitchen tour on 5/4/15, at 12:30 p.m. the following was observed and confirmed by the dietary director (DD): The Commons area dining room automatic ice dispenser was observed to have a buildup of brown spills and brown matter inside of the ice shoot and behind the lever that released the ice. DD verified the ice machine was not clean and stated that housekeeping was in charge of	F 371	a. The ice machines and convection oven will be cleaned to ensure sanitary condition. b. DDS is responsible to complete routine audits of kitchen and dining room equipment to ensure sanitary condition. c. Education will be provided to all staff on kitchen and dining room equipment sanitation procedures. d. DDS or designee will audit all ice machines and oven equipment 1x weekly for sanitary condition. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results	6/17/15

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F 371	Continued From page 81 cleaning it. During the followup kitchen tour on 5/6/15, at 10:17 a.m. the following was observed and confirmed by the DD: The convection oven on the 'cook's line' had heavy buildup of black/brown substance around and in the grooves of the temperature knob on the unit. DD verified it had not been thoroughly cleaned "for awhile." The convection oven near the food preparation area had a heavy buildup of brown/black food debris on the inside corners of the oven, a black greasy substance on and around the temperature knob and where an on/off knob used to be and in the corners of the door surface when the door was opened. The Commons area dining room automatic ice dispenser was observed to have a buildup of brown spills and brown matter inside of the ice shoot and on the backside of the ice lever. DD verified the ice machine was still dirty and contacted the housekeeping manager (HM). The Two East Touchfree automatic ice dispenser had brown spill buildup on the inside of the ice shoot. HM verified that both ice machine units needed to be cleaned, stating they try to clean the ice machines with lime scale solution one time per month but all units should be wiped down daily by housekeeping staff. An ice dispenser cleaning policy was requested but was not provided. The facility's Oven cleaning policy dated 2011, indicated the oven exterior was to be cleaned daily with warm detergent solution and weekly	F 371	of the audits.	

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F 371	Continued From page 82 cleaning of the oven exterior included to remove burner-operating knobs, washing knobs in warm water and detergent and washing the front and sides of the oven base with a solution of water and grease solvent. The facility's Cleaning Schedules policy (undated) stated the director of dining must develop, post and enforce the cleaning schedules and monitor the completion of assigned cleaning tasks to ensure a sanitary environment.	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents received necessary rehabilitative services to maintain their highest level of functioning for 3 of 3 residents (R28, R50, R257) in the sample reviewed for rehabilitative services. Findings include: During an observation on 5/5/15, at 11:32 a.m. R28 asked an un-identified therapy staff person if	F 406	a. The plan of care for R28, R50, R257 are reviewed and revised to ensure provision of specialized rehabilitative services. b. All residents who require specialized rehabilitative services will be provided with these services. Each plan of care is reviewed and revised by therapy staff according to residents status.	6/17/15

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F 406	Continued From page 83 she would receive therapy today, staff stated, "We'll try, you know we're short staffed." \Iimmediately after the comment was made to the resident, the resident stated to the surveyor, she would not walk today and did not walk yesterday due to short staffed in "therapy." R28's electronic health record (eHR) was reviewed and the Face Sheet indicated R28 was admitted 3/4/15, with multiple diagnoses which included diabetes mellitus and muscle weakness. R28's Minimum Data Set (MDS) dated 3/11/15, indicated R28 received physical and occupational therapy which was started on 3/6/15. The MDS also depicted R28 as being cognitively intact. Physical therapy assessment and recommendations per Physicians Orders, dated 3/6/15, was for skilled physical therapy to focus on therapeutic exercises, neuromuscular re-education, gait training, and therapeutic activities. On 3/4/15, the frequency and duration for physical therapy was six times a week for thirty days with a continuation through April 29, 2014 at which time the frequency changed to five times a week for thirty days according to the form titled, Physical Therapy Plan of Care. On 5/7/15, at 7:53 a.m. during review of the form titled, "Physical Therapy Log" for the month of May 2015 indicated R28 received physical therapy three times in the seven day period, and missed two treatments. A review of the April 2015 therapy log indicated R28 received 15 physical therapy treatments when R28 should have had 24	F 406	c. All therapy staff is educated on provision of specialized rehabilitative services according to plan of care. d. Director of Therapy or designee will audit 5 residents on therapy caseload weekly for therapy services provided according to plan of care. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 406	Continued From page 84 days of physical therapy treatments. R50 was seated in a wheel chair with bilateral foot pedals during an observation on 5/5/15, at 1:00 p.m. When interviewed on 5/5/15, at 1:44 p.m. family member (F-A) of R50 expressed concern because "Mom was here for physical therapy following a hip fracture but therapy is short staffed." R50's eHR was reviewed and the Face Sheet indicated R50 was admitted 3/3/15, due to a non-operative fracture of the left femur neck. R50' ability to make self understood was cognitively impaired and non-English speaking. Physical therapy assessment and recommendation per Physicians Orders 4/10/15, was for skilled physical therapy to focus on therapeutic exercises, gait training, and therapeutic activities. On 4/10/15, according to the form titled, Physical Therapy Plan of Care, the frequency and duration for physical therapy was 6 times a week for thirty days with a continuation through 5/9/15. On 5/7/15, at 8:30 a.m. during review of the form titled, "Physical Therapy Log" for the month of May 2015, indicated R50 received physical therapy three times out of the seven day period and missed three treatments. A review of the April 2015 therapy log indicated R50 received 14 physical therapy treatments when R50 should have had 19 physical therapy treatment days in the month of April 2015. R257 was interviewed on 5/6/15, at 8:05 a.m.	F 406		

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F 406	Continued From page 85	F 406		

concern was expressed because physical therapy cancels the services due to staffing issues and not having therapists available. R257 revealed the lack of services was frustrating and R257 stated "they do not see me as important enough to get therapy." R257 said therapy staff have said, you are not on my schedule today, and then no explanation is given as to why the services are canceled.

R257's eHR was reviewed and the Face Sheet indicated R257 was admitted 11/10/14, due to fatigue and arthritis pain with an inability to perform activities of daily living without significant physical assistance. R257, who was assessed as cognitively intact according to the CAA dated 11/17/14.

Physical therapy assessment and recommendation per Physicians Orders from 3/26/15, was for skilled physical therapy to focus on hot/cold packs, diathermy, therapeutic exercises, manual therapy, and therapeutic activities. On 4/3/15 and 5/1/15, the frequency and duration for physical therapy physician order was five times a week according to the form titled. Physical Therapy Plan of Care.

On 5/7/15 at 9:00 a.m. during review of the form titled, "Physical Therapy Log" for the month of May 2015 indicated R257 received physical therapy once out of the seven day period, and missed four treatments. A review of the April 2015 therapy log indicated R257 received 17 physical therapy treatments when R257 should have had 20 physical therapy treatment days in the month of April 2015.

The director of rehabilitation therapy (DRT) was

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F 406	Continued From page 86 interviewed on 5/6/15, at 1:11 p.m. and verified R28, R50, and R257 did not receive the frequency for physical therapy due to staff therapist call ins, vacations, and furthermore stated, "We overbook people for therapy and there are people who are not going to be seen." According to the DRT, the facility did not have a policy or procedure for canceling/selection of residents from therapy for the day and the facility did not call the physician to report the order was not followed for physical therapy, occupational therapy or speech therapy when a therapist was not available to treat the resident.	F 406		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure equipment was maintained in a safe operating manner, including mechanical lifts and a convection oven. This had the potential to affect all residents who received meals from the kitchen, and any residents who utilized the mechanical lift. Findings include: On 5/7/15, at 12:36 p.m. to 1:32 p.m. the environmental tour was conducted with the maintenance director (MD) and the administrator. During the tour the following concerns were	F 456	a. All resident lift equipment and its location in the facility and current safe operating condition status will be documented. The oven has been repaired to safe operating condition. b. The ED or designee is responsbile to complete routine enviornmental rounds to ensure essential equipment is in safe operating condition. c. Education provided to all staff on completing inventory of essential equipment and documenting safe	6/17/15

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F 456	Continued From page 87 verified: Lifts: Mechanical lifts and stands used for resident transfer were not maintained in a safe manner for 2 of 4 mechanical devices used for 12 residents on the second east unit. When interviewed on 5/6/15, at 8:06 a.m. R257 expressed concern because the mechanical lifts are not always available without having to wait a long time and that the slings they use are not the proper size. R257 complained of the sling hurting between the thighs and legs. When interviewed on 5/7/15, at 7:53 a.m. R96 expressed concern about waiting long periods of time to get the right mechanical lift for transfer because the facility does not have enough working lifts. R96 further explained two of the mechanical lifts for this unit are actually broken but the staff keep using them. One mechanical lift doesn't open all the way at the base which is a safety concern for balance and the other mechanical lift is reversed in the mechanical directions, up means down and down means up so the staff have to turn the devise on and off to get it to start properly. Furthermore, R96 expressed the sling is not the right size and they wrap it around and around before they hook it up. R96 stated, " I am terrified of the lift". When interviewed on 5/7/15, at 8:28 a.m. nurse manager, registered nurse (RN-A) did not know the number of mechanical lifts that were available for staff to use for resident transfers and did not realize two of the mechanical lifts were not working properly and still in use with residents.	F 456	operating condition. Education provided to all staff to remove or label unsafe equipment, and notify management for needed repair or replacement. Inventory of equipment and safe operating condition will be reviewed at monthly safety committee meeting. d. DNS or designee will complete inventory of lifts and audit lifts on unit 1x weekly for safe operating condition or removed from service. DNS or desingee to interview 5 staff weekly related to lifts available and safe operating condition. DDS or designee to audit kitchen equipment, ovens, for safe operating condition. Audit results will be reivewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 456	Continued From page 88 When interviewed on 5/7/15, at 1:24 p.m. nursing assistants (NA)-B NA-C, and NA-J verified the mechanical lifts are not in correct working order and the residents know the lifts don't always work correctly and that extends the time residents have to wait for cares and then they get impatient and sometimes refuse cares. The NA's agreed the mechanical lifts operating properly has been an ongoing issue and they thought management knew about the issues. During an interview on 5/7/15, at 2:34 p.m. NA-A and NA-C verified the mechanical lifts did not always work properly and that it was not unusual to wrap the sling attachments around several times before hooking them because the slings available were not the proper size. Both NA's verified residents have refused care because the proper lifts were not available for long periods of time. When interviewed on 5/7/15, at 3:00 p.m. maintenance (M)-A was not sure of the number of mechanical lifts and stands available in the facility and referred to the company they buy the product from as doing preventative maintenance. Furthermore, M-A did not have an updated list by serial/model number of documentation currently to verify the mechanical lifts were maintained according to manufacturer recommendation. M-A discussed currently having 2 mechanical lifts in the shop waiting for repair, and stated "for about a week now", and would be calling the company but had not done so yet.. M-A was not aware of the two mechanical lifts currently not working properly, and being used for residents on second floor.	F 456		

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F 456	Continued From page 89	F 456		

The facility did not have a policy and procedure for preventative maintenance of the mechanical lifts and stands.

Blodgett convection oven was not in safe operating condition.

During the kitchen tour on 5/4/15, at 12:30 p.m. the following was observed and confirmed by the Dietary Director (DD).

The Blodgett convection oven across from the food preparation area was hot to the touch and the on/off gas knob located above the temperature knob was missing. DD stated they do not use the unit because it is not working, "we have been having issues on and off with it for the past few weeks." DD verified the unit was hot, stated it "was on all the time" and she had work order emails sent to maintenance for it to get fixed, however had not notified maintenance about it in the past few weeks.

Review of a work order email dated 12/11/14, indicated under details: oven not heating please fix asap [as soon as possible]. On 3/17/15, the work order indicated the task status was closed with completion date of 3/17/15.

Review of a work order email dated 2/23/15, indicated under details: when should we expect oven to be repaired? On 2/25/15, at 5:50 am the work order indicated the task status was closed.

On 5/4/15, at 3:40 p.m. a paper note was observed on the front of the unit stating DO NOT USE and a thermometer was in the unit reading 149 degrees Fahrenheit (F). Cook (C)-A, stated when he started his shift the thermometer read

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F 456	Continued From page 90 250F, "I don't know how it got that hot, we don't use it." - At 4:05 p.m. the director of maintenance (DM) stated the temperature knob below the knob that is missing regulates the temperature and if it is turned all the way to the right, it is off. DM stated the missing gas knob fit too tight with potential for gas leakage, so it was taken off. DM stated "all the cooks know that the oven gas line can be turned off behind the unit and they know where that is." DM stated that if the unit was hot today, they were using it. "The stove functions just fine and has been working since we closed that ticket." On 5/6/15, at 10:17 a.m. the DD stated they needed maintenance to in-service them on use of the convection oven if it was fixed "To my understanding we could not regulate the temperature, so we were not using it." Cook (C-B) stated they hadn't used the oven in a month, "I don't know how it got hot." - At 11:30 a.m. the DM stated about two to three weeks ago they thought they smelled gas after replacing the thermocouple on the convection oven. The on/off knob would not fit properly after it was fixed so they in serviced C-B on usage of the oven without the on/off knob on the unit. DM stated he did not have documentation of the in-service, did not have manufacturer usage guidelines and that although he did not have a maintenance request policy, staff all know how to request repairs on the computer. DM indicated both requests from the DD were for the thermostat and thermocouple, not the missing on/off knob. - At 12:42 p.m. the administrator stated he was not aware of the issue until Monday night "when you brought it to my attention."	F 456		

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F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms, bathrooms, the laundry chute room, and hallways were maintained in a clean and sanitary manner for 9 of 40 residents reviewed (R215, R10, R102, R45, R56, R57, R72, R150, and R257). Findings include: On 5/7/15, at 12:36 p.m. to 1:32 p.m. the environmental tour was conducted with the maintenance director (MD) and the administrator. During the tour the following concerns were verified: Hallway odors: On 5/4/15, at 11:45 a.m. to 7:15 p.m. and consecutive days of the survey 5/5/15, 5/6/15, 5/7/15, and 5/7/15, the hallways were noted to have a malodorous odor when walking down the hallways which was strong. 1 North hallway from rooms 107 to 119 was noted to have a malodorous odor during the tour on 5/8/15, when asked if he was able to smell MD indicated "I don't smell anything." 2 North hallway from rooms 207 through room	F 465	a. Housekeeping and maintenance will provide services to address odor issues in 2n cooridor and resident bathrooms R72, R150, R257, R57,R10. The privacy curtain for R56 was replaced at the time of survey. The laundry chute room floor was cleaned at the time of survey. R215 room is being painted and the register repaired. b. The ED or designee is responsible to complete routine enviornmental rounds to ensure safe, functional, sanitary and comfortable enviornment. c. Edcuation will be provided to all staff on identifying odors, repair needs in resident rooms including painting and radaitor condition, and privacy curtain cleanliness and notifying housekeeping or maintenance for follow up. d. ED or designee to audit 5 resident rooms per unit 1x weekly for good repair, including wall paint and registers. ED or designee to audit cooridors, laundry chute rooms, and 5 resident bathrooms per unit per week for odors and floor cleanliness.	6/17/15

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F 465	Continued From page 92 219 during the tour still had the malodorous odor. During the tour the administrator verified the smell indicated there was a slight urine odor and later stated he wanted to change it to generalized odors. Resident rooms: R215's wall by his bed was observed patched with white paint and the heat register was noted to be in ill repair on 5/5/15, at 8:00 a.m. When interviewed, R215 stated he actually wanted to hang some pictures up but was not so sure because of the state of the wall. During the tour both the administrator and MD verified the heat register was in ill repair. MD indicated heat registers were on a preventative program and were checked every quarter. Both verified the white patches on the wall. MD stated the patch by bed wall was from when the trapezes had gone through the wall and would provide the dates when that had happened. Laundry Chute Room: On 5/6/15, at 11:00 a.m. two residents who wanted to remain anonymous reported on 5/5/15, they had observed the floor with feces and several staff were dragging plastic bags into the room and leaving and at the time they had requested the room to be cleaned which one of the laundry staff came and clean the feces. On 5/7/15, during the tour MD verified the laundry chute room had thick brown debris on the floor into the wall corners and the heat register had heavy debris. MD indicated he was going to let housekeeping know of all the concern to have the room cleaned.	F 465	Audit results reviewed at monthly QAPI meeting. Audit frequency adjusted based on results of audits.	

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F 465	Continued From page 93 Bathroom Odors: On 5/5/15, at 8:00 a.m. to 4:00 p.m. and consecutive days of the survey 5/6/15, and 5/7/15, at 8:00 a.m. to 12:00 p.m. the shared bathroom for R72, R150, R257 and R57 was noted to have a strong malodorous smells during all observations. During the tour MD and administrator verified the smell indicated was urine. When asked how often the rooms and bathrooms were cleaned the administrator stated daily. R10's shared bathroom on 5/5/15, at 2:21 p.m. during room observation a strong pervasive malodorous smell was noted coming from the bathroom shared by R10, R102 and R45. In addition the bathroom floor was noted to be sticky when walking on it. On 5/6/15, at 7:15 a.m. to 2:30 p.m. and on 5/7/15, at 9:30 a.m. the shared bathroom continued to have the strong malodorous smell despite housekeeping staff observed to be cleaning other rooms by the rooms. On 5/7/15, during the tour the administrator verified indicated the smell was of urine. Privacy curtain: On 5/5/15, at 3:00 p.m. the privacy curtain by the door when entering R56's room was noted to have several smears of brown matter, approximately 1 centimeter by one centimeter in size, visible from the hallway. On 5/6/15, during observations from 7:25 a.m. to 3:00 p.m., the privacy curtain on R56's side was still observed to have the brown smears visible from the hallway.	F 465		

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F 465	Continued From page 94 On 5/7/15, at 7:55 a.m. the brown smear marks remained visible from the hallway. On 5/7/15, at 9:39 a.m. licensed practical nurse (LPN)-B verified the soiling on R56's privacy curtain. LPN-B was not able to state what the soiling was from. When asked if the staff were supposed to let housekeeping know LPN-B stated, "Yes if they saw it."	F 465		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		6/17/15

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	245148	A. BUILDING _____ B. WING _____	05/08/2015

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F 520	Continued From page 95 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to ensure the quality assessment and assurance committee identified and acted upon quality of care and quality of life concerns. These practices had the potential to affect all 182 residents in the facility which included (R1, R55, R96, R193, R257, R154, R135, R90, R41, R118, R200, R28, R50). Findings include: Refer to 241: the facility failed to ensure individual resident dignity was maintained for 7 of 8 residents (R154, R257, R1, R55, R96, R193, R135) reviewed for dignity. Refer to 314: the facility failed to comprehensively reassess a recurrent pressure ulcer in order to develop interventions for appropriate treatment for 1 of 3 residents (R90) reviewed for pressure ulcers. Refer to 315: the facility failed to ensure 2 of 3 residents (R257, R200) identified as incontinent of urine, received the necessary care and services to meet their toileting needs. Refer to F353: the facility failed to provide sufficient staffing to meet the needs of the residents in accordance with their plan of care for 9 of 9 residents (R1, R96, R55, R41, R118, R200, R154, R90, R257) reviewed for toileting, transferring and position changes. Refer to F406: the facility failed to ensure residents received necessary rehabilitative	F 520	a. The facility QAPI committee consists of ED, DNS, Medical Directors, Pharmacist Consultant, and at least 3 other members of the facility staff. The meeting is normally held monthly on the 3rd Wednesday of the month unless there is a schedule conflict and it is rescheduled to occur in the same month. The QAPI meeting notes will be updated to include action plans and/or performance improvement projects relating to dignity, pressure ulcers, provision of incontinence cares, rehabilitative services recieved, sufficient staffing. Plans will particularly address behavioral/ mental health on 2n/2s and long term care on 2e. b. The facility QAPI committee meets monthly, and consists of ED, DNS, Medical Directors, Pharmacist Conultant and at least 3 other members of the facility staff. c. All staff will be educated to bring potential quality issues to management or to request to personally attend QAPI meeting or subcomittee meetings. All staff will be provided basic information on the QAPI process and ways the committee works to improve quality of care. d. ED or designee will audit 1x weekly the progress of each action plan or PIP related to dignity, pressure ulcers, provision of incontinence cares,	

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F 520	Continued From page 96 services to maintain their highest level of functioning for 3 of 3 residents (R28, R50, R257) in the sample reviewed for rehabilitative services. Review of Responding to Resident needs and Call Light Audit forms dated 3/6/15, 3/16/15, 3/18/15, 4/17/15, 4/28/15, 4/29/15, 5/1/15, 5/4/15, 5/5/15, and 5/6/15, revealed the call light audit forms did not consistently provide follow up or indicated resident had confirmed needs were met, the audits were mostly completed at the start to mid-week, no Thursdays, Saturdays and Sundays. The audits provided none had been done for 2 South which was one of the units where call light concerns brought up by both residents and staff concerns for adequate care. On 5/8/15, at 11:56 a.m. when asked what the facility did when residents complained about call lights, the director of nursing (DON) stated they completed grievance forms on call lights. When asked what else they had done related to the call light grievances, the DON stated "We are talking about customer service training, how residents are feeling and how we are treating residents." The DON indicated another staff person was working on customer service training, also the facility was working on holding the staff accountable and call light audits were being done to ensure they are answered timely. Although the DON stated currently improvement plans were being implemented on 2 East, and staffing numbers were being looked, there had been no improvement plan developed for 2 South and 2 North. When asked how the facility determined the staffing patterns for the units DON stated "We staff according to acuity and census. We have overall PPS [Prospective Payment System] and in addition we look at CMI [Case Mix Index]	F 520	rehabilitative services recieved, sufficient staffing Audit results will be reviewed at monthly QAPI meeting and the frequency of the audits will be changed depending on the results.	

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F 520	Continued From page 97 numbers and if high or trending down we pull from that." On 5/8/15, at 12:55 p.m. Administrator discussed dignity complaints and concerns on 2 East related to nurse staff attitudes and getting care timely in appropriate manner. He stated they have been working on consistent assignment, and developed a subcommittee that meets every Monday. They discussed staffing getting most appropriate staff, they have experienced lots of turnover. Their findings were to get appropriate staff to fill open positions. They used to have five nursing assistants, now have six nursing assistants due to showers/baths, and meals times are more efficient. He and director of nursing (DON) attended the last staff meeting, have improved, and discussed residents should be satisfied. Administrator said we looked at QA incentive payment (QUIP) and Department of Human Services (DHS) contracts vital research. They have looked at relationship domain for 2015, questions are related to satisfaction with nursing care, whether people stop to talk, say hi. Administrator stated they looked at potentials to picked, but have not started on it. On 5/8/15, at 1:00 p.m. assistant director of nursing (ADON) did attend monthly pressure ulcer committee with staff and medical director. The ADON indicated the facility had lots of pressure reduction mattresses and alternating air mattresses. When the surveyor asked about pressure ulcer re-occurring, and need comprehensive assessment component. The ADON indicated assessment should be done when it first appears.	F 520		

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F 520	Continued From page 98 On 5/8/15, at 1:16 p.m. the DON spoke about pressure ulcers. She said they saw a trend of more pressure ulcers the facility discussed staff education, different products to use, foam at back of heels to keep heels off bed, Prafo boots (soft boot with a heel lift), and good interventions. The facility was working on getting skin assessments in Point Click Care where they will be able to see assessments, and the assessment would flag if it was missed the day before. Even though the facility acknowledged they knew about the above addressed concerns, none of the addressed areas had interventions implemented to address the ongoing concerns of cares, dignity, pressure ulcers, toileting, call lights, grievances and staffing.	F 520		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. At the time of this survey, Golden Livingcenter St. Louis Park 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: Healthcare Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/05/2015

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

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K 000	Continued From page 1 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. Golden Livingcenter St. Louis Park is a 3-story building with no basement. The building was constructed at 2 different times The original building was constructed in 1966 and was determined to be of Type II (222) construction. In 1972 a two- story addition was constructed to the East Wing and determined to be of Type II (222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 208 beds and had a census of 183 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020	NFPA 101 LIFE SAFETY CODE STANDARD	K 020		6/17/15

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K 020 SS=D	Continued From page 2 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.1.1. This deficient practice could affect all residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 05/06/2015, observation revealed that the second floor linen chute door does not have a fire rated label. This deficient practice was verified by the administrator at the time of the inspection.	K 020	a. The second floor linen chute door will be replaced with a door that has a fire rated label or will be assessed by approved contractor for placement of fire rated label. b. All linen chute doors will have fire rated label. c. An inventory of linen chute doors will be completed to verify they have fire rated label. d. ED or designee will audit all linen chute doors quarterly for fire rated label. Audit results will be reviewed by QAPI committee and frequency of audits changed based on results.	
K 021 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:	K 021		6/17/15

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K 021	Continued From page 3 a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to meet the requirements of NFPA 101, 2000 Edition Sections 19.2.2.2.6 and 7.2.1.8.2. This deficient practice could affect all residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 05/06/2015, observation revealed that the second floor middle and middle north stairwell doors do not latch closed. This deficient practice was verified by the administrator at the time of the inspection.	K 021	a. The second floor middle and middle north stairwell doors will be repaired to latch closed. b. All stairwell doors will latch closed. c. An inventory of all stairwell doors will be completed to verify they latch closed. d. ED or designee to audit all stairwell doors quarterly to verify they latch closed. Audit results will be reviewed by QAPI committee and the frequency of the audits will be changed based on the results.	
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2	K 043		6/17/15

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K 043	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the door locks in accordance with Life Safety Code Section 18.2.2.4. This deficient practice could affect the residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 05/06/2015, observation revealed that the second floor middle north stair door delayed egress control device does not function. This deficient practice was verified by the administrator at the time of the inspection.	K 043	a. The second floor middle north stair door delayed egress control device will be repaired to function. b. All stairwell door delayed egress control devices will function. c. An inventory will be completed to verify all delayed egress control devices will function. d. ED or designee to complete quarterly audit to verify that all delayed egress control devices will function. Audit results will be reviewed by QAPI committee and the frequency of the audits will be changed based on the results.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's kitchen cooking equipment has not been maintained in accordance with Sec. 9.2.3 and NFPA 10. This deficient practice could affect the residents if near the kitchen. Findings include: On facility tour between 9:45 AM and 12:00 PM	K 069	a. The kitchen exhaust filters will be replaced to baffle type. b. All kitchen exhaust filters will meet regulation. c. An inventory of kitchen exhaust filters will be completed to verify they meet regulation.	6/17/15

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K 069	Continued From page 5 on 05/06/2015, observation revealed that the kitchen exhaust filters are mesh type and not baffle type. This deficient practice was verified by the administrator at the time of the inspection.	K 069	d. ED or designee will audit kitchen exhaust filters quarterly to verify they meet regulation. The audit results will be reviewed by QAPI committee and the frequency of the audits will be changed based on results.	