Electronically delivered
February 2, 2018

Ms. Jean Cole, Administrator
Augustana Health Care Center of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

Subject: Augustana Health Care Center of Minneapolis - Independent Dispute Resolution (IDR)
CMS Certification Number (CCN): 245242
Project Number: S5242027

Dear Ms. Cole:

This is in response to your letter from September 28, 2017, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tags F225, F226, F280, F282, F310, and F315 issued pursuant to the survey event M4PX11, completed on August 24, 2017.

The information presented with your letter, the CMS 2567 dated August 24, 2017 and corresponding Plan of Correction, as well as survey documents and **discussion with representatives from your facility** and representatives of L&C staff, have been carefully considered and the following determination has been made:

F225 Scope and severity of (S/S) - D 42 CFR § 483.12 (a) The facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately and not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury.

F226 S/S - D 42 CFR § 483.12(b) Abuse: The facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.

Summary of the facility's reason for IDR of this tag: The facility alleges the nursing assistant providing care for R123 when R123 fell from a mechanical lift had been following R123's plan of care and all other interventions. The facility alleges the sling popped off the lift accidentally. The facility acknowledged the sling failure caused R123 to fall to the floor however, since R123 received no injury, they'd determined the incident was not reportable.

Summary of facts: On 8/5/17, the facility was aware the lift sling had malfunctioned, when the sling "popped" and the lift suddenly stopped moving. As a result, R123 fell to the floor from the lift without sustaining an injury. R123's Minimum Data Set (MDS) dated 9/19/17, indicated R123's weight was 361 pounds. The manufacturer's guidelines recommended a sling size of "extra-large" for the resident's weight. The incident report documentation failed to identify the size of the sling being utilized at the time of the fall. On 8/24/17, at 11:30 a.m. the director of nursing (DON) verified a sling size assessment had not been documented, indicating determination of the sling size was more of a judgement based on clinical

factors. On 8/24/17, at 3:52 p.m. the director of maintenance was interviewed and stated he was unaware of any residents ever having fallen from a mechanical lift. The director of maintenance stated staff would update him with any event and he would then inspect the lift equipment for safety and proper functioning. The facility's Vulnerable Adult Reporting and Investigation Procedure revised 8/2016, indicated: "Those criminal activities that do not result in serious harm or threat will be reported within 24 hours." Although R123 did not receive bodily harm, the facility had 24 hours to report the event to the State Agency (SA). The report was not submitted to the SA.

Summary of findings: Because the provider failed to have a system in place to ensure staff had assessed the size of the sling required for residents in accordance with their weight, and other factors; and because the facility had not implemented any corrective action following the resident's fall, it was determined these are valid deficiencies at F225 for failure to report an allegation of neglect of care, and at F226 for the facility's failure to implement their reporting policies, with both tags identified at the correct scope and severity (s/s) of "D."

F280 S/S - D 42 CFR §483.21 (b) Comprehensive Care Plans. A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident; a nurse aide with the responsibility for the resident; a member of food and nutrition services staff; to the extent practicable, the participation of the resident and the resident's representative(s); other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident; and reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

Summary of the facility's reason for IDR of this tag: The facility alleged the plan of care did not require revision as the facility had utilized R338's son, an interpreter service and staff to communicate with R338. In addition, upon return from the hospital on August 3, 2017, communication cards were utilized.

Summary of facts: The facility had knowledge of R338's inability to communicate in English as the Minimum Data Set (MDS) dated 2/5/17, noted the resident's preferred language was "Somali." The MDS further noted the resident needed or wanted an interpreter to communicate with a doctor or health care staff. The MDS manual 3.0 dated October 2016, identified that the "Inability to make needs known and to engage in social interaction because of language barrier can be frustrating and can result in isolation, depression, and unmet needs." The care plan process directed staff to:

"• When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.
• An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the resident to point to (if able).
• Identifies residents who need interpreter services in order to answer interview items or participate in consent process."

The plan of care for R338 dated 2/10/17, related to cognitive loss/dementia noted R338 had a language barrier. Staff were to provide calendars, clocks, written notes and were to communicate at eye level whenever able. In addition, staff were to provide reminders and cues as needed however, the care plan

did not specify whether this communication was to be implemented in Somali or English. The communication problem dated 2/6/17, indicated R338 made herself understood by use of an interpreter and R338's hearing was adequate. The approach was to have staff "report any changes in ability to communicate, understand others, or in ability to hear. Refer for hearing exam PRN [as needed]." Although the facility placed a phone in R338's room and utilized communication cards after August 3, 2017 (approximately three months after admission) during the survey process, R338's care plan prior to the survey, lacked evidence of any revision for other alternative ways for the staff to communicate with R338 and to meet basic needs.

Summary of findings: Following review of the CMS 2567, information submitted by the facility, a face to face meeting with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined this is a valid deficiency at this tag and at the correct scope and severity of a "D."

F282 S/S - D 42 CFR § 483.21 (b)(3) Comprehensive Care Plans: The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.

Summary of the facility's reason for IDR of this tag: The facility dropped this deficiency from the IDR review during the face- to- face review on November 17, 2017.

F310 S/S - G 42 CFR § 483.24 (a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, …
(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

(1) Hygiene -bathing, dressing, grooming, and oral care,
(2) Mobility-transfer and ambulation, including walking,
(3) Elimination-toileting,
(4) Dining-eating, including meals and snacks,
(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.

Summary of the facility's reason for IDR of this tag: The facility alleges that interpreter services were involved in resident care. The facility made use of staff, the son and an interpreter service in order to communicate with R338, therefore R338 did not suffer any harm.

Summary of facts: The facility had knowledge of R338's inability to communicate in English as the Minimum Data Set (MDS) dated 2/5/17, noted the resident's preferred language was "Somali." The MDS further noted the resident needed or wanted an interpreter to communicate with a doctor or health care staff. The MDS manual 3.0 dated October 2016, identified that the "Inability to make needs known and to engage in social interaction because of language barrier can be frustrating and can result in isolation, depression, and unmet needs." The care plan process directed the staff to:

"• When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.
• An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the resident to point to (if able).
• Identifies residents who need interpreter services in order to answer interview items or participate in consent process."

R338's Psychosocial Well-being Care Area Assessment (CAA) dated 2/5/17, indicated R338 had exhibited mood symptoms of "little interest or pleasure in doing things."

The plan of care for R338 dated 2/10/17, related to cognitive loss/dementia noted R338 had a language barrier. Staff were to provide calendars, clocks, written notes and were to communicate at eye level whenever able. In addition, staff were to provide reminders and cues as needed. However, the care plan did not specify to staff whether the communication was to be done in Somali or English language. The communication problem dated 2/6/17, indicated R338 made herself understood with the use of an interpreter and R338's hearing was adequate. The approach was to have staff "report any changes in ability to communicate, understand others, or in ability to hear. Refer for hearing exam PRN [as needed]."

The undated TCU (transitional care unit) Care Card (used by nursing assistants), lacked evidence of how staff were to communicate with R338. The card only identified R338 had a language barrier and failed to identify the preferred language to use for R338.

On 8/23/17, at 12:25 p.m. during a second interview, family member (FM)-A indicated he posted a note with telephone numbers to the wall in R338's room to help with R338's language barrier, but the facility staff did not use the telephone numbers. FM-A had been told by the facility staff R338 refused cares and did not use her call light. FM-A stated R338 would call him by telephone, and she would call the facility to get R338 assistance with toileting. FM-A stated R338 would not refuse care if she understood what the staff were offering. FM-A indicated he felt the number one issue with her care had been related to the communication barrier.

FM-A indicated he visited every day and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language as R338 and that R338 would point and/or slap her hip when she had to go to the bathroom. NA-J stated when she cared for R338, the resident remained continent and did not need a brief. NA-J stated when other staff, who could not properly communicate with R338 during care, provided cares R338 wore a brief. NA-J further explained R338 had reported to her she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had informed nursing staff many times of her concerns related to R338's language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. NA-J stated, "She did not have that paper in her room before."

Although the facility utilized communication cards after August 3, 2017 (approximately three months after admission), placed a phone in R338's room and posted the interpreter hotline number during the survey process, R338's care plan prior to survey lacked evidence of any revision for other alternate ways for the staff to communicate with R338 to ensure basic needs were met.

Summary of findings: Following review of the CMS 2567, information submitted by the facility, a face to face conference with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined this is a valid deficiency at this tag and at the correct scope and severity of a "G."

F315 S/S - G 42 CFR § 483.25 (e) Incontinence: The facility must ensure that a resident, with or without, a catheter receives the appropriate care and services to prevent infections to the extent possible.

Summary of the facility's reason for IDR of this tag: The facility alleges that R338 had improved in the urinary incontinence.

Summary of facts: R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, required extensive assistance of one staff for all of her activities of daily living. The MDS also indicated R338 was occasionally incontinent of urine and frequently incontinent of bowel and was not on a toileting program.

R338's current care plan revised on 8/22/17, indicated R338 had incontinence of bowel and bladder with some control and history of stress incontinence. Contributing factors included: dementia, obesity, impaired mobility related to weakness, right lower extremity wounds, pain, anemia, use of narcotics, anti-depressants and language barrier. Related to confusion, R338 was not consistent with letting staff know she needed to be changed or use the bedpan. The care plan listed various interventions such as: check and change upon rising, before and after meals, before bed, night rounds and as needed, offer bed pan when not confused, peri-cares with incontinence episodes, and needed extensive assist of one or two staff depending on cognition. No interventions were identified regarding how to communicate with R338 regarding the language barrier and her incontinence or toileting needs.

R338's undated Transitional Care Plan for the NA (nursing assistant), indicated R338 required maximum assistance with toileting, and the resident called for assistance. The sheet indicated R338 was continent of bowel and bladder with occasional incontinence of bladder and wore an incontinent brief. The information on the card conflicted with most recent MDS. No interventions were listed on how to communicate with R338 regarding the language barrier and her incontinence or toileting needs.

During observation on 8/23/17, at 8:56 a.m. R338 wore a hospital gown and sat on the edge of her bed with her call light on. NA-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.

At 8:59 a.m. on 8/23/17, NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

On 8/23/17, at 12:25 p.m. family member (FM)-A indicated he visited every day and would assist R338 with toileting, dressing and anything else she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and R338 had reported she could not hold her urine any longer. FM-A indicated he discussed his concerns related to R338's language barrier with facility staff many times in the past. He indicated he suggested the use of an interpreter or staff to utilize pictures of various items or objects from the Internet to assist with communication. FM-A stated he noted pictures were used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication with cares for R338.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language as R338 and that R338 would point and/or slap her hip when she had to go to the bathroom. NA-J stated when she cared for R338, the resident remained continent and did not need a brief. NA-J stated when other staff, who could not properly communicate with R338 during care, provided cares R338 wore a brief. NA-J further explained R338 had reported to her she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had informed nursing staff many times of her concerns related to R338's language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. NA-J stated, "She did not have that paper in her room before."

Although the facility placed a phone and posted the number for the interpreter hotline in R338's room during the survey process, the facility failed to implement alternative communication interventions to promote urinary incontinence. However, R338 did not experience a decline in urinary incontinence as a result.

Summary of findings: Following review of the CMS 2567, information submitted by the facility, a face to face conference with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined this is a valid deficiency at this tag and the scope and severity will be reduced to a "D."

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

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

Sincerely,

Maria King, Assistant Program Manager
Licensing and Certification Program
Health Regulation Division
Telephone: (507) 344-2716 Fax: (507) 344-2723

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gail Anderson, Fergus Falls District Office Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS REVISED CMS 2567 as a result of an IDR On 8/21/2017- through 8/24/2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F 225		10/12/17

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

Electronically Signed | 09/29/2017

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F 225	Continued From page 1 (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 225		

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F 225	Continued From page 2 (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA) and thoroughly investigate an incident of potential neglect of care for 1 of 3 residents (R123) who fell from a mechanical lift in the facility. Findings include: R123's face sheet dated 12/29/16, identified current diagnoses of chronic pain, muscle and bilateral leg weakness, lymphedema, conversion disorder with seizures or convulsions, anxiety, depression, pain in left ankle and joints of left foot and repeated falls prior to admission. R123's admission Minimum Date Set (MDS) dated 1/5/17, identified R123 had intact cognition and required extensive assistance for transfers. Review of Event Report dated 8/5/17, at 6:45 p.m. indicated R123 had been transferred from her chair to bed, EZ stand sling popped out of place causing resident to land on her buttocks. Staff re-educated on proper use of EZ stand and to ensure correct size sling is being used. Further, the report listed the EZ stand had suddenly stopped moving, resident and nursing assistant did not remember what happened next,	F 225	Augustana Health Care Center of Minneapolis' Plan of correction is a written credible assertion of substantial compliance with the Federal and State requirements of Nursing facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medical Assistance programs. Please note that nothing set forth in this document is to be or should be construed to be an admission by Augustana Health Care Center of Minneapolis, or the validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification, and enforcement effort at issue. Further please note that any and all documents transmitted or otherwise provided by Augustana Health Care Center of Minneapolis in relation to the Plan of correction, as well as any and all other communications in writing or otherwise by or on behalf of Augustana Health Care Center of Minneapolis, at law and/or in equity, all of which are not waived and all of which are reserved and retained by, for and on behalf of Augustana Health Care Center of Minneapolis F225	

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F 225	Continued From page 3 one side of the sling was out of place and resident landed on the floor on buttocks. Resident was helped off the floor utilizing a hoyer lift, and no pain or injuries were evident at that time. Review of R123's Incident Review Form, dated 8/7/17, indicated R123 had a fall on 8/5/17, with no injury. The interdisciplinary team reviewed and documented there were no medication concerns, environmental concerns or change of condition noted. The form listed the new intervention of staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling. During interview on 8/23/17, at 8:07 a.m. R123 reported a few weeks ago she had fallen from the EZ stand lift used during a transfer. R123 reported when the staff member hooked her up to the lift, the staff member had not hooked the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since that fall, all staff had been hooking up all of the belts, and she had not had any further falls. During interview on 8/23/17, at 11:43 a.m. registered nurse (RN)-C confirmed R123 fell from the EZ stand lift during a transfer, and stated after talking with staff she believed the strap snapped off or open, and thought the size of the sling was maybe incorrect. RN-C stated re-education was given to the staff member involved regarding the lift use and sling sizes. RN-C verified there were no further investigations or documentation regarding R123's fall on 8/5/17. When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123	F 225	It is the policy of Augustana Health Care Center to ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are immediately reported to the administrator and other state officials in accordance with state law and to have evidence that all violations are thoroughly investigated. Corrective Action: Staff person was educated at time of the original incident on proper use of the EZ stand, and using the correct sling size for identified resident R123 8-7-17 All care sheets were updated with sling size for all residents to ensure safe transfers 10-3-17 Identification of Other Residents: All current (August 1 - September 30) incident reports were reviewed to ensure appropriate and immediate Vulnerable Adult reporting of abuse and/or neglect is reported if indicated. 10-4-17 Measures Put In Place: Incident review summary form was revised to add an additional review measure related to any possible indication of Abuse or Neglect to ensure a full investigation has been completed Mandatory all staff education was completed to review Vulnerable Adult reporting, investigation, and definitions of abuse and neglect Mandatory all staff education was completed to review appropriate sling use and size, and use of transfer equipment.	

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F 225	Continued From page 4 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, and as staff further investigated, the wording "popped off" was in the incident report, due to being too tight or the loop "popped off." The DON stated the facility did not complete a report to the SA as the facility did not feel this was a reportable event as there was no negative outcome for R123. During group interview on 8/24/17, at 3:41 p.m. with the administrator and DON, they confirmed the current faciilty policy, and the administrator confirmed she expected all neglect of care and suspected neglect or not providing care as needed to be reported to the SA. The administrator and the DON stated they did not feel R123's fall from the EZ stand mechanical lift was reportable due to the fact there was no negative outcome, no harm, no abuse or no negative intent. The administrator and DON stated they expected staff to give the highest level of care possible, and expected the care plan to be followed. Review of the facility's Vulnerable Adult Reporting and Investigation Procedure policy dated, 8/2016 indicated incidents that must be reported immediately to MDH (Minnesota Department of Health) included neglect. The policy indicated the Administrator and DON would appoint a person to investigate the alleged incident, including: - review of the incident - the residnets' medical record to determine events leading up to the incident - interview the person reporting the incident - interview the witnesses to the incident	F 225	10-11-17 Monitoring Mechanisms: Per facility policy all incident reports are reviewed by the Administrator, Director of Nursing, and Medical Director for proper completion and appropriate interventions. This review now includes the additional measure to review for any possible indication of abuse or neglect. Incident report patterns/trends are reviewed at the quarterly QAA/QAPI meetings for maintaining an acceptable standard of practice in regards to investigation of all incidents. We will review on-going for the next year and track and incident review that indicated abuse or neglect on or before: 10-19-17 11-30-17 12-31-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 6-30-18 7-31-18 8-31-18 9-30-18 Responsible Person/s Administrator Director of Nursing Clinical Managers Quality Improvement Director	

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F 225	Continued From page 5 - interview the resident, interview the staff members , interview the the resident's physician, roommate, family member, and visitors as indicated - interview other residents to whom the accused employee provides care or services. Review of the facility's Maltreatment of Vulnerable Adults Policy, dated 10/2016, indicated all allegations and/or suspicious of abuse must be reported to the administrator immediately. The policy further indicated if injury is unexplainable, or allegation of abuse is reported or witnessed, if there is caregiver neglect a report must immediately be reported to the Minnesota Department of Health (MDH) and call the administrator immediately. The policy also indicated an internal, facility investigation of reports will be completed.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95	F 226		10/12/17

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F 226	Continued From page 6 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prevention policy to immediately report to the State agency (SA) and thoroughly investigate potential incidents of neglect 1 of 1 resident (R123) who fell from a mechanical lift in the facility. Findings include: Review of the facility's Vulnerable Adult Reporting and Investigation Procedure policy dated, 8/2016 indicated incidents that must be reported immediately to MDH (Minnesota Department of Health) included neglect. The policy indicated the Administrator and DON would appoint a person to investigate the alleged incident, including: - review of the incident - the resident's medical record to determine events leading up to the incident - interview the person reporting the incident	F 226	F226 It is the policy of Augustana Health Care Center to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. To establish policies and procedures to investigate such allegations and include the required abuse, neglect, and exploitation staff training. Corrective Action: Staff person was educated at time of original incident on proper use of the EZ stand, and using the correct sling size for identified resident R123 8-7-17 All care sheets were updated with sling size for all residents to ensure safe transfers 10-3-17 Identification of Other Residents:	

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F 226	Continued From page 7 - interview the witnesses to the incident - interview the resident, interview the staff members, interview the the resident's physician, roommate, family member, and visitors as indicated - interview other residents to whom the accused employee provides care or services. R123's face sheet dated 12/29/16, identified current diagnoses of chronic pain, muscle and bilateral leg weakness, lymphedema, conversion disorder with seizures or convulsions, anxiety, depression, pain in left ankle and joints of left foot and repeated falls prior to admission. R123's admission Minimum Date Set (MDS) dated 1/5/17, identified R123 had intact cognition and required extensive assistance for transfers. Review of Event Report dated 8/5/17, at 6:45 p.m. indicated R123 had been transferred from her chair to bed, EZ stand sling popped out of place causing resident to land on her buttocks. Staff re-educated on proper use of EZ stand and to ensure correct size sling is being used. Further, the report listed the EZ stand had suddenly stopped moving, resident and nursing assistant did not remember what happened next, one side of the sling was out of place and resident landed on the floor on buttocks. Resident was helped off the floor utilizing a hoyer lift, and no pain or injuries were evident at that time. Review of R123's Incident Review Form, dated 8/7/17, indicated R123 had a fall on 8/5/17, with no injury. The interdisciplinary team reviewed and documented there were no medication concerns, environmental concerns or change of condition noted. The form listed the new	F 226	All current (August 1 - September 30) incidents reports were reviewed to ensure appropriate and immediate Vulnerable Adult reporting of abuse and/or neglect is reported if indicated. 10-4-17 Measures Put in Place: Incident review summary form was revised to add an additional review measure related to any possible indication of Abuse or Neglect to ensure a full investigation has been completed. Mandatory all staff education was completed to review Vulnerable Adult reporting, investigation, and definitions of abuse and neglect. Mandatory all staff education was completed to review appropriate sling use and size and use of transfer equipment. 10-11-17 Monitoring Mechanisms: Per facility policy all incident reports are reviewed by the Administrator, Director of Nursing, and Medical Director for proper completion and appropriate interventions. This review now includes the additional measure to review for any possible indication of abuse or neglect. Incident report patterns/trends are reviewed at the quarterly/monthly QAA/QAPI meetings for maintaining an acceptable standard of practice in regards to investigation of all incidents. We will review on-going for the next year and track any incident review that indicated abuse or neglect on or before: 10-19-17 11-30-17 12-31-17	

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F 226	Continued From page 8 intervention of staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling. During interview on 8/23/17, at 8:07 a.m. R123 reported a few weeks ago she had fallen from the EZ stand lift used during a transfer. R123 reported when the staff member hooked her up to the lift, the staff member had not hooked the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since that fall, all staff had been hooking up all of the belts, and she had not had any further falls. During interview on 8/23/17, at 11:43 a.m. registered nurse (RN)-C confirmed R123 fell from the EZ stand lift during a transfer, and stated after talking with staff she believed the strap snapped off or open, and thought the size of the sling was maybe incorrect. RN-C stated re-education was given to the staff member involved regarding the lift use and sling sizes. RN-C verified there were no further investigations or documentation regarding R123's fall on 8/5/17. When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, and as staff further investigated, the wording "popped off" was in the incident report, due to being too tight or the loop "popped off." The DON stated the facility did not complete a report to the SA as the facility did not feel this was a reportable event as there was no negative outcome for R123.	F 226	1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 6-30-18 7-31-18 8-31-18 9-30-18 Responsible Person/S Administrator Director of Nursing Clinical Managers Quality Improvement Director	

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F 226	Continued From page 9 During group interview on 8/24/17, at 3:41 p.m. with the administrator and DON, they confirmed the current faciilty policy, and the administrator confirmed she expected all neglect of care and suspected neglect or not providing care as needed to be reported to the SA. The administrator and the DON stated they did not feel R123's fall from the EZ stand mechanical lift was reportable due to the fact there was no negative outcome, no harm, no abuse or no negative intent. The administrator and DON stated they expected staff to give the highest level of care possible, and expected the care plan to be followed.	F 226		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 280		10/12/17

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F 280	Continued From page 10 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280		

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F 280	Continued From page 11 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include individualized interventions to effectively communicate with 1 of 1 resident (R338) with a language barrier. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and	F 280	F280 It is the policy of Augustana Health Care Center that residents have the right to participate in the development and implementation of his or her person-centered plan of care. Corrective Action: Communication audit was done with identified resident R338 to ensure all communication needs were addressed. Resident's electronic care plan, and TCU Care Card were updated with individualized communication interventions. 9-27-17 Identification of Other Residents: Communication Section was added to TCU Care Card to ensure communication interventions will be identified for all new admits with a Language barrier.	

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F 280	Continued From page 12 did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program. R338's Care Area Assessment (CAA) dated 2/9/17, indicated R338's primary language was Somali and family reported confusion and at times R338 thought she was in Africa. The CAA listed various causes and contributing factors which included cultural/language barrier, not recognizing caregivers or medical equipment and risk factors included social isolation, confusion, decreased progress and participation in rehab therapies. Also, the CAA indicated R338 had bowel and bladder incontinence with some control, history of stress incontinence and R338 was not consistent with letting staff know she needs to be changed. The CAA for communication did not trigger and was not addressed on the CAA. R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS indicated R338 required extensive assistance for all activities of daily living (ADL). The MDS also indicated R338 was occasionally incontinent of urine, frequently incontinent of bowel and had no toileting program. R338's current care plan, revised on 8/22/17, listed the problem of communication, hearing was adequate, and indicated R338 made herself understood through an interpreter. The care plan directed staff to report any changes in ability to communicate, understand others, or in ability to hear and to refer for hearing exam as needed.	F 280	9-27-17 Communication audits were completed on all residents with an identified language or communication barrier to ensure communication needs are addressed. Resident's electronic care plans and NAR care sheets were updated as needed with individualized communication interventions. 10-6-17 Measures Put in Place: Mandatory all staff education was completed on the importance of communication interventions as a part of developing a resident-centered plan of care. 10-11-17 Monitoring Mechanisms: 20% random audits will be done of TCU Care Cards, LTC resident care sheets, and electronic care plans on all units monthly for the next 60 days. 10-10-17 11-10-17 12-10-17 Audits will be reviewed by the Quality Improvement Committee for compliance with providing a resident-centered plan of care on or before 10-19-17 11-30-17 12-31-17 Responsible Person/s: Director of Nursing Clinical Managers Quality Improvement Director	

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F 280	Continued From page 13	F 280		

R338's care plan identified R338's primary language was Somali, had frequent pain, weakness, dementia, required extensive assistance with bed mobility, boost up in bed, assist to lift legs in/out of bed, and sitting position in bed. R338's care plan directed staff to speak simply and clearly and repeat as needed, utilize environmental cues as calendars, clocks, notes, communicate at eye level and establish calm, explain cares/treatments before beginning, as needed and consistent routine when providing cares. The care plan directed to provide opportunity for patient to express feelings, involve social services as needed, encourage resident to talk through anger and frustration, and to schedule an interpreter for rehab therapies, nurse practitioner/physician visits, care conferences and upon request. No further care plan interventions were listed to effectively communicate with R338, or assistive devices to use to communicate with R338.

Review of R338's undated Transitional Care Card listed various interventions which included assistance with ADLs, however, the care card lacked any interventions for R338's language barrier.

During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs.

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R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.

At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-D and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants."

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F 280	Continued From page 15 R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a rapid, frustrated voice and frantically assisted to place the bedpan by moving her hospital gown out of the way of the bedpan. With the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine. During interview on 8/23/17, at 9:11 a.m. RN-D stated staff had a hard time knowing what R338 wanted when she called for assistance and stated staff have to guess a lot of the time and the resident got frustrated during that time. On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on R338's wall for staff to utilize to call him to help communicate with R338. On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's primary language. RN-D indicated she had	F 280		

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contacted R338's son when she was not sure what R338 needed or wanted.

On 8/23/17, at 9:41 a.m. during a follow up interview with NA-G, she stated she used hand gestures to attempt to communicate with R338 and stated she was not aware of any other interventions to utilize while communicating with R338. NA-G indicated in the past she had called the family member to attempt to figure out what R338 needed assistance with. NA-G stated she had not utilized an interpreter in the past and was not aware how to request for or use needed interpreter services.

On 8/23/17, at 9:50 a.m. NA-H indicated communication was difficult with R338 and stated she pointed at objects or had her son translate when he was available. NA-H indicated her usual routine was to stand in her room, have R338 point until she figured out what R338 needed or wanted. NA-H indicated she had not utilized interpreter services with R338.

On 8/23/17, at 12:18 p.m. an interpreter was present in the building and he stated interpreter services were utilized for scheduled medical appointments with residents and was not aware of any other time interpreter services were utilized in the facility. The interpreter indicated that day (8/23/17), was the first time he had met R338 for a schedule medical appointment with the doctor today.

On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps with that sometimes. R338 indicated because she had been left on the bedpan without assistance in

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F 280	Continued From page 17 the past, she had tried not to go to the bathroom so she could avoid that from happening again. R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad, sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were. On 8/23/17 at 12:25 p.m. during second interview, FM-A indicated he posted a note with telephone numbers to the wall in R338's room to help with R338's language barrier, but the facility staff did not use the telephone numbers. FM-A had been told by the facility staff R338 refused cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.	F 280		

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F 280	Continued From page 18 FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338. On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to dial the cellular telephone. Above the night stand, which was next to R338's bed, a white piece of paper, approximately 8 inches (in) by 11 in. was taped to the wall. On the paper, typed in black ink, were instructions for contacting an online interpreter service. On 8/24/17 at 8:56 a.m. RN-G was present in R338's room and indicated staff had used communication cards with words on them, but R338 was not able to read the cards and stated, "so did not really work that well." RN-G stated it was easier to have staff to assist with communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what	F 280		

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R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with R338 and stated, "I don't think the problem is communication."

On 8/24/17 at 9:43 a.m. during a follow up interview, FM-A indicated when staff did not respond to her, she would be incontinent on the bed and stated "happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues. FM-A stated the interpreter information in R338's room was not there until they came to visit her last night.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J indicated she was aware R338 has had incontinence with bowel and bladder when other staff who do not understand what she wants cared for her. NA-J indicated when she cared for R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have

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incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. She stated, "She did not have that paper in her room before."

On 8/24/17, at 9:07 a.m. NA-K stated she was able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated "she has not had accidents for me." NA-K indicated R338 was able to communicate her needs, was pretty pleasant, cooperative with cares and did not refuse cares.

On 8/24/17, at 12:08 p.m. social worker (SW)-A confirmed R338 primary language was Somali and indicated he would schedule an interpreter for R338 or use the online service when R338 had medical appointments or when he completed his portion of the MDS. SW-A indicated the usual facility practice was to encourage R338 to use the son to translate, other staff members, and staff to be patient and explain cares to her. The SW-A indicated staff were expected to follow the care plan and to utilize the online interpreter services if having trouble communicating with R338. He

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indicated he was not aware of any problems communicating with R338. SW-A confirmed no other interventions had been put in place to assist R338 to effectively communicate with staff.

On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier. The DON indicated when residents were admitted who have language barriers, the usual facility practice was to send an email notification to all staff to notify them of the individual resident's primary language and if the family was available to assist. She stated "90%" of the time we have family to accommodate for their needs. The DON indicated the facility routinely scheduled an interpreter for therapy appointments and medical appointments, and stated the facility did not schedule any further services unless they felt the communication was unclear. The DON indicated 338's son came to the facility quite a lot and stated she had not heard of any concerns with communication that impacted 338's care.

Review of the facility policy titled Care Plans, revised on 11/2016, indicated care plans are

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F 280	Continued From page 22 developed after completion of the comprehensive assessment or as changes occur. The care plan will be reviewed at least quarterly and revised as needed. The policy also indicated the residents personal and cultural references will be incorporated into the development of the care plan goals. The policy further indicated care plans provide written guides for intervention, assisting the resident to meet their needs for ADL's, health care and psychosocial needs and to provide for person-centered development of the resident's plan of care. This policy also indicated "NAR Care sheets and /or profiles are updated per care plan changes to ensure the practice of following the plan of care."	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 implement care plan interventions for use of transfer equipment for 2 of 2 residents (R123, R228) who required use of mechanical equipment for assistance with transfers. Findings include:	F 282	F282: It is the policy of Augustana Health Care Center that the services provided by the facility as outlined in the comprehensive care plan must be provided by qualified persons in accordance with each resident's plan of care. Corrective Action: Staff were immediately re-educated on	10/12/17

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F 282	Continued From page 23 R123's care plan dated 8/22/17, indicated R123 required extensive assistance of one staff with transfers, staff to cue resident before and during transfers, R123 may use the EZ stand when resident reports feeling weak. R123's fall care plan dated 8/14/17, indicated R123 was resized for sling related to a fall, appropriate large fitting EZ stand strap/sling obtained. R123's undated care sheet, indicated R123 was a fall risk, required extensive assist of one staff for stand pivot transfer with four wheeled walker and protective boot, OR required EZ stand with large sling when resident report feeling weak. The following words were typed on the care sheet and underlined and in red ink wer " be sure to use LG(large) sling with all EZ stand transfers." During observation on 8/23/17, at 7:29 a.m. R123 was observed lying in bed, nursing assistant (NA)-A present in the room. NA-A asked R123 if she was ready to get up for the day, R123 stated yes, NA-A proceeded to provide morning cares. At 7:55 a.m. NA-A retrieved an EZ stand mechanical lift and brought into R123's room, the lift had a sling with beige colored binding draped over the top of the lift. NA-A brought the EZ stand lift up to the edge of the bed, R123 placed both of her feet on the lift's foot platform and locked the lift into place. NA-A then placed the sling behind R123's back, attached all loops of the sling on to the hooks of the EZ stand lift, and attached the safety belt around R123's abdomen and behind R123's calves. NA-A used the remote control, and utilized the hydraulic lift to stand R123 upright while R123 wore black grippy type gloves and held on to both handles. NA-A proceeded to unlock the EZ stand lift brakes, widened the legs and transferred R123 in front of her wheelchair,	F 282	proper use of the EZ stand, with correct sling size for identified residents F123 8-23-17 Staff were immediately re-educated on necessity to use the proper transfer equipment per resident's plan of care for identified resident R228 8-24-17 Identification of Other Residents: All residents were audited for appropriate transfer equipment and sling size per weight, transfer ability and care plan. All care plans and care sheets were reviewed and revised if needed stating the correct sling size and appropriate transfer equipment for each resident. 9-30-17 Measures Put in Place: Mandatory education for al nursing staff was conducted on use of EZ stand, EZ lift, proper sling size, and safety protocols for resident transfers. 10-11-7 Monitoring Mechanisms: Staff skill checks will be conducted for all residents requiring the use of transfer equipment to ensure proper equipment and sling size is used. 10-10-17 Random staff skill checks will be conducted for residents on all units weekly for the next 30 days to ensure proper equipment and sling size is used. 10-17-17 10-24-17 10-31-17 11-4-17 Random staff skill checks will be conducted for residents on all units	

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F 282	Continued From page 24 she then locked the lift in place once R123 was in front of her wheelchair, and used the remote control to lower R123 into her wheelchair. Once R123 was seated in the wheelchair, she stated NA-A was really good about putting all the belts on. NA-A unlocked the EZ stand lift, R123 removed her feet from the platform, both safety belts were released, loops unhooked, and the sling with beige colored binding was removed. NA-A confirmed the sling used to transfer R123 was a size medium, as she visualized the white tag attached to the sling with a letter M on the tag. During interview on 8/23/17, at 8:07 a.m. R123 reported she fell from the EZ stand lift a few weeks ago. R123 reported when the staff member hooked her up to the lift, the staff member did not hook the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since she fell from the lift all staff had been hooking up all of the belts, and she has not had any further falls. R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 stated she still gets scared, and repeats the picture in her mind of falling when she gets transferred. R123 stated she now wears gripper gloves to make sure she has a secure hold on the handles of the lift during transfers. R123 reported prior to her fall from the lift, staff were not always attaching the safety belt around her abdomen, then stated she had not reported that information to any nurses. R123 stated the fall from the EZ stand lift has been her only fall since admission. During interview on 8/23/17, at 8:17 a.m. NA-A confirmed R123 required extensive assistance of one staff member for all ADL's, with the exception	F 282	monthly for the next 60 days to ensure proper equipment and sling size is used. 12-4-17 1-4-18 All skills checks will be reviewed at the monthly QI/QAA meetings for compliance with standard of care for the next 90 days on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Nursing Clinical Managers Staff Development Director Quality Improvement Director	

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of eating which she was independent. NA-A reported staff carry care guide sheets that indicate what each resident needs for assistance. NA-A reported R123 did have one fall only that she was aware of, stated R123 fell from the lift because the lift was not working. NA-A verified staff decide and choose which size sling to use for each resident, and stated if the sling fits, we use it. NA-A confirmed she used a medium sized sling to transfer R123, and verified the tag marked with a M on it. NA-A also indicated a color guide attached to the lift used for R123's transfer which indicated slings with a beige colored binding were size medium. NA-A also indicated the sling size was on R123's care plan.

During interview on 8/24/17, at 9:44 a.m. RN-C stated sling size was determined by staff discretion and to the resident's comfort level, then staff document the size on the care plan and care sheet. RN-C was notified R123 was observed to be transferred with a medium sized sling, RN-C stated R123's identified sling size on her care plan and care sheet indicated a large size sling, but reported the resident stated the medium sized sling felt comfortable for her when she visited with R123.

When interviewed on 8/23/17, at 11:50 a.m. licensed practical nurse (LPN)-B stated residents were measured around their abdomen, then the sling sizes were determined by the measurement, like a girdle. LPN-B stated the sling size to be used was documented in the resident's care plan, and confirmed R123 should use a large sized sling with all transfers.

When interviewed on 8/23/17, at 12:14 p.m. NA-B reported the staff had access to several sizes of

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slings for the EZ stand lift, and stated if they do not have the correct size, staff would notify laundry to obtain the correct size.
NA-B believed R123 required an extra large sized sling.

When interviewed on 8/24/17, at 9:30 a.m. NA-C verified R123 used an EZ stand lift for all transfers and extensive assistance of one staff. NA-C stated R123 required the use of a large sized sling for all transfers, and indicated this information was also on the care sheets. NA-C verified she was given education on the use of the mechanical lifts upon hire.

When interviewed on 8/24/17, at 9:20 a.m. NA-D indicated R123 required extensive assistance of one staff and the EZ stand lift for all transfers with a large sized sling.

When interviewed on 8/24/17, at 9:36 a.m. LPN-C confirmed R123 required the EZ stand lift for all transfers, and indicated that is how she had always transferred. LPN-C confirmed RN-C completed the assessments to determine the appropriate sling sizes for each resident, an the correct size was documented on the care sheet and care plan.

When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, as staff further investigated, the wording popped off was in the incident report, due to being too tight or the loop popped off. The DON stated the staff member involved was immediately given education to

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ensure the sling fit properly and was comfortable. The DON stated after the investigation, staff believed a different size sling should be used. The DON confirmed prior to the fall R123 utilized a medium sized sling. The DON stated when determining the proper size sling, staff look at weight, but weights were pretty fluid and variable according the manufacture's chart and guidelines. She stated we take in to consideration the resident's comfort level of sling, generalized width, and what looks safe. The DON verified the sling size assessment was not documented, as it was more of a judgement based on clinical factors, then the size was documented on the care sheet and care plan. The DON verified staff should use a large sized sling for all EZ stand lift transfers with R123, unless there was some reason there needed to be a change, the change would be reviewed by the clinical manager. The DON stated staff do not routinely document if the sling size changes, then stated it would be indicated on the care sheet as being a different size. The DON stated she had the clinical manager re-assess R123 on 8/23/17 for proper sling size, and based on the assessment that she did, the sling should be a large size, and verified all staff should be providing care as directed by the care sheets and care plan which also indicates a large size sling to be used. The DON confirmed there were no other documents or assessments regarding R123's fall from the EZ stand lift, other than the event report. The DON stated the interdisciplinary team (IDT) had more of a discussion, talks with people to get more of a picture of what happened, so we know what the new interventions should be, and verified this is all done "off the record" as the IDT talked. The DON reported the nursing assistants were expected to visualize the lifts for obvious damage

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F 282	Continued From page 28 of sling and lift prior to each use, and stated maintenance routinely inspects the lifts and slings. R228 care plan revision dated 8/19/17, indicated R228 required assist with transfers due to impaired mobility related to Parkinson disease. R228 careplan directed staff "transfers with assist of two via an EZ lift." The untitled, undated nursing assistant care sheet updated 8/21/17, indicated for R228 "Transfers: EZ-Lift." During an observation on 8/24/17, at 1:14 p.m. nurses aide (NA)-O and nurses aide (NA)-P rolled an EZ stand down the hallway and entered R228 room. NA-O verbally cued R228 she was going to use the EZ stand to transfer him from his wheel chair to his bed. NA-O and NA-P placed an EZ sling under R228 back and cued R228 "lean forward so can get sling behind you, your weaker arm is on right." NA-O cued R228 to hold onto EZ stand handles with his arms. NA-O placed his feet onto stand to transfer R228 from his wheelchair to his bed. NA-O and NA-P continued with transfer from wheelchair to the bed. As R228 was lowered to on edge of bed he said "wait a minute." R228 leaned to right side as legs removed from the EZ stand. NA-O and NA-P lifted R228 legs up onto the bed and positioned him in bed.	F 282		

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F 282	Continued From page 29 During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand. CM-A stated R228 careplan interventions had been changed to use of a EZ lift to ensure a safe transfer. CM-A stated staff were made aware of care plan changes through shift communication, careplan review and aid care sheets. CM-A stated the NA-O and NA-P should have been using the EZ lift with R228. During the interview with CM-A , NA-O approached the desk area and stated R228 was hollering and said he didn't want a strap between his legs so she used an EZ stand. CM-A stated to NA-O, he was supposed to be transferred with the EZ lift. NA-O did not respond. During an interview on 8/24/17, at 3:59 p.m. with director of nursing (DON) stated R228 care plan had been updated on 8/19/17 for an EZ lift to be used as R228 had weakness in arms and legs and was not safe to use on a EZ stand. DON also stated staff had been informed of the changes and were provided education. The facility's Care Plan policy dated 11/2016, indicated care plans are developed to provide written guides for intervention, assisting the resident to meet their needs for ADL's, health care and psychosocial needs and to provide for person-centered development of the resident's plan of care.	F 282		
F 310 SS=G	ADLS DO NOT DECLINE UNLESS UNAVOIDABLE CFR(s): 483.24(a)(b) (a) Based on the comprehensive assessment of a	F 310		10/12/17

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F 310	Continued From page 30 resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: (1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, … (b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: (1) Hygiene -bathing, dressing, grooming, and oral care, (2) Mobility-transfer and ambulation, including walking, (3) Elimination-toileting, (4) Dining-eating, including meals and snacks, (5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 310		

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F 310	Continued From page 31 Based on observation, interview and document review, the facility failed to provide sufficient communication services for activities of daily living to ensure basic needs were met for 1 of 1 resident (R338) with a language barrier. This deficient practice resulted in psychosocial harm for R338, who experienced isolation and emotional distress related to incontinence when her basic needs were unable to be met due to inadequate communication with facility staff. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program. R338's Care Area Assessment (CAA) dated 2/9/17, indicated R338's primary language was Somali and family reported confusion and at times R338 thought she was in Africa. The CAA listed various causes and contributing factors which included cultural/language barrier, not recognizing caregivers or medical equipment and risk factors included social isolation, confusion, decreased progress and participation in rehab therapies. Also, the CAA indicated R338 had	F 310	F310 It is the policy of the Augustana Health Care Center to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrates that such diminution was unavoidable. corrective Action: Identified resident R338 was assessed for incontinence and communication care areas and appropriate changes were made to the care plan. Resident was supplied with wall mounted communication cards that can be used by staff to speak her language and for the resident to point to when communicating her needs. 9-28-17 Identification of Other Residents: Communication Section was added to TCU Care Card to ensure communication interventions will be identified for all new admits with a language barrier. 9-27-17 Communication audits were completed on all residents with an identified language or communication barrier to ensure communication needs are addressed. Resident's electronic care plans and NAR care sheets were updated as needed with individualized communication interventions. 10-6-17 Measures Put in Place: Mandatory all staff education was completed to review communication needs of residents, communication tools	

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F 310	Continued From page 32 bowel and bladder incontinence with some control, history of stress incontinence and R338 was not consistent with letting staff know she needs to be changed. The CAA for communication did not trigger and was not addressed on the CAA. R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS indicated R338 required extensive assistance for all activities of daily living (ADL). The MDS also indicated R338 was occasionally incontinent of urine, frequently incontinent of bowel and had no toileting program. R338's current care plan, revised on 8/22/17, listed the problem of communication, hearing was adequate, and indicated R338 made herself understood through an interpreter. The care plan directed staff to report any changes in ability to communicate, understand others, or in ability to hear and to refer for hearing exam as needed. R338's care plan identified R338's primary language was Somali, had frequent pain, weakness, dementia, required extensive assistance with bed mobility, boost up in bed, assist to lift legs in/out of bed, and sitting position in bed. R338's care plan directed staff to speak simply and clearly and repeat as needed, utilize environmental cues as calendars, clocks, notes, communicate at eye level and establish calm, explain cares/treatments before beginning and as needed and consistent routine when providing cares. The care plan directed to provide opportunity for patient to express feelings, involve social services as needed, encourage resident to	F 310	available to all residents, and the importance of reporting any difficulties in communicating with residents when providing cares and services. 10-11-17 Monitoring Mechanisms: Staff communication skill checks will be done with all residents who have a language barrier. Skills checks will include demonstrated staff proficiency with using communication devices/tools and individualized interventions specific to each resident's comprehensive assessment. 10-10-17 Staff communication skill checks will be done for all residents who have a language barrier weekly for the next 60 days and monthly for 6 months. 10-10-17 10-17-17 10-24-17 10-31-17 11-7-17 11-14-17 11-21-17 11-28-17 12-28-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 All communication skill checks will be reviewed at the monthly QI/QAA meetings for compliance with staff competency in communication interventions on or before 10-31-17 11-30-17	

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F 310	Continued From page 33 talk through anger and frustration, and to schedule an interpreter for rehab therapies, nurse practitioner/physician visits, care conferences and upon request. No further care plan interventions were listed to effectively communicate with R338, or assistive devices to use to communicate with R338. Review of R338's undated Transitional Care Card listed various interventions which included assistance with ADLs, however, the care card lacked any interventions for R338's language barrier. During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m. At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand	F 310	12-31-17 1-31-18 Responsible Person/s Director of Nursing Clinical Managers Quality Improvement Director	

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F 310	Continued From page 34	F 310		

gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-D and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants."

R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a rapid, frustrated voice and frantically assisted to place the bedpan by moving her hospital gown out of the way of the bedpan. With the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine.

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F 310	Continued From page 35 During interview on 8/23/17, at 9:11 a.m. RN-D stated staff had a hard time knowing what R338 wanted when she called for assistance and stated staff have to guess a lot of the time and the resident got frustrated during that time. Review of R338's progress notes from 5/1/17 to 8/21/17, revealed the following: -5/5/17, Somali interpreter used for assessment, had moderately impaired cognition and was at moderate risk for mood disturbance. R338 had reported trouble falling asleep, feeling tired and trouble concentrating because of pain and poor appetite. R338 did not have mental health diagnoses, not receiving psychotropic medications, refused psychiatric services referral. The note listed social services would follow up and assist as needed. -5/7/17, alert and orientated to facility, needs interpreter, no English. -6/6/17, care conference scheduled for that day, son will attend and interpreter requested interpreter service. -6/8/17, wound nurse visited with patient, her son translated for the visit and R338 had no questions. -7/14/17, social services met with patient and patient's family through phone interpreter to discuss room transfer. Patient and family understand and agreeable to transfer. -7/24/17, R338 transferred to another unit in the facility	F 310		

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F 310	Continued From page 36 -7/25/17, social service met with son and son indicated that he is present at most times but requested that an interpreter be utilized for formal assessments. - 8/3/17, son expressed concerns regarding language barrier. Son concerned resident's needs were not being met when he was not there as she was not able to communicate to staff. Facility staff suggested making flash cards with pictures as well as English/Somali commands for resident to use to communicate her needs. Son indicated he would like the flash cards implemented, and facility staff were to create the flash cards and provide to the resident to use. -8/4/17, resident unable to communicate due to language barrier. Family and interpreter assist with communicating with staff. Staff to assist with communication by providing communication cards. No further documentation of implementation of flash cards, the effectiveness of the flash cards or any alternative communication aides were found in the chart. -8/10/17, R338 hospitalized at this time, social service assessment done by staff interview. Staff reported R338 had no short or long term memory problems, had difficulty in new situations only with daily decision making skills and minimal symptoms of mood disorder. -8/20/17, on Heparin, teaching not effective due to language and inability to understand. On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A	F 310		

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F 310	Continued From page 37 stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on R338's wall for staff to utilize to call him to help communicate with R338. On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's primary language. RN-D indicated she had contacted R338's son when she was not sure what R338 needed or wanted. On 8/23/17, at 9:41 a.m. during a follow up interview with NA-G, she stated she used hand gestures to attempt to communicate with R338 and stated she was not aware of any other interventions to utilize while communicating with R338. NA-G indicated in the past she had called the family member to attempt to figure out what R338 needed assistance with. NA-G stated she had not utilized an interpreter in the past and was not aware how to request for or use needed interpreter services. On 8/23/17, at 9:50 a.m. NA-H indicated communication was difficult with R338 and stated she pointed at objects or had her son translate when he was available. NA-H indicated her usual routine was to stand in her room, have R338 point until she figured out what R338 needed or wanted. NA-H indicated she had not utilized interpreter services with R338.	F 310		

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F 310	Continued From page 38 On 8/23/17, at 12:18 p.m. an interpreter was present in the building and he stated interpreter services were utilized for scheduled medical appointments with residents and was not aware of any other time interpreter services were utilized in the facility. The interpreter indicated that day (8/23/17), was the first time he had met R338 for a schedule medical appointment with the doctor today. On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps with that sometimes. R338 indicated because she had been left on the bedpan without assistance in the past, she had tried not to go to the bathroom so she could avoid that from happening again. R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad, sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were.	F 310		

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F 310	Continued From page 39 On 8/23/17 at 12:25 p.m. during second interview, FM-A indicated he posted a note with telephone numbers to the wall in R338's room to help with R338's language barrier, but the facility staff did not use the telephone numbers. FM-A had been told by the facility staff R338 refused cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier. FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338. On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to dial the cellular telephone. Above the night stand, which was next to R338's bed, a white piece of paper,	F 310		

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approximately 8 inches (in) by 11 in. was taped to the wall. On the paper, typed in black ink, were instructions for contacting an online interpreter service.

On 8/24/17 at 8:56 a.m. RN-G was present in R338's room and indicated staff had used communication cards with words on them, but R338 was not able to read the cards and stated, "so did not really work that well." RN-G stated it was easier to have staff to assist with communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with R338 and stated, "I don't think the problem is communication."

On 8/24/17 at 9:43 a.m. during a follow up interview, FM-A indicated when staff did not respond to her, she would be incontinent on the bed and stated "happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues. FM-A stated the interpreter information in R338's room was not there until they came to visit her last night.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap

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AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J indicated she was aware R338 has had incontinence with bowel and bladder when other staff who do not understand what she wants cared for her. NA-J indicated when she cared for R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. She stated, "She did not have that paper in her room before."

On 8/24/17, at 9:07 a.m. NA-K stated she was able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated "she has not had accidents for me." NA-K indicated R338 was able to communicate

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her needs, was pretty pleasant, cooperative with cares and did not refuse cares.

On 8/24/17, at 12:08 p.m. social worker (SW)-A confirmed R338 primary language was Somali and indicated he would schedule an interpreter for R338 or use the online service when R338 had medical appointments or when he completed his portion of the MDS. SW-A indicated the usual facility practice was to encourage R338 to use the son to translate, other staff members, and staff to be patient and explain cares to her. The SW-A indicated staff were expected to follow the care plan and to utilize the online interpreter services if having trouble communicating with R338. He indicated he was not aware of any problems communicating with R338. SW-A confirmed no other interventions had been put in place to assist R338 to effectively communicate with staff.

On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier. The DON indicated when residents were admitted who have language barriers, the usual facility practice was to send an email notification

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to all staff to notify them of the individual resident's primary language and if the family was available to assist. She stated "90%" of the time we have family to accommodate for their needs. The DON indicated the facility routinely scheduled an interpreter for therapy appointments and medical appointments, and stated the facility did not schedule any further services unless they felt the communication was unclear. The DON indicated 338's son came to the facility quite a lot and stated she had not heard of any concerns with communication that impacted 338's care.

On 8/24/17, at 4:18 p.m. during a phone interview medical director (MD) indicated he was not aware if the facility had access to an interpreter 24 hours a day. The MD indicated he would expect all residents would have ongoing assessment and care to meet their needs and also indicated he felt it was difficult for foreign speaking resident because families do not always tell staff the concerns.

Review of facility policy titled, Communication: Interpreter/Translation Services for limited English Proficiency revised on 1/2016, indicated the interdisciplinary team will assess residents communication needs/deficits upon pre-admission, admission and throughout the residents stay at the care center. the social worker will arrange for any on-going interpreter needs for resident. Augustana Health Care Center will be responsible for the charges. Social worker will write a progress note describing communication needs and arrangements. The policy listed various auxiliary aids to be available used such as: universal communication cards, communication boards and if additions aids are need they will be ordered in a prompt manner.

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F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide assistance with shaving for 1 of 3 residents (R162) reviewed who required staff assistance to complete activities of daily living. Findings include: R162's quarterly Minimum Data Set (MDS) dated 7/14/17, indicated R162 had diagnoses which included Alzheimer's disease, psychotic disorder and chronic pain. The MDS indicated R162 had severely impaired cognition and required extensive assistance for dressing. The MDS indicated R162 required set up help for completing personal hygiene including shaving and supervision with bathing. R162's care plan dated 7/23/17, indicated R162 required hands on assistance at times due to Alzheimer disease for grooming and directed staff to encourage and assist as needed for grooming. Review of R162's nursing assistance care sheet, undated, identified R162 received assistance with her shower on Monday mornings. On 8/22/17, at 8:37 a.m. R162 was seated in her wheelchair at dining room table. She was independently eating the breakfast meal, with	F 312	F312: It is the policy of the Augustana Health Care Center to provide the necessary services to maintain good nutrition, grooming, personal, and oral hygiene. Corrective Action: Identified resident R162 received the immediate services required for facial hair removal. The staff person responsible for the grooming of identified resident received a written work performance education 8-24-17 Identification of Other Residents: A facility wide shaving audit was conducted to ensure appropriate shaving services were completed and/or offered to all residents. 9-29-17 Measures Put in Place: Mandatory education for all nursing staff was conducted to ensure appropriate shaving services are completed and/or offered to all residents. Noting residents will continue to have the right to refuse shaving. 10-11-17 Monitoring Mechanism: Random shaving audits will be done on all units weekly for the next 30 days.	10/12/17

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F 312	Continued From page 45 several other residents present in the dining room. R162 was noted to have many long, coarse, white hairs under her chin. On 8/23/17, at 7:14 a.m. R162 ambulated with her walker down the hallway toward the dining room. R162 was observed to have the same long, white coarse hairs under her chin. At 8:58 a.m., R162 remained in the dining room with the same long, coarse, white chin hairs present. During an interview on 8/23/17, at 11:17 a.m. nursing assistant (NA)-M confirmed R162 had many coarse, white chin hairs present. NA-M stated the usual facility practice was to remove facial hair as part of bathing cares. NA-M stated R162's chin hair should have been removed on Monday with her bath. NA-A stated if long facial hair was noticed on a resident, the facial hair was to be taken care of right away. NA-A confirmed R162 dressed herself, but staff assisted her as needed. During an interview on 8/23/17, at 11:49 a.m. with licensed practical nurse (LPN)-A stated R162 had always liked to look nice. but had resisted cares in the past. LPN-A stated R162 typically allowed care when staff re-approached her later. Review of R162's Skin-Body Visual Inspection/Observation form, dated 8/21/17, indicated a body audit had been completed for R162. The form indicated various inspections were completed such as visualizing for new bruises, rashes and indicated "resident shaved/facial hair removed-No, not needed." During an interview on 8/24/17, at 8:24 a.m. with clinical manager (CM)-A stated the expectation	F 312	10-10-17 10-17-17 10-24-17 10-31-17 Random shaving audits will be done on all units monthly for the next 60 days. 11-30-17 12-31-17 Audits will be reviewed by the Quality Improvement committee for compliance with providing and/or offering shaving services for residents on or before. 10-19-17 11-30-17 12-31-17 1-31-18 Responsible Person's Director of Nursing or designee Clinical Managers Quality Improvement Director	

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F 312	Continued From page 46 was for all residents to be checked with shower/bath, and everyday with cares to ensure facial hair is removed. CM-A also stated she expected staff to let the nurse know if a resident refused cares. Facility policy on grooming was requested but was not provided.	F 312		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 315		10/12/17

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F 315	Continued From page 47 prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess bowel and bladder patterns and implement a toileting program to restore continence of bowel and bladder to the extent possible for 1 of 1 residents (R338) who was not being provided assistance with toileting routinely due to a language barrier. R338 sustained harm due to an avoidable decrease in bowel and bladder function. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program.	F 315	F315: It is the policy of the Augustana Health Care Center to accurately assess bowel and bladder patterns and implement a toileting schedule/plan to restore continence of bowel and bladder to the extent possible. Corrective Action: Upon review of resident's communication patterns related to elimination specific interventions including the Somalian word for bathroom and gestures have been identified and care planned to indicate need for toileting. Upon review of the past 60 days of bowel and bladder point of care documentation improved continence was demonstrated for identified resident R338. R338 Bowel and Bladder assessment has been reviewed and remains current. 9-28-17 Identification of Other Residents: Communication section was added to TCU Care Cards to ensure communication interventions will be identified for all new admits with a language barrier. 9-27-17	

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F 315	Continued From page 48 R338's Care Area Assessment (CAA) dated 2/9/17, indicated R338 had bowel and bladder incontinence with some control and history of stress incontinence. Contributing factors included mornings with confusion, obesity, impaired mobility related to weakness, two right lower extremity wounds with wound vac, pain, anemia, use of narcotics, antidepressants, and language barrier. Staff were to check and change upon rising, before and after meals, bedtime, night rounds and as needed related to confusion. R338 was not consistent with letting staff know she needed to be changed and staff were to assist with peri care with incontinence. R338's quarterly MDS dated 5/8/17, indicated R338 was moderately impaired, needed extensive assistance of two staff for bed mobility, transfers and extensive assistance of one staff for dressing, toileting and personal hygiene. The MDS also indicated R338 was frequently incontinent of urine and always continent of bowel and had no toileting program. R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, needed extensive assistance of one staff for all of her activities of daily living. The MDS also indicated R338 was occasionally incontinent of urine and frequently incontinent of bowel and had no toileting program. Review of R338's current care plan revised on 8/22/17, indicated R338 had incontinence of bowel and bladder with some control and history of stress incontinence. Contributing factors included: dementia, obesity, impaired mobility related to weakness, right lower extremity	F 315	Communication audits were completed on all residents with an identified language or communication barrier to ensure communication needs are addressed. Residents electronic care plans and NAR care sheets were updated as needed with individualized communication interventions. 10-6-17 All bowel and bladder assessments for residents with a language barrier were reviewed for decline. 10-9-17 Measures Put in Place: Mandatory all staff education was completed on the importance of identifying communication needs of residents and use of communication interventions to ensure standard of care is maintained. 10-11-17 Monitoring Mechanisms: Clinical Managers are notified by RAI staff of any decline in bowel and bladder at the time of their quarterly assessment, which triggers a review of the current assessments, and any additional assessments as needed are completed. Monthly review of Bowel and Bladder assessments for residents with language barriers will be done for the next 6 months to ensure all bowel and bladder care needs of residents with language barriers are being met. 10-31-17 11-30-17 12-31-17 1-31-18 2-27-18	

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F 315	Continued From page 49 wounds, pain, anemia, use of narcotics, anti-depressants and language barrier. Related to confusion she is not consistent with letting staff know she needs to be changed or when to use the bedpan. The care plan listed various interventions such as: check and change upon rising, before and after meals, before bed, night rounds and as needed, offer bed pan when not confused, peri cares with incontinence episodes, and needed extensive assist of one or two staff depending on cognition. No interventions were listed on how to communicate with R338 regarding the language barrier and her incontinence or toileting needs. Review of R338's Transitional Care Plan for the NA (nursing assistant) undated, indicated R338 was max for toileting assistance and resident calls for assistance. The sheet indicated R338 was continent of bowel and bladder with occasional incontinence of bladder and wore a incontinent brief. No interventions were listed on how to communicate with R338 regarding the language barrier and her incontinence or toileting needs. During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew"	F 315	3-31-18 Staff communication skill checks will be done with all residents who have a language barrier. Skill checks will include demonstrated staff proficiency with using communication devices/tools and individualized interventions specific to each resident's comprehensive assessment 10-10-17 Staff communication skill checks will be done for all residents who have a language barrier weekly for the next 60 days and monthly for the next 6 months. 10-10-17 10-17-17 10-24-17 10-31-17 11-7-17 11-14-17 11-21-17 11-28-17 12-28-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 All communication skill checks will be reviewed at the monthly QI/QAA meetings for compliance with staff competency in communication interventions on or before. 10-31-17 11-30-17 12-31-17 1-31-18 2-27-18 3-31-18	

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F 315	Continued From page 50 sound repeatedly. R338 continued make the "'sheeeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.. At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338. At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-A and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants." R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper,	F 315	4-30-18 5-31-18 Responsible Person/s Director of Nursing Clinical Managers Quality Improvement Director	

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F 315	Continued From page 51 cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a rapid, frustrated voice and frantically assisted to place the bedpan by moving her hospital gown out of the way of the bedpan. At 9:05 a.m., with the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine. R338's disposable brief was dry. Review of R338's admission Bowel and Bladder Assessment, dated 2/9/17, indicated R338 had short term memory loss, was able to identify the need or urge to void/defecate some of the time, was able to use the call light, ask to go to the toilet sometimes, and had been admitted with incontinence. The assessment indicated R338 had incontinence of bladder, had incontinence episodes with position changes. The assessment indicated R338 had diagnoses which included recent surgery, obesity, edema and required assistance to transfer. Further, R338 was incontinent of bowel, had no problem with pattern irregularity, loose stools or diarrhea or constipation and was functionally disabled and had urgency. The assessment indicated R338 had stress and functional incontinence. The documentation was blank regarding R338's 3 day voiding pattern and for the 3 day bowel pattern. The analysis of the assessment indicated R338 had confusion, was not consistent with letting staff know she needed to be changed and was to be on a check and change program, upon arising, before and after meals, before bed, with night rounds and as needed and wore a brief.	F 315		

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AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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F 315	Continued From page 52 Review of R338's initial Bowel and Bladder Assessment dated 4/28/17, indicated R338 had short term memory loss, able to identify the need to urge to void/defecate all of the time, able to use call light, able to ask to go to the toilet. The assessment indicated R338 was incontinent of bladder, unknown how long resident has been incontinent of bladder, no problem with leaking urine, had no incontinent episodes with laughing, coughing, changing positions, sneezing or exercise. The assessment indicated R338 was continent of bowel, utilized a bedside commode, constipation problems sometimes, and no symptoms affecting eliminations patterns. Further, the assessment indicated R338 required assistance with ambulation, transfers and used adaptive equipment. R338 has pain that effected elimination patterns, required weight bearing assistance, resident somewhat involved, showed patterns of urinary continence greater than 2 hours,was able to use toilet majority of time on all shifts and had problems with constipation. R338's assessment indicated R338 had functional incontinence (decreased mental awareness/decreased or loss mobility or personal unwillingness). R338's elimination plan was scheduled toileting due to being cognitively impaired, functional disabilities and care giver dependent. The elimination plan included: Check and change due to cognitive impairment, retraining to return to previous pattern due to able to feel sensation, able to understand and learn to inhibit urge, toilets independently or with minimal assist and prompt voiding due to able to request toilet (however a retraining program to improve continence was never implemented). The plan included for R338 to utilize the bedpan or commode for voiding and to use the commode	F 315		

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for bowel movements and wore a brief.

Review of R338's Bowel and Bladder Quarterly Assessment, reviewed on 5/4/17, indicated the bladder and bowel management programs were effective and no changes were needed to the current plan of care.

Review of R338's Bowel and Bladder Quarterly Assessment, reviewed on 7/13/17, indicated R338 was incontinent of bladder and bowel, the current bowel and bladder plan was effective and did not indicate any changes to the current plan of care.

Review of R338's Hennepin County Medical Center physician progress notes revealed a note dated 4/18/17, from the nurse practitioner which indicated "nursing assistants report the patient is continent of bowel and bladder and is utilizing a bedpan but occasionally utilizing commode."

On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on R338's wall for staff to utilize to call him to help communicate with 338.

On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's

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primary language. RN-D indicated she had contacted R338's son when she was not sure what R338 needed or wanted.

On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps with that sometimes. R338 indicated because she had been left on the bedpan without assistance in the past, she had tried not to go to the bathroom so she could avoid that from happening again. R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad, sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were.

On 8/24/17, at 8:56 a.m. RN-G indicated staff had used communication cards with words on them, but R338 was not able to read the cards and stated, "So did not really work that well." RN-G stated it was easer to have staff to assist with

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communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with R338 and stated, "I don't think the problem is communication."

On 8/24/17, at 9:43 a.m. during a follow up interview, FM-A indicated R338 had been continent of bowel and bladder before she got sick and was only incontinent and wore a brief when she was sick. FM-A indicated when staff did not respond to R338, she would be incontinent on the bed and stated," happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J indicated she was aware R338 has had incontinence with bowel and bladder when other staff who do not understand what she wants cared for her. NA-J indicated when she cared for

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R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's language barrier.

On 8/24/17, at 9:07 a.m. NA-K stated she was able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated, "she has not had accidents for me." NA-K indicated R338 was able to communicate her needs, was pretty pleasant, cooperative with cares and did not refuse cares.

On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if

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F 315	Continued From page 57 available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier. Review of facility policy titled, Bladder Programming/Toileting revised on 1/2016, indicated the facility would assess residents upon admission, and at other appropriate clinical times (EX: removal of catheter) for bladder retraining/toileting programs.	F 315		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		10/12/17

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F 323	Continued From page 58 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement individualized equipment requirements to ensure the appropriate transfer equipment was utilized during transfers for 2 of 2 residents (R123, R228) who had a history of fall during a transfer utilizing a mechanical lift. In addition, the facility failed to follow manufacturer's guidelines for the proper use of a wheeled walker to prevent accident hazards for 1 of 1 resident (R224) who utilized a walker for ambulation. Findings include: R123's face sheet dated 12/29/16, identified current diagnoses of chronic pain, muscle and bilateral leg weakness, lymphedema, conversion disorder with seizures or convulsions, anxiety, depression, pain in left ankle and joints of left foot and repeated falls prior to admission. R123's admission Minimum Data Set (MDS) dated 1/5/17, identified she required extensive assistance for transfers, had a history of falls prior to admission and had intact cognition. R123's Care Area Assessment (CAA) dated 1/9/17, indicated R123 admitted with weakness, required extensive assistance for transfers and was at risk for falls related to a history of falls, deconditioning, pseuedoseizures, depression, obesity, impaired balance, the need for extensive	F 323	F323 It is the policy of Augustana Health Care Center that the environment remains as free from accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: Staff were immediately re-educated on proper use of the EZ stand, with correct sling size for identified resident R123 8-23-17 Staff were immediately re-educated on necessity to use the proper transfer equipment per resident's plan of care for identified resident R228 8-24-17 Staff were immediately re-educated on proper method of transporting resident, and care sheet was updated with the proper method of transporting resident for identified resident R224 8-21-17 EZ stand policy was updated to include information regarding appropriate sling size use. 9-29-17 Identification of Other Residents: All residents were audited for appropriate transfer equipment and sling size per weight, transfer ability and care plan. all care plans and care sheets were reviewed	

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F 323	Continued From page 59 assistance with activities of daily living (ADL's), pain, and use of medications. R123's care plan dated 8/22/17, indicated R123 required extensive assistance of one staff with transfers, staff to cue resident before and during transfers, R123 may use the EZ stand when resident reports feeling weak. R123's fall care plan dated 8/14/17, indicated R123 was resized for sling related to a fall, appropriate large fitting EZ stand strap/sling obtained. R123's undated care sheet, indicated R123 was a fall risk, required extensive assist of one staff for stand pivot transfer with four wheeled walker and protective boot, or required EZ stand with large sling when resident reports feeling weak. The following words were typed on the care sheet and underlined in red ink "be sure to use LG [large] sling with all EZ stand transfers." During observation on 8/23/17, at 7:29 a.m. R123 was observed lying in bed, nursing assistant (NA)-A present in the room. NA-A asked R123 if she was ready to get up for the day, R123 stated yes, NA-A proceeded to provide morning cares. At 7:55 a.m. NA-A retrieved an EZ stand mechanical lift and brought into R123's room, the lift had a sling with beige colored binding draped over the top of the lift. NA-A brought the EZ stand lift up to the edge of the bed, R123 placed both of her feet on the lift's foot platform and locked the lift into place. NA-A then placed the sling behind R123's back, attached all loops of the sling on to the hooks of the EZ stand lift, and attached the safety belt around R123's abdomen and behind R123's calves. NA-A used the remote control, and utilized the hydraulic lift to stand R123 upright while R123 wore black, grippy type gloves and	F 323	and revised if needed stating the correct sling size and appropriate transfer equipment for each resident. 9-29-17 All care sheets of residents with seated walkers were updated to state, "Do not transport residents at any time in seated walker." 9-29-17 Measures Put in Place: Mandatory all staff education was conducted on prevention of accidents and resident safety. Mandatory education for all nursing staff was conducted on use of EZ stand, EZ Lift, proper sling size and safety protocols for resident transfers 10-11-17 Monitoring Mechanisms: Safety rounds specific to transporting of residents with seated walker will be conducted for al residents by 10-10-17 and monthly for the next 90 days. 11-10-17 12-10-17 1-10-18 Staff skill checks will be conducted for all residents requiring the use of transfer equipment to ensure proper equipment and sling size is used. 10-10-17 Random staff skill checks will be conducted for residents on all units weekly for the next 30 days to ensure proper equipment and sling size is used. 10-17-17 10-24-17 10-31-17 11-4-17	

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F 323	Continued From page 60 held on to both handles of the lift. NA-A proceeded to unlock the EZ stand lift brakes, widened the legs of the lift and transferred R123 in front of her wheelchair, she then locked the lift in place once R123 was in front of her wheelchair, and used the remote control to lower R123 into her wheelchair. Once R123 was seated in the wheelchair, she stated NA-A was really good about putting all the belts on. NA-A unlocked the EZ stand lift, R123 removed her feet from the platform, both safety belts were released, loops unhooked, and the sling with beige colored binding was removed. NA-A confirmed the sling used to transfer R123 was a size medium, as she visualized the white tag attached to the sling with a letter M on the tag. Review of Event Report dated 8/5/17, at 5:45 p.m. indicated R123 suffered a witnessed fall during an EZ stand transfer. According to the report, the EZ stand suddenly stopped moving, R123 or nursing assistant was unable to remember what happened next, then one side of the sling was out of place which caused R123 to land on her buttocks, on the floor, with legs straight out. R123 was wearing shoes at the time of the fall. At the time of the fall R123 denied pain, hitting her head, range of motion in all extremities without pain or limitations, and there were no signs of injury. The Event Report indicated R123 was alert and oriented times three, communicated the situation well at the time, but was unable to describe what happened. Interventions identified on the Event Report, educated resident and staff the importance of checking on function of the equipment before using it, staff re-educated on proper use of EZ stand and to ensure correct size sling is used. Evaluation note of the event, indicated while	F 323	Random skill checks will be conducted for residents on all units monthly for the next 60 days to ensure proper equipment and sling size is used. 12-4-17 1-4-18 Responsible Person/s Director of Nursing Clinical Managers Staff Development Staff Quality Improvement Director	

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transferring R123 from her chair to bed, the EZ(stand) stanc [sic] sling popped out of place causing resident to land on her buttocks. No injuries observed, resident remains alert and oriented. Staff re-educated on proper use of EZ stand and to ensure correct size sling was being used.

Review of R123's Incident Review Form dated 8/7/17, indicated R123 had a fall on 8/5/17, with no injury. The interdisciplinary team reviewed and documented the following:
-no medication concerns, Environmental concerns or change of condition noted. Plan of Care Changes/New Interventions: staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling.

Review of the printed education for NA-L dated 8/7/17, indicated staff had performance issues related to the incorrect use of EZ stand sling causing resident to fall on 8/5/17. Policy, procedures and standards of practice were reviewed with NA-L, which included the following:
-All assigned tasks should be performed with meticulous attention to detail, the quality of life of our resident depend on it.
-Correct use of EZ stand is vital to safety of residents and staff members.
-Correct size of sling is extremely pertinent for providing safe transfers; all slings used should be the appropriate size at all times. The proper fit will involve the judgment of the caregiver.
-Nursing assistants has the task of inspecting both machine, battery and sling before every lift to ensure safety.
-The sling must be secured to the machine on both sides; the foot and waist buckle must be

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F 323	Continued From page 62 latched prior to every lift. -A copy of the EZ WAY harness sizing chart given to resident and placed on machine. Review of nursing progress notes dated 8/5/17 to 8/22/17, revealed the following: -On 8/7/17, at 1:45 p.m. R123 complained of left rib pain, no bruises noted. A call was placed to R123's nurse practitioner to request an x-ray to rule out fracture. -8/7/17, at 4:02 p.m., R123 returned to the facility, with negative result from x-ray. At 11:32 p.m. R123 continued to complain of pain to the left side, medication and a cold pack given with some relief noted, also note was a 2 centimeter (cm) x 2 cm bruise to R123's inner right arm. -On 8/8/17, at 2:46 p.m. R123 complained of pain of left side and rib cage area, and rated 8/10. Results of x-ray were sent to R123's primary nurse practitioner, no new orders received. -On 8/13/17, at 6:51 a.m. resolution of fall noted, indicated while transferring R123 from her chair to bed, the EZ(stand) stanc [sic] sling popped out of place causing resident to land on her buttocks. No injuries observed, resident remains alert and oriented. Staff re-educated on proper use of EZ stand and to ensure correct size sling was being used. -No further complaints of pain or injuries documented after 8/8/17. Review of X-ray report dated 8/7/17, indicated R123 had mild bibasilar infiltrates or atelectasis, however, no acute fracture was found. Review of R123's fall risk assessment dated 6/21/17, indicated R123 did not have any falls within the past six months, and was a low fall risk for falls.	F 323		

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F 323	Continued From page 63 During interview on 8/23/17, at 8:07 a.m. R123 reported she fell from the EZ stand lift a few weeks ago. R123 reported when the staff member hooked her up to the lift, the staff member did not hook the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since she fell from the lift all staff had been hooking up all of the belts, and she has not had any further falls. R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 stated she still gets scared, and repeats the picture in her mind of falling when she gets transferred. R123 stated she now wears gripper gloves to make sure she has a secure hold on the handles of the lift during transfers. R123 reported prior to her fall from the lift, staff were not always attaching the safety belt around her abdomen, then stated she had not reported that information to any nurses. R123 stated the fall from the EZ stand lift has been her only fall since admission. When interviewed at 12:49 a.m., R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 verified she did receive an x-ray and there were no fractures, she stated she did not have the pain in that location of her body prior to the fall, and still continues to have discomfort in her lower back and hip area. During interview on 8/23/17, at 8:17 a.m. NA-A confirmed R123 required extensive assistance of one staff member for all ADL's, with the exception of eating which she was independent. NA-A reported staff carry care guide sheets that indicate what each resident needs for assistance. NA-A reported R123 did have one fall only that she was aware of, stated R123 fell from the lift	F 323		

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because the lift was not working. NA-A verified staff decide and choose which size sling to use for each resident, and stated if the sling fits, "we use it." NA-A confirmed she used a medium sized sling to transfer R123, and verified the tag marked with a M on it. NA-A also indicated a color guide attached to the lift used for R123's transfer which indicated slings with a beige colored binding were size medium. NA-A also indicated the sling size was on R123's care plan. NA-A reported when staff use the EZ stand lift, all safety belts were to be attached, on the abdomen and behind legs. NA-A verified she had received education regarding the safe use of the EZ stand lifts when she started working at the facility.

During interview on 8/23/17, at 11:43 a.m. RN-C confirmed R123 fell from the EZ stand lift during a transfer. RN-C stated after talking with staff she believed the strap snapped off or open, and thought the size of the sling was maybe incorrect. RN-C stated re-education was given to the staff member involved regarding the lift use and sling sizes. RN-C verified the staff did not complete a specific assessment when determining the correct sling size to use. RN-C was not aware of the color coded sling size sticker attached to the lifts, and when asked how the staff determines the size of sling to use, if they go by weight or size, she did not answer.

During follow up interview on 8/24/17, at 9:44 a.m. RN-C stated sling size was determined by staff discretion and to the resident's comfort level, then staff document the size on the care plan and care sheet. RN-C was notified R123 was observed to be transferred with a medium sized sling, RN-C stated R123's identified sling size on her care plan and care sheet indicated a large

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sling size, but reported the resident stated the medium sized sling felt comfortable for her when she visited with R123. RN-C reported R123 was not injured from the fall, confirmed R123 did complain of pain, an x-ray was completed to rule out fractures, and was found to have some atelactisis. RN-C verified there were no further investigations or documentation regarding R123's fall on 8/5/17.

When interviewed on 8/23/17, at 11:50 a.m. licensed practical nurse (LPN)-B stated residents were measured around their abdomen, then the sling sizes were determined by the measurement, like a girdle. LPN-B stated the sling size to be used was documented in the resident's care plan, and confirmed R123 should use a large sized sling with all transfers.

When interviewed on 8/23/17, at 12:14 p.m. NA-B reported the staff had access to several sizes of slings for the EZ stand lift, and stated if they do not have the correct size, staff would notify laundry to obtain the correct size.
NA-B believed R123 required an extra large sized sling.

When interviewed on 8/24/17, at 9:30 a.m. NA-C verified R123 used an EZ stand lift for all transfers and extensive assistance of one staff. NA-C stated R123 required the use of a large sized sling for all transfers, and indicated this information was also on the care sheets. NA-C verified she was given education on the use of the mechanical lifts upon hire.

When interviewed on 8/24/17, at 9:20 a.m. NA-D indicated R123 required extensive assistance of one staff and the EZ stand lift for all transfers with

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F 323	Continued From page 66 a large sized sling. When interviewed on 8/24/17, at 9:36 a.m. LPN-C confirmed R123 required the EZ stand lift for all transfers, and indicated that is how she had always transferred. LPN-C confirmed RN-C completed the assessments to determine the appropriate sling sizes for each resident, an the correct size was documented on the care sheet and care plan. When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, as staff further investigated, the wording "popped off" was in the incident report, due to being too tight or the loop "popped off." The DON stated the staff member involved was immediately given education to ensure the sling fit properly and was comfortable. The DON stated after the investigation, staff believed a different size sling should be used. The DON confirmed prior to the fall R123 utilized a medium sized sling. The DON stated when determining the proper size sling, staff look at weight, but weights were pretty fluid and variable according the manufacture's chart and guidelines. She stated we take in to consideration the resident's comfort level of sling, generalized width, and what looks safe. The DON verified the sling size assessment was not documented, as it was more of a judgement based on clinical factors, then the size was documented on the care sheet and care plan. The DON verified staff should use a large sized sling for all EZ stand lift transfers with R123, unless there was some reason there needed to be a change, the change	F 323		

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would be reviewed by the clinical manager. The DON stated staff do not routinely document if the sling size changes, then stated it would be indicated on the care sheet as being a different size. The DON stated she had the clinical manager re-assess R123 on 8/23/17 for proper sling size, and based on the assessment that she did, the sling should be a large size, and verified all staff should be providing care as directed by the care sheets and care plan which also indicates a large size sling to be used. The DON confirmed there were no other documents or assessments regarding R123's fall from the EZ stand lift, other than the event report. The DON stated the interdisciplinary team (IDT) had more of a discussion, talks with people to get more of a picture of what happened, so we know what the new interventions should be, and verified this is all done "off the record" as the IDT talked. The DON reported the nursing assistants were expected to visualize the lifts for obvious damage of sling and lift prior to each use, and stated maintenance routinely inspects the lifts and slings.

When interviewed on 8/24/17, at 3:52 p.m. the director of maintenance (DOM) indicated he completed monthly audits and inspections on all mechanical lifts used in the facility. The DOM stated he looked for broken, loose or worn parts, and replaced them as needed, and looked to ensure the lifts were functioning safely. The DOM stated he was not aware of any residents ever falling from a mechanical lift or EZ stand lift, then stated if staff would update him in that type of event, he would want to go look at the lift or standing lift to inspect the lift for safety and proper functioning.

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F 323	Continued From page 68 Review of the undated, EZ way, Inc. smart stand manufacturer's sizing guidelines document included a color coding system, separating different sizes by different colored binding on the harnesses. Beige colored represent a size medium for use of 90-220 pounds, 34-46 inches of circumference of patient's torso where harness is applied. The chart indicates the size/weight of designations were merely estimates and basic guidelines. A proper fit would involve the judgement of the caregiver.	F 323		

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R228 quarterly Minimum Data Set(MDS) dated 7/28/17, indicated R228 had severe cognitive impairment and required assist of two for transferring.

R228 face sheet indicated diagnoses included dementia with Lewy Bodies, Parkinson disease, muscle weakness, orthostatic hypotension, and major depressive disorder.

R228 care plan revision dated 8/19/17, indicated R228 required assist with transfers due to impaired mobility related to Parkinson disease. R228 careplan directed staff "transfers with assist of two via an EZ lift."

The untitled, undated nursing assistant care sheet updated 8/21/17, indicated for R228 "Transfers: EZ-Lift."

Review of R228's progress note dated 8/19/17, at 6:44 p.m. indicated while transferring R228 with EZ stand lift, R228 became weak and unable to hold on to the bar of the lift and nursing staff lowered R228 to the ground by his arms. Three staff assisted R228 to bed utilizing a (EZ lift) full mechanical lift. The note indicated the EZ lift should be utilized for R228 and an order obtained for evaluation of the lift for R228.

During an observation on 8/24/17, at 1:14 p.m. nurses aide (NA)-O and nurses aide (NA)-P rolled an EZ stand down the hallway and entered R228 room. NA-O verbally cued R228 she was going to use the EZ stand to transfer him from his wheel chair to his bed. NA-O and NA-P placed an EZ sling under R228 back and cued R228 "lean forward so can get sling behind you, your weaker arm is on right." NA-O cued R228 to hold onto

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F 323	Continued From page 70 EZ stand handles with his arms. NA-O placed his feet onto stand to transfer R228 from his wheelchair to his bed. NA-O and NA-P continued with transfer from wheelchair to the bed. As R228 was lowered to on edge of bed he said "wait a minute." R228 leaned to right side as legs removed from the EZ stand. NA-O and NA-P lifted R228 legs up onto the bed and positioned him in bed. During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand. CM-A stated R228 careplan interventions had been changed to use of a EZ lift to ensure a safe transfer. CM-A stated staff were made aware of care plan changes through shift communication, careplan review and aid care sheets. CM-A stated the NA-O and NA-P should have been using the EZ lift with R228. During the interview with CM-A , NA-O approached the desk area and stated R228 was hollering and said he didn't want a strap between his legs so she used an EZ stand. CM-A stated to NA-O, he was supposed to be transferred with the EZ lift. NA-O did not respond. During an interview on 8/24/17, at 3:59 p.m. with director of nursing (DON) stated R228 care plan had been updated on 8/19/17 for an EZ lift to be used as R228 had weakness in arms and legs and was not safe to use on a EZ stand. DON also stated staff had been informed of the changes and were provided education.	F 323		

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R224's quarterly Minimum Data Set (MDS) dated 7/15/17, identified R224 was cognitively intact and had diagnoses which included: Parkinson's disease, schizophrenia and hypertension. The MDS identified R224 was independent with all activities of daily living (ADL's.) except required staff assistance with dressing, toilet use and personal hygiene. The MDS identified R70 ambulated independently and required a walker for mobility.

R224's care plan revised 8/21/17, at 8:03 p.m. identified R224 ambulated independently with use of a walker. The care plan indicated R224 had fatigue with distance at times, would often ask staff and visitors to push him on the seat of the walker and was not easily re-directed. The care plan directed staff to assist R224 if a decline in self performance was noted. The care plan indicated R224 was independent with transfers and did not use a wheelchair regularly. The care plan further instructed staff to use extensive to total assist to propel R224's wheelchair depending on weakness. The care plan identified R224 was at risk for falls related to Parkinson's disease effects, use of antihypertensive meds, use of a devise and the potential for unsafe behavior related to schizophrenia. The care plan directed staff to encourage and remind R224 to ambulate with his 4 wheeled walker.

The untitled, undated nursing assistant care sheet indicated R224 was ambulatory and used a 4 wheeled walker and wheelchair as needed. The sheet further indicated R224 was independent with transfers. The care sheet instructed staff to offer use of wheelchair for mobility if R224 became weak or had an

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F 323	Continued From page 72 unsteady gait. On 8/21/17, at 6:39 p.m. R224 was observed seated on the bench of his 4 wheeled walker in the hallway near the nurses station, while nursing assistant (NA)-F pushed R224's walker down the hall. NA-F pushed R224, seated on the bench of the walker while he faced backwards, approximately 50 feet from the nursing station desk to the table in the dining room located past the common sitting area. R224 stood up and seated himself in a chair at the dining room table. On 8/21/17 at 7:39 p.m. NA-F confirmed she had transported R224 utilizing the bench of his wheeled walker. NA-F indicated R224 had requested her to push him to the dining room because he felt weak. NA-F indicated she transported R224 utilizing the bench of his wheeled walker every 2-3 weeks. NA-F visualized and verified the nursing assistant care sheet that indicated R224 utilized a 4 wheeled walker and had a wheel chair to be used as needed. On 8/21/17, at 7:44 p.m., clinical manager (CM)-A verified she was present at the nursing station when she observed NA-F transport R224 from the nursing station to the dining room. CM-A verified NA-F pushed R224 while he sat on the bench of his 4 wheeled walker. CM-A indicated she told NA-F not to transport R224 while he sat on his walker, but did not intervene. CM-A indicated she had instructed staff not to transport residents while they sat on the bench of their walkers. CM-A indicated R224 at times the staff would use a wheelchair to transport R224. On 8/23/17, at 8:17 a.m. R224 indicated he was able to ambulate independently with his 4	F 323		

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wheeled walker. R224 confirmed in the past staff had used the Rollator walker to transport him while he sat on the bench of the walker.

On 8/23/17, at 9:00 a.m. director of rehab (DR)-A indicated she would not recommend a 4 wheeled walker to be used for transportation while a resident sat on the bench. DR-A indicated that if she witnessed a staff member pushing a resident while they sat on the bench of a 4 wheeled walker she would intervene and stop them. DR-A indicated she would expect staff and residents would be educated to not use 4 wheeled walkers as a wheelchair for transportation.

On 8/23/17, at 9:10 a.m. director of nursing (DON) confirmed she had been made aware staff had utilized R224's walker to transport him in the facility. DON indicated she would expect staff would not push residents while they sat on the bench of their 4 wheeled walkers.

Review of undated manufacturer's guidelines, attached to R224's Rollator walker titled Roscoe Medical Rollator revealed Rollators are NOT to be used as a wheelchair. Doing so may cause it to tip-over, resulting in injury.

The facility's EZ-stand policy dated 04/08, directed staff to check for loose nuts and bolts, damaged parts and to check the sling to ensure it was not ripped or frayed. The policy did not address sling sizes.

The facility's Accident Prevention and Reduction policy, dated 4/2017 indicated the facility was committed to providing a safe environment for residents, and would use a systematic approach to assist in the identification, evaluation and

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F 323	Continued From page 74 analysis of risk factors in the environment and need for supervision for either groups of resident or individual residents with the goal that: each resident's environment remain as free of accident and hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents.	F 323		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals.	F 431		10/12/17

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F 431	Continued From page 75 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication was labeled with accurate directions for use for 1 of 1 resident (R323) whose insulin was observed to be mislabeled during medication administration. Findings include: R323's Physician Order Report dated 8/23/17 to 2/23/18, identified R323 had diagnoses which included diabetes mellitus, Alzheimer's disease and kidney failure. The report included an order for Humalog (insulin) solution 100 unit/ml	F 431	F431: It is the policy of the Augustana Health Care Center that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Corrective Action: Clinical Manager immediately obtained medication change labels from the pharmacy and placed on the insulin bottle upon identification by the surveyor.	

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F 431	Continued From page 76 (milliliter) 12 units (U) injected subcutaneously before breakfast, 14 units before lunch, and 10 units before dinner. R323 had an order for Humalog to be given with a sliding scale that included to give 12 units if blood sugar was 351 to 400. On 8/21/17, at 6:40 p.m. registered nurse (RN)-E was observed to prepare for administration of R323's insulin. RN-E had drawn 22 units of Humalog insulin into the syringe. RN-E explained 10 units for R323's dinner dose and 12 units because the physician was called and did not want to give more than the current highest sliding scale dose of 12 units. R323's Humalog vial was kept in a amber medication container. The container was labeled with administration directions to inject 10 units subcutaneous 3 times daily before meals with sliding scale parameters as follows: blood sugar 130-150=0 blood sugar 151-200=2U blood sugar 201-250=4U blood sugar 151-300=6U blood sugar 301-350=8U blood sugar 351-400=10U blood sugar greater than 400 call MD (medical doctor) On 8/21/17, at 6:43 p.m. RN-E verified R323's Humalog order had changed on 7/20/17. RN-E indicated the order labels on medications can not always be relied on to be the correct directions/dose. RN-E identified the facility practice was to complete three checks to ensure the correct dose of medication was administered. RN-E verified the dose transcribed on the Humalog container did not match the dose in the	F 431	8-22-17 Identification of Other Residents: All med carts were audited to ensure proper labeling of medications for residents . 9-29-17 Measures Put in Place: All licensed staff and TMA's were re-educated with a read and sign document specific to medication labeling. 10-11-17 Monitoring Mechanisms: Clinical Managers or their designee will audit their unit med carts one time weekly to ensure proper labeling for the next 30 days. 10-10-17 10-24-17 10-31-17 11-4-17 Clinical Managers or their designee will audit their unit med carts monthly for the next 60 days. 12-4-17 1-4-18 Med cart audits will be reviewed by the Quality Improvement Committee to ensure clinical standards of practice for medication labeling on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Nursing or designee Clinical Managers or designee Quality Improvement Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 77 Medication Administration Record (MAR). On 8/23/17, at 7:33 a.m. licensed practical nurse (LPN)-D prepared 24 units of Humalog insulin for R323. LPN- explained 12 units for R323's morning dose of insulin and 12 units for the sliding scale dose. On 8/23/17, at 8:05 a.m. LPN-D verified R323's insulin medication bottle container was different than the directions in the MAR and did not have a change of order sticker on it. On 8/23/17, at 8:10 a.m. the clinical manager (CM)-B verified R323's Humalog insulin orders were changed 8/22/2017, and the pharmacy was called to provide a change of order sticker to place on the insulin bottle. With further review of the clinical record CM-B verified the insulin sliding scale order had also changed in July, increasing from 10 units to 12 units for a blood sugar reading of 351 to 400. CM-B verified when the order had changed in July a sticker had not been placed to alert staff of the order change, and should have. On 8/24/17, at 10:14 a.m the director of nursing (DON) verified medications were administered based on the the MAR and the medication label. The DON indicated when a discrepancy was noted staff were expected to check the original orders and if there was a dosage change found, the pharmacy should have been contacted for a change of order sticker. The DON verified a change of order sticker would be used to alert staff to a dosage change and aid in prevention of a possible medication error. The DON verified knowledge of the medication in question, the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 78 recent order change and prior sliding scale order change. The requested facility policy was not provided.	F 431		
F 465 SS=D	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping services necessary to maintain a clean and sanitary condition in resident rooms and bathrooms for 2 of 2 resident rooms and shared bathrooms (Main 109, 111, East 252) reviewed. Findings include: During the initial tour on 8/22/17, the following were noted: - at 2:13 p.m. room 109 and 111 on the first floor main unit were found to have a strong urine odor in the rooms and shared bath room. - at 2:38 p.m. room 252 on the second floor East unit was found to have a strong urine odor	F 465	F465: It is the policy of the Augustana Health Care Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Corrective Action: The three identified rooms on the 2567 have been deep cleaned and checked numerous times to ensure sanitary conditions have been maintained 9-29-17 Identification of Other Residents: Every resident room was audited for sanitary conditions and deep cleaned if indicated. 9-29-17 Measures Put in Place:	10/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 79 through out the room and bathroom. On 8/24/17, at 11:14 p.m. during the environmental tour with the director of environmental services (DES) the above environmental concerns were verified. On 8/24/17, at 11:14 a.m. the DES verified the responsibility of managing the house keeping staff. The DES explained housekeeping staffing and duties to include the following: - one staff person was assigned to each unit for a total of seven hours per day. -staff were provided schedules to follow for daily and weekly cleaning tasks. - identified smells were managed promptly. The DES verified the first floor main unit was odorous and difficult to manage due to the clientele living on that unit. The DES agreed the East unit room 252 was odorous and had been an ongoing concern due to residents urinating on the floor. The DES identified numerous additional cleaning procedures to manage the odors, however, agreed that the problem was not under control. On 8/24/17, at 11:49 a.m. the quality improvement director (QID) indicated the director of environmental services provided deep cleaning services to resident rooms and completed follow up checks to ensure staff were providing the cleaning services. On 8/24/17, at 12:23 p.m. in the administrators office with the administrator, DON, QID, and director of maintenance, the DES verified the two rooms and shared bathroom had a strong odor. The DES indicate he personally stripped, waxed	F 465	Mandatory all staff education was conducted on the importance of maintaining a sanitary, clean and comfortable environment for residents, staff and the public. 10-11-17 Monitoring Mechanisms: All resident rooms will be audited one time weekly for the next 30 days to ensure a sanitary, clean and comfortable environment is maintained. 10-10-17 10-17-17 10-24-17 10-31-17 All resident rooms will be audited 2 times monthly for the next 60 days to ensure a sanitary, clean and comfortable environment is maintained. 11-30-17 12-31-17 Resident Room audits will be reviewed by the Quality Improvement committee for compliance with providing a sanitary, clean and comfortable environment on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Environmental Services Quality Improvement Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 80 and went thorough clothing and etcetera in room 252 on the East unit. The DES stated, "There is only so much time we can spend in there." The requested facility policy was not provided.	F 465		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: M4PX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/18/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **250** (L18)
13.Total Certified Beds **250** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
x 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **A**,5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	250			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE - NE II 11/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 11/29/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/25/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5242

On August 24, 2017, a standard survey was completed at this facility by the Minnesota Departments of Health and Public Safety to determine if the facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567.

The facility met one or more criterion and remedies were imposed immediately. Therefore, this Department imposed the following remedy:

• State Monitoring effective September 25, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F315. (42 CFR 488.430 through 488.444)

Further, Submitted documentation supporting the facility's request for a continuing waiver involving life safety code deficiency cited at K521 has been forwarded to CMS. Approval of the waiver request was recommended.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245242

November 29, 2017

Ms. Jean Cole, Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

Dear Ms. Cole:

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 October 12, 2017 the above facility is recommended for:

250 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 250 skilled nursing facility beds.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirement: K521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 29, 2017

Ms. Jean Cole, Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

Re: Reinspection Results - Project Number S5242027

Dear Ms. Cole:

On October 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 24, 2017, with orders received by you on September 21, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 20, 2017

Ms. Jean Cole, Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

Re: Reinspection Results - Project Number S5242027

Dear Ms. Cole:

On October 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 24, 2017, with orders received by you on September 21, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M4PX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/24/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **250** (L18)
13.Total Certified Beds **250** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	250			
(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 :
Denise Erickson, HFE NEII 10/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
AW LSC K521 Emailed ROCHI 10/25/2017 Co.
Posted 10/25/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5242

On August 24, 2017, a standard survey was completed at this facility by the Minnesota Departments of Health and Public Safety to determine if the facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567.

The facility met one or more criterion and remedies were imposed immediately. Therefore, this Department imposed the following remedy:

• State Monitoring effective September 25, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F315. (42 CFR 488.430 through 488.444)

Further, Submitted documentation supporting the facility's request for a continuing waiver involving life safety code deficiency cited at K521 has been forwarded to CMS. Approval of the waiver request was recommended.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 20, 2017

Ms. Jean Cole, Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

RE: Project Number S5242027

Dear Ms. Cole:

On August 24, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140 Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective September 25, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F315. (42 CFR 488.430 through 488.444)

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 24, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process.

You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/21/2017- through 8/24/2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or	F 225		10/12/17

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

Electronically Signed | 09/29/2017

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F 225	Continued From page 1 misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance	F 225		

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F 225	Continued From page 2 with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA) and thoroughly investigate an incident of potential neglect of care for 1 of 3 residents (R123) who fell from a mechanical lift in the facility. Findings include: R123's face sheet dated 12/29/16, identified current diagnoses of chronic pain, muscle and bilateral leg weakness, lymphedema, conversion disorder with seizures or convulsions, anxiety, depression, pain in left ankle and joints of left foot and repeated falls prior to admission. R123's admission Minimum Date Set (MDS) dated 1/5/17, identified R123 had intact cognition and required extensive assistance for transfers. Review of Event Report dated 8/5/17, at 6:45 p.m. indicated R123 had been transferred from her chair to bed, EZ stand sling popped out of place causing resident to land on her buttocks. Staff re-educated on proper use of EZ stand and to ensure correct size sling is being used. Further, the report listed the EZ stand had suddenly stopped moving, resident and nursing assistant did not remember what happened next, one side of the sling was out of place and resident landed on the floor on buttocks. Resident was helped off the floor utilizing a hoyer lift, and no pain or injuries were evident at that time.	F 225	Augustana Health Care Center of Minneapolis' Plan of correction is a written credible assertion of substantial compliance with the Federal and State requirements of Nursing facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medical Assistance programs. Please note that nothing set forth in this document is to be or should be construed to be an admission by Augustana Health Care Center of Minneapolis, or the validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification, and enforcement effort at issue. Further please note that any and all documents transmitted or otherwise provided by Augustana Health Care Center of Minneapolis in relation to the Plan of correction, as well as any and all other communications in writing or otherwise by or on behalf of Augustana Health Care Center of Minneapolis, at law and/or in equity, all of which are not waived and all of which are reserved and retained by, for and on behalf of Augustana Health Care Center of Minneapolis F225 It is the policy of Augustana Health Care Center to ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and	

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F 225	Continued From page 3 Review of R123's Incident Review Form, dated 8/7/17, indicated R123 had a fall on 8/5/17, with no injury. The interdisciplinary team reviewed and documented there were no medication concerns, environmental concerns or change of condition noted. The form listed the new intervention of staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling. During interview on 8/23/17, at 8:07 a.m. R123 reported a few weeks ago she had fallen from the EZ stand lift used during a transfer. R123 reported when the staff member hooked her up to the lift, the staff member had not hooked the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since that fall, all staff had been hooking up all of the belts, and she had not had any further falls. During interview on 8/23/17, at 11:43 a.m. registered nurse (RN)-C confirmed R123 fell from the EZ stand lift during a transfer, and stated after talking with staff she believed the strap snapped off or open, and thought the size of the sling was maybe incorrect. RN-C stated re-education was given to the staff member involved regarding the lift use and sling sizes. RN-C verified there were no further investigations or documentation regarding R123's fall on 8/5/17. When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, and as staff	F 225	misappropriation of resident property are immediately reported to the administrator and other state officials in accordance with state law and to have evidence that all violations are thoroughly investigated. Corrective Action: Staff person was educated at time of the original incident on proper use of the EZ stand, and using the correct sling size for identified resident R123 8-7-17 All care sheets were updated with sling size for all residents to ensure safe transfers 10-3-17 Identification of Other Residents: All current (August 1 - September 30) incident reports were reviewed to ensure appropriate and immediate Vulnerable Adult reporting of abuse and/or neglect is reported if indicated. 10-4-17 Measures Put In Place: Incident review summary form was revised to add an additional review measure related to any possible indication of Abuse or Neglect to ensure a full investigation has been completed Mandatory all staff education was completed to review Vulnerable Adult reporting, investigation, and definitions of abuse and neglect Mandatory all staff education was completed to review appropriate sling use and size, and use of transfer equipment. 10-11-17 Monitoring Mechanisms: Per facility policy all incident reports are reviewed by the Administrator, Director of	

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F 225	Continued From page 4 further investigated, the wording "popped off" was in the incident report, due to being too tight or the loop "popped off." The DON stated the facility did not complete a report to the SA as the facility did not feel this was a reportable event as there was no negative outcome for R123. During group interview on 8/24/17, at 3:41 p.m. with the administrator and DON, they confirmed the current faciilty policy, and the administrator confirmed she expected all neglect of care and suspected neglect or not providing care as needed to be reported to the SA. The administrator and the DON stated they did not feel R123's fall from the EZ stand mechanical lift was reportable due to the fact there was no negative outcome, no harm, no abuse or no negative intent. The administrator and DON stated they expected staff to give the highest level of care possible, and expected the care plan to be followed. Review of the facility's Vulnerable Adult Reporting and Investigation Procedure policy dated, 8/2016 indicated incidents that must be reported immediately to MDH (Minnesota Department of Health) included neglect. The policy indicated the Administrator and DON would appoint a person to investigate the alleged incident, including: - review of the incident - the residnets' medical record to determine events leading up to the incident - interview the person reporting the incident - interview the witnesses to the incident - interview the resident, interview the staff members , interview the the resident's physician, roommate, family member, and visitors as indicated	F 225	Nursing, and Medical Director for proper completion and appropriate interventions. This review now includes the additional measure to review for any possible indication of abuse or neglect. Incident report patterns/trends are reviewed at the quarterly QAA/QAPI meetings for maintaining an acceptable standard of practice in regards to investigation of all incidents. We will review on-going for the next year and track and incident review that indicated abuse or neglect on or before: 10-19-17 11-30-17 12-31-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 6-30-18 7-31-18 8-31-18 9-30-18 Responsible Person/s Administrator Director of Nursing Clinical Managers Quality Improvement Director	

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F 225	Continued From page 5 - interview other residents to whom the accused employee provides care or services. Review of the facility's Maltreatment of Vulnerable Adults Policy, dated 10/2016, indicated all allegations and/or suspicious of abuse must be reported to the administrator immediately. The policy further indicated if injury is unexplainable, or allegation of abuse is reported or witnessed, if there is caregiver neglect a report must immediately be reported to the Minnesota Department of Health (MDH) and call the administrator immediately. The policy also indicated an internal, facility investigation of reports will be completed.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum	F 226		10/12/17

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F 226	Continued From page 6 educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prevention policy to immediately report to the State agency (SA) and thoroughly investigate potential incidents of neglect 1 of 1 resident (R123) who fell from a mechanical lift in the facility. Findings include: Review of the facility's Vulnerable Adult Reporting and Investigation Procedure policy dated, 8/2016 indicated incidents that must be reported immediately to MDH (Minnesota Department of Health) included neglect. The policy indicated the Administrator and DON would appoint a person to investigate the alleged incident, including: - review of the incident - the resident's medical record to determine events leading up to the incident - interview the person reporting the incident - interview the witnesses to the incident - interview the resident, interview the staff members, interview the the resident's physician, roommate, family member, and visitors as	F 226	F226 It is the policy of Augustana Health Care Center to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. To establish policies and procedures to investigate such allegations and include the required abuse, neglect, and exploitation staff training. Corrective Action: Staff person was educated at time of original incident on proper use of the EZ stand, and using the correct sling size for identified resident R123 8-7-17 All care sheets were updated with sling size for all residents to ensure safe transfers 10-3-17 Identification of Other Residents: All current (August 1 - September 30) incidents reports were reviewed to ensure appropriate and immediate Vulnerable Adult reporting of abuse and/or neglect is	

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F 226	Continued From page 7 indicated - interview other residents to whom the accused employee provides care or services. R123's face sheet dated 12/29/16, identified current diagnoses of chronic pain, muscle and bilateral leg weakness, lymphedema, conversion disorder with seizures or convulsions, anxiety, depression, pain in left ankle and joints of left foot and repeated falls prior to admission. R123's admission Minimum Date Set (MDS) dated 1/5/17, identified R123 had intact cognition and required extensive assistance for transfers. Review of Event Report dated 8/5/17, at 6:45 p.m. indicated R123 had been transferred from her chair to bed, EZ stand sling popped out of place causing resident to land on her buttocks. Staff re-educated on proper use of EZ stand and to ensure correct size sling is being used. Further, the report listed the EZ stand had suddenly stopped moving, resident and nursing assistant did not remember what happened next, one side of the sling was out of place and resident landed on the floor on buttocks. Resident was helped off the floor utilizing a hoyer lift, and no pain or injuries were evident at that time. Review of R123's Incident Review Form, dated 8/7/17, indicated R123 had a fall on 8/5/17, with no injury. The interdisciplinary team reviewed and documented there were no medication concerns, environmental concerns or change of condition noted. The form listed the new intervention of staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling.	F 226	reported if indicated. 10-4-17 Measures Put in Place: Incident review summary form was revised to add an additional review measure related to any possible indication of Abuse or Neglect to ensure a full investigation has been completed. Mandatory all staff education was completed to review Vulnerable Adult reporting, investigation, and definitions of abuse and neglect. Mandatory all staff education was completed to review appropriate sling use and size and use of transfer equipment. 10-11-17 Monitoring Mechanisms: Per facility policy all incident reports are reviewed by the Administrator, Director of Nursing, and Medical Director for proper completion and appropriate interventions. This review now includes the additional measure to review for any possible indication of abuse or neglect. Incident report patterns/trends are reviewed at the quarterly/monthly QAA/QAPI meetings for maintaining an acceptable standard of practice in regards to investigation of all incidents. We will review on-going for the next year and track any incident review that indicated abuse or neglect on or before: 10-19-17 11-30-17 12-31-17 1-31-18 2-27-18 3-31-18 4-30-18	

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F 226	Continued From page 8 During interview on 8/23/17, at 8:07 a.m. R123 reported a few weeks ago she had fallen from the EZ stand lift used during a transfer. R123 reported when the staff member hooked her up to the lift, the staff member had not hooked the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since that fall, all staff had been hooking up all of the belts, and she had not had any further falls. During interview on 8/23/17, at 11:43 a.m. registered nurse (RN)-C confirmed R123 fell from the EZ stand lift during a transfer, and stated after talking with staff she believed the strap snapped off or open, and thought the size of the sling was maybe incorrect. RN-C stated re-education was given to the staff member involved regarding the lift use and sling sizes. RN-C verified there were no further investigations or documentation regarding R123's fall on 8/5/17. When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, and as staff further investigated, the wording "popped off" was in the incident report, due to being too tight or the loop "popped off." The DON stated the facility did not complete a report to the SA as the facility did not feel this was a reportable event as there was no negative outcome for R123. During group interview on 8/24/17, at 3:41 p.m. with the administrator and DON, they confirmed the current faciilty policy, and the administrator confirmed she expected all neglect of care and	F 226	5-31-18 6-30-18 7-31-18 8-31-18 9-30-18 Responsible Person/S Administrator Director of Nursing Clinical Managers Quality Improvement Director	

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F 226	Continued From page 9 suspected neglect or not providing care as needed to be reported to the SA. The administrator and the DON stated they did not feel R123's fall from the EZ stand mechanical lift was reportable due to the fact there was no negative outcome, no harm, no abuse or no negative intent. The administrator and DON stated they expected staff to give the highest level of care possible, and expected the care plan to be followed.	F 226		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280		10/12/17

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F 280	Continued From page 10 right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 280		

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F 280	Continued From page 11 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include individualized interventions to effectively communicate with 1 of 1 resident (R338) with a language barrier. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program. R338's Care Area Assessment (CAA) dated	F 280	F280 It is the policy of Augustana Health Care Center that residents have the right to participate in the development and implementation of his or her person-centered plan of care. Corrective Action: Communication audit was done with identified resident R338 to ensure all communication needs were addressed. Resident's electronic care plan, and TCU Care Card were updated with individualized communication interventions. 9-27-17 Identification of Other Residents: Communication Section was added to TCU Care Card to ensure communication interventions will be identified for all new admits with a Language barrier. 9-27-17 Communication audits were completed on all residents with an identified language or communication barrier to ensure communication needs are addressed.	

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F 280	Continued From page 12 2/9/17, indicated R338's primary language was Somali and family reported confusion and at times R338 thought she was in Africa. The CAA listed various causes and contributing factors which included cultural/language barrier, not recognizing caregivers or medical equipment and risk factors included social isolation, confusion, decreased progress and participation in rehab therapies. Also, the CAA indicated R338 had bowel and bladder incontinence with some control, history of stress incontinence and R338 was not consistent with letting staff know she needs to be changed. The CAA for communication did not trigger and was not addressed on the CAA. R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS indicated R338 required extensive assistance for all activities of daily living (ADL). The MDS also indicated R338 was occasionally incontinent of urine, frequently incontinent of bowel and had no toileting program. R338's current care plan, revised on 8/22/17, listed the problem of communication, hearing was adequate, and indicated R338 made herself understood through an interpreter. The care plan directed staff to report any changes in ability to communicate, understand others, or in ability to hear and to refer for hearing exam as needed. R338's care plan identified R338's primary language was Somali, had frequent pain, weakness, dementia, required extensive assistance with bed mobility, boost up in bed, assist to lift legs in/out of bed, and sitting position	F 280	Resident's electronic care plans and NAR care sheets were updated as needed with individualized communication interventions. 10-6-17 Measures Put in Place: Mandatory all staff education was completed on the importance of communication interventions as a part of developing a resident-centered plan of care. 10-11-17 Monitoring Mechanisms: 20% random audits will be done of TCU Care Cards, LTC resident care sheets, and electronic care plans on all units monthly for the next 60 days. 10-10-17 11-10-17 12-10-17 Audits will be reviewed by the Quality Improvement Committee for compliance with providing a resident-centered plan of care on or before 10-19-17 11-30-17 12-31-17 Responsible Person/s: Director of Nursing Clinical Managers Quality Improvement Director	

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in bed. R338's care plan directed staff to speak simply and clearly and repeat as needed, utilize environmental cues as calendars, clocks, notes, communicate at eye level and establish calm, explain cares/treatments before beginning, as needed and consistent routine when providing cares. The care plan directed to provide opportunity for patient to express feelings, involve social services as needed, encourage resident to talk through anger and frustration, and to schedule an interpreter for rehab therapies, nurse practitioner/physician visits, care conferences and upon request. No further care plan interventions were listed to effectively communicate with R338, or assistive devices to use to communicate with R338.

Review of R338's undated Transitional Care Card listed various interventions which included assistance with ADLs, however, the care card lacked any interventions for R338's language barrier.

During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.

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At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-D and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants."

R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a

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bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a rapid, frustrated voice and frantically assisted to place the bedpan by moving her hospital gown out of the way of the bedpan. With the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine.

During interview on 8/23/17, at 9:11 a.m. RN-D stated staff had a hard time knowing what R338 wanted when she called for assistance and stated staff have to guess a lot of the time and the resident got frustrated during that time.

On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on R338's wall for staff to utilize to call him to help communicate with R338.

On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's primary language. RN-D indicated she had contacted R338's son when she was not sure what R338 needed or wanted.

On 8/23/17, at 9:41 a.m. during a follow up interview with NA-G, she stated she used hand

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gestures to attempt to communicate with R338 and stated she was not aware of any other interventions to utilize while communicating with R338. NA-G indicated in the past she had called the family member to attempt to figure out what R338 needed assistance with. NA-G stated she had not utilized an interpreter in the past and was not aware how to request for or use needed interpreter services.

On 8/23/17, at 9:50 a.m. NA-H indicated communication was difficult with R338 and stated she pointed at objects or had her son translate when he was available. NA-H indicated her usual routine was to stand in her room, have R338 point until she figured out what R338 needed or wanted. NA-H indicated she had not utilized interpreter services with R338.

On 8/23/17, at 12:18 p.m. an interpreter was present in the building and he stated interpreter services were utilized for scheduled medical appointments with residents and was not aware of any other time interpreter services were utilized in the facility. The interpreter indicated that day (8/23/17), was the first time he had met R338 for a schedule medical appointment with the doctor today.

On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps with that sometimes. R338 indicated because she had been left on the bedpan without assistance in the past, she had tried not to go to the bathroom so she could avoid that from happening again. R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad,

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sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were.

On 8/23/17 at 12:25 p.m. during second interview, FM-A indicated he posted a note with telephone numbers to the wall in R338's room to help with R338's language barrier, but the facility staff did not use the telephone numbers. FM-A had been told by the facility staff R338 refused cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.

FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had

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been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338.

On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to dial the cellular telephone. Above the night stand, which was next to R338's bed, a white piece of paper, approximately 8 inches (in) by 11 in. was taped to the wall. On the paper, typed in black ink, were instructions for contacting an online interpreter service.

On 8/24/17 at 8:56 a.m. RN-G was present in R338's room and indicated staff had used communication cards with words on them, but R338 was not able to read the cards and stated, "so did not really work that well." RN-G stated it was easier to have staff to assist with communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be

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incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with R338 and stated, "I don't think the problem is communication."

On 8/24/17 at 9:43 a.m. during a follow up interview, FM-A indicated when staff did not respond to her, she would be incontinent on the bed and stated "happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues. FM-A stated the interpreter information in R338's room was not there until they came to visit her last night.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J indicated she was aware R338 has had incontinence with bowel and bladder when other staff who do not understand what she wants cared for her. NA-J indicated when she cared for R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's

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language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. She stated, "She did not have that paper in her room before."

On 8/24/17, at 9:07 a.m. NA-K stated she was able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated "she has not had accidents for me." NA-K indicated R338 was able to communicate her needs, was pretty pleasant, cooperative with cares and did not refuse cares.

On 8/24/17, at 12:08 p.m. social worker (SW)-A confirmed R338 primary language was Somali and indicated he would schedule an interpreter for R338 or use the online service when R338 had medical appointments or when he completed his portion of the MDS. SW-A indicated the usual facility practice was to encourage R338 to use the son to translate, other staff members, and staff to be patient and explain cares to her. The SW-A indicated staff were expected to follow the care plan and to utilize the online interpreter services if having trouble communicating with R338. He indicated he was not aware of any problems communicating with R338. SW-A confirmed no other interventions had been put in place to assist R338 to effectively communicate with staff.

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F 280	Continued From page 21 On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier. The DON indicated when residents were admitted who have language barriers, the usual facility practice was to send an email notification to all staff to notify them of the individual resident's primary language and if the family was available to assist. She stated "90%" of the time we have family to accommodate for their needs. The DON indicated the facility routinely scheduled an interpreter for therapy appointments and medical appointments, and stated the facility did not schedule any further services unless they felt the communication was unclear. The DON indicated 338's son came to the facility quite a lot and stated she had not heard of any concerns with communication that impacted 338's care. Review of the facility policy titled Care Plans, revised on 11/2016, indicated care plans are developed after completion of the comprehensive assessment or as changes occur. The care plan will be reviewed at least quarterly and revised as needed. The policy also indicated the residents personal and cultural references will be	F 280		

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F 280	Continued From page 22 incorporated into the development of the care plan goals. The policy further indicated care plans provide written guides for intervention, assisting the resident to meet their needs for ADL's, health care and psychosocial needs and to provide for person-centered development of the resident's plan of care. This policy also indicated "NAR Care sheets and /or profiles are updated per care plan changes to ensure the practice of following the plan of care."	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 implement care plan interventions for use of transfer equipment for 2 of 2 residents (R123, R228) who required use of mechanical equipment for assistance with transfers. Findings include: R123's care plan dated 8/22/17, indicated R123 required extensive assistance of one staff with transfers, staff to cue resident before and during transfers, R123 may use the EZ stand when resident reports feeling weak. R123's fall care plan dated 8/14/17, indicated R123 was resized	F 282	F282: It is the policy of Augustana Health Care Center that the services provided by the facility as outlined in the comprehensive care plan must be provided by qualified persons in accordance with each resident's plan of care. Corrective Action: Staff were immediately re-educated on proper use of the EZ stand, with correct sling size for identified residents F123 8-23-17 Staff were immediately re-educated on necessity to use the proper transfer equipment per resident's plan of care for	10/12/17

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F 282	Continued From page 23 for sling related to a fall, appropriate large fitting EZ stand strap/sling obtained. R123's undated care sheet, indicated R123 was a fall risk, required extensive assist of one staff for stand pivot transfer with four wheeled walker and protective boot, OR required EZ stand with large sling when resident report feeling weak. The following words were typed on the care sheet and underlined and in red ink wer " be sure to use LG(large) sling with all EZ stand transfers." During observation on 8/23/17, at 7:29 a.m. R123 was observed lying in bed, nursing assistant (NA)-A present in the room. NA-A asked R123 if she was ready to get up for the day, R123 stated yes, NA-A proceeded to provide morning cares. At 7:55 a.m. NA-A retrieved an EZ stand mechanical lift and brought into R123's room, the lift had a sling with beige colored binding draped over the top of the lift. NA-A brought the EZ stand lift up to the edge of the bed, R123 placed both of her feet on the lift's foot platform and locked the lift into place. NA-A then placed the sling behind R123's back, attached all loops of the sling on to the hooks of the EZ stand lift, and attached the safety belt around R123's abdomen and behind R123's calves. NA-A used the remote control, and utilized the hydraulic lift to stand R123 upright while R123 wore black grippy type gloves and held on to both handles. NA-A proceeded to unlock the EZ stand lift brakes, widened the legs and transferred R123 in front of her wheelchair, she then locked the lift in place once R123 was in front of her wheelchair, and used the remote control to lower R123 into her wheelchair. Once R123 was seated in the wheelchair, she stated NA-A was really good about putting all the belts on. NA-A unlocked the EZ stand lift, R123	F 282	identified resident R228 8-24-17 Identification of Other Residents: All residents were audited for appropriate transfer equipment and sling size per weight, transfer ability and care plan. All care plans and care sheets were reviewed and revised if needed stating the correct sling size and appropriate transfer equipment for each resident. 9-30-17 Measures Put in Place: Mandatory education for al nursing staff was conducted on use of EZ stand, EZ lift, proper sling size, and safety protocols for resident transfers. 10-11-7 Monitoring Mechanisms: Staff skill checks will be conducted for all residents requiring the use of transfer equipment to ensure proper equipment and sling size is used. 10-10-17 Random staff skill checks will be conducted for residents on all units weekly for the next 30 days to ensure proper equipment and sling size is used. 10-17-17 10-24-17 10-31-17 11-4-17 Random staff skill checks will be conducted for residents on all units monthly for the next 60 days to ensure proper equipment and sling size is used. 12-4-17 1-4-18 All skills checks will be reviewed at the monthly QI/QAA meetings for compliance	

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F 282	Continued From page 24 removed her feet from the platform, both safety belts were released, loops unhooked, and the sling with beige colored binding was removed. NA-A confirmed the sling used to transfer R123 was a size medium, as she visualized the white tag attached to the sling with a letter M on the tag. During interview on 8/23/17, at 8:07 a.m. R123 reported she fell from the EZ stand lift a few weeks ago. R123 reported when the staff member hooked her up to the lift, the staff member did not hook the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since she fell from the lift all staff had been hooking up all of the belts, and she has not had any further falls. R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 stated she still gets scared, and repeats the picture in her mind of falling when she gets transferred. R123 stated she now wears gripper gloves to make sure she has a secure hold on the handles of the lift during transfers. R123 reported prior to her fall from the lift, staff were not always attaching the safety belt around her abdomen, then stated she had not reported that information to any nurses. R123 stated the fall from the EZ stand lift has been her only fall since admission. During interview on 8/23/17, at 8:17 a.m. NA-A confirmed R123 required extensive assistance of one staff member for all ADL's, with the exception of eating which she was independent. NA-A reported staff carry care guide sheets that indicate what each resident needs for assistance. NA-A reported R123 did have one fall only that she was aware of, stated R123 fell from the lift because the lift was not working. NA-A verified	F 282	with standard of care for the next 90 days on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Nursing Clinical Managers Staff Development Director Quality Improvement Director	

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F 282	Continued From page 25	F 282		

staff decide and choose which size sling to use for each resident, and stated if the sling fits, we use it. NA-A confirmed she used a medium sized sling to transfer R123, and verified the tag marked with a M on it. NA-A also indicated a color guide attached to the lift used for R123's transfer which indicated slings with a beige colored binding were size medium. NA-A also indicated the sling size was on R123's care plan.

During interview on 8/24/17, at 9:44 a.m. RN-C stated sling size was determined by staff discretion and to the resident's comfort level, then staff document the size on the care plan and care sheet. RN-C was notified R123 was observed to be transferred with a medium sized sling, RN-C stated R123's identified sling size on her care plan and care sheet indicated a large size sling, but reported the resident stated the medium sized sling felt comfortable for her when she visited with R123.

When interviewed on 8/23/17, at 11:50 a.m. licensed practical nurse (LPN)-B stated residents were measured around their abdomen, then the sling sizes were determined by the measurement, like a girdle. LPN-B stated the sling size to be used was documented in the resident's care plan, and confirmed R123 should use a large sized sling with all transfers.

When interviewed on 8/23/17, at 12:14 p.m. NA-B reported the staff had access to several sizes of slings for the EZ stand lift, and stated if they do not have the correct size, staff would notify laundry to obtain the correct size.
NA-B believed R123 required an extra large sized sling.

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When interviewed on 8/24/17, at 9:30 a.m. NA-C verified R123 used an EZ stand lift for all transfers and extensive assistance of one staff. NA-C stated R123 required the use of a large sized sling for all transfers, and indicated this information was also on the care sheets. NA-C verified she was given education on the use of the mechanical lifts upon hire.

When interviewed on 8/24/17, at 9:20 a.m. NA-D indicated R123 required extensive assistance of one staff and the EZ stand lift for all transfers with a large sized sling.

When interviewed on 8/24/17, at 9:36 a.m. LPN-C confirmed R123 required the EZ stand lift for all transfers, and indicated that is how she had always transferred. LPN-C confirmed RN-C completed the assessments to determine the appropriate sling sizes for each resident, an the correct size was documented on the care sheet and care plan.

When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, as staff further investigated, the wording popped off was in the incident report, due to being too tight or the loop popped off. The DON stated the staff member involved was immediately given education to ensure the sling fit properly and was comfortable. The DON stated after the investigation, staff believed a different size sling should be used. The DON confirmed prior to the fall R123 utilized a medium sized sling. The DON stated when determining the proper size sling, staff look at

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F 282	Continued From page 27	F 282		

weight, but weights were pretty fluid and variable according the manufacture's chart and guidelines. She stated we take in to consideration the resident's comfort level of sling, generalized width, and what looks safe. The DON verified the sling size assessment was not documented, as it was more of a judgement based on clinical factors, then the size was documented on the care sheet and care plan. The DON verified staff should use a large sized sling for all EZ stand lift transfers with R123, unless there was some reason there needed to be a change, the change would be reviewed by the clinical manager. The DON stated staff do not routinely document if the sling size changes, then stated it would be indicated on the care sheet as being a different size. The DON stated she had the clinical manager re-assess R123 on 8/23/17 for proper sling size, and based on the assessment that she did, the sling should be a large size, and verified all staff should be providing care as directed by the care sheets and care plan which also indicates a large size sling to be used. The DON confirmed there were no other documents or assessments regarding R123's fall from the EZ stand lift, other than the event report. The DON stated the interdisciplinary team (IDT) had more of a discussion, talks with people to get more of a picture of what happened, so we know what the new interventions should be, and verified this is all done "off the record" as the IDT talked. The DON reported the nursing assistants were expected to visualize the lifts for obvious damage of sling and lift prior to each use, and stated maintenance routinely inspects the lifts and slings.

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R228 care plan revision dated 8/19/17, indicated R228 required assist with transfers due to impaired mobility related to Parkinson disease. R228 careplan directed staff "transfers with assist of two via an EZ lift."

The untitled, undated nursing assistant care sheet updated 8/21/17, indicated for R228 "Transfers: EZ-Lift."

During an observation on 8/24/17, at 1:14 p.m. nurses aide (NA)-O and nurses aide (NA)-P rolled an EZ stand down the hallway and entered R228 room. NA-O verbally cued R228 she was going to use the EZ stand to transfer him from his wheel chair to his bed. NA-O and NA-P placed an EZ sling under R228 back and cued R228 "lean forward so can get sling behind you, your weaker arm is on right." NA-O cued R228 to hold onto EZ stand handles with his arms. NA-O placed his feet onto stand to transfer R228 from his wheelchair to his bed. NA-O and NA-P continued with transfer from wheelchair to the bed. As R228 was lowered to on edge of bed he said "wait a minute." R228 leaned to right side as legs removed from the EZ stand. NA-O and NA-P lifted R228 legs up onto the bed and positioned him in bed.

During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand. CM-A stated R228 careplan interventions had

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F 282	Continued From page 29 been changed to use of a EZ lift to ensure a safe transfer. CM-A stated staff were made aware of care plan changes through shift communication, careplan review and aid care sheets. CM-A stated the NA-O and NA-P should have been using the EZ lift with R228. During the interview with CM-A , NA-O approached the desk area and stated R228 was hollering and said he didn't want a strap between his legs so she used an EZ stand. CM-A stated to NA-O, he was supposed to be transferred with the EZ lift. NA-O did not respond. During an interview on 8/24/17, at 3:59 p.m. with director of nursing (DON) stated R228 care plan had been updated on 8/19/17 for an EZ lift to be used as R228 had weakness in arms and legs and was not safe to use on a EZ stand. DON also stated staff had been informed of the changes and were provided education. The facility's Care Plan policy dated 11/2016, indicated care plans are developed to provide written guides for intervention, assisting the resident to meet their needs for ADL's, health care and psychosocial needs and to provide for person-centered development of the resident's plan of care.	F 282		
F 310 SS=G	483.24(a)(b) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE (a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the	F 310		10/12/17

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F 310	Continued From page 30 facility ensuring that: (1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, … (b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: (1) Hygiene -bathing, dressing, grooming, and oral care, (2) Mobility-transfer and ambulation, including walking, (3) Elimination-toileting, (4) Dining-eating, including meals and snacks, (5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient communication services for activities of daily living to ensure basic needs were met for 1 of 1 resident (R338) with a language barrier. This deficient practice resulted in psychosocial harm for R338, who experienced isolation and	F 310	F310 It is the policy of the Augustana Health Care Center to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical	

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F 310	Continued From page 31 emotional distress related to incontinence when her basic needs were unable to be met due to inadequate communication with facility staff. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program. R338's Care Area Assessment (CAA) dated 2/9/17, indicated R338's primary language was Somali and family reported confusion and at times R338 thought she was in Africa. The CAA listed various causes and contributing factors which included cultural/language barrier, not recognizing caregivers or medical equipment and risk factors included social isolation, confusion, decreased progress and participation in rehab therapies. Also, the CAA indicated R338 had bowel and bladder incontinence with some control, history of stress incontinence and R338 was not consistent with letting staff know she needs to be changed. The CAA for communication did not trigger and was not addressed on the CAA.	F 310	condition demonstrates that such diminution was unavoidable. corrective Action: Identified resident R338 was assessed for incontinence and communication care areas and appropriate changes were made to the care plan. Resident was supplied with wall mounted communication cards that can be used by staff to speak her language and for the resident to point to when communicating her needs. 9-28-17 Identification of Other Residents: Communication Section was added to TCU Care Card to ensure communication interventions will be identified for all new admits with a language barrier. 9-27-17 Communication audits were completed on all residents with an identified language or communication barrier to ensure communication needs are addressed. Resident's electronic care plans and NAR care sheets were updated as needed with individualized communication interventions. 10-6-17 Measures Put in Place: Mandatory all staff education was completed to review communication needs of residents, communication tools available to all residents, and the importance of reporting any difficulties in communicating with residents when providing cares and services. 10-11-17 Monitoring Mechanisms: Staff communication skill checks will be	

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F 310	Continued From page 32 R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS indicated R338 required extensive assistance for all activities of daily living (ADL). The MDS also indicated R338 was occasionally incontinent of urine, frequently incontinent of bowel and had no toileting program. R338's current care plan, revised on 8/22/17, listed the problem of communication, hearing was adequate, and indicated R338 made herself understood through an interpreter. The care plan directed staff to report any changes in ability to communicate, understand others, or in ability to hear and to refer for hearing exam as needed. R338's care plan identified R338's primary language was Somali, had frequent pain, weakness, dementia, required extensive assistance with bed mobility, boost up in bed, assist to lift legs in/out of bed, and sitting position in bed. R338's care plan directed staff to speak simply and clearly and repeat as needed, utilize environmental cues as calendars, clocks, notes, communicate at eye level and establish calm, explain cares/treatments before beginning and as needed and consistent routine when providing cares. The care plan directed to provide opportunity for patient to express feelings, involve social services as needed, encourage resident to talk through anger and frustration, and to schedule an interpreter for rehab therapies, nurse practitioner/physician visits, care conferences and upon request. No further care plan interventions were listed to effectively communicate with R338, or assistive devices to use to communicate with R338.	F 310	done with all residents who have a language barrier. Skills checks will include demonstrated staff proficiency with using communication devices/tools and individualized interventions specific to each resident's comprehensive assessment. 10-10-17 Staff communication skill checks will be done for all residents who have a language barrier weekly for the next 60 days and monthly for 6 months. 10-10-17 10-17-17 10-24-17 10-31-17 11-7-17 11-14-17 11-21-17 11-28-17 12-28-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 All communication skill checks will be reviewed at the monthly QI/QAA meetings for compliance with staff competency in communication interventions on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Nursing Clinical Managers Quality Improvement Director	

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Review of R338's undated Transitional Care Card listed various interventions which included assistance with ADLs, however, the care card lacked any interventions for R338's language barrier.

During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.

At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very

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fast to registered nurse (RN)-D and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants."

R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a rapid, frustrated voice and frantically assisted to place the bedpan by moving her hospital gown out of the way of the bedpan. With the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine.

During interview on 8/23/17, at 9:11 a.m. RN-D stated staff had a hard time knowing what R338 wanted when she called for assistance and stated staff have to guess a lot of the time and the resident got frustrated during that time.

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F 310	Continued From page 35 Review of R338's progress notes from 5/1/17 to 8/21/17, revealed the following: -5/5/17, Somali interpreter used for assessment, had moderately impaired cognition and was at moderate risk for mood disturbance. R338 had reported trouble falling asleep, feeling tired and trouble concentrating because of pain and poor appetite. R338 did not have mental health diagnoses, not receiving psychotropic medications, refused psychiatric services referral. The note listed social services would follow up and assist as needed. -5/7/17, alert and orientated to facility, needs interpreter, no English. -6/6/17, care conference scheduled for that day, son will attend and interpreter requested interpreter service. -6/8/17, wound nurse visited with patient, her son translated for the visit and R338 had no questions. -7/14/17, social services met with patient and patient's family through phone interpreter to discuss room transfer. Patient and family understand and agreeable to transfer. -7/24/17, R338 transferred to another unit in the facility -7/25/17, social service met with son and son indicated that he is present at most times but requested that an interpreter be utilized for formal assessments. - 8/3/17, son expressed concerns regarding	F 310		

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language barrier. Son concerned resident's needs were not being met when he was not there as she was not able to communicate to staff. Facility staff suggested making flash cards with pictures as well as English/Somali commands for resident to use to communicate her needs. Son indicated he would like the flash cards implemented, and facility staff were to create the flash cards and provide to the resident to use.

-8/4/17, resident unable to communicate due to language barrier. Family and interpreter assist with communicating with staff. Staff to assist with communication by providing communication cards. No further documentation of implementation of flash cards, the effectiveness of the flash cards or any alternative communication aides were found in the chart.

-8/10/17, R338 hospitalized at this time, social service assessment done by staff interview. Staff reported R338 had no short or long term memory problems, had difficulty in new situations only with daily decision making skills and minimal symptoms of mood disorder.

-8/20/17, on Heparin, teaching not effective due to language and inability to understand.

On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on

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R338's wall for staff to utilize to call him to help communicate with R338.

On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's primary language. RN-D indicated she had contacted R338's son when she was not sure what R338 needed or wanted.

On 8/23/17, at 9:41 a.m. during a follow up interview with NA-G, she stated she used hand gestures to attempt to communicate with R338 and stated she was not aware of any other interventions to utilize while communicating with R338. NA-G indicated in the past she had called the family member to attempt to figure out what R338 needed assistance with. NA-G stated she had not utilized an interpreter in the past and was not aware how to request for or use needed interpreter services.

On 8/23/17, at 9:50 a.m. NA-H indicated communication was difficult with R338 and stated she pointed at objects or had her son translate when he was available. NA-H indicated her usual routine was to stand in her room, have R338 point until she figured out what R338 needed or wanted. NA-H indicated she had not utilized interpreter services with R338.

On 8/23/17, at 12:18 p.m. an interpreter was present in the building and he stated interpreter services were utilized for scheduled medical appointments with residents and was not aware of any other time interpreter services were utilized in the facility. The interpreter indicated that day (8/23/17), was the first time he had met R338 for

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F 310	Continued From page 38 a schedule medical appointment with the doctor today. On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps with that sometimes. R338 indicated because she had been left on the bedpan without assistance in the past, she had tried not to go to the bathroom so she could avoid that from happening again. R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad, sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were. On 8/23/17 at 12:25 p.m. during second interview, FM-A indicated he posted a note with telephone numbers to the wall in R338's room to help with R338's language barrier, but the facility staff did not use the telephone numbers. FM-A had been told by the facility staff R338 refused	F 310		

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cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.

FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338.

On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to dial the cellular telephone. Above the night stand, which was next to R338's bed, a white piece of paper, approximately 8 inches (in) by 11 in. was taped to the wall. On the paper, typed in black ink, were instructions for contacting an online interpreter service.

On 8/24/17 at 8:56 a.m. RN-G was present in R338's room and indicated staff had used

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communication cards with words on them, but R338 was not able to read the cards and stated, "so did not really work that well." RN-G stated it was easier to have staff to assist with communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with R338 and stated, "I don't think the problem is communication."

On 8/24/17 at 9:43 a.m. during a follow up interview, FM-A indicated when staff did not respond to her, she would be incontinent on the bed and stated "happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues. FM-A stated the interpreter information in R338's room was not there until they came to visit her last night.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J indicated she was aware R338 has had

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incontinence with bowel and bladder when other staff who do not understand what she wants cared for her. NA-J indicated when she cared for R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. She stated, "She did not have that paper in her room before."

On 8/24/17, at 9:07 a.m. NA-K stated she was able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated "she has not had accidents for me." NA-K indicated R338 was able to communicate her needs, was pretty pleasant, cooperative with cares and did not refuse cares.

On 8/24/17, at 12:08 p.m. social worker (SW)-A confirmed R338 primary language was Somali and indicated he would schedule an interpreter for R338 or use the online service when R338

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had medical appointments or when he completed his portion of the MDS. SW-A indicated the usual facility practice was to encourage R338 to use the son to translate, other staff members, and staff to be patient and explain cares to her. The SW-A indicated staff were expected to follow the care plan and to utilize the online interpreter services if having trouble communicating with R338. He indicated he was not aware of any problems communicating with R338. SW-A confirmed no other interventions had been put in place to assist R338 to effectively communicate with staff.

On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier. The DON indicated when residents were admitted who have language barriers, the usual facility practice was to send an email notification to all staff to notify them of the individual resident's primary language and if the family was available to assist. She stated "90%" of the time we have family to accommodate for their needs. The DON indicated the facility routinely scheduled an interpreter for therapy appointments and medical appointments, and stated the facility did

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F 310	Continued From page 43 not schedule any further services unless they felt the communication was unclear. The DON indicated 338's son came to the facility quite a lot and stated she had not heard of any concerns with communication that impacted 338's care. On 8/24/17, at 4:18 p.m. during a phone interview medical director (MD) indicated he was not aware if the facility had access to an interpreter 24 hours a day. The MD indicated he would expect all residents would have ongoing assessment and care to meet their needs and also indicated he felt it was difficult for foreign speaking resident because families do not always tell staff the concerns. Review of facility policy titled, Communication: Interpreter/Translation Services for limited English Proficiency revised on 1/2016, indicated the interdisciplinary team will assess residents communication needs/deficits upon pre-admission, admission and throughout the residents stay at the care center. the social worker will arrange for any on-going interpreter needs for resident. Augustana Health Care Center will be responsible for the charges. Social worker will write a progress note describing communication needs and arrangements. The policy listed various auxiliary aids to be available used such as: universal communication cards, communication boards and if additions aids are need they will be ordered in a prompt manner.	F 310		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 312		10/12/17

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F 312	Continued From page 44 personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide assistance with shaving for 1 of 3 residents (R162) reviewed who required staff assistance to complete activities of daily living. Findings include: R162's quarterly Minimum Data Set (MDS) dated 7/14/17, indicated R162 had diagnoses which included Alzheimer's disease, psychotic disorder and chronic pain. The MDS indicated R162 had severely impaired cognition and required extensive assistance for dressing. The MDS indicated R162 required set up help for completing personal hygiene including shaving and supervision with bathing. R162's care plan dated 7/23/17, indicated R162 required hands on assistance at times due to Alzheimer disease for grooming and directed staff to encourage and assist as needed for grooming. Review of R162's nursing assistance care sheet, undated, identified R162 received assistance with her shower on Monday mornings. On 8/22/17, at 8:37 a.m. R162 was seated in her wheelchair at dining room table. She was independently eating the breakfast meal, with several other residents present in the dining room. R162 was noted to have many long, coarse, white hairs under her chin. On 8/23/17, at 7:14 a.m. R162 ambulated with her walker down the hallway toward the dining	F 312	F312: It is the policy of the Augustana Health Care Center to provide the necessary services to maintain good nutrition, grooming, personal, and oral hygiene. Corrective Action: Identified resident R162 received the immediate services required for facial hair removal. The staff person responsible for the grooming of identified resident received a written work performance education 8-24-17 Identification of Other Residents: A facility wide shaving audit was conducted to ensure appropriate shaving services were completed and/or offered to all residents. 9-29-17 Measures Put in Place: Mandatory education for all nursing staff was conducted to ensure appropriate shaving services are completed and/or offered to all residents. Noting residents will continue to have the right to refuse shaving. 10-11-17 Monitoring Mechanism: Random shaving audits will be done on all units weekly for the next 30 days. 10-10-17 10-17-17 10-24-17 10-31-17 Random shaving audits will be done on all units monthly for the next 60 days.	

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F 312	Continued From page 45 room. R162 was observed to have the same long, white coarse hairs under her chin. At 8:58 a.m., R162 remained in the dining room with the same long, coarse, white chin hairs present. During an interview on 8/23/17, at 11:17 a.m. nursing assistant (NA)-M confirmed R162 had many coarse, white chin hairs present. NA-M stated the usual facility practice was to remove facial hair as part of bathing cares. NA-M stated R162's chin hair should have been removed on Monday with her bath. NA-A stated if long facial hair was noticed on a resident, the facial hair was to be taken care of right away. NA-A confirmed R162 dressed herself, but staff assisted her as needed. During an interview on 8/23/17, at 11:49 a.m. with licensed practical nurse (LPN)-A stated R162 had always liked to look nice. but had resisted cares in the past. LPN-A stated R162 typically allowed care when staff re-approached her later. Review of R162's Skin-Body Visual Inspection/Observation form, dated 8/21/17, indicated a body audit had been completed for R162. The form indicated various inspections were completed such as visualizing for new bruises, rashes and indicated "resident shaved/facial hair removed-No, not needed." During an interview on 8/24/17, at 8:24 a.m. with clinical manager (CM)-A stated the expectation was for all residents to be checked with shower/bath, and everyday with cares to ensure facial hair is removed. CM-A also stated she expected staff to let the nurse know if a resident refused cares.	F 312	11-30-17 12-31-17 Audits will be reviewed by the Quality Improvement committee for compliance with providing and/or offering shaving services for residents on or before. 10-19-17 11-30-17 12-31-17 1-31-18 Responsible Person's Director of Nursing or designee Clinical Managers Quality Improvement Director	

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F 312	Continued From page 46 Facility policy on grooming was requested but was not provided.	F 312		
F 315 SS=G	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate	F 315		10/12/17

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F 315	Continued From page 47 treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess bowel and bladder patterns and implement a toileting program to restore continence of bowel and bladder to the extent possible for 1 of 1 residents (R338) who was not being provided assistance with toileting routinely due to a language barrier. R338 sustained harm due to an avoidable decrease in bowel and bladder function. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program. R338's Care Area Assessment (CAA) dated 2/9/17, indicated R338 had bowel and bladder incontinence with some control and history of stress incontinence. Contributing factors included mornings with confusion, obesity, impaired mobility related to weakness, two right lower	F 315	F315: It is the policy of the Augustana Health Care Center to accurately assess bowel and bladder patterns and implement a toileting schedule/plan to restore continence of bowel and bladder to the extent possible. Corrective Action: Upon review of resident's communication patterns related to elimination specific interventions including the Somalian word for bathroom and gestures have been identified and care planned to indicate need for toileting. Upon review of the past 60 days of bowel and bladder point of care documentation improved continence was demonstrated for identified resident R338. R338 Bowel and Bladder assessment has been reviewed and remains current. 9-28-17 Identification of Other Residents: Communication section was added to TCU Care Cards to ensure communication interventions will be identified for all new admits with a language barrier. 9-27-17 Communication audits were completed on all residents with an identified language or communication barrier to ensure communication needs are addressed. Residents electronic care plans and NAR care sheets were updated as needed with individualized communication	

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F 315	Continued From page 48 extremity wounds with wound vac, pain, anemia, use of narcotics, antidepressants, and language barrier. Staff were to check and change upon rising, before and after meals, bedtime, night rounds and as needed related to confusion. R338 was not consistent with letting staff know she needed to be changed and staff were to assist with peri care with incontinence. R338's quarterly MDS dated 5/8/17, indicated R338 was moderately impaired, needed extensive assistance of two staff for bed mobility, transfers and extensive assistance of one staff for dressing, toileting and personal hygiene. The MDS also indicated R338 was frequently incontinent of urine and always continent of bowel and had no toileting program. R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, needed extensive assistance of one staff for all of her activities of daily living. The MDS also indicated R338 was occasionally incontinent of urine and frequently incontinent of bowel and had no toileting program. Review of R338's current care plan revised on 8/22/17, indicated R338 had incontinence of bowel and bladder with some control and history of stress incontinence. Contributing factors included: dementia, obesity, impaired mobility related to weakness, right lower extremity wounds, pain, anemia, use of narcotics, anti-depressants and language barrier. Related to confusion she is not consistent with letting staff know she needs to be changed or when to use the bedpan. The care plan listed various interventions such as: check and change upon rising, before and after meals, before bed, night	F 315	interventions. 10-6-17 All bowel and bladder assessments for residents with a language barrier were reviewed for decline. 10-9-17 Measures Put in Place: Mandatory all staff education was completed on the importance of identifying communication needs of residents and use of communication interventions to ensure standard of care is maintained. 10-11-17 Monitoring Mechanisms: Clinical Managers are notified by RAI staff of any decline in bowel and bladder at the time of their quarterly assessment, which triggers a review of the current assessments, and any additional assessments as needed are completed. Monthly review of Bowel and Bladder assessments for residents with language barriers will be done for the next 6 months to ensure all bowel and bladder care needs of residents with language barriers are being met. 10-31-17 11-30-17 12-31-17 1-31-18 2-27-18 3-31-18 Staff communication skill checks will be done with all residents who have a language barrier. Skill checks will include demonstrated staff proficiency with using communication devices/tools and	

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F 315	Continued From page 49 rounds and as needed, offer bed pan when not confused, peri cares with incontinence episodes, and needed extensive assist of one or two staff depending on cognition. No interventions were listed on how to communicate with R338 regarding the language barrier and her incontinence or toileting needs. Review of R338's Transitional Care Plan for the NA (nursing assistant) undated, indicated R338 was max for toileting assistance and resident calls for assistance. The sheet indicated R338 was continent of bowel and bladder with occasional incontinence of bladder and wore a incontinent brief. No interventions were listed on how to communicate with R338 regarding the language barrier and her incontinence or toileting needs. During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.. At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language,	F 315	individualized interventions specific to each resident's comprehensive assessment 10-10-17 Staff communication skill checks will be done for all residents who have a language barrier weekly for the next 60 days and monthly for the next 6 months. 10-10-17 10-17-17 10-24-17 10-31-17 11-7-17 11-14-17 11-21-17 11-28-17 12-28-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 All communication skill checks will be reviewed at the monthly QI/QAA meetings for compliance with staff competency in communication interventions on or before. 10-31-17 11-30-17 12-31-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 Responsible Person/s Director of Nursing Clinical Managers Quality Improvement Director	

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it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-A and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants."

R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a

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rapid, frustrated voice and frantically assisted to place the bedpan by moving her hospital gown out of the way of the bedpan. At 9:05 a.m., with the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine. R338's disposable brief was dry.

Review of R338's admission Bowel and Bladder Assessment, dated 2/9/17, indicated R338 had short term memory loss, was able to identify the need or urge to void/defecate some of the time, was able to use the call light, ask to go to the toilet sometimes, and had been admitted with incontinence. The assessment indicated R338 had incontinence of bladder, had incontinence episodes with position changes. The assessment indicated R338 had diagnoses which included recent surgery, obesity, edema and required assistance to transfer. Further, R338 was incontinent of bowel, had no problem with pattern irregularity, loose stools or diarrhea or constipation and was functionally disabled and had urgency. The assessment indicated R338 had stress and functional incontinence. The documentation was blank regarding R338's 3 day voiding pattern and for the 3 day bowel pattern. The analysis of the assessment indicated R338 had confusion, was not consistent with letting staff know she needed to be changed and was to be on a check and change program, upon arising, before and after meals, before bed, with night rounds and as needed and wore a brief.

Review of R338's initial Bowel and Bladder Assessment dated 4/28/17, indicated R338 had short term memory loss, able to identify the need to urge to void/defecate all of the time, able to use call light, able to ask to go to the toilet. The assessment indicated R338 was incontinent of

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F 315	Continued From page 52 bladder, unknown how long resident has been incontinent of bladder, no problem with leaking urine, had no incontinent episodes with laughing, coughing, changing positions, sneezing or exercise. The assessment indicated R338 was continent of bowel, utilized a bedside commode, constipation problems sometimes, and no symptoms affecting eliminations patterns. Further, the assessment indicated R338 required assistance with ambulation, transfers and used adaptive equipment. R338 has pain that effected elimination patterns, required weight bearing assistance, resident somewhat involved, showed patterns of urinary continence greater than 2 hours,was able to use toilet majority of time on all shifts and had problems with constipation. R338's assessment indicated R338 had functional incontinence (decreased mental awareness/decreased or loss mobility or personal unwillingness). R338's elimination plan was scheduled toileting due to being cognitively impaired, functional disabilities and care giver dependent. The elimination plan included: Check and change due to cognitive impairment, retraining to return to previous pattern due to able to feel sensation, able to understand and learn to inhibit urge, toilets independently or with minimal assist and prompt voiding due to able to request toilet (however a retraining program to improve continence was never implemented). The plan included for R338 to utilize the bedpan or commode for voiding and to use the commode for bowel movements and wore a brief. Review of R338's Bowel and Bladder Quarterly Assessment, reviewed on 5/4/17, indicated the bladder and bowel management programs were effective and no changes were needed to the current plan of care.	F 315		

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Review of R338's Bowel and Bladder Quarterly Assessment, reviewed on 7/13/17, indicated R338 was incontinent of bladder and bowel, the current bowel and bladder plan was effective and did not indicate any changes to the current plan of care.

Review of R338's Hennepin County Medical Center physician progress notes revealed a note dated 4/18/17, from the nurse practitioner which indicated "nursing assistants report the patient is continent of bowel and bladder and is utilizing a bedpan but occasionally utilizing commode."

On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on R338's wall for staff to utilize to call him to help communicate with 338.

On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's primary language. RN-D indicated she had contacted R338's son when she was not sure what R338 needed or wanted.

On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps

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with that sometimes. R338 indicated because she had been left on the bedpan without assistance in the past, she had tried not to go to the bathroom so she could avoid that from happening again. R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad, sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were.

On 8/24/17, at 8:56 a.m. RN-G indicated staff had used communication cards with words on them, but R338 was not able to read the cards and stated, "So did not really work that well." RN-G stated it was easer to have staff to assist with communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until

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now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with R338 and stated, "I don't think the problem is communication."

On 8/24/17, at 9:43 a.m. during a follow up interview, FM-A indicated R338 had been continent of bowel and bladder before she got sick and was only incontinent and wore a brief when she was sick. FM-A indicated when staff did not respond to R338, she would be incontinent on the bed and stated," happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J indicated she was aware R338 has had incontinence with bowel and bladder when other staff who do not understand what she wants cared for her. NA-J indicated when she cared for R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility

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F 315	Continued From page 56	F 315		

when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's language barrier.

On 8/24/17, at 9:07 a.m. NA-K stated she was able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated, "she has not had accidents for me." NA-K indicated R338 was able to communicate her needs, was pretty pleasant, cooperative with cares and did not refuse cares.

On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier.

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F 315	Continued From page 57 Review of facility policy titled, Bladder Programming/Toileting revised on 1/2016, indicated the facility would assess residents upon admission, and at other appropriate clinical times (EX: removal of catheter) for bladder retraining/toileting programs.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 323	F323	10/12/17

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F 323	Continued From page 58 review, the facility failed to implement individualized equipment requirements to ensure the appropriate transfer equipment was utilized during transfers for 2 of 2 residents (R123, R228) who had a history of fall during a transfer utilizing a mechanical lift. In addition, the facility failed to follow manufacturer's guidelines for the proper use of a wheeled walker to prevent accident hazards for 1 of 1 resident (R224) who utilized a walker for ambulation. Findings include: R123's face sheet dated 12/29/16, identified current diagnoses of chronic pain, muscle and bilateral leg weakness, lymphedema, conversion disorder with seizures or convulsions, anxiety, depression, pain in left ankle and joints of left foot and repeated falls prior to admission. R123's admission Minimum Data Set (MDS) dated 1/5/17, identified she required extensive assistance for transfers, had a history of falls prior to admission and had intact cognition. R123's Care Area Assessment (CAA) dated 1/9/17, indicated R123 admitted with weakness, required extensive assistance for transfers and was at risk for falls related to a history of falls, deconditioning, pseuedoseizures, depression, obesity, impaired balance, the need for extensive assistance with activities of daily living (ADL's), pain, and use of medications. R123's care plan dated 8/22/17, indicated R123 required extensive assistance of one staff with transfers, staff to cue resident before and during transfers, R123 may use the EZ stand when resident reports feeling weak. R123's fall care	F 323	It is the policy of Augustana Health Care Center that the environment remains as free from accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: Staff were immediately re-educated on proper use of the EZ stand, with correct sling size for identified resident R123 8-23-17 Staff were immediately re-educated on necessity to use the proper transfer equipment per resident's plan of care for identified resident R228 8-24-17 Staff were immediately re-educated on proper method of transporting resident, and care sheet was updated with the proper method of transporting resident for identified resident R224 8-21-17 EZ stand policy was updated to include information regarding appropriate sling size use. 9-29-17 Identification of Other Residents: All residents were audited for appropriate transfer equipment and sling size per weight, transfer ability and care plan. all care plans and care sheets were reviewed and revised if needed stating the correct sling size and appropriate transfer equipment for each resident. 9-29-17 All care sheets of residents with seated walkers were updated to state, "Do not transport residents at any time in seated walker."	

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F 323	Continued From page 59 plan dated 8/14/17, indicated R123 was resized for sling related to a fall, appropriate large fitting EZ stand strap/sling obtained. R123's undated care sheet, indicated R123 was a fall risk, required extensive assist of one staff for stand pivot transfer with four wheeled walker and protective boot, or required EZ stand with large sling when resident reports feeling weak. The following words were typed on the care sheet and underlined in red ink "be sure to use LG [large] sling with all EZ stand transfers." During observation on 8/23/17, at 7:29 a.m. R123 was observed lying in bed, nursing assistant (NA)-A present in the room. NA-A asked R123 if she was ready to get up for the day, R123 stated yes, NA-A proceeded to provide morning cares. At 7:55 a.m. NA-A retrieved an EZ stand mechanical lift and brought into R123's room, the lift had a sling with beige colored binding draped over the top of the lift. NA-A brought the EZ stand lift up to the edge of the bed, R123 placed both of her feet on the lift's foot platform and locked the lift into place. NA-A then placed the sling behind R123's back, attached all loops of the sling on to the hooks of the EZ stand lift, and attached the safety belt around R123's abdomen and behind R123's calves. NA-A used the remote control, and utilized the hydraulic lift to stand R123 upright while R123 wore black, grippy type gloves and held on to both handles of the lift. NA-A proceeded to unlock the EZ stand lift brakes, widened the legs of the lift and transferred R123 in front of her wheelchair, she then locked the lift in place once R123 was in front of her wheelchair, and used the remote control to lower R123 into her wheelchair. Once R123 was seated in the wheelchair, she stated NA-A was	F 323	9-29-17 Measures Put in Place: Mandatory all staff education was conducted on prevention of accidents and resident safety. Mandatory education for all nursing staff was conducted on use of EZ stand, EZ Lift, proper sling size and safety protocols for resident transfers 10-11-17 Monitoring Mechanisms: Safety rounds specific to transporting of residents with seated walker will be conducted for al residents by 10-10-17 and monthly for the next 90 days. 11-10-17 12-10-17 1-10-18 Staff skill checks will be conducted for all residents requiring the use of transfer equipment to ensure proper equipment and sling size is used. 10-10-17 Random staff skill checks will be conducted for residents on all units weekly for the next 30 days to ensure proper equipment and sling size is used. 10-17-17 10-24-17 10-31-17 11-4-17 Random skill checks will be conducted for residents on all units monthly for the next 60 days to ensure proper equipment and sling size is used. 12-4-17 1-4-18 Responsible Person/s Director of Nursing Clinical Managers	

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F 323	Continued From page 60 really good about putting all the belts on. NA-A unlocked the EZ stand lift, R123 removed her feet from the platform, both safety belts were released, loops unhooked, and the sling with beige colored binding was removed. NA-A confirmed the sling used to transfer R123 was a size medium, as she visualized the white tag attached to the sling with a letter M on the tag. Review of Event Report dated 8/5/17, at 5:45 p.m. indicated R123 suffered a witnessed fall during an EZ stand transfer. According to the report, the EZ stand suddenly stopped moving, R123 or nursing assistant was unable to remember what happened next, then one side of the sling was out of place which caused R123 to land on her buttocks, on the floor, with legs straight out. R123 was wearing shoes at the time of the fall. At the time of the fall R123 denied pain, hitting her head, range of motion in all extremities without pain or limitations, and there were no signs of injury. The Event Report indicated R123 was alert and oriented times three, communicated the situation well at the time, but was unable to describe what happened. Interventions identified on the Event Report, educated resident and staff the importance of checking on function of the equipment before using it, staff re-educated on proper use of EZ stand and to ensure correct size sling is used. Evaluation note of the event, indicated while transferring R123 from her chair to bed, the EZ(stand) stanc [sic] sling popped out of place causing resident to land on her buttocks. No injuries observed, resident remains alert and oriented. Staff re-educated on proper use of EZ stand and to ensure correct size sling was being used.	F 323	Staff Development Staff Quality Improvement Director	

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Review of R123's Incident Review Form dated 8/7/17, indicated R123 had a fall on 8/5/17, with no injury. The interdisciplinary team reviewed and documented the following:
-no medication concerns, Environmental concerns or change of condition noted. Plan of Care Changes/New Interventions: staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling.

Review of the printed education for NA-L dated 8/7/17, indicated staff had performance issues related to the incorrect use of EZ stand sling causing resident to fall on 8/5/17. Policy, procedures and standards of practice were reviewed with NA-L, which included the following:
-All assigned tasks should be performed with meticulous attention to detail, the quality of life of our resident depend on it.
-Correct use of EZ stand is vital to safety of residents and staff members.
-Correct size of sling is extremely pertinent for providing safe transfers; all slings used should be the appropriate size at all times. The proper fit will involve the judgment of the caregiver.
-Nursing assistants has the task of inspecting both machine, battery and sling before every lift to ensure safety.
-The sling must be secured to the machine on both sides; the foot and waist buckle must be latched prior to every lift.
-A copy of the EZ WAY harness sizing chart given to resident and placed on machine.

Review of nursing progress notes dated 8/5/17 to 8/22/17, revealed the following:
-On 8/7/17, at 1:45 p.m. R123 complained of left rib pain, no bruises noted. A call was placed to

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F 323	Continued From page 62 R123's nurse practitioner to request an x-ray to rule out fracture. -8/7/17, at 4:02 p.m., R123 returned to the facility, with negative result from x-ray. At 11:32 p.m. R123 continued to complain of pain to the left side, medication and a cold pack given with some relief noted, also note was a 2 centimeter (cm) x 2 cm bruise to R123's inner right arm. -On 8/8/17, at 2:46 p.m. R123 complained of pain of left side and rib cage area, and rated 8/10. Results of x-ray were sent to R123's primary nurse practitioner, no new orders received. -On 8/13/17, at 6:51 a.m. resolution of fall noted, indicated while transferring R123 from her chair to bed, the EZ(stand) stanc [sic] sling popped out of place causing resident to land on her buttocks. No injuries observed, resident remains alert and oriented. Staff re-educated on proper use of EZ stand and to ensure correct size sling was being used. -No further complaints of pain or injuries documented after 8/8/17. Review of X-ray report dated 8/7/17, indicated R123 had mild bibasilar infiltrates or atelectasis, however, no acute fracture was found. Review of R123's fall risk assessment dated 6/21/17, indicated R123 did not have any falls within the past six months, and was a low fall risk for falls. During interview on 8/23/17, at 8:07 a.m. R123 reported she fell from the EZ stand lift a few weeks ago. R123 reported when the staff member hooked her up to the lift, the staff member did not hook the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since she fell	F 323		

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from the lift all staff had been hooking up all of the belts, and she has not had any further falls. R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 stated she still gets scared, and repeats the picture in her mind of falling when she gets transferred. R123 stated she now wears gripper gloves to make sure she has a secure hold on the handles of the lift during transfers. R123 reported prior to her fall from the lift, staff were not always attaching the safety belt around her abdomen, then stated she had not reported that information to any nurses. R123 stated the fall from the EZ stand lift has been her only fall since admission. When interviewed at 12:49 a.m., R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 verified she did receive an x-ray and there were no fractures, she stated she did not have the pain in that location of her body prior to the fall, and still continues to have discomfort in her lower back and hip area.

During interview on 8/23/17, at 8:17 a.m. NA-A confirmed R123 required extensive assistance of one staff member for all ADL's, with the exception of eating which she was independent. NA-A reported staff carry care guide sheets that indicate what each resident needs for assistance. NA-A reported R123 did have one fall only that she was aware of, stated R123 fell from the lift because the lift was not working. NA-A verified staff decide and choose which size sling to use for each resident, and stated if the sling fits, "we use it." NA-A confirmed she used a medium sized sling to transfer R123, and verified the tag marked with a M on it. NA-A also indicated a color guide attached to the lift used for R123's transfer which indicated slings with a beige

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colored binding were size medium. NA-A also indicated the sling size was on R123's care plan. NA-A reported when staff use the EZ stand lift, all safety belts were to be attached, on the abdomen and behind legs. NA-A verified she had received education regarding the safe use of the EZ stand lifts when she started working at the facility.

During interview on 8/23/17, at 11:43 a.m. RN-C confirmed R123 fell from the EZ stand lift during a transfer. RN-C stated after talking with staff she believed the strap snapped off or open, and thought the size of the sling was maybe incorrect. RN-C stated re-education was given to the staff member involved regarding the lift use and sling sizes. RN-C verified the staff did not complete a specific assessment when determining the correct sling size to use. RN-C was not aware of the color coded sling size sticker attached to the lifts, and when asked how the staff determines the size of sling to use, if they go by weight or size, she did not answer.

During follow up interview on 8/24/17, at 9:44 a.m. RN-C stated sling size was determined by staff discretion and to the resident's comfort level, then staff document the size on the care plan and care sheet. RN-C was notified R123 was observed to be transferred with a medium sized sling, RN-C stated R123's identified sling size on her care plan and care sheet indicated a large sling size, but reported the resident stated the medium sized sling felt comfortable for her when she visited with R123. RN-C reported R123 was not injured from the fall, confirmed R123 did complain of pain, an x-ray was completed to rule out fractures, and was found to have some atelactisis. RN-C verified there were no further investigations or documentation regarding R123's

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F 323	Continued From page 65 fall on 8/5/17. When interviewed on 8/23/17, at 11:50 a.m. licensed practical nurse (LPN)-B stated residents were measured around their abdomen, then the sling sizes were determined by the measurement, like a girdle. LPN-B stated the sling size to be used was documented in the resident's care plan, and confirmed R123 should use a large sized sling with all transfers. When interviewed on 8/23/17, at 12:14 p.m. NA-B reported the staff had access to several sizes of slings for the EZ stand lift, and stated if they do not have the correct size, staff would notify laundry to obtain the correct size. NA-B believed R123 required an extra large sized sling. When interviewed on 8/24/17, at 9:30 a.m. NA-C verified R123 used an EZ stand lift for all transfers and extensive assistance of one staff. NA-C stated R123 required the use of a large sized sling for all transfers, and indicated this information was also on the care sheets. NA-C verified she was given education on the use of the mechanical lifts upon hire. When interviewed on 8/24/17, at 9:20 a.m. NA-D indicated R123 required extensive assistance of one staff and the EZ stand lift for all transfers with a large sized sling. When interviewed on 8/24/17, at 9:36 a.m. LPN-C confirmed R123 required the EZ stand lift for all transfers, and indicated that is how she had always transferred. LPN-C confirmed RN-C completed the assessments to determine the appropriate sling sizes for each resident, an the	F 323		

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F 323	Continued From page 66 correct size was documented on the care sheet and care plan. When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, as staff further investigated, the wording "popped off" was in the incident report, due to being too tight or the loop "popped off." The DON stated the staff member involved was immediately given education to ensure the sling fit properly and was comfortable. The DON stated after the investigation, staff believed a different size sling should be used. The DON confirmed prior to the fall R123 utilized a medium sized sling. The DON stated when determining the proper size sling, staff look at weight, but weights were pretty fluid and variable according the manufacture's chart and guidelines. She stated we take in to consideration the resident's comfort level of sling, generalized width, and what looks safe. The DON verified the sling size assessment was not documented, as it was more of a judgement based on clinical factors, then the size was documented on the care sheet and care plan. The DON verified staff should use a large sized sling for all EZ stand lift transfers with R123, unless there was some reason there needed to be a change, the change would be reviewed by the clinical manager. The DON stated staff do not routinely document if the sling size changes, then stated it would be indicated on the care sheet as being a different size. The DON stated she had the clinical manager re-assess R123 on 8/23/17 for proper sling size, and based on the assessment that she did, the sling should be a large size, and verified	F 323		

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all staff should be providing care as directed by the care sheets and care plan which also indicates a large size sling to be used. The DON confirmed there were no other documents or assessments regarding R123's fall from the EZ stand lift, other than the event report. The DON stated the interdisciplinary team (IDT) had more of a discussion, talks with people to get more of a picture of what happened, so we know what the new interventions should be, and verified this is all done "off the record" as the IDT talked. The DON reported the nursing assistants were expected to visualize the lifts for obvious damage of sling and lift prior to each use, and stated maintenance routinely inspects the lifts and slings.

When interviewed on 8/24/17, at 3:52 p.m. the director of maintenance (DOM) indicated he completed monthly audits and inspections on all mechanical lifts used in the facility. The DOM stated he looked for broken, loose or worn parts, and replaced them as needed, and looked to ensure the lifts were functioning safely. The DOM stated he was not aware of any residents ever falling from a mechanical lift or EZ stand lift, then stated if staff would update him in that type of event, he would want to go look at the lift or standing lift to inspect the lift for safety and proper functioning.

Review of the undated, EZ way, Inc. smart stand manufacturer's sizing guidelines document included a color coding system, separating different sizes by different colored binding on the harnesses. Beige colored represent a size medium for use of 90-220 pounds, 34-46 inches of circumference of patient's torso where harness is applied. The chart indicates the size/weight of

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	245242	A. BUILDING _____ B. WING _____	08/24/2017

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F 323	Continued From page 68 designations were merely estimates and basic guidelines. A proper fit would involve the judgement of the caregiver. R228 quarterly Minimum Data Set(MDS) dated 7/28/17, indicated R228 had severe cognitive impairment and required assist of two for transferring. R228 face sheet indicated diagnoses included dementia with Lewy Bodies, Parkinson disease, muscle weakness, orthostatic hypotension, and	F 323		

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F 323	Continued From page 69 major depressive disorder. R228 care plan revision dated 8/19/17, indicated R228 required assist with transfers due to impaired mobility related to Parkinson disease. R228 careplan directed staff "transfers with assist of two via an EZ lift." The untitled, undated nursing assistant care sheet updated 8/21/17, indicated for R228 "Transfers: EZ-Lift." Review of R228's progress note dated 8/19/17, at 6:44 p.m. indicated while transferring R228 with EZ stand lift, R228 became weak and unable to hold on to the bar of the lift and nursing staff lowered R228 to the ground by his arms. Three staff assisted R228 to bed utilizing a (EZ lift) full mechanical lift. The note indicated the EZ lift should be utilized for R228 and an order obtained for evaluation of the lift for R228. During an observation on 8/24/17, at 1:14 p.m. nurses aide (NA)-O and nurses aide (NA)-P rolled an EZ stand down the hallway and entered R228 room. NA-O verbally cued R228 she was going to use the EZ stand to transfer him from his wheel chair to his bed. NA-O and NA-P placed an EZ sling under R228 back and cued R228 "lean forward so can get sling behind you, your weaker arm is on right." NA-O cued R228 to hold onto EZ stand handles with his arms. NA-O placed his feet onto stand to transfer R228 from his wheelchair to his bed. NA-O and NA-P continued with transfer from wheelchair to the bed. As R228 was lowered to on edge of bed he said "wait a minute." R228 leaned to right side as legs removed from the EZ stand. NA-O and NA-P lifted R228 legs up onto the bed and positioned	F 323		

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F 323	Continued From page 70 him in bed. During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand. CM-A stated R228 careplan interventions had been changed to use of a EZ lift to ensure a safe transfer. CM-A stated staff were made aware of care plan changes through shift communication, careplan review and aid care sheets. CM-A stated the NA-O and NA-P should have been using the EZ lift with R228. During the interview with CM-A , NA-O approached the desk area and stated R228 was hollering and said he didn't want a strap between his legs so she used an EZ stand. CM-A stated to NA-O, he was supposed to be transferred with the EZ lift. NA-O did not respond. During an interview on 8/24/17, at 3:59 p.m. with director of nursing (DON) stated R228 care plan had been updated on 8/19/17 for an EZ lift to be used as R228 had weakness in arms and legs and was not safe to use on a EZ stand. DON also stated staff had been informed of the changes and were provided education. R224's quarterly Minimum Data Set (MDS) dated 7/15/17, identified R224 was cognitively intact and had diagnoses which included: Parkinson's disease, schizophrenia and hypertension. The MDS identified R224 was independent with all activities of daily living (ADL's.) except required staff assistance with dressing, toilet use and	F 323		

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personal hygiene. The MDS identified R70 ambulated independently and required a walker for mobility.

R224's care plan revised 8/21/17, at 8:03 p.m. identified R224 ambulated independently with use of a walker. The care plan indicated R224 had fatigue with distance at times, would often ask staff and visitors to push him on the seat of the walker and was not easily re-directed. The care plan directed staff to assist R224 if a decline in self performance was noted. The care plan indicated R224 was independent with transfers and did not use a wheelchair regularly. The care plan further instructed staff to use extensive to total assist to propel R224's wheelchair depending on weakness. The care plan identified R224 was at risk for falls related to Parkinson's disease effects, use of antihypertensive meds, use of a devise and the potential for unsafe behavior related to schizophrenia. The care plan directed staff to encourage and remind R224 to ambulate with his 4 wheeled walker.

The untitled, undated nursing assistant care sheet indicated R224 was ambulatory and used a 4 wheeled walker and wheelchair as needed. The sheet further indicated R224 was independent with transfers. The care sheet instructed staff to offer use of wheelchair for mobility if R224 became weak or had an unsteady gait.

On 8/21/17, at 6:39 p.m. R224 was observed seated on the bench of his 4 wheeled walker in the hallway near the nurses station, while nursing assistant (NA)-F pushed R224's walker down the hall. NA-F pushed R224, seated on the bench of the walker while he faced backwards,

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approximately 50 feet from the nursing station desk to the table in the dining room located past the common sitting area. R224 stood up and seated himself in a chair at the dining room table.

On 8/21/17 at 7:39 p.m. NA-F confirmed she had transported R224 utilizing the bench of his wheeled walker. NA-F indicated R224 had requested her to push him to the dining room because he felt weak. NA-F indicated she transported R224 utilizing the bench of his wheeled walker every 2-3 weeks. NA-F visualized and verified the nursing assistant care sheet that indicated R224 utilized a 4 wheeled walker and had a wheel chair to be used as needed.

On 8/21/17, at 7:44 p.m., clinical manager (CM)-A verified she was present at the nursing station when she observed NA-F transport R224 from the nursing station to the dining room. CM-A verified NA-F pushed R224 while he sat on the bench of his 4 wheeled walker. CM-A indicated she told NA-F not to transport R224 while he sat on his walker, but did not intervene. CM-A indicated she had instructed staff not to transport residents while they sat on the bench of their walkers. CM-A indicated R224 at times the staff would use a wheelchair to transport R224.

On 8/23/17, at 8:17 a.m. R224 indicated he was able to ambulate independently with his 4 wheeled walker. R224 confirmed in the past staff had used the Rollator walker to transport him while he sat on the bench of the walker.

On 8/23/17, at 9:00 a.m. director of rehab (DR)-A indicated she would not recommend a 4 wheeled walker to be used for transportation while a resident sat on the bench. DR-A indicated that if

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she witnessed a staff member pushing a resident while they sat on the bench of a 4 wheeled walker she would intervene and stop them. DR-A indicated she would expect staff and residents would be educated to not use 4 wheeled walkers as a wheelchair for transportation.

On 8/23/17, at 9:10 a.m. director of nursing (DON) confirmed she had been made aware staff had utilized R224's walker to transport him in the facility. DON indicated she would expect staff would not push residents while they sat on the bench of their 4 wheeled walkers.

Review of undated manufacturer's guidelines, attached to R224's Rollator walker titled Roscoe Medical Rollator revealed Rollators are NOT to be used as a wheelchair. Doing so may cause it to tip-over, resulting in injury.

The facility's EZ-stand policy dated 04/08, directed staff to check for loose nuts and bolts, damaged parts and to check the sling to ensure it was not ripped or frayed. The policy did not address sling sizes.

The facility's Accident Prevention and Reduction policy, dated 4/2017 indicated the facility was committed to providing a safe environment for residents, and would use a systematic approach to assist in the identification, evaluation and analysis of risk factors in the environment and need for supervision for either groups of resident or individual residents with the goal that: each resident's environment remain as free of accident and hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents.

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F 431	Continued From page 74	F 431		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431		10/12/17

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F 431	Continued From page 75 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication was labeled with accurate directions for use for 1 of 1 resident (R323) whose insulin was observed to be mislabeled during medication administration. Findings include: R323's Physician Order Report dated 8/23/17 to 2/23/18, identified R323 had diagnoses which included diabetes mellitus, Alzheimer's disease and kidney failure. The report included an order for Humalog (insulin) solution 100 unit/ml (milliliter) 12 units (U) injected subcutaneously before breakfast, 14 units before lunch, and 10 units before dinner. R323 had an order for Humalog to be given with a sliding scale that included to give 12 units if blood sugar was 351 to 400. On 8/21/17, at 6:40 p.m. registered nurse (RN)-E	F 431	F431: It is the policy of the Augustana Health Care Center that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Corrective Action: Clinical Manager immediately obtained medication change labels from the pharmacy and placed on the insulin bottle upon identification by the surveyor. 8-22-17 Identification of Other Residents: All med carts were audited to ensure proper labeling of medications for residents . 9-29-17 Measures Put in Place: All licensed staff and TMA's were	

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F 431	Continued From page 76 was observed to prepare for administration of R323's insulin. RN-E had drawn 22 units of Humalog insulin into the syringe. RN-E explained 10 units for R323's dinner dose and 12 units because the physician was called and did not want to give more than the current highest sliding scale dose of 12 units. R323's Humalog vial was kept in a amber medication container. The container was labeled with administration directions to inject 10 units subcutaneous 3 times daily before meals with sliding scale parameters as follows: blood sugar 130-150=0 blood sugar 151-200=2U blood sugar 201-250=4U blood sugar 151-300=6U blood sugar 301-350=8U blood sugar 351-400=10U blood sugar greater than 400 call MD (medical doctor) On 8/21/17, at 6:43 p.m. RN-E verified R323's Humalog order had changed on 7/20/17. RN-E indicated the order labels on medications can not always be relied on to be the correct directions/dose. RN-E identified the facility practice was to complete three checks to ensure the correct dose of medication was administered. RN-E verified the dose transcribed on the Humalog container did not match the dose in the Medication Administration Record (MAR). On 8/23/17, at 7:33 a.m. licensed practical nurse (LPN)-D prepared 24 units of Humalog insulin for R323. LPN- explained 12 units for R323's morning dose of insulin and 12 units for the sliding scale dose.	F 431	re-educated with a read and sign document specific to medication labeling. 10-11-17 Monitoring Mechanisms: Clinical Managers or their designee will audit their unit med carts one time weekly to ensure proper labeling for the next 30 days. 10-10-17 10-24-17 10-31-17 11-4-17 Clinical Managers or their designee will audit their unit med carts monthly for the next 60 days. 12-4-17 1-4-18 Med cart audits will be reviewed by the Quality Improvement Committee to ensure clinical standards of practice for medication labeling on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Nursing or designee Clinical Managers or designee Quality Improvement Director	

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F 431	Continued From page 77 On 8/23/17, at 8:05 a.m. LPN-D verified R323's insulin medication bottle container was different than the directions in the MAR and did not have a change of order sticker on it. On 8/23/17, at 8:10 a.m. the clinical manager (CM)-B verified R323's Humalog insulin orders were changed 8/22/2017, and the pharmacy was called to provide a change of order sticker to place on the insulin bottle. With further review of the clinical record CM-B verified the insulin sliding scale order had also changed in July, increasing from 10 units to 12 units for a blood sugar reading of 351 to 400. CM-B verified when the order had changed in July a sticker had not been placed to alert staff of the order change, and should have. On 8/24/17, at 10:14 a.m the director of nursing (DON) verified medications were administered based on the the MAR and the medication label. The DON indicated when a discrepancy was noted staff were expected to check the original orders and if there was a dosage change found, the pharmacy should have been contacted for a change of order sticker. The DON verified a change of order sticker would be used to alert staff to a dosage change and aid in prevention of a possible medication error. The DON verified knowledge of the medication in question, the recent order change and prior sliding scale order change. The requested facility policy was not provided.	F 431		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		10/12/17

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F 465	Continued From page 78 (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping services necessary to maintain a clean and sanitary condition in resident rooms and bathrooms for 2 of 2 resident rooms and shared bathrooms (Main 109, 111, East 252) reviewed. Findings include: During the initial tour on 8/22/17, the following were noted: - at 2:13 p.m. room 109 and 111 on the first floor main unit were found to have a strong urine odor in the rooms and shared bath room. - at 2:38 p.m. room 252 on the second floor East unit was found to have a strong urine odor through out the room and bathroom. On 8/24/17, at 11:14 p.m. during the environmental tour with the director of environmental services (DES) the above environmental concerns were verified. On 8/24/17, at 11:14 a.m. the DES verified the	F 465	F465: It is the policy of the Augustana Health Care Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Corrective Action: The three identified rooms on the 2567 have been deep cleaned and checked numerous times to ensure sanitary conditions have been maintained 9-29-17 Identification of Other Residents: Every resident room was audited for sanitary conditions and deep cleaned if indicated. 9-29-17 Measures Put in Place: Mandatory all staff education was conducted on the importance of maintaining a sanitary, clean and comfortable environment for residents, staff and the public. 10-11-17 Monitoring Mechanisms: All resident rooms will be audited one time	

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F 465	Continued From page 79 responsibility of managing the house keeping staff. The DES explained housekeeping staffing and duties to include the following: - one staff person was assigned to each unit for a total of seven hours per day. -staff were provided schedules to follow for daily and weekly cleaning tasks. - identified smells were managed promptly. The DES verified the first floor main unit was odorous and difficult to manage due to the clientele living on that unit. The DES agreed the East unit room 252 was odorous and had been an ongoing concern due to residents urinating on the floor. The DES identified numerous additional cleaning procedures to manage the odors, however, agreed that the problem was not under control. On 8/24/17, at 11:49 a.m. the quality improvement director (QID) indicated the director of environmental services provided deep cleaning services to resident rooms and completed follow up checks to ensure staff were providing the cleaning services. On 8/24/17, at 12:23 p.m. in the administrators office with the administrator, DON, QID, and director of maintenance, the DES verified the two rooms and shared bathroom had a strong odor. The DES indicate he personally stripped, waxed and went thorough clothing and etcetera in room 252 on the East unit. The DES stated, "There is only so much time we can spend in there." The requested facility policy was not provided.	F 465	weekly for the next 30 days to ensure a sanitary, clean and comfortable environment is maintained. 10-10-17 10-17-17 10-24-17 10-31-17 All resident rooms will be audited 2 times monthly for the next 60 days to ensure a sanitary, clean and comfortable environment is maintained. 11-30-17 12-31-17 Resident Room audits will be reviewed by the Quality Improvement committee for compliance with providing a sanitary, clean and comfortable environment on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Environmental Services Quality Improvement Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/22/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	**1007 EAST 14TH STREET** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 22, 2017. At the time of this survey, Augustana Health Care Center of Minneapolis was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/29/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/22/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	**1007 EAST 14TH STREET** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Augustana Health Care Center of Minneapolis is a 6-story building with a full basement that was constructed at 3 different times. The original building was constructed in 1945 and was determined to be of Type II(222) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. In 1974, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler systems and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/22/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	**1007 EAST 14TH STREET MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 250 beds and had a census of 231 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 231 residents. Findings include: On a facility tour between the hours of 1000 and 1500 on August 22, 2017, observation revealed that the ventilation system for the main building appears to be utilizing the egress corridor as an exhaust plenum. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 521	See attached waiver for K521	10/12/17

Name of Facility	2012 LIFE SAFETY CODE
Augustana HCC	

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K400	
K 521 SS=F The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated April 12, 2017 for a complying ducted HVAC system is $2,028,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work) 2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 92% as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases 3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too: a. The building electrical system would need to be upgraded to support a new ducted system. b. The system would also require a new meter at additional costs to the ducted HVAC bid. c. Installation of a ducted system would require asbestos abatement which would also increase the cost. Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* *Thomas Linhoff 12424*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 10-03-2017

Name of Facility **2012 LIFE SAFETY CODE**

Augustana HCC MPLS

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K400 K 521 SS=F The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum	Continued 4. Due to these extensive costs, disruption and possible relocation of residents there are no immediate plans to implement the above major physical plant renovation. In addition to the extra associated projects and costs, the ducted system would need to penetrate load bearing walls decreasing building structural integrity. 5. The building is currently 55 years old and not slated for replacement in the foreseeable future. The building has a useful life of an additional 75+ years and meets all LSC to ensure a safe physical environment for residents and staff, which in turn allows the existing non-complying HVAC to remain in use.. . B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because: 1. The facility is Type II with an interior finish rating of Class A. 2. The walls, floors, ceiling and vertical openings resist the passage of smoke

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linkoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal	Date 10-03-2017

Name of Facility **2012 LIFE SAFETY CODE**

Augustana HCC

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K400 K 521 SS=F The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum	Continued 3. The following safety features are installed: a. Fire Alarm EST-3 addressable, transmission type SD4 Version 5.2 b. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1199 Ed. As of January 2008. (Fully (sprinkled, wetpipe quick response) c. Fire extinguishers – Dry chemical 4-A 60-BC d. The building is equipped with an approved, addressable fire alarm/smoke detector system, and all resident rooms are equipped with automatic smoke detection tied into the nurses call station. 4. In accordance with LSC 19.7.2.2, the facility has a compliant fire safety plan which included fire plans for all departments and employees, training on plans is conducted upon hire, and annually for all employees. Fire drills are conducted at least quarterly on each shift. 5. Operational plans include: Plans for all departments, and all office areas, Fire Out, Fire Drills, Fire Watch Alarms Out, Fire Watch Sprinkler systems out.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	State Fire Marshal	10-03-2017

Name of Facility

Augustana HCC

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K400 K 521 SS=F The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum	Continued 6. The facility sets a staff ratio at 3.70 nursing hours per day per resident. 7. There are 5 smoke compartments on Ground Floor, 1st, 2nd, and 3rd floor, 4 smoke compartments on 4th floor, and 3 on 5th floor Main which is currently closed 8. TCU residents are located on the first floor of both the East and Main building and houses 53 residents, the dementia care unit is located on 4th floor Main and houses 28 residents 9. The closest fire department is 1 mile away and has an average of 5 minutes or less response time.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* *Thomas Linhoff 12424*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 10-03-2017

MMC

April 12, 2017

Clark Worden
Augustana Apartments
1007 East 14th Street
Minneapolis, MN 55404

RE: Bldg A Ventilation Budget

Dear Mr. Worden:

Per your request the following budget proposal is to provide 100% outside air ventilation to all floors of the main building.

Included items in this proposal:

- Demo and relocate existing exhaust fans and roof vents to accommodate new air handler.
- Furnish and install one (1) 100% outside air rooftop complete with desiccant wheel, roof curb and controls.
- Structural engineering design for new rooftop and core drilling for new shafts.
- Necessary new ductwork and diffusers.
- Necessary new gas piping. New meter required and provided by others.
- Necessary new fire smoke dampers.
- Temperature controls
- Rigging
- Equipment rental
- Power wiring
- Insulation
- Air balance
- Check, Test, Start

The following items are not included:

- Overtime labor
- Painting
- Condition of existing systems.
- Dumpsters
- Structural Work Required
- General Construction

The budget cost to complete this scope of work is.....$2,028,000.00

Thank you for the opportunity! Please contact me with any questions.

Metropolitan **M**echanical **C**ontractors, Inc.
7340 Washington Avenue South ♦ Eden Prairie, Minnesota 55344
Phone: 952-941-7010 ♦ Fax: 952-941-9118

Sincerely,

Metropolitan Mechanical Contractors, Inc.

Apartments

Accepted By:_____
Augustana

Date:_____

Dale Haupert
Service Sales Manager
612-919-4701
dale.haupert@metromech.com

Electronically delivered

September 20, 2017

Ms. Jean Cole, Administrator
Augustana Health Care Center of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders - Project Number S5242027

Dear Ms. Cole:

The above facility was surveyed on August 21, 2017 through August 24, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

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

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
	00164	A. BUILDING: _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINI	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/21/17, 8/22/17, 8/23/17, and 8/24/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced	2 302		10/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 302	Continued From page 3 by: Based on interview and document review, the facility failed to provide consumers in written or electronic form, information regarding facility staff training for Alzheimer's disease and related disorders. Findings include: During interview on 8/22/17, at 10:01 a.m. registered nurse (RN)-A indicated she was not aware of the requirement regarding provision of written or electronic information to facility consumers, of staff training for care of residents with Alzheimer's disease and related disorders. RN-A stated it was provided only upon request in electronic or hard copy format. During interview on 8/22/17, at 1:59 p.m. the director of nursing (DON) verified the facility had not provided all facility consumers in writing or electronic form, the details of Alzheimer training regarding what training is provided, what staff were trained or the frequency of training. The DON indicated this information was only provided to consumers admitted to the memory care unit or upon request. Review of the facility's document labeled Dementia Care Training directed access to the document for the public would be provided to consumers in electronic or hard copy format per their request. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet for consumer information. The DON or designee could educate staff and conduct audits to ensure compliance.	2 302	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 302	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions for use of transfer equipment for 2 of 2 residents (R123, R228) who required use of mechanical equipment for assistance with transfers. Findings include: R123's care plan dated 8/22/17, indicated R123 required extensive assistance of one staff with transfers, staff to cue resident before and during transfers, R123 may use the EZ stand when resident reports feeling weak. R123's fall care plan dated 8/14/17, indicated R123 was resized for sling related to a fall, appropriate large fitting EZ stand strap/sling obtained. R123's undated care sheet, indicated R123 was a fall risk, required extensive assist of one staff for stand pivot transfer with four wheeled walker and protective boot, OR required EZ stand with large sling when resident report feeling weak. The	2 565	Corrected	10/12/17

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2 565	Continued From page 5 following words were typed on the care sheet and underlined and in red ink wer " be sure to use LG(large) sling with all EZ stand transfers." During observation on 8/23/17, at 7:29 a.m. R123 was observed lying in bed, nursing assistant (NA)-A present in the room. NA-A asked R123 if she was ready to get up for the day, R123 stated yes, NA-A proceeded to provide morning cares. At 7:55 a.m. NA-A retrieved an EZ stand mechanical lift and brought into R123's room, the lift had a sling with beige colored binding draped over the top of the lift. NA-A brought the EZ stand lift up to the edge of the bed, R123 placed both of her feet on the lift's foot platform and locked the lift into place. NA-A then placed the sling behind R123's back, attached all loops of the sling on to the hooks of the EZ stand lift, and attached the safety belt around R123's abdomen and behind R123's calves. NA-A used the remote control, and utilized the hydraulic lift to stand R123 upright while R123 wore black grippy type gloves and held on to both handles. NA-A proceeded to unlock the EZ stand lift brakes, widened the legs and transferred R123 in front of her wheelchair, she then locked the lift in place once R123 was in front of her wheelchair, and used the remote control to lower R123 into her wheelchair. Once R123 was seated in the wheelchair, she stated NA-A was really good about putting all the belts on. NA-A unlocked the EZ stand lift, R123 removed her feet from the platform, both safety belts were released, loops unhooked, and the sling with beige colored binding was removed. NA-A confirmed the sling used to transfer R123 was a size medium, as she visualized the white tag attached to the sling with a letter M on the tag. During interview on 8/23/17, at 8:07 a.m. R123 reported she fell from the EZ stand lift a few	2 565		

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2 565	Continued From page 6 weeks ago. R123 reported when the staff member hooked her up to the lift, the staff member did not hook the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since she fell from the lift all staff had been hooking up all of the belts, and she has not had any further falls. R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 stated she still gets scared, and repeats the picture in her mind of falling when she gets transferred. R123 stated she now wears gripper gloves to make sure she has a secure hold on the handles of the lift during transfers. R123 reported prior to her fall from the lift, staff were not always attaching the safety belt around her abdomen, then stated she had not reported that information to any nurses. R123 stated the fall from the EZ stand lift has been her only fall since admission. During interview on 8/23/17, at 8:17 a.m. NA-A confirmed R123 required extensive assistance of one staff member for all ADL's, with the exception of eating which she was independent. NA-A reported staff carry care guide sheets that indicate what each resident needs for assistance. NA-A reported R123 did have one fall only that she was aware of, stated R123 fell from the lift because the lift was not working. NA-A verified staff decide and choose which size sling to use for each resident, and stated if the sling fits, we use it. NA-A confirmed she used a medium sized sling to transfer R123, and verified the tag marked with a M on it. NA-A also indicated a color guide attached to the lift used for R123's transfer which indicated slings with a beige colored binding were size medium. NA-A also indicated the sling size was on R123's care plan.	2 565		

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2 565	Continued From page 7 During interview on 8/24/17, at 9:44 a.m. RN-C stated sling size was determined by staff discretion and to the resident's comfort level, then staff document the size on the care plan and care sheet. RN-C was notified R123 was observed to be transferred with a medium sized sling, RN-C stated R123's identified sling size on her care plan and care sheet indicated a large size sling, but reported the resident stated the medium sized sling felt comfortable for her when she visited with R123. When interviewed on 8/23/17, at 11:50 a.m. licensed practical nurse (LPN)-B stated residents were measured around their abdomen, then the sling sizes were determined by the measurement, like a girdle. LPN-B stated the sling size to be used was documented in the resident's care plan, and confirmed R123 should use a large sized sling with all transfers. When interviewed on 8/23/17, at 12:14 p.m. NA-B reported the staff had access to several sizes of slings for the EZ stand lift, and stated if they do not have the correct size, staff would notify laundry to obtain the correct size. NA-B believed R123 required an extra large sized sling. When interviewed on 8/24/17, at 9:30 a.m. NA-C verified R123 used an EZ stand lift for all transfers and extensive assistance of one staff. NA-C stated R123 required the use of a large sized sling for all transfers, and indicated this information was also on the care sheets. NA-C verified she was given education on the use of the mechanical lifts upon hire. When interviewed on 8/24/17, at 9:20 a.m. NA-D indicated R123 required extensive assistance of	2 565		

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one staff and the EZ stand lift for all transfers with a large sized sling.

When interviewed on 8/24/17, at 9:36 a.m. LPN-C confirmed R123 required the EZ stand lift for all transfers, and indicated that is how she had always transferred. LPN-C confirmed RN-C completed the assessments to determine the appropriate sling sizes for each resident, an the correct size was documented on the care sheet and care plan.

When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, as staff further investigated, the wording popped off was in the incident report, due to being too tight or the loop popped off. The DON stated the staff member involved was immediately given education to ensure the sling fit properly and was comfortable. The DON stated after the investigation, staff believed a different size sling should be used. The DON confirmed prior to the fall R123 utilized a medium sized sling. The DON stated when determining the proper size sling, staff look at weight, but weights were pretty fluid and variable according the manufacture's chart and guidelines. She stated we take in to consideration the resident's comfort level of sling, generalized width, and what looks safe. The DON verified the sling size assessment was not documented, as it was more of a judgement based on clinical factors, then the size was documented on the care sheet and care plan. The DON verified staff should use a large sized sling for all EZ stand lift transfers with R123, unless there was some reason there needed to be a change, the change

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2 565	Continued From page 9	2 565		

would be reviewed by the clinical manager. The DON stated staff do not routinely document if the sling size changes, then stated it would be indicated on the care sheet as being a different size. The DON stated she had the clinical manager re-assess R123 on 8/23/17 for proper sling size, and based on the assessment that she did, the sling should be a large size, and verified all staff should be providing care as directed by the care sheets and care plan which also indicates a large size sling to be used. The DON confirmed there were no other documents or assessments regarding R123's fall from the EZ stand lift, other than the event report. The DON stated the interdisciplinary team (IDT) had more of a discussion, talks with people to get more of a picture of what happened, so we know what the new interventions should be, and verified this is all done "off the record" as the IDT talked. The DON reported the nursing assistants were expected to visualize the lifts for obvious damage of sling and lift prior to each use, and stated maintenance routinely inspects the lifts and slings.

R228 care plan revision dated 8/19/17, indicated R228 required assist with transfers due to impaired mobility related to Parkinson disease. R228 careplan directed staff "transfers with assist of two via an EZ lift."

The untitled, undated nursing assistant care sheet updated 8/21/17, indicated for R228 "Transfers: EZ-Lift."

During an observation on 8/24/17, at 1:14 p.m. nurses aide (NA)-O and nurses aide (NA)-P rolled an EZ stand down the hallway and entered R228 room. NA-O verbally cued R228 she was going to use the EZ stand to transfer him from his wheel

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2 565	Continued From page 10 chair to his bed. NA-O and NA-P placed an EZ sling under R228 back and cued R228 "lean forward so can get sling behind you, your weaker arm is on right." NA-O cued R228 to hold onto EZ stand handles with his arms. NA-O placed his feet onto stand to transfer R228 from his wheelchair to his bed. NA-O and NA-P continued with transfer from wheelchair to the bed. As R228 was lowered to on edge of bed he said "wait a minute." R228 leaned to right side as legs removed from the EZ stand. NA-O and NA-P lifted R228 legs up onto the bed and positioned him in bed. During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand. CM-A stated R228 careplan interventions had been changed to use of a EZ lift to ensure a safe transfer. CM-A stated staff were made aware of care plan changes through shift communication, careplan review and aid care sheets. CM-A stated the NA-O and NA-P should have been using the EZ lift with R228. During the interview with CM-A , NA-O approached the desk area and stated R228 was hollering and said he didn't want a strap between his legs so she used an EZ stand. CM-A stated to NA-O, he was supposed to be transferred with the EZ lift. NA-O did not respond. During an interview on 8/24/17, at 3:59 p.m. with director of nursing (DON) stated R228 care plan had been updated on 8/19/17 for an EZ lift to be used as R228 had weakness in arms and legs and was not safe to use on a EZ stand. DON also stated staff had been informed of the changes and were provided education.	2 565		

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2 565	Continued From page 11 The facility's Care Plan policy dated 11/2016, indicated care plans are developed to provide written guides for intervention, assisting the resident to meet their needs for ADL's, health care and psychosocial needs and to provide for person-centered development of the resident's plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include individualized interventions to effectively	2 570	Corrected	10/12/17

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2 570	Continued From page 12 communicate with 1 of 1 resident (R338) with a language barrier. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program. R338's Care Area Assessment (CAA) dated 2/9/17, indicated R338's primary language was Somali and family reported confusion and at times R338 thought she was in Africa. The CAA listed various causes and contributing factors which included cultural/language barrier, not recognizing caregivers or medical equipment and risk factors included social isolation, confusion, decreased progress and participation in rehab therapies. Also, the CAA indicated R338 had bowel and bladder incontinence with some control, history of stress incontinence and R338 was not consistent with letting staff know she needs to be changed. The CAA for communication did not trigger and was not addressed on the CAA. R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, her	2 570		

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2 570	Continued From page 13 preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS indicated R338 required extensive assistance for all activities of daily living (ADL). The MDS also indicated R338 was occasionally incontinent of urine, frequently incontinent of bowel and had no toileting program. R338's current care plan, revised on 8/22/17, listed the problem of communication, hearing was adequate, and indicated R338 made herself understood through an interpreter. The care plan directed staff to report any changes in ability to communicate, understand others, or in ability to hear and to refer for hearing exam as needed. R338's care plan identified R338's primary language was Somali, had frequent pain, weakness, dementia, required extensive assistance with bed mobility, boost up in bed, assist to lift legs in/out of bed, and sitting position in bed. R338's care plan directed staff to speak simply and clearly and repeat as needed, utilize environmental cues as calendars, clocks, notes, communicate at eye level and establish calm, explain cares/treatments before beginning, as needed and consistent routine when providing cares. The care plan directed to provide opportunity for patient to express feelings, involve social services as needed, encourage resident to talk through anger and frustration, and to schedule an interpreter for rehab therapies, nurse practitioner/physician visits, care conferences and upon request. No further care plan interventions were listed to effectively communicate with R338, or assistive devices to use to communicate with R338. Review of R338's undated Transitional Care Card listed various interventions which included	2 570		

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2 570	Continued From page 14	2 570		

assistance with ADLs, however, the care card lacked any interventions for R338's language barrier.

During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.

At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-D and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast,

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angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants."

R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a rapid, frustrated voice and frantically assisted to place the bedpan by moving her hospital gown out of the way of the bedpan. With the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine.

During interview on 8/23/17, at 9:11 a.m. RN-D stated staff had a hard time knowing what R338 wanted when she called for assistance and stated staff have to guess a lot of the time and the resident got frustrated during that time.

On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being

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left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on R338's wall for staff to utilize to call him to help communicate with R338.

On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's primary language. RN-D indicated she had contacted R338's son when she was not sure what R338 needed or wanted.

On 8/23/17, at 9:41 a.m. during a follow up interview with NA-G, she stated she used hand gestures to attempt to communicate with R338 and stated she was not aware of any other interventions to utilize while communicating with R338. NA-G indicated in the past she had called the family member to attempt to figure out what R338 needed assistance with. NA-G stated she had not utilized an interpreter in the past and was not aware how to request for or use needed interpreter services.

On 8/23/17, at 9:50 a.m. NA-H indicated communication was difficult with R338 and stated she pointed at objects or had her son translate when he was available. NA-H indicated her usual routine was to stand in her room, have R338 point until she figured out what R338 needed or wanted. NA-H indicated she had not utilized interpreter services with R338.

On 8/23/17, at 12:18 p.m. an interpreter was present in the building and he stated interpreter services were utilized for scheduled medical

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2 570	Continued From page 17	2 570		

appointments with residents and was not aware of any other time interpreter services were utilized in the facility. The interpreter indicated that day (8/23/17), was the first time he had met R338 for a schedule medical appointment with the doctor today.

On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps with that sometimes. R338 indicated because she had been left on the bedpan without assistance in the past, she had tried not to go to the bathroom so she could avoid that from happening again. R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad, sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were.

On 8/23/17 at 12:25 p.m. during second interview, FM-A indicated he posted a note with telephone numbers to the wall in R338's room to

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2 570	Continued From page 18 help with R338's language barrier, but the facility staff did not use the telephone numbers. FM-A had been told by the facility staff R338 refused cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier. FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338. On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to dial the cellular telephone. Above the night stand, which was next to R338's bed, a white piece of paper, approximately 8 inches (in) by 11 in. was taped to the wall. On the paper, typed in black ink, were instructions for contacting an online interpreter service.	2 570		

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2 570	Continued From page 19 On 8/24/17 at 8:56 a.m. RN-G was present in R338's room and indicated staff had used communication cards with words on them, but R338 was not able to read the cards and stated, "so did not really work that well." RN-G stated it was easier to have staff to assist with communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with R338 and stated, "I don't think the problem is communication." On 8/24/17 at 9:43 a.m. during a follow up interview, FM-A indicated when staff did not respond to her, she would be incontinent on the bed and stated "happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues. FM-A stated the interpreter information in R338's room was not there until they came to visit her last night. On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J	2 570		

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2 570	Continued From page 20	2 570		

indicated she was aware R338 has had incontinence with bowel and bladder when other staff who do not understand what she wants cared for her. NA-J indicated when she cared for R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. She stated, "She did not have that paper in her room before."

On 8/24/17, at 9:07 a.m. NA-K stated she was able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated "she has not had accidents for me." NA-K indicated R338 was able to communicate her needs, was pretty pleasant, cooperative with cares and did not refuse cares.

On 8/24/17, at 12:08 p.m. social worker (SW)-A confirmed R338 primary language was Somali and indicated he would schedule an interpreter for R338 or use the online service when R338

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2 570	Continued From page 21	2 570		

had medical appointments or when he completed his portion of the MDS. SW-A indicated the usual facility practice was to encourage R338 to use the son to translate, other staff members, and staff to be patient and explain cares to her. The SW-A indicated staff were expected to follow the care plan and to utilize the online interpreter services if having trouble communicating with R338. He indicated he was not aware of any problems communicating with R338. SW-A confirmed no other interventions had been put in place to assist R338 to effectively communicate with staff.

On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier. The DON indicated when residents were admitted who have language barriers, the usual facility practice was to send an email notification to all staff to notify them of the individual resident's primary language and if the family was available to assist. She stated "90%" of the time we have family to accommodate for their needs. The DON indicated the facility routinely scheduled an interpreter for therapy appointments and medical appointments, and stated the facility did not schedule any further services unless they felt

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2 570	Continued From page 22 the communication was unclear. The DON indicated 338's son came to the facility quite a lot and stated she had not heard of any concerns with communication that impacted 338's care. Review of the facility policy titled Care Plans, revised on 11/2016, indicated care plans are developed after completion of the comprehensive assessment or as changes occur. The care plan will be reviewed at least quarterly and revised as needed. The policy also indicated the residents personal and cultural references will be incorporated into the development of the care plan goals. The policy further indicated care plans provide written guides for intervention, assisting the resident to meet their needs for ADL's, health care and psychosocial needs and to provide for person-centered development of the resident's plan of care. This policy also indicated "NAR Care sheets and /or profiles are updated per care plan changes to ensure the practice of following the plan of care." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		10/12/17

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2 830	Continued From page 23 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement individualized equipment requirements to ensure the appropriate transfer equipment was utilized during transfers for 2 of 2 residents (R123, R228) who had a history of fall during a transfer utilizing a mechanical lift. In addition, the facility failed to follow manufacturer's guidelines for the proper use of a wheeled walker to prevent accident hazards for 1 of 1 resident (R224) who utilized a walker for ambulation. Findings include: R123's face sheet dated 12/29/16, identified current diagnoses of chronic pain, muscle and bilateral leg weakness, lymphedema, conversion disorder with seizures or convulsions, anxiety, depression, pain in left ankle and joints of left foot and repeated falls prior to admission. R123's admission Minimum Data Set (MDS) dated 1/5/17, identified she required extensive	2 830	Corrected	

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2 830	Continued From page 24 assistance for transfers, had a history of falls prior to admission and had intact cognition. R123's Care Area Assessment (CAA) dated 1/9/17, indicated R123 admitted with weakness, required extensive assistance for transfers and was at risk for falls related to a history of falls, deconditioning, pseuedoseizures, depression, obesity, impaired balance, the need for extensive assistance with activities of daily living (ADL's), pain, and use of medications. R123's care plan dated 8/22/17, indicated R123 required extensive assistance of one staff with transfers, staff to cue resident before and during transfers, R123 may use the EZ stand when resident reports feeling weak. R123's fall care plan dated 8/14/17, indicated R123 was resized for sling related to a fall, appropriate large fitting EZ stand strap/sling obtained. R123's undated care sheet, indicated R123 was a fall risk, required extensive assist of one staff for stand pivot transfer with four wheeled walker and protective boot, or required EZ stand with large sling when resident reports feeling weak. The following words were typed on the care sheet and underlined in red ink "be sure to use LG [large] sling with all EZ stand transfers." During observation on 8/23/17, at 7:29 a.m. R123 was observed lying in bed, nursing assistant (NA)-A present in the room. NA-A asked R123 if she was ready to get up for the day, R123 stated yes, NA-A proceeded to provide morning cares. At 7:55 a.m. NA-A retrieved an EZ stand mechanical lift and brought into R123's room, the lift had a sling with beige colored binding draped over the top of the lift. NA-A brought the EZ stand lift up to the edge of the bed, R123 placed both of	2 830		

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2 830	Continued From page 25	2 830		

her feet on the lift's foot platform and locked the lift into place. NA-A then placed the sling behind R123's back, attached all loops of the sling on to the hooks of the EZ stand lift, and attached the safety belt around R123's abdomen and behind R123's calves. NA-A used the remote control, and utilized the hydraulic lift to stand R123 upright while R123 wore black, grippy type gloves and held on to both handles of the lift. NA-A proceeded to unlock the EZ stand lift brakes, widened the legs of the lift and transferred R123 in front of her wheelchair, she then locked the lift in place once R123 was in front of her wheelchair, and used the remote control to lower R123 into her wheelchair. Once R123 was seated in the wheelchair, she stated NA-A was really good about putting all the belts on. NA-A unlocked the EZ stand lift, R123 removed her feet from the platform, both safety belts were released, loops unhooked, and the sling with beige colored binding was removed. NA-A confirmed the sling used to transfer R123 was a size medium, as she visualized the white tag attached to the sling with a letter M on the tag.

Review of Event Report dated 8/5/17, at 5:45 p.m. indicated R123 suffered a witnessed fall during an EZ stand transfer. According to the report, the EZ stand suddenly stopped moving, R123 or nursing assistant was unable to remember what happened next, then one side of the sling was out of place which caused R123 to land on her buttocks, on the floor, with legs straight out. R123 was wearing shoes at the time of the fall. At the time of the fall R123 denied pain, hitting her head, range of motion in all extremities without pain or limitations, and there were no signs of injury. The Event Report indicated R123 was alert and oriented times three, communicated the situation well at the

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2 830	Continued From page 26 time, but was unable to describe what happened. Interventions identified on the Event Report, educated resident and staff the importance of checking on function of the equipment before using it, staff re-educated on proper use of EZ stand and to ensure correct size sling is used. Evaluation note of the event, indicated while transferring R123 from her chair to bed, the EZ(stand) stanc [sic] sling popped out of place causing resident to land on her buttocks. No injuries observed, resident remains alert and oriented. Staff re-educated on proper use of EZ stand and to ensure correct size sling was being used. Review of R123's Incident Review Form dated 8/7/17, indicated R123 had a fall on 8/5/17, with no injury. The interdisciplinary team reviewed and documented the following: -no medication concerns, Environmental concerns or change of condition noted. Plan of Care Changes/New Interventions: staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling. Review of the printed education for NA-L dated 8/7/17, indicated staff had performance issues related to the incorrect use of EZ stand sling causing resident to fall on 8/5/17. Policy, procedures and standards of practice were reviewed with NA-L, which included the following: -All assigned tasks should be performed with meticulous attention to detail, the quality of life of our resident depend on it. -Correct use of EZ stand is vital to safety of residents and staff members. -Correct size of sling is extremely pertinent for providing safe transfers; all slings used should be the appropriate size at all times. The proper fit	2 830		

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2 830	Continued From page 27 will involve the judgment of the caregiver. -Nursing assistants has the task of inspecting both machine, battery and sling before every lift to ensure safety. -The sling must be secured to the machine on both sides; the foot and waist buckle must be latched prior to every lift. -A copy of the EZ WAY harness sizing chart given to resident and placed on machine. Review of nursing progress notes dated 8/5/17 to 8/22/17, revealed the following: -On 8/7/17, at 1:45 p.m. R123 complained of left rib pain, no bruises noted. A call was placed to R123's nurse practitioner to request an x-ray to rule out fracture. -8/7/17, at 4:02 p.m., R123 returned to the facility, with negative result from x-ray. At 11:32 p.m. R123 continued to complain of pain to the left side, medication and a cold pack given with some relief noted, also note was a 2 centimeter (cm) x 2 cm bruise to R123's inner right arm. -On 8/8/17, at 2:46 p.m. R123 complained of pain of left side and rib cage area, and rated 8/10. Results of x-ray were sent to R123's primary nurse practitioner, no new orders received. -On 8/13/17, at 6:51 a.m. resolution of fall noted, indicated while transferring R123 from her chair to bed, the EZ(stand) stanc [sic] sling popped out of place causing resident to land on her buttocks. No injuries observed, resident remains alert and oriented. Staff re-educated on proper use of EZ stand and to ensure correct size sling was being used. -No further complaints of pain or injuries documented after 8/8/17. Review of X-ray report dated 8/7/17, indicated R123 had mild bibasilar infiltrates or atelectasis, however, no acute fracture was found.	2 830		

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2 830	Continued From page 28 Review of R123's fall risk assessment dated 6/21/17, indicated R123 did not have any falls within the past six months, and was a low fall risk for falls. During interview on 8/23/17, at 8:07 a.m. R123 reported she fell from the EZ stand lift a few weeks ago. R123 reported when the staff member hooked her up to the lift, the staff member did not hook the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since she fell from the lift all staff had been hooking up all of the belts, and she has not had any further falls. R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 stated she still gets scared, and repeats the picture in her mind of falling when she gets transferred. R123 stated she now wears gripper gloves to make sure she has a secure hold on the handles of the lift during transfers. R123 reported prior to her fall from the lift, staff were not always attaching the safety belt around her abdomen, then stated she had not reported that information to any nurses. R123 stated the fall from the EZ stand lift has been her only fall since admission. When interviewed at 12:49 a.m., R123 reported after she fell she had pain from her ribs all the way down to her bottom. R123 verified she did receive an x-ray and there were no fractures, she stated she did not have the pain in that location of her body prior to the fall, and still continues to have discomfort in her lower back and hip area. During interview on 8/23/17, at 8:17 a.m. NA-A confirmed R123 required extensive assistance of one staff member for all ADL's, with the exception of eating which she was independent. NA-A	2 830		

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AUGUSTANA HEALTH CARE CENTER OF MINI	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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2 830	Continued From page 29	2 830		

reported staff carry care guide sheets that indicate what each resident needs for assistance. NA-A reported R123 did have one fall only that she was aware of, stated R123 fell from the lift because the lift was not working. NA-A verified staff decide and choose which size sling to use for each resident, and stated if the sling fits, "we use it." NA-A confirmed she used a medium sized sling to transfer R123, and verified the tag marked with a M on it. NA-A also indicated a color guide attached to the lift used for R123's transfer which indicated slings with a beige colored binding were size medium. NA-A also indicated the sling size was on R123's care plan. NA-A reported when staff use the EZ stand lift, all safety belts were to be attached, on the abdomen and behind legs. NA-A verified she had received education regarding the safe use of the EZ stand lifts when she started working at the facility.

During interview on 8/23/17, at 11:43 a.m. RN-C confirmed R123 fell from the EZ stand lift during a transfer. RN-C stated after talking with staff she believed the strap snapped off or open, and thought the size of the sling was maybe incorrect. RN-C stated re-education was given to the staff member involved regarding the lift use and sling sizes. RN-C verified the staff did not complete a specific assessment when determining the correct sling size to use. RN-C was not aware of the color coded sling size sticker attached to the lifts, and when asked how the staff determines the size of sling to use, if they go by weight or size, she did not answer.

During follow up interview on 8/24/17, at 9:44 a.m. RN-C stated sling size was determined by staff discretion and to the resident's comfort level, then staff document the size on the care plan and care sheet. RN-C was notified R123 was

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2 830	Continued From page 30 observed to be transferred with a medium sized sling, RN-C stated R123's identified sling size on her care plan and care sheet indicated a large sling size, but reported the resident stated the medium sized sling felt comfortable for her when she visited with R123. RN-C reported R123 was not injured from the fall, confirmed R123 did complain of pain, an x-ray was completed to rule out fractures, and was found to have some atelactisis. RN-C verified there were no further investigations or documentation regarding R123's fall on 8/5/17. When interviewed on 8/23/17, at 11:50 a.m. licensed practical nurse (LPN)-B stated residents were measured around their abdomen, then the sling sizes were determined by the measurement, like a girdle. LPN-B stated the sling size to be used was documented in the resident's care plan, and confirmed R123 should use a large sized sling with all transfers. When interviewed on 8/23/17, at 12:14 p.m. NA-B reported the staff had access to several sizes of slings for the EZ stand lift, and stated if they do not have the correct size, staff would notify laundry to obtain the correct size. NA-B believed R123 required an extra large sized sling. When interviewed on 8/24/17, at 9:30 a.m. NA-C verified R123 used an EZ stand lift for all transfers and extensive assistance of one staff. NA-C stated R123 required the use of a large sized sling for all transfers, and indicated this information was also on the care sheets. NA-C verified she was given education on the use of the mechanical lifts upon hire. When interviewed on 8/24/17, at 9:20 a.m. NA-D	2 830		

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2 830	Continued From page 31 indicated R123 required extensive assistance of one staff and the EZ stand lift for all transfers with a large sized sling. When interviewed on 8/24/17, at 9:36 a.m. LPN-C confirmed R123 required the EZ stand lift for all transfers, and indicated that is how she had always transferred. LPN-C confirmed RN-C completed the assessments to determine the appropriate sling sizes for each resident, an the correct size was documented on the care sheet and care plan. When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, as staff further investigated, the wording "popped off" was in the incident report, due to being too tight or the loop "popped off." The DON stated the staff member involved was immediately given education to ensure the sling fit properly and was comfortable. The DON stated after the investigation, staff believed a different size sling should be used. The DON confirmed prior to the fall R123 utilized a medium sized sling. The DON stated when determining the proper size sling, staff look at weight, but weights were pretty fluid and variable according the manufacture's chart and guidelines. She stated we take in to consideration the resident's comfort level of sling, generalized width, and what looks safe. The DON verified the sling size assessment was not documented, as it was more of a judgement based on clinical factors, then the size was documented on the care sheet and care plan. The DON verified staff should use a large sized sling for all EZ stand lift transfers with R123, unless there was some	2 830		

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2 830	Continued From page 32 reason there needed to be a change, the change would be reviewed by the clinical manager. The DON stated staff do not routinely document if the sling size changes, then stated it would be indicated on the care sheet as being a different size. The DON stated she had the clinical manager re-assess R123 on 8/23/17 for proper sling size, and based on the assessment that she did, the sling should be a large size, and verified all staff should be providing care as directed by the care sheets and care plan which also indicates a large size sling to be used. The DON confirmed there were no other documents or assessments regarding R123's fall from the EZ stand lift, other than the event report. The DON stated the interdisciplinary team (IDT) had more of a discussion, talks with people to get more of a picture of what happened, so we know what the new interventions should be, and verified this is all done "off the record" as the IDT talked. The DON reported the nursing assistants were expected to visualize the lifts for obvious damage of sling and lift prior to each use, and stated maintenance routinely inspects the lifts and slings. When interviewed on 8/24/17, at 3:52 p.m. the director of maintenance (DOM) indicated he completed monthly audits and inspections on all mechanical lifts used in the facility. The DOM stated he looked for broken, loose or worn parts, and replaced them as needed, and looked to ensure the lifts were functioning safely. The DOM stated he was not aware of any residents ever falling from a mechanical lift or EZ stand lift, then stated if staff would update him in that type of event, he would want to go look at the lift or standing lift to inspect the lift for safety and proper functioning.	2 830		

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2 830	Continued From page 33 Review of the undated, EZ way, Inc. smart stand manufacturer's sizing guidelines document included a color coding system, separating different sizes by different colored binding on the harnesses. Beige colored represent a size medium for use of 90-220 pounds, 34-46 inches of circumference of patient's torso where harness is applied. The chart indicates the size/weight of designations were merely estimates and basic guidelines. A proper fit would involve the judgement of the caregiver. R228 quarterly Minimum Data Set (MDS) dated 7/28/17, indicated R228 had severe cognitive impairment and required assist of two for transferring. R228 face sheet indicated diagnoses included dementia with Lewy Bodies, Parkinson disease, muscle weakness, orthostatic hypotension, and major depressive disorder. R228 care plan revision dated 8/19/17, indicated R228 required assist with transfers due to impaired mobility related to Parkinson disease. R228 careplan directed staff "transfers with assist of two via an EZ lift." The untitled, undated nursing assistant care sheet updated 8/21/17, indicated for R228 "Transfers: EZ-Lift." Review of R228's progress note dated 8/19/17, at 6:44 p.m. indicated while transferring R228 with EZ stand lift, R228 became weak and unable to hold on to the bar of the lift and nursing staff lowered R228 to the ground by his arms. Three staff assisted R228 to bed utilizing a (EZ lift) full mechanical lift. The note indicated the EZ lift should be utilized for R228 and an order obtained	2 830		

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2 830	Continued From page 34 for evaluation of the lift for R228. During an observation on 8/24/17, at 1:14 p.m. nurses aide (NA)-O and nurses aide (NA)-P rolled an EZ stand down the hallway and entered R228 room. NA-O verbally cued R228 she was going to use the EZ stand to transfer him from his wheel chair to his bed. NA-O and NA-P placed an EZ sling under R228 back and cued R228 "lean forward so can get sling behind you, your weaker arm is on right." NA-O cued R228 to hold onto EZ stand handles with his arms. NA-O placed his feet onto stand to transfer R228 from his wheelchair to his bed. NA-O and NA-P continued with transfer from wheelchair to the bed. As R228 was lowered to on edge of bed he said "wait a minute." R228 leaned to right side as legs removed from the EZ stand. NA-O and NA-P lifted R228 legs up onto the bed and positioned him in bed. During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand. CM-A stated R228 careplan interventions had been changed to use of a EZ lift to ensure a safe transfer. CM-A stated staff were made aware of care plan changes through shift communication, careplan review and aid care sheets. CM-A stated the NA-O and NA-P should have been using the EZ lift with R228. During the interview with CM-A , NA-O approached the desk area and stated R228 was hollering and said he didn't want a strap between his legs so she used an EZ stand. CM-A stated to NA-O, he was supposed to be transferred with the EZ lift. NA-O did not respond. During an interview on 8/24/17, at 3:59 p.m. with	2 830		

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director of nursing (DON) stated R228 care plan had been updated on 8/19/17 for an EZ lift to be used as R228 had weakness in arms and legs and was not safe to use on a EZ stand. DON also stated staff had been informed of the changes and were provided education.

R224's quarterly Minimum Data Set (MDS) dated 7/15/17, identified R224 was cognitively intact and had diagnoses which included: Parkinson's disease, schizophrenia and hypertension. The MDS identified R224 was independent with all activities of daily living (ADL's.) except required staff assistance with dressing, toilet use and personal hygiene. The MDS identified R70 ambulated independently and required a walker for mobility.

R224's care plan revised 8/21/17, at 8:03 p.m. identified R224 ambulated independently with use of a walker. The care plan indicated R224 had fatigue with distance at times, would often ask staff and visitors to push him on the seat of the walker and was not easily re-directed. The care plan directed staff to assist R224 if a decline in self performance was noted. The care plan indicated R224 was independent with transfers and did not use a wheelchair regularly. The care plan further instructed staff to use extensive to total assist to propel R224's wheelchair depending on weakness. The care plan identified R224 was at risk for falls related to Parkinson's disease effects, use of antihypertensive meds, use of a devise and the potential for unsafe behavior related to schizophrenia. The care plan directed staff to encourage and remind R224 to ambulate with his 4 wheeled walker.

The untitled, undated nursing assistant care sheet indicated R224 was ambulatory and used a

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4 wheeled walker and wheelchair as needed. The sheet further indicated R224 was independent with transfers. The care sheet instructed staff to offer use of wheelchair for mobility if R224 became weak or had an unsteady gait.

On 8/21/17, at 6:39 p.m. R224 was observed seated on the bench of his 4 wheeled walker in the hallway near the nurses station, while nursing assistant (NA)-F pushed R224's walker down the hall. NA-F pushed R224, seated on the bench of the walker while he faced backwards, approximately 50 feet from the nursing station desk to the table in the dining room located past the common sitting area. R224 stood up and seated himself in a chair at the dining room table.

On 8/21/17 at 7:39 p.m. NA-F confirmed she had transported R224 utilizing the bench of his wheeled walker. NA-F indicated R224 had requested her to push him to the dining room because he felt weak. NA-F indicated she transported R224 utilizing the bench of his wheeled walker every 2-3 weeks. NA-F visualized and verified the nursing assistant care sheet that indicated R224 utilized a 4 wheeled walker and had a wheel chair to be used as needed.

On 8/21/17, at 7:44 p.m., clinical manager (CM)-A verified she was present at the nursing station when she observed NA-F transport R224 from the nursing station to the dining room. CM-A verified NA-F pushed R224 while he sat on the bench of his 4 wheeled walker. CM-A indicated she told NA-F not to transport R224 while he sat on his walker, but did not intervene. CM-A indicated she had instructed staff not to transport residents while they sat on the bench of their walkers. CM-A indicated R224 at times the staff

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2 830	Continued From page 37 would use a wheelchair to transport R224. On 8/23/17, at 8:17 a.m. R224 indicated he was able to ambulate independently with his 4 wheeled walker. R224 confirmed in the past staff had used the Rollator walker to transport him while he sat on the bench of the walker. On 8/23/17, at 9:00 a.m. director of rehab (DR)-A indicated she would not recommend a 4 wheeled walker to be used for transportation while a resident sat on the bench. DR-A indicated that if she witnessed a staff member pushing a resident while they sat on the bench of a 4 wheeled walker she would intervene and stop them. DR-A indicated she would expect staff and residents would be educated to not use 4 wheeled walkers as a wheelchair for transportation. On 8/23/17, at 9:10 a.m. director of nursing (DON) confirmed she had been made aware staff had utilized R224's walker to transport him in the facility. DON indicated she would expect staff would not push residents while they sat on the bench of their 4 wheeled walkers. Review of undated manufacturer's guidelines, attached to R224's Rollator walker titled Roscoe Medical Rollator revealed Rollators are NOT to be used as a wheelchair. Doing so may cause it to tip-over, resulting in injury. The facility's EZ-stand policy dated 04/08, directed staff to check for loose nuts and bolts, damaged parts and to check the sling to ensure it was not ripped or frayed. The policy did not address sling sizes. The facility's Accident Prevention and Reduction policy, dated 4/2017 indicated the facility was	2 830		

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2 830	Continued From page 38 committed to providing a safe environment for residents, and would use a systematic approach to assist in the identification, evaluation and analysis of risk factors in the environment and need for supervision for either groups of resident or individual residents with the goal that: each resident's environment remain as free of accident and hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents that utilize assistive devices to ensure they are used appropriately. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIME PERIOD OF CORRECTION: Twenty-one (21) days	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as	2 910		10/12/17

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2 910	Continued From page 39 much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess bowel and bladder patterns and implement a toileting program to restore continence of bowel and bladder to the extent possible for 1 of 1 residents (R338) who was not being provided assistance with toileting routinely due to a language barrier. R338 sustained harm due to an avoidable decrease in bowel and bladder function. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program. R338's Care Area Assessment (CAA) dated 2/9/17, indicated R338 had bowel and bladder incontinence with some control and history of stress incontinence. Contributing factors included	2 910	Corrected	

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2 910	Continued From page 40	2 910		

mornings with confusion, obesity, impaired mobility related to weakness, two right lower extremity wounds with wound vac, pain, anemia, use of narcotics, antidepressants, and language barrier. Staff were to check and change upon rising, before and after meals, bedtime, night rounds and as needed related to confusion. R338 was not consistent with letting staff know she needed to be changed and staff were to assist with peri care with incontinence.

R338's quarterly MDS dated 5/8/17, indicated R338 was moderately impaired, needed extensive assistance of two staff for bed mobility, transfers and extensive assistance of one staff for dressing, toileting and personal hygiene. The MDS also indicated R338 was frequently incontinent of urine and always continent of bowel and had no toileting program.

R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, needed extensive assistance of one staff for all of her activities of daily living. The MDS also indicated R338 was occasionally incontinent of urine and frequently incontinent of bowel and had no toileting program.

Review of R338's current care plan revised on 8/22/17, indicated R338 had incontinence of bowel and bladder with some control and history of stress incontinence. Contributing factors included: dementia, obesity, impaired mobility related to weakness, right lower extremity wounds, pain, anemia, use of narcotics, anti-depressants and language barrier. Related to confusion she is not consistent with letting staff know she needs to be changed or when to use the bedpan. The care plan listed various interventions such as: check and change upon

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2 910	Continued From page 41 rising, before and after meals, before bed, night rounds and as needed, offer bed pan when not confused, peri cares with incontinence episodes, and needed extensive assist of one or two staff depending on cognition. No interventions were listed on how to communicate with R338 regarding the language barrier and her incontinence or toileting needs. Review of R338's Transitional Care Plan for the NA (nursing assistant) undated, indicated R338 was max for toileting assistance and resident calls for assistance. The sheet indicated R338 was continent of bowel and bladder with occasional incontinence of bladder and wore a incontinent brief. No interventions were listed on how to communicate with R338 regarding the language barrier and her incontinence or toileting needs. During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.. At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language,	2 910		

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2 910	Continued From page 42	2 910		

it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-A and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants."

R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a rapid, frustrated voice and frantically assisted to

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2 910	Continued From page 43	2 910		

place the bedpan by moving her hospital gown out of the way of the bedpan. At 9:05 a.m., with the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine. R338's disposable brief was dry.

Review of R338's admission Bowel and Bladder Assessment, dated 2/9/17, indicated R338 had short term memory loss, was able to identify the need or urge to void/defecate some of the time, was able to use the call light, ask to go to the toilet sometimes, and had been admitted with incontinence. The assessment indicated R338 had incontinence of bladder, had incontinence episodes with position changes. The assessment indicated R338 had diagnoses which included recent surgery, obesity, edema and required assistance to transfer. Further, R338 was incontinent of bowel, had no problem with pattern irregularity, loose stools or diarrhea or constipation and was functionally disabled and had urgency. The assessment indicated R338 had stress and functional incontinence. The documentation was blank regarding R338's 3 day voiding pattern and for the 3 day bowel pattern. The analysis of the assessment indicated R338 had confusion, was not consistent with letting staff know she needed to be changed and was to be on a check and change program, upon arising, before and after meals, before bed, with night rounds and as needed and wore a brief.

Review of R338's initial Bowel and Bladder Assessment dated 4/28/17, indicated R338 had short term memory loss, able to identify the need to urge to void/defecate all of the time, able to use call light, able to ask to go to the toilet. The assessment indicated R338 was incontinent of bladder, unknown how long resident has been incontinent of bladder, no problem with leaking

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2 910	Continued From page 44 urine, had no incontinent episodes with laughing, coughing, changing positions, sneezing or exercise. The assessment indicated R338 was continent of bowel, utilized a bedside commode, constipation problems sometimes, and no symptoms affecting eliminations patterns. Further, the assessment indicated R338 required assistance with ambulation, transfers and used adaptive equipment. R338 has pain that effected elimination patterns, required weight bearing assistance, resident somewhat involved, showed patterns of urinary continence greater than 2 hours,was able to use toilet majority of time on all shifts and had problems with constipation. R338's assessment indicated R338 had functional incontinence (decreased mental awareness/decreased or loss mobility or personal unwillingness). R338's elimination plan was scheduled toileting due to being cognitively impaired, functional disabilities and care giver dependent. The elimination plan included: Check and change due to cognitive impairment, retraining to return to previous pattern due to able to feel sensation, able to understand and learn to inhibit urge, toilets independently or with minimal assist and prompt voiding due to able to request toilet (however a retraining program to improve continence was never implemented). The plan included for R338 to utilize the bedpan or commode for voiding and to use the commode for bowel movements and wore a brief. Review of R338's Bowel and Bladder Quarterly Assessment, reviewed on 5/4/17, indicated the bladder and bowel management programs were effective and no changes were needed to the current plan of care. Review of R338's Bowel and Bladder Quarterly Assessment, reviewed on 7/13/17, indicated	2 910		

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2 910	Continued From page 45 R338 was incontinent of bladder and bowel, the current bowel and bladder plan was effective and did not indicate any changes to the current plan of care. Review of R338's Hennepin County Medical Center physician progress notes revealed a note dated 4/18/17, from the nurse practitioner which indicated "nursing assistants report the patient is continent of bowel and bladder and is utilizing a bedpan but occasionally utilizing commode." On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on R338's wall for staff to utilize to call him to help communicate with 338. On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's primary language. RN-D indicated she had contacted R338's son when she was not sure what R338 needed or wanted. On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps with that sometimes. R338 indicated because she had been left on the bedpan without assistance in the past, she had tried not to go to the bathroom so she could avoid that from happening again.	2 910		

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2 910	Continued From page 46 R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad, sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were. On 8/24/17, at 8:56 a.m. RN-G indicated staff had used communication cards with words on them, but R338 was not able to read the cards and stated, "So did not really work that well." RN-G stated it was easer to have staff to assist with communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with	2 910		

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2 910	Continued From page 47 R338 and stated, "I don't think the problem is communication." On 8/24/17, at 9:43 a.m. during a follow up interview, FM-A indicated R338 had been continent of bowel and bladder before she got sick and was only incontinent and wore a brief when she was sick. FM-A indicated when staff did not respond to R338, she would be incontinent on the bed and stated," happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues. On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J indicated she was aware R338 has had incontinence with bowel and bladder when other staff who do not understand what she wants cared for her. NA-J indicated when she cared for R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's language barrier. On 8/24/17, at 9:07 a.m. NA-K stated she was	2 910		

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2 910	Continued From page 48 able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated, "she has not had accidents for me." NA-K indicated R338 was able to communicate her needs, was pretty pleasant, cooperative with cares and did not refuse cares. On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier. Review of facility policy titled, Bladder Programming/Toileting revised on 1/2016, indicated the facility would assess residents upon admission, and at other appropriate clinical times (EX: removal of catheter) for bladder retraining/toileting programs.	2 910		

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2 910	Continued From page 49 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for urinary incontinence to assure they are receiving the necessary treatment/services to prevent urinary tract infections and to restore as much normal bladder function as possible. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced	2 915		10/12/17

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2 915	Continued From page 50 by: Based on observation, interview and document review, the facility failed to provide sufficient communication services for activities of daily living to ensure basic needs were met for 1 of 1 resident (R338) with a language barrier. This deficient practice resulted in psychosocial harm for R338, who experienced isolation and emotional distress related to incontinence when her basic needs were unable to be met due to inadequate communication with facility staff. Findings include: R338's admission Minimum Data Set (MDS) dated 2/5/17, identified R338 had diagnoses which included arthritis, chronic pain syndrome, and unspecified urinary incontinence. The MDS indicated R338 had both short and long term memory problems, had moderately impaired cognitive skills for daily decision making, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS also indicated R338 required extensive assistance for bed mobility, dressing, toileting, personal hygiene and did not ambulate. Further, the MDS indicated R338 was frequently incontinent of urine and bowel and was not on a toileting program. R338's Care Area Assessment (CAA) dated 2/9/17, indicated R338's primary language was Somali and family reported confusion and at times R338 thought she was in Africa. The CAA listed various causes and contributing factors which included cultural/language barrier, not recognizing caregivers or medical equipment and risk factors included social isolation, confusion, decreased progress and participation in rehab therapies. Also, the CAA indicated R338 had	2 915	Corrected	

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2 915	Continued From page 51	2 915		

bowel and bladder incontinence with some control, history of stress incontinence and R338 was not consistent with letting staff know she needs to be changed. The CAA for communication did not trigger and was not addressed on the CAA.

R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, her preferred language was Somali and needed or wanted an interpreter to communicate with doctor or health care staff. The MDS indicated R338 required extensive assistance for all activities of daily living (ADL). The MDS also indicated R338 was occasionally incontinent of urine, frequently incontinent of bowel and had no toileting program.

R338's current care plan, revised on 8/22/17, listed the problem of communication, hearing was adequate, and indicated R338 made herself understood through an interpreter. The care plan directed staff to report any changes in ability to communicate, understand others, or in ability to hear and to refer for hearing exam as needed. R338's care plan identified R338's primary language was Somali, had frequent pain, weakness, dementia, required extensive assistance with bed mobility, boost up in bed, assist to lift legs in/out of bed, and sitting position in bed. R338's care plan directed staff to speak simply and clearly and repeat as needed, utilize environmental cues as calendars, clocks, notes, communicate at eye level and establish calm, explain cares/treatments before beginning and as needed and consistent routine when providing cares. The care plan directed to provide opportunity for patient to express feelings, involve social services as needed, encourage resident to talk through anger and frustration, and to

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2 915	Continued From page 52	2 915		

schedule an interpreter for rehab therapies, nurse practitioner/physician visits, care conferences and upon request. No further care plan interventions were listed to effectively communicate with R338, or assistive devices to use to communicate with R338.

Review of R338's undated Transitional Care Card listed various interventions which included assistance with ADLs, however, the care card lacked any interventions for R338's language barrier.

During observations on 8/23/17, at 8:56 a.m. R338 wore a hospital gown, seated on the edge of her bed with her call light on. Nursing assistant (NA)-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "'sheeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.

At 8:59 a.m. NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective

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2 915	Continued From page 53 when working with R338. At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-D and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants." R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may need to go to the bathroom and brought a bedpan to the bed. RN-D proceeded to attempt to place the bedpan under R338's buttocks, while she removed R338's disposable brief. R338 repeatedly moaned, "uhhh, uhhh, uhhh" in a rapid, frustrated voice and frantically assisted to place the bedpan by moving her hospital gown out of the way of the bedpan. With the bedpan placed under her buttocks, R338 proceeded to void on the bedpan a large amount of urine. During interview on 8/23/17, at 9:11 a.m. RN-D stated staff had a hard time knowing what R338	2 915		

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2 915	Continued From page 54 wanted when she called for assistance and stated staff have to guess a lot of the time and the resident got frustrated during that time. Review of R338's progress notes from 5/1/17 to 8/21/17, revealed the following: -5/5/17, Somali interpreter used for assessment, had moderately impaired cognition and was at moderate risk for mood disturbance. R338 had reported trouble falling asleep, feeling tired and trouble concentrating because of pain and poor appetite. R338 did not have mental health diagnoses, not receiving psychotropic medications, refused psychiatric services referral. The note listed social services would follow up and assist as needed. -5/7/17, alert and orientated to facility, needs interpreter, no English. -6/6/17, care conference scheduled for that day, son will attend and interpreter requested interpreter service. -6/8/17, wound nurse visited with patient, her son translated for the visit and R338 had no questions. -7/14/17, social services met with patient and patient's family through phone interpreter to discuss room transfer. Patient and family understand and agreeable to transfer. -7/24/17, R338 transferred to another unit in the facility -7/25/17, social service met with son and son indicated that he is present at most times but requested that an interpreter be utilized for formal	2 915		

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2 915	Continued From page 55 assessments. - 8/3/17, son expressed concerns regarding language barrier. Son concerned resident's needs were not being met when he was not there as she was not able to communicate to staff. Facility staff suggested making flash cards with pictures as well as English/Somali commands for resident to use to communicate her needs. Son indicated he would like the flash cards implemented, and facility staff were to create the flash cards and provide to the resident to use. -8/4/17, resident unable to communicate due to language barrier. Family and interpreter assist with communicating with staff. Staff to assist with communication by providing communication cards. No further documentation of implementation of flash cards, the effectiveness of the flash cards or any alternative communication aides were found in the chart. -8/10/17, R338 hospitalized at this time, social service assessment done by staff interview. Staff reported R338 had no short or long term memory problems, had difficulty in new situations only with daily decision making skills and minimal symptoms of mood disorder. -8/20/17, on Heparin, teaching not effective due to language and inability to understand. On 8/21/17, at 7:53 p.m. family member (FM)-A stated in the past when family have come to facility to visit R338, she had been crying. FM-A stated he was aware R338 had attempted to not void or have a bowel movement, to avoid being left on the bedpan for extended periods of time. FM-A indicated he had reported the concerns with R338's elimination needs, to nursing staff and	2 915		

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2 915	Continued From page 56	2 915		

had been told the staff do not have time to assist R338. FM-A indicated he had posted a note on R338's wall for staff to utilize to call him to help communicate with R338.

On 8/23/17, at 9:21 a.m. RN-D indicated it was difficult to communicate with R338 due to the language barrier and indicated she only knew a few words such as medication, pain in R338's primary language. RN-D indicated she had contacted R338's son when she was not sure what R338 needed or wanted.

On 8/23/17, at 9:41 a.m. during a follow up interview with NA-G, she stated she used hand gestures to attempt to communicate with R338 and stated she was not aware of any other interventions to utilize while communicating with R338. NA-G indicated in the past she had called the family member to attempt to figure out what R338 needed assistance with. NA-G stated she had not utilized an interpreter in the past and was not aware how to request for or use needed interpreter services.

On 8/23/17, at 9:50 a.m. NA-H indicated communication was difficult with R338 and stated she pointed at objects or had her son translate when he was available. NA-H indicated her usual routine was to stand in her room, have R338 point until she figured out what R338 needed or wanted. NA-H indicated she had not utilized interpreter services with R338.

On 8/23/17, at 12:18 p.m. an interpreter was present in the building and he stated interpreter services were utilized for scheduled medical appointments with residents and was not aware of any other time interpreter services were utilized in the facility. The interpreter indicated that day

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2 915	Continued From page 57 (8/23/17), was the first time he had met R338 for a schedule medical appointment with the doctor today. On 8/23/17, at 12:20 p.m. during interview with the interpreter and R338, R338 stated she could not communicate with staff and her son helps with that sometimes. R338 indicated because she had been left on the bedpan without assistance in the past, she had tried not to go to the bathroom so she could avoid that from happening again. R338 indicated she had bowel movements in her incontinent product due to avoiding use of the bedpan and stated it made her feel bad, sometimes made her cry. R338 indicated she felt if she was able to communicate with staff, her care would be better. R338 indicated she would welcome staff help, but staff comes in her room, then they just leave without providing assistance and indicated she felt regret not getting the education when she was younger and stated she blamed herself and people before her for not learning the language. R338 indicated she felt isolated, could not get up on her own, and stated because staff could not communicate with her, they were unable to help her. Through the use of the interpreter, R338 stated when she did not receive assistance at times she felt like exploding and bursting. R338 indicated she had pictures in her room in the past for assistance with communication, however, the pictures were no longer in her room and was not aware where the pictures were. On 8/23/17 at 12:25 p.m. during second interview, FM-A indicated he posted a note with telephone numbers to the wall in R338's room to help with R338's language barrier, but the facility staff did not use the telephone numbers. FM-A had been told by the facility staff R338 refused	2 915		

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2 915	Continued From page 58	2 915		

cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.

FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338.

On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to dial the cellular telephone. Above the night stand, which was next to R338's bed, a white piece of paper, approximately 8 inches (in) by 11 in. was taped to the wall. On the paper, typed in black ink, were instructions for contacting an online interpreter service.

On 8/24/17 at 8:56 a.m. RN-G was present in R338's room and indicated staff had used communication cards with words on them, but

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2 915	Continued From page 59 R338 was not able to read the cards and stated, "so did not really work that well." RN-G stated it was easier to have staff to assist with communication and to translate for her. RN-G indicated the usual practice if R338 needed something, she would call her son and then her son would call the desk to let staff know what R338 wanted or needed assistance with. She confirmed the interpreter hot line information posted in R338's room had not in her room until now. RN-G indicated of R338 did not receive assistance in time or had urgency she would be incontinent of urine and stated she felt R338 was always continent of bowel. RN-G denied she was not aware of any communication concerns with R338 and stated, "I don't think the problem is communication." On 8/24/17 at 9:43 a.m. during a follow up interview, FM-A indicated when staff did not respond to her, she would be incontinent on the bed and stated "happens quite a bit, she holds it, and holds it." He indicated when she called for assistance she would have incontinence issues. FM-A stated the interpreter information in R338's room was not there until they came to visit her last night. On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language (Somali) as R338. She indicated R338 would point or slap her hip when she had to go to the bathroom. She stated other staff think this gesture was for pain but R338 used these gestures to indicate she has to go to the bathroom. NA-J verified R338 needed assistance with toileting, used the bedpan and utilized the call light for assistance. NA-J indicated she was aware R338 has had incontinence with bowel and bladder when other staff who do not understand what she wants	2 915		

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2 915	Continued From page 60	2 915		

cared for her. NA-J indicated when she cared for R338, she was continent and did not wear a brief, but when staff who could not properly communicate with her provided cares for R338, R338 wore a brief. She indicated R338 had reported she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had told nursing staff many times of her concerns with R338's language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. She stated, "She did not have that paper in her room before."

On 8/24/17, at 9:07 a.m. NA-K stated she was able to speak the same language (Somali) as R338. NA-K verified R338 needed assistance with toileting, used the bedpan and was able to use the call light. NA-K confirmed R338 was continent of bowel and bladder. NA-K indicated R338 will have incontinence if staff were late assisting her with toileting and not understanding what R338 needed. NA-K indicated she felt a lot of the staff did not know what R338 wanted and verified R338 has had incontinence due to staff not understanding what she is trying to tell them and stated "she has not had accidents for me." NA-K indicated R338 was able to communicate her needs, was pretty pleasant, cooperative with cares and did not refuse cares.

On 8/24/17, at 12:08 p.m. social worker (SW)-A confirmed R338 primary language was Somali and indicated he would schedule an interpreter for R338 or use the online service when R338 had medical appointments or when he completed his portion of the MDS. SW-A indicated the usual facility practice was to encourage R338 to use the

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2 915	Continued From page 61	2 915		

son to translate, other staff members, and staff to be patient and explain cares to her. The SW-A indicated staff were expected to follow the care plan and to utilize the online interpreter services if having trouble communicating with R338. He indicated he was not aware of any problems communicating with R338. SW-A confirmed no other interventions had been put in place to assist R338 to effectively communicate with staff.

On 8/24/17, at 12:33 p.m. director of nursing (DON) confirmed R338's current care plan and stated she expected staff to follow R338's care plan, staff to assist as needed, and meet her needs consistently. DON indicated she would expect staff to assist the resident to stay continent, help the resident with cares, answer call lights. DON indicated R338 had a language barrier due to not speaking English and would expect staff to call an interpreter, family if available, or use picture cards or online service. She stated all staff had access to the online interpreter services and she would expect staff to utilize the resources available to communicate with R338. The DON indicated she was not aware of any concerns with R338's language barrier. The DON indicated when residents were admitted who have language barriers, the usual facility practice was to send an email notification to all staff to notify them of the individual resident's primary language and if the family was available to assist. She stated "90%" of the time we have family to accommodate for their needs. The DON indicated the facility routinely scheduled an interpreter for therapy appointments and medical appointments, and stated the facility did not schedule any further services unless they felt the communication was unclear. The DON indicated 338's son came to the facility quite a lot and stated she had not heard of any concerns

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2 915	Continued From page 62 with communication that impacted 338's care. On 8/24/17, at 4:18 p.m. during a phone interview medical director (MD) indicated he was not aware if the facility had access to an interpreter 24 hours a day. The MD indicated he would expect all residents would have ongoing assessment and care to meet their needs and also indicated he felt it was difficult for foreign speaking resident because families do not always tell staff the concerns. Review of facility policy titled, Communication: Interpreter/Translation Services for limited English Proficiency revised on 1/2016, indicated the interdisciplinary team will assess residents communication needs/deficits upon pre-admission, admission and throughout the residents stay at the care center. the social worker will arrange for any on-going interpreter needs for resident. Augustana Health Care Center will be responsible for the charges. Social worker will write a progress note describing communication needs and arrangements. The policy listed various auxiliary aids to be available used such as: universal communication cards, communication boards and if additions aids are need they will be ordered in a prompt manner. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents that need assistance with activities of daily living with communication barriors to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIME PERIOD OF CORRECTION: Twenty-one	2 915		

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2 915	Continued From page 63 (21) days	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide assistance with shaving for 1 of 3 residents (R162) reviewed who required staff assistance to complete activities of daily living. Findings include: R162's quarterly Minimum Data Set (MDS) dated 7/14/17, indicated R162 had diagnoses which included Alzheimer's disease, psychotic disorder and chronic pain. The MDS indicated R162 had severely impaired cognition and required extensive assistance for dressing. The MDS indicated R162 required set up help for completing personal hygiene including shaving and supervision with bathing. R162's care plan dated 7/23/17, indicated R162 required hands on assistance at times due to Alzheimer disease for grooming and directed staff to encourage and assist as needed for grooming. Review of R162's nursing assistance care sheet,	2 920	Corrected	10/12/17

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2 920	Continued From page 64 undated, identified R162 received assistance with her shower on Monday mornings. On 8/22/17, at 8:37 a.m. R162 was seated in her wheelchair at dining room table. She was independently eating the breakfast meal, with several other residents present in the dining room. R162 was noted to have many long, coarse, white hairs under her chin. On 8/23/17, at 7:14 a.m. R162 ambulated with her walker down the hallway toward the dining room. R162 was observed to have the same long, white coarse hairs under her chin. At 8:58 a.m., R162 remained in the dining room with the same long, coarse, white chin hairs present. During an interview on 8/23/17, at 11:17 a.m. nursing assistant (NA)-M confirmed R162 had many coarse, white chin hairs present. NA-M stated the usual facility practice was to remove facial hair as part of bathing cares. NA-M stated R162's chin hair should have been removed on Monday with her bath. NA-A stated if long facial hair was noticed on a resident, the facial hair was to be taken care of right away. NA-A confirmed R162 dressed herself, but staff assisted her as needed. During an interview on 8/23/17, at 11:49 a.m. with licensed practical nurse (LPN)-A stated R162 had always liked to look nice. but had resisted cares in the past. LPN-A stated R162 typically allowed care when staff re-approached her later. Review of R162's Skin-Body Visual Inspection/Observation form, dated 8/21/17, indicated a body audit had been completed for R162. The form indicated various inspections were completed such as visualizing for new	2 920		

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2 920	Continued From page 65 bruises, rashes and indicated "resident shaved/facial hair removed-No, not needed." During an interview on 8/24/17, at 8:24 a.m. with clinical manager (CM)-A stated the expectation was for all residents to be checked with shower/bath, and everyday with cares to ensure facial hair is removed. CM-A also stated she expected staff to let the nurse know if a resident refused cares. Facility policy on grooming was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all employees responsible for providing direct cares for residents the need to follow the residents comprehensive care plan. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication was labeled with accurate directions for use for 1 of 1 resident (R323) whose insulin was observed to be mislabeled during medication administration.	21620	Corrected	10/12/17

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21620	Continued From page 66 Findings include: R323's Physician Order Report dated 8/23/17 to 2/23/18, identified R323 had diagnoses which included diabetes mellitus, Alzheimer's disease and kidney failure. The report included an order for Humalog (insulin) solution 100 unit/ml (milliliter) 12 units (U) injected subcutaneously before breakfast, 14 units before lunch, and 10 units before dinner. R323 had an order for Humalog to be given with a sliding scale that included to give 12 units if blood sugar was 351 to 400. On 8/21/17, at 6:40 p.m. registered nurse (RN)-E was observed to prepare for administration of R323's insulin. RN-E had drawn 22 units of Humalog insulin into the syringe. RN-E explained 10 units for R323's dinner dose and 12 units because the physician was called and did not want to give more than the current highest sliding scale dose of 12 units. R323's Humalog vial was kept in a amber medication container. The container was labeled with administration directions to inject 10 units subcutaneous 3 times daily before meals with sliding scale parameters as follows: blood sugar 130-150=0 blood sugar 151-200=2U blood sugar 201-250=4U blood sugar 151-300=6U blood sugar 301-350=8U blood sugar 351-400=10U blood sugar greater than 400 call MD (medical doctor) On 8/21/17, at 6:43 p.m. RN-E verified R323's Humalog order had changed on 7/20/17. RN-E indicated the order labels on medications can not	21620		

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21620	Continued From page 67 always be relied on to be the correct directions/dose. RN-E identified the facility practice was to complete three checks to ensure the correct dose of medication was administered. RN-E verified the dose transcribed on the Humalog container did not match the dose in the Medication Administration Record (MAR). On 8/23/17, at 7:33 a.m. licensed practical nurse (LPN)-D prepared 24 units of Humalog insulin for R323. LPN- explained 12 units for R323's morning dose of insulin and 12 units for the sliding scale dose. On 8/23/17, at 8:05 a.m. LPN-D verified R323's insulin medication bottle container was different than the directions in the MAR and did not have a change of order sticker on it. On 8/23/17, at 8:10 a.m. the clinical manager (CM)-B verified R323's Humalog insulin orders were changed 8/22/2017, and the pharmacy was called to provide a change of order sticker to place on the insulin bottle. With further review of the clinical record CM-B verified the insulin sliding scale order had also changed in July, increasing from 10 units to 12 units for a blood sugar reading of 351 to 400. CM-B verified when the order had changed in July a sticker had not been placed to alert staff of the order change, and should have. On 8/24/17, at 10:14 a.m the director of nursing (DON) verified medications were administered based on the the MAR and the medication label. The DON indicated when a discrepancy was noted staff were expected to check the original orders and if there was a dosage change found, the pharmacy should have been contacted for a	21620		

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21620	Continued From page 68 change of order sticker. The DON verified a change of order sticker would be used to alert staff to a dosage change and aid in prevention of a possible medication error. The DON verified knowledge of the medication in question, the recent order change and prior sliding scale order change. The requested facility policy was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping services necessary to maintain a clean and sanitary condition in resident rooms and bathrooms for 2 of 2 resident rooms and shared bathrooms (Main 109, 111, East 252) reviewed.	21695	Corrected	10/12/17

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21695	Continued From page 69 Findings include: During the initial tour on 8/22/17, the following were noted: - at 2:13 p.m. room 109 and 111 on the first floor main unit were found to have a strong urine odor in the rooms and shared bath room. - at 2:38 p.m. room 252 on the second floor East unit was found to have a strong urine odor through out the room and bathroom. On 8/24/17, at 11:14 p.m. during the environmental tour with the director of environmental services (DES) the above environmental concerns were verified. On 8/24/17, at 11:14 a.m. the DES verified the responsibility of managing the house keeping staff. The DES explained housekeeping staffing and duties to include the following: - one staff person was assigned to each unit for a total of seven hours per day. -staff were provided schedules to follow for daily and weekly cleaning tasks. - identified smells were managed promptly. The DES verified the first floor main unit was odorous and difficult to manage due to the clientele living on that unit. The DES agreed the East unit room 252 was odorous and had been an ongoing concern due to residents urinating on the floor. The DES identified numerous additional cleaning procedures to manage the odors, however, agreed that the problem was not under control. On 8/24/17, at 11:49 a.m. the quality improvement director (QID) indicated the director	21695		

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21695	Continued From page 70 of environmental services provided deep cleaning services to resident rooms and completed follow up checks to ensure staff were providing the cleaning services. On 8/24/17, at 12:23 p.m. in the administrators office with the administrator, DON, QID, and director of maintenance, the DES verified the two rooms and shared bathroom had a strong odor. The DES indicate he personally stripped, waxed and went thorough clothing and etcetera in room 252 on the East unit. The DES stated, "There is only so much time we can spend in there." The requested facility policy was not provided. SUGGESTED METHOD OF CORRECTION: The director of environmental services (DES) could review and revise the policies, educate housekeeping and nursing staff and identify trends of lingering odors. The DES could work with the Director of nursing (DON) to ensure staff are reporting environmental issues appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21985	MN St. Statute 626.557 Subd. 3a Reporting - Maltreatment of Vulnerable Adults Subd. 3a. Report not required. The following events are not required to be reported under this section: (a) A circumstance where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected maltreatment, unless the vulnerable adult, or the vulnerable adult's	21985		10/12/17

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21985	Continued From page 71 guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected maltreatment from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who are prohibited by federal law from reporting an incident of suspected maltreatment shall immediately seek consent to make a report. (b) Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies. (c) Accidents as defined in section 626.5572, subdivision 3. (d) Events occurring in a facility that result from an individual's error in the provision of therapeutic conduct to a vulnerable adult, as provided in section 626.5572, subdivision 17, paragraph (c), clause (4). (e) Nothing in this section shall be construed to require a report of financial exploitation, as defined in section 626.5572, subdivision 9, solely on the basis of the transfer of money or property by gift or as compensation for services rendered.	21985		

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21985	Continued From page 72 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA) and thoroughly investigate an incident of potential neglect of care for 1 of 3 residents (R123) who fell from a mechanical lift in the facility. Findings include: R123's face sheet dated 12/29/16, identified current diagnoses of chronic pain, muscle and bilateral leg weakness, lymphedema, conversion disorder with seizures or convulsions, anxiety, depression, pain in left ankle and joints of left foot and repeated falls prior to admission. R123's admission Minimum Date Set (MDS) dated 1/5/17, identified R123 had intact cognition and required extensive assistance for transfers. Review of Event Report dated 8/5/17, at 6:45 p.m. indicated R123 had been transferred from her chair to bed, EZ stand sling popped out of place causing resident to land on her buttocks. Staff re-educated on proper use of EZ stand and to ensure correct size sling is being used. Further, the report listed the EZ stand had suddenly stopped moving, resident and nursing assistant did not remember what happened next, one side of the sling was out of place and resident landed on the floor on buttocks. Resident was helped off the floor utilizing a hoyer lift, and no pain or injuries were evident at that time. Review of R123's Incident Review Form, dated 8/7/17, indicated R123 had a fall on 8/5/17, with no injury. The interdisciplinary team reviewed and documented there were no medication	21985	Corrected	

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21985	Continued From page 73	21985		

concerns, environmental concerns or change of condition noted. The form listed the new intervention of staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling.

During interview on 8/23/17, at 8:07 a.m. R123 reported a few weeks ago she had fallen from the EZ stand lift used during a transfer. R123 reported when the staff member hooked her up to the lift, the staff member had not hooked the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since that fall, all staff had been hooking up all of the belts, and she had not had any further falls.

During interview on 8/23/17, at 11:43 a.m. registered nurse (RN)-C confirmed R123 fell from the EZ stand lift during a transfer, and stated after talking with staff she believed the strap snapped off or open, and thought the size of the sling was maybe incorrect. RN-C stated re-education was given to the staff member involved regarding the lift use and sling sizes. RN-C verified there were no further investigations or documentation regarding R123's fall on 8/5/17.

When interviewed on 8/24/17, at 11:30 a.m. the director of nursing (DON) reported after R123 had the fall from the EZ stand lift, a root cause analysis was completed. The DON reported R123 let go of the handles on the lift because she felt the harness was a little tight, and as staff further investigated, the wording "popped off" was in the incident report, due to being too tight or the loop "popped off." The DON stated the facility did not complete a report to the SA as the facility did not feel this was a reportable event as there was no negative outcome for R123.

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21985	Continued From page 74 During group interview on 8/24/17, at 3:41 p.m. with the administrator and DON, they confirmed the current faciilty policy, and the administrator confirmed she expected all neglect of care and suspected neglect or not providing care as needed to be reported to the SA. The administrator and the DON stated they did not feel R123's fall from the EZ stand mechanical lift was reportable due to the fact there was no negative outcome, no harm, no abuse or no negative intent. The administrator and DON stated they expected staff to give the highest level of care possible, and expected the care plan to be followed. Review of the facility's Vulnerable Adult Reporting and Investigation Procedure policy dated, 8/2016 indicated incidents that must be reported immediately to MDH (Minnesota Department of Health) included neglect. The policy indicated the Administrator and DON would appoint a person to investigate the alleged incident, including: - review of the incident - the residnets' medical record to determine events leading up to the incident - interview the person reporting the incident - interview the witnesses to the incident - interview the resident, interview the staff members , interview the the resident's physician, roommate, family member, and visitors as indicated - interview other residents to whom the accused employee provides care or services. Review of the facility's Maltreatment of Vulnerable Adults Policy, dated 10/2016, indicated all allegations and/or suspicious of abuse must be reported to the administrator	21985		

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21985	Continued From page 75 immediately. The policy further indicated if injury is unexplainable, or allegation of abuse is reported or witnessed, if there is caregiver neglect a report must immediately be reported to the Minnesota Department of Health (MDH) and call the administrator immediately. The policy also indicated an internal, facility investigation of reports will be completed. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could create/update facility policy if needed. They could ensure all staff are aware of the importance of following the facility policy for Abuse/Neglect reporting. They could establish a system to audit to ensure all allegations are properly reported in accordance with the State of Minnesota- Vulnerable Adults Act and also facility policy. They could report that information gathered from those audits to the quality assurance performance improvement (QAPI) committee, for a determined amount of time set by the QAPI committee, to ensure correction and compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21985		