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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MEZ0
Facility ID: 00943

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

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

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

4. TYPE OF ACTION: **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 **03/21/2017** (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)
12/31

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

12.Total Facility Beds **208** (L18)
13.Total Certified Beds **208** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
Program Requirements
Compliance Based On:
___ 1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 03/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 09/08/2017 (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
03/01/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/14/2017
(L33)

DETERMINATION APPROVAL

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

CNN: 24-5148

On January 30, 2017, an extended survey was completed at this facility. Conditions in the facility constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The most serious deficiencies were issued at a S/S level of K (225 and 226).

The IJ was identified on 1/22/17, was brought to the attention of the facility's executive director on 1/26/17, at 4:32 p.m. and was removed on 1/30/17, at 3:05 p.m.

As a result of the survey findings we imposed State monitoring, effective February 26, 2017. In addition, we recommended to the CMS RO the following remedy for imposition and CMS concurred:

- Civil money penalty for deficiency cited at F225 and F226 effective January 30, 2017.
- Mandatory denial of payment for new admissions effective April 30, 2017.

Due to the extended survey and finding of substandard quality of care, the facility is subject to a loss of NATCEP for two years from January 30, 2017.

On March 21, 2017, the Minnesota Department of Health completed a PCR and found the health deficiencies corrected and the facility was found in substantial compliance as of March 11, 2017.

As a result of the finding, the Department discontinued the Category 1 remedy of state monitoring.

In addition, we recommended the following actions to the CMS RO as it relates to the remedies detailed in our letter of February 21, 2017 and CMS concurred:

- Civil money penalty for deficiencies cited at F225 and F226, be imposed.
- Mandatory denial of payment for new admissions effective April 30, 2017 be rescinded effective March 11, 2017.

Due to the extended survey, this facility would be subject to a two year loss of NATCEP.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 24-5148 September 7, 2017

Ms. Laurie Sykes, Administrator
Golden Livingcenter - St Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, Minnesota 55426

Dear Ms. Sykes:

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

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

Effective March 11, 2017 the above facility is certified for:

208 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Certification Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 29, 2017

Ms. Laurie Sykes, Administrator
Golden LivingCenter - St. Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: Project Number S5148026 and Complaint Number H5148165

Dear Ms. Sykes:

On February 21, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 26, 2017. (42 CFR 488.422)

Also, on February 21, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiencies cited at F225 and 226. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on January 30, 2017 that included an investigation of complaint number H5148165. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On March 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 30, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on January 30, 2017, as of March 11, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 11, 2017.

However, as we notified you in our letter of February 21, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited

from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 30, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty for the deficiencies cited at F225 and F226 (42 CFR 488.430 through 488.444)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Email: Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MEZ0
Facility ID: 00943

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

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

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

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

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

6. DATE OF SURVEY **01/30/2017** (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) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NE II 02/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/23/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00450** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CNN-24-5148

On January 30, 2017, an extended survey was completed at this facility. Conditions in the facility constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The most serious deficiencies were issued at a S/S level of K (225 and 226).

The IJ was identified on 1/22/17, was brought to the attention of the facility's executive director on 1/26/17, at 4:32 p.m. and was removed on 1/30/17, at 3:05 p.m.

As a result of the survey findings we have imposed State monitoring, effective February 26, 2017. In addition, we have recommended to the CMS RO the following remedy for imposition:

A civil money penalty for deficiency cited at F225 and F226 effective January 30, 2017.

Due to the extended survey and finding of substandard quality of care, the facility is subject to a loss of NATCEP for two years from January 30, 2017.

We have received an acceptable plan of correction. Post certification visit to follow.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted

February 21, 2017

Ms. Laurie Sykes, Administrator
Golden LivingCenter - St. Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: Project Number S5148026

Dear Ms. Sykes:

On January 30, 2017, an extended survey was completed at your facility by the Minnesota Department 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. In addition, at the time of the January 30, 2017 extended survey the Minnesota Department of Health completed an investigation of complaint numbers H5148165.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the January 30, 2017 extended survey the Minnesota Department of Health completed an investigation of complaint number H5148166 that was found to be unsubstantiated.

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

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> 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);
>
> Substandard Quality of Care - means one or more deficiencies related to participation

requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on January 30, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

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

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective February 26, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F225 and F226, effective January 30, 2017. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Golden Livingcenter - St Louis Park Plaza is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 30, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to

conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your 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 April 30, 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 July 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING ______ B. WING ______	C 01/30/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A survey was conducted by the Minnesota Department of Health on January 23 through January 30, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F225 and F226 related to the facility's failed response to to identify, report and thoroughly investigate, allegations of abuse resulting in residents being afraid of unwanted touch and/or threats of physical harm from staff and other residents which resulted in a high potential for harm or death. The IJ which began on 1/22/17, was brought to the attention of the facility's executive director on 1/26/17, at 4:32 p.m. and was removed on 1/30/17, at 3:05 p.m. At the time of the survey, a complaint investigation(s) were also completed at the time of the standard survey: An investigation of complaint H#5148165 was completed. The complaint was substantiated at F353. An investigation of complaint H#5148166 was completed. The complaint was not substanitated.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/24/2017

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.

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F 000	Continued From page 1 In addition, an extended survey was conducted by the Minnesota Department of Health on 1/25/17 through 1/30/17.	F 000		
F 154 SS=D	483.10(c)(1)(2)(iii)(4)(5) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS (c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: (c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. (c)(iii) The right to be informed, in advance, of changes to the plan of care. (c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. (c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to inform in advance the risk(s) of side effects for the medication Pyridium (a pain reliever used to stop the pain, or burning caused by urinary tract infection or irritation) for 1 of 1 resident (R165) who had urinary discomfort.	F 154	R165 Discharged from facility on 1/31/17 Current residents will be informed of health status, care, medications and treatments. Resident Education will be documented in the resident's chart in their progress notes.	3/11/17

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F 154	Continued From page 2 Findings include: On 1/23/17, at 4:48 p.m. R165 was observed sitting on bed during interview. R165 said, "I was not told about the antibiotic [Pyridium] that started in January. It turned my urine red. I thought I was bleeding." R165's admission Minimum Data Set (MDS) dated 1/5/17, indicated R165 was cognitively intact with no hallucinations, delusions or behaviors and had diagnoses of hypertension, spinal stenosis and post-acute procedural pain. R165's MDS indicated R165 required assistance with bed mobility, dressing, toileting, personal hygiene and walking in room or on the unit. R165's MDS indicated resident was occasionally incontinent of bladder, had constant pain at 8/10 (10 scale being the highest level of pain) and had impairment in range of motion for one side upper and lower body. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) Worksheet dated 1/10/17, indicated R165 was occasionally incontinent of urine. Urinary CAA indicated contributing factors included pain, restricted mobility and urinary urgency. Urinary CAA care plan considerations indicated R165 was frequently incontinent of urine and required assistance of staff with cares. The discharge care plan dated 12/30/16, instructed staff to educate R165 about medications, their side effects and when they should be taken. A Progress Note dated 1/2/17, indicated nursing staff had reported urine culture reports to on call	F 154	Licensed nurses and TMAs will be re-educated on informing residents and documenting of changes in medications, treatment, conditions and cares to include side effects of medication. Nurse Managers will be responsible for monitoring compliance. Weekly audits will be completed on education on documentation of any changes in medications, treatments, conditions and cares on all floors. QAPI committee will review audits and actions to provide direction or changes as needed.	

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medical doctor (MD) and informed MD "[R165] continuous to complaint [sic] of pain/frequency with urination."

Review of Progress Notes from 1/2/17 through 1/26/17, did not show evidence that R165 was told about new order for Pyridium on 1/2/17, nor did the Progress Notes indicate R165 was told Pyridium could turn urine bright orange to red in color.

The Order Summary Report dated 1/4/17, indicated R165 had a Physician's Order dated 1/2/17, for Pyridium 200 mg three times a day for seven days for the treatment of pain and frequency with urination.

A Grievance Form dated 1/5/17, indicated R165 was not told that a urinary tract infection (UTI) medication had been added. The information provided to the nurse's and certified medication technician (CMT's) instructed staff as follows: "Nurses, when you have a new medication order, please make sure you explain to the resident what it is for. Nurses and TMA's-please identify pills for the resident, especially if they are new medications."

During interview on 1/26/17, at 7:56 a.m. registered nurse (RN)-J said when a telephone order was received, "I talk to the patient about the new medication, what it is for and side effects if any. I document in the nurses notes the new orders and that I explained it to the resident." RN-J reviewed Physician Orders and Progress Notes in computer and verified there was no documentation that the telephone order for Pyridium was explained to R165. RN-J stated "The doctors explain their orders to the residents

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F 154	Continued From page 4 during their visits." During interview on 1/26/17, at 8:01 a.m. R165 said, "I was told about the med [medication] when I asked why my urine was bright red. I was on an antibiotic for an UTI and this was the side effect." R165 said, "No one told me before they gave it to me that it could cause it to look like I was bleeding." During interview on 1/26/17, at 8:56 a.m. director of nursing services (DNS) said, "When they [nurses] get a new order, the nurses are to tell the resident about the new medications. We provide education on side effects." The DNS said, "The nurses are to document in the nurses notes that they informed the resident and family about medication." The DNS verified the medical record lacked evidence of R165 ever receiving information or communication about the new order for Pyridium and the Pyridium's side effects. Change of condition policy requested and not recieved.	F 154		
F 225 SS=K	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (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,	F 225		3/11/17

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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 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.

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F 225	Continued From page 6 (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 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 observation, interview and document review, the facility failed to identify, report and thoroughly investigate allegations of abuse, this resulted in an immediate jeopardy (IJ) for 6 of 12 residents who had allegations of abuse (R118, R183, R1, R12, R260, R80) due to these residents being afraid of unwanted touch and/or threats of physical harm from staff and other residents. In addition to the residents in IJ, the facility failed to identify, report and thoroughly investigate allegations of abuse that were not an IJ for the other 6 of 12 residents (R28, R45, R112, R186, R218, R167). The IJ began on 1/22/17, when R118 notified facility staff that a nursing assistant (NA) had threatened to hurt her and the facility failed to intervene. The IJ was identified on 1/26/17, and the executive director (ED) was notified of the IJ at 4:32 p.m. on 1/26/17. The IJ was removed on 1/30/17, at 3:05 p.m., but non-compliance remained at the lower scope and severity level of E. Findings include:	F 225	R183 and R260 Will meet weekly with the unit social worker to discuss concerns at mutually agreed upon time and any concerns brought forward will be addressed. Customer service and sensitivity training has been completed for staff. PHQ9 assessment will be completed on R183 to determine if resident would benefit from medication adjustment. Pain assessment to be completed on R183 to include direct care observation to ensure comfort with cares. Night supervisor will complete direct care observation audits weekly to ensure comfort with cares. R118 Concerns brought forward will be addressed R1 Concerns brought forward will be addressed in a timely manner	

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R183 was interviewed on 1/26/17, at 4:00 p.m. and stated she was aware of the reporting process, but felt it was useless to report, because they were "blaming, and accusing her of making up stories." R183 stated she had tried to report to the nurse on the night shift about an incident that had occurred this past spring (date unncertain). R183 stated, "she [the night nurse] came in and was blaming me, saying '[NA-HH] is just trying to take care of you.' So I told her to get out. I don't trust anyone here. That director of nursing (DNS) came in to talk to me and I told him to get out. I don't trust him." R183 had tears in her eyes and reported that NA-HH had rubbed her arm, and then had moved to her breast area. R183 said she'd yelled at NA-HH, "Stop, what the H**l are you doing?" She further stated, "He then took his finger [demonstrated a circular motion with her index finger] around my anus. I told him to stop, saying 'what the h**l are you doing?', but he didn't stop, so I slapped him [demonstrated a backhanded slapping motion], and he still didn't stop, so I slapped him again." R183 stated NA-HH was still working here, so she had kept a fork on her bedside table for a long time, as defense, but then they took it away with a dinner tray. R183 stated she woke up last week and he [NA-HH] was standing at the end of her bed. She stated, "I picked up my bottle [demonstrated picking up a large glass bottle of hot sauce, with a long thin neck] from my bedside table and threatened to hit him with it if he didn't leave. I had to say I will crack your head open to get him to leave." R183 agreed to speak with licensed practical nurse (LPN)-B, because she felt she could trust her, but said she would not speak with the DNS because she did not trust him at all.

At 4:34 p.m. on 1/26/17, LPN-B was asked

F 225

NA-AA received Customer Service Training and was reassigned to a different unit, no further concerns from resident have been reported since transferred to new unit.

R12 Nursing Staff have been re-educated on residents rights to make choices including but not limited to choice of bedtime.

R80 Staff have been reeducated to explain actions of cares prior to meeting residents needs.

Staff have been reeducated to timely report allegations of abuse and neglect to the ED/DNS for further investigations

R28, R45, R112, R167, R186 Any concerns of allegations of abuse will be reported to the ED/DNS

All staff have been reeducated on Abuse, Neglect, Maltreatment and Misappropriation of resident property, to include what constitutes as abuse and immediate reporting of allegations of abuse.

Weekly audits will be conducted to identify any concerns related to abuse, neglect, maltreatment and misappropriation of resident property.

The ED or designee will monitor for compliance

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F 225	Continued From page 8 whether she had noted any changes in R183's behavior or if she had heard any report about R183 having threated to hit a NA-HH. After some thought LPN-B stated, "About three or four months ago, R183 would not let anyone turn her or touch her on the night shift. I asked her if anything was wrong, but she wouldn't tell me." LPN-B added, "I have talked to my nurses, months and months ago, she wouldn't turn in bed, she wouldn't roll over. We have to be careful with her, she makes things up. She has a history of conversion disorder, hallucinations and delusions. I had been asking her what's wrong, and she specifically told me it was ok for NA-HH to take care of her." LPN-B went on to say that R183 was 'tough with mental health, and she tries to get people in trouble. A social worker (SW) and I interviewed her, then the DNS comes up and she kicks him out of the room." The surveyor then asked LPN-B whether she'd been awared that R183 had alleged having been touched inappropriately by NA-HH. LPN-B stated she had not be aware, then proceeded to go in to discuss with R183, and following their conversation LPN-B reported the allegation of sexual abuse to the State agency (SA). Acording to her Admission Record, R183 was admitted to the facility on 11/11/14, with diagnoses including psychosis (an abnormal condition of the mind that involves a loss of contact with reality), and major depressive disorder. A quarterly Minimum Data Set (MDS) dated 9/6/16, indicated R183 was cognitively intact and had no signs or symptoms of delirium or hallucinations. In addition, the MDS indicated R183 did not reject cares and had demonstrated	F 225	QAPI will review audits and actions to provide direction or change as needed.	

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no verbal or physical behaviors towards others. R183 was totally dependent on two staff and utilized a mechanical lift for transfers, required extensive physical assistance of two staff for bed mobility, dressing and toilet use, and did not have antipsychotic or antidepressant medications ordered.

An MDS dated 11/29/16, also indicated R183 was cognitively intact and had no signs or symptoms of delirium or hallucinations. However, the MDS indicated R183 had demonstrated physical behaviors directed towards others during one to three days, verbal behaviors directed towards others on four to six days, and had rejected cares one to three days, all days in reference to the MDS look back period. The MDS indicated R183 was totally dependent on two staff and a mechanical lift for transfers, required extensive physical assistance of two staff for bed mobility, dressing and toilet use, and did not have antipsychotic or antidepressant medications ordered.

A Care Area Assessment (CAA) dated 6/27/16, indicated R183 had triggered delirium as an area for assessment. The CAA analysis indicated the delirium was due to a decrease in her cognitive score and a recent change in mood; sad or anxious (for example crying, social withdrawal).

The Care Plan (CP) dated as far back as 11/14/14, indicated R183 had a potential for abuse due to decreased physical ability, need for care and history of allegations towards staff that were found to be unsubstantiated. The CP dated 6/11/15, indicated behaviors which include shouting, crying and stating "I am not crazy. I have a history of psychiatric disorders and will

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often state a complaint but change my story which results in an inconsistent reporting history. I sometimes refuse the bedpan when offered. Potential conversion disorder exhibited by: 1) verbalize I am having health issues that are not present upon examination/tests. I have paranoia related to my psychosis diagnosis that staff are listening to my conversations through the doorways and bathrooms. I often have concerns regarding the delivery of my cares. I meet with staff on a regular basis to discuss my concerns and resolutions. I often state the NAR's [nursing assistants/registered] are not helping me when in fact I have refused cares." Although the care plan indicated R183 had identified behaviors, the facility did not thoroughly investigate her allegations to determine validity of the allegations.

An Associated Clinic of Psychology (ACP) note dated 10/11/16, indicated the therapist and R183 had discussed the resident's feelings of anger and distress with staff at the facility, and that R183 had elaborated on three of her concerns regarding staff behavior towards her and how she was not pleased with the follow-up thus far. The ACP note also indicated R183 had reported she had not been sleeping well recently, and that she had been encouraged to watch TV and play games on her phone to keep from being overwhelmed by current situation. The note indicated the resident utilized no known medications (for depression or psychosis). The ACP therapists recommendations included: She had been requesting staff to leave her alone as much as possible while continuing to appropriately address her care needs. She seemed to be in a protective mode at that time and thus staff should be very mindful of their behavior around her which includes the way in

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F 225	Continued From page 11 which they care for her, what they say to her and their body language in her presence. Ongoing: It may be important for staff to know that she liked people to be straight with her. She reported she will become impatient, and most likely verbally aggressive, if she feels others are not being truthful with her. It is important she feels listened to. Staff trying to make sure she understands what is being asked of her and clarifying information with her will most likely be helpful. A subsequent ACP note dated 10/25/16, included: "In wheelchair in depressed mood with distressed affect. She reported sad and tearful due to family issues and grievances with staff at facility which she discussed in detail. Recent events have challenged her beliefs about staff at facility and has continued to find concerns that lead her to question their skills. No known medications (for depression or psychosis). Recommendations: Staff will inquire about her willingness to move to a different unit within the facility as she does not trust her current direct care staff and does not feel that relationships can be healed. She remains in protective mode at this time and thus staff should be very mindful of their behavior around her which includes way in which they care for her." An ACP note dated 11/8/16, "In wheelchair in room, dysphoric (state of unease or dissatisfaction) mood and angry affect. Reports progressively becoming more distressed and angry the longer she stays at the facility. She does not trust any staff or their motives. Unable to sleep or eat well because of this. Unrealistic about placement in the community. No known medications (for depression or psychosis). Recommendations: Not open to staff challenging her beliefs regarding her health and perceptions and thus staff should continue to address her care and flow with delusions. She is not open to	F 225		

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trying medications that may help to reduce her internal emotional distress as she does not believe that she has any mental health concerns. Staff who interact with her should be mindful to present with a neutral demeanor and facial expression as she does not trust "fake smiles", to improve rapport with her." An ACP note dated 11/15/16, "In bed in room, incident claimed that direct care staff were rough with her. Dysphoric mood with angry affect. Appears she reacted in way she did due to exacerbation of pain that staff caused her when staff assisted in turning her. Vented frustration, does not trust staff. Not able to consider reconciling differences with staff at this time and shared her belief that only option to improve her situation was to leave facility, even though she has no plans or means to do so. Unit Social worker has initiated process of getting her a relocation worker to help find her appropriate placement in the community. Staff her interact with her should be mindful to present with a neutral demeanor and facial expression as she does not trust "fake smiles", to improve rapport with her." The ACP note dated 11/22/16, R183 sitting in a wheelchair in a slightly euthymic (normal) mood with calm affect. She had developed a technique of refraining from interacting with direct care staff so they have nothing to use against her. Recommendations: Had developed a trust with physical therapist, and would like to work with him to assist her doctors with orders for exercise."

R183's 11/30/16, CP included: "I recently bought a set of ankle weights and have a history of stating that I want to throw things at staff. I will request to have the weights or other objects in my hands while I am worked up. I have a history of swinging out at staff with these objects."

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Behavior charting for R183 was reviewed from 7/31/16 through 1/27/17:

Charting from 9/24/16, at 10:24 a.m. alleged R183 cursed (no further description) at NA-P, a female staff on the day shift.
On 10/4/16, at 9:54 p.m. R183 rejected assistance of dressing and personal hygiene (no further description) from male staff NA-JJ.
On 10/30/16, at 8:33 p.m. R183 had behaviors not directed towards others (no further description) from male staff NA-LL.
On 11/10/16, at 8:34 a.m. R183 rejected care (no further description) from female staff NA-P.
On 11/12/16, at 1:12 a.m. R183 had behaviors not directed towards others "socially inappropriate behavior", male staff NA-LL.
On 11/14/16, at 4:03 p.m. R183 had behavior not directed towards others "socially inappropriate behaviors", male staff NA-LL.
On 11/26/16, at 12:49 a.m. R183, rejected care by male staff NA-LL.
On 12/7/16, at 9:23 p.m. R183 had verbal behaviors directed towards others, male staff NA-LL.
On 12/19/16, at 1:58 a.m. rejection of care, assistance dressing and personal hygiene by male staff NA-EE.
On 1/26/16, at 12:32 a.m. behaviors not directed towards others (no further description) male staff NA-LL.
On 1/27/16, at 1:48 a.m. rejection of care, male staff NA-LL.

The facility's Behavior documentation book was reviewed and noted:
On 1/13/17, night shift documented "episode of resistant to cares, redirected."

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On 1/14/17, (no shift noted) "resistant to cares, redirected no change."
On 1/15/17, day shift "accusing staff of unsubstantiated things occurred on days, redirected."
On 1/18/17, "resistant to cares on nights, redirected same."
On 1/19/17, "resistant to cares on nights redirected same."
On 1/20/17, (no shift noted) "Resistant to care."
On 1/24/17, "Resistant to cares on night shift redirected."
On 1/26/17, "Resistant to cares on night shift."

Nursing Progress notes reviewed:
On 12/4/16, at 9:16 a.m. R183 requested to speak with licensed practical nurse (LPN)-B "I am tired. These damn NAs refuse to take care of me and tell me I am trouble. I fell asleep last evening and woke up at midnight, asked to have my food heated and then be cleaned up. No one helped me." "I told them to leave the food tray here so I could show you and you wouldn't think, I was lying." LPN-B documented resident displaying paranoid behaviors, R183 asked the nurse to look into the bathroom to ensure no-one was listening to the conversation. NA-HH (alleged abuser of R183) and NA-LL had worked the night shift prior.

On 12/9/16, at 8:00 a.m., LPN-M wrote a nursing note that R183 said "both PM [afternoon shift] and night aides did not change me all night, I am completely wet." LPN-M documented that she'd stated to R183, "put on your call light when you need help." She further documented that R183 had gotten mad and started to use profanity. "Get the F*** out of my room you B****", LPN-B notified. NA-HH (alleged abuser of R183) and NA-LL had worked the night shift prior.

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On 12/9/16 at 8:48 a.m., LPN-B had gone in to see R183 and two NAs were working with her. LPN-B told R183 she would back to get R183's statement about cares when finished with cares and breakfast trays. R183 noted to be incontinent in her brief at that time. R183 stated "you want to see what I'm talking about." LPN-B told R183, she would return when cares were done, and would speak with NA's about what they'd found. Documentation indicated R183 had began yelling and stated "Oh never mind, you don't care anyway. Get the F**k out, all of you just leave me alone...leave me the F**k alone. The note indicated R183 was thrashing in bed while hooked up to mechanical lift (Marissa Lift), and when staff had started to unhook the sling, R183 had stated, "I didn't tell you to stop, get me up.'" R183 asked to speak to ED, said she was wet all night, and she was not going to ring and tell anyone what to do. "Get out of my room." The author indicated an unidentified SW had been notified.

On 12/9/16 at 12:11 p.m. LPN-B documented she had returned to R183's room with unidentified SW, R183 was quiet at first and did not want to talk to staff, then starting stating. "I don't have to put my call light on when I need cares. No one came in to take care of me all night." R183 stated "I'm not crazy, I know you all think I am, but I'm not crazy." DNS knocked and entered to respond to request for ED, R183 told DNS to get out of her room, stated "I can't stand that SOB [curse word], I ain't talking to him, I don't trust him." R183 remained angry and refusing meals... Placed phone calls to the night shift staff and awaiting call back.

On 12/9/16 at 3:23 p.m., documentation indicated LPN-B had interviewed night shift aides who

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F 225	Continued From page 16 stated they had attempted to provide cares twice for R183, but they stated she was asleep and refused cares. However, during the interview with R183, she stated she stayed awake all night to see if anyone would come into her room. On 12/15/16, at 12:45 p.m. "in house LICSW [licensed clinical social worker]" met with resident on 12/13/16, R183 was in dysthymic mood with angry affect, less distressed than past sessions. R183 able to vent about staff with whom she does not work well and the coping skill she has developed where she asks people to leave her room as a means to protect herself. "Staff should continue to be respectful of R183's right to refuse services and reapproach later." NA-SS and NA-OO worked the night shift prior. NA-P, NA-QQ, NA-YY, and NA-AAA worked the day shift. On 1/11/17, at 8:19 a.m. noted R183 wanting to meet with LPN-B in room, with roommate. Residents are usually conversing and laughing in room. R183 will say to roommate "tell her what happened last night", roommate will not remember and R183 tells her what to say. R183 stated "I'm telling you girl these aides are worthless, and I am going to report that to the state when they get here. R183 refused to meet with DNS." NA-HH (alleged abuser of R183) and NA-LL worked the night shift prior. On 1/14/17, at 2:02 p.m. R183 "had a run in with a NA." Apparently he walked in when she was talking to a different NA, and she felt that was rude. R183 told the unnamed NA to get out. The unnamed NA stated "I don't have to." R183 became very angry and cussed NA out. NA left and registered nurse (RN)-O came in and talked with R183, who calmed down. NA-HH (alleged abuser of R183), NA-SS worked the night shift prior. NA-P, NA-QQ, NA-UU, NA-E worked the day shift. There was no facility documentation that the	F 225		

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F 225	Continued From page 17 unnamed NA was investigated for the incident. 1/15/17, at 4:27 a.m. RN-K noted R 183 refused cares that shift, NA attempted two times. RN-K went in and R183 attempted to get roommate to tell RN-K what happened. Roommate didn't quiet [sic] know what to say. R183 was upset at NA and yet refused to talk with them or receive help from them. R183 angrily yelled "no one is going to touch me, I'll hurt somebody." "I will stay like this and I will call the state about it". NA-HH (alleged abuser of R183), NA-VV, and NA-SS worked the night shift. On 1/23/17, at 4:34 p.m. LPN-B noted, early that morning, was notified by NA that R183 asked them to get out of her room when they were attempting to get her up with the Marisa Lift to her chair. NA's reported they did nothing wrong and R183 won't say why she was upset. LPN-B and an unidentified SW talked with R183, "Get me up, they don't know what they are doing." "They didn't put the sling under me right." NA-HH (alleged abuser of R183), NA-LL, NA-OO worked the night shift prior. NA-F, NA-TT, NA-UU, NA-VV, NA-WW worked the day shift. On 1/24/17, at 11:27 a.m. [unnamed] NA came to SW-D to assist with R183. R183 was in wheelchair (w/c) but was not positioned well. R183 said that one of the NA's helping didn't know what she was doing. SW-D, NA and trainee got resident on lift and repositioned in w/c correctly. Internal investigation began. NA-N, NA-PP, NA-QQ, and NA-RR worked the shift. On 1/26/17, at 6:25 a.m. RN-K noted R183 refused cares that shift, reapproached and continued to refuse. When the day shift NA arrived, R183 allowed cares, was changed and cleaned up. NA-OO and NA-SS worked the night shift. On 1/26/17, at 3:30 p.m. LPN-B stated R183 had been interviewed and NA-HH was going to be suspended.	F 225		

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On 1/27/16, at 6:06 a.m. RN-K noted 15 minute safety checks, slept in room all night and was safe. No concerns noted [no documentation why 15 minute safety checks].
-At 6:16 R183 refused cares this shift, reapproached three times. Risks and benefits explained. Morning staff updated. NA-HH (alleged abuser of R183), NA-LL, NA-OO worked the night shift.
-At 12:00 p.m. LPN-B stated R183 had been put on 15 minute checks, was happy and had no complaints.
-At 1:43 p.m. R183 stated the assistant director of nursing (ADNS) had told her NA-HH was gone.

During 7 of the 11 behavior episodes, the alleged abuser NA-HH had been working that shift, or the night shift prior. During 9 of 11 behavior episodes, at least one of three NAs consistently working that shift or the prior shift (including NA-HH, NA-LL, and NA-P).

The employee files were reviewed and the following was noted:
NA-HH, hired 6/6/11, undated training in new hire file for abuse/neglect, patient rights. NA-HH was disciplined on 10/18/11, for poor work quality and productivity for leaving a resident in a bed soaked with urine, changed sheets, but immediately wet again, and NA-HH left for day shift. On 1/8/12, NA-HH had left the floor to buy a can of pop for resident, did not ask nurse if resident could have pop. NA-HH did not tell anyone he was leaving the floor. Notice of 2 week voluntary resignation dated 4/9/15, with last day being 4/21/15. NA-HH was rehired 2/24/16. On 11/18/16, Step 1 discipline notice instructed NA-HH to improve

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getting to work on time.

NA-LL hired 9/12/16, received preventing abuse training on 9/22/16, and Alzheimer's training on 10/26/16.

NA-N, hired 3/20/15, received preventing resident abuse training on 4/7/15, and Alzheimer's training on 10/26/17. Discipline notice on 4/7/15, for failure to perform assigned duties in an appropriate manner or at assigned times. Discipline notice dated 9/25/15 indicated, "staff is loud and demanding when she approaches them [residents]. Makes the resident anxious and sometimes feel intimidated, always provide excellent customer service. Knock before entering and announce self by name and title. Greet all your residents at the beginning of your shift to let them know that you are their aide that day. Utilize words such as please and thank you frequently. Ask for resident preference, do not just tell them what to do. Provide explanations and plan ahead with them for them. Approach with calm, patient tone. Not all residents are deaf and speaking louder does not always help. It may seem intimidating if a resident is having a difficult time understanding, always ask for assistance from another staff member. Resident needs always come first. Ask questions." Discipline notice dated 1/25/17, instructed NA-N "customer service: be aware of how you approach a patient, be aware to speak clearly, make sure that if a resident is asking for your help, you are helping them safely. Address all needs while working with a patient. If you feel uncomfortable being the only staff caring for a resident, bring another staff with."

The facility failed to fully investigate a change in

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patient behavior, and rejection of cares. The facility failed to track and trend staffing patterns with R183's behavioral outbursts to identify a potential staff abuse.

R118's quarterly MDS dated 12/16/16, indicated she was cognitively intact and required minimal assistance with activities of daily living (ADLs).

During interview with R118 at 8:22 a.m. on 1/24/17, the resident stated she had been threatened by NA-BB the week prior. She said the NA had threatened to "knock her head off." R118 further stated she was afraid of NA-BB. R118 stated she had reported the threat to the Alzheimer's Care Director (ACD). R118 stated the ACD had replied, "it was just a joke."

A facility document titled Verification Of Investigation (VOI) dated 1/22/17, was reviewed. The documentation indicated R118 had been interviewed by facility staff regarding the threat by the NA. The VOI included recommendations taken to prevent reoccurrence which included suspension of the employee, and customer service education having been provided to the employee. The recommendations also included re-directing R118 during episodes of inappropriate behaviors, even though the allegation of inappropriate behavior was made by R118. The facility's VOI document indicated abuse had not been substantiated and further indicated, "per investigation there was a misunderstanding by client regarding employee's comment which does not substantiate."

R1's quarterly MDS dated 12/28/16, indicated she

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F 225	Continued From page 21 was severely cognitively impaired and required extensive assistance with ADLs. The care plan dated 12/26/17, identified R1's potential for abuse. The care plan further identified a physical functioning deficit and directed staff to assist with transfers, toileting and personal hygiene. During interview on 1/23/17, at 5:01 p.m., R1 stated NA-AA had pushed her. R1 stated NA-AA was "rough" with her. She stated she needed help to get dressed and that she was afraid NA-AA would come to help her and stated, "I don't want to get in trouble." R1 stated she had not reported the incident to the facility. On 1/23/17, at 5:21 p.m., the allegation of abuse was reported to the DNS. At 6:28 p.m., the DNS reported to the surveyor that NA-AA had been sent home pending investigation of the abuse allegation and that the allegation had been reported to the State agency. The facility had documented a VOI on 1/24/17 for the allegation R1 had made 1/23/17. The VOI indicated R1 had reported to facility staff that when she requests assistance from NA-AA, the staff member tells her, "do it yourself, get into your chair." R1 reported NA-AA is rude to her and always had been. The VOI further identified recommendations/interventions to prevent reoccurrence as follows: NA (AA) suspended pending outcome of investigation, staff encourage R1 to transfer independently which R1 "interprets as being rude." Unable to substantiate allegation of abuse as resident does transfer herself and staff encourage her to promote independence. Customer service education will be given to NA-AA upon her return.	F 225		

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On 1/25/17, NA-AA was observed working the a.m. shift on the unit where R1 resides.

During an interview on 1/25/17, at 10:56 a.m., the social services director (SSD) stated if someone reports an allegation of abuse, she immediately reports it to the DNS and the ED. She stated the DNS and ED make the decision whether or not the allegation gets reported to the State agency. The SSD stated if an allegation is made on the weekend, "it's harder because we're [management] not here so it goes on a grievance and staff would notify the building supervisor." The SSD stated LPN-B had told her about the allegation made by R1 and stated LPN-B and SW-C completed the investigation.

During an interview on 1/25/17, at 11:07 a.m. with LPN-B and SW-C, LPN-B stated if a resident reports mistreatment by staff she would immediately report to the ADNS, DNS and ED. LPN-B stated the ED and DNS determine if an allegation is reportable to the State agency. SW-B verified she had assisted with the investigation regarding R1's report to the surveyor. SW-C stated she had not followed up with R1 but stated she had reported the allegation to the social worker from the ACP who was scheduled to see R1 on 1/24/17. SW-C stated she was aware the ACP social worker had spoken to R1 about her report however, SW-C stated she had not read the ACP social worker's report after the visit. She further stated she had not been aware R1 had accused NA-AA of pushing her or being rough with her prior to the investigation. At 11:14 a.m., LPN-B stated the DNS had told her R1 had reported to the surveyor that staff had been rude to her. LPN-B stated she was not aware R1 had reported that a staff

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F 225	Continued From page 23 member had pushed her or been rough with her and stated the DNS had not told her that. LPN-B stated R1 had told her NA-AA refused to help her. Review of the ACP Progress Note dated 1/24/17, indicated a licensed social worker had visited with R1 that day and identified the following: Staff shared R1 had reported abuse from a direct care worker to the State assessor yesterday. Met with R1, she showed no obvious evidence of any current delusions or hallucinations. When asked, she expressed some anxiety about sharing her concerns to the State worker and reassured her that it was her right to do so and important to keep her safe. R1 was unable to identify any clear reasons why she had not brought up her concerns during her care conference the previous week aside from stating she was awoken to attend. She (R1) was unable to confidently state that she would feel comfortable reporting similar concerns to the unit nurse manager (LPN-B) or SW-C in the future. During an interview on 1/25/17, at 11:24 a.m., the DNS stated if the facility received an allegation of abuse he would call the ED and they would report the allegation to the SA. He stated R1's allegation was still being investigated, but stated interviews with staff and other residents had been completed. The DNS stated based on the conclusion of the interview, the facility felt that NA-AA had been trying to promote independence by encouraging R1 to transfer herself and that he interpreted NA-AA's behavior as "rude," and had scheduled her for additional customer service training. He verified NA-AA had not completed the training prior to returning to work on the floor because they "had call-ins." The DNS further stated he did not interview the resident himself	F 225		

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and stated the ADNS had interviewed her.

During interview on 1/25/17, at 11:36 a.m., the ADNS stated she had not talked to R1. She stated she talked to the facility's human resource specialist (HRS) who placed modules in NA-AA's bin and stated NA-AA "needed to complete them today."

During a subsequent interview on 1/25/17, at 11:37 a.m., the DNS acknowledged no one had had followed up with R1 after NA-AA returned to work, nor had anyone asked R1 whether any staff had pushed her or been rough with her. He stated SW-C should have done that. In addition, the DNS stated if an employee needs to be educated, "we provide the education". The DNS stated he felt the allegation from R1 was mistaken information or a communication issue. At that time, the ED added, if there was a second incident with an employee the suspension could be longer or the employee could be terminated. The DNS stated NA-AA's employment file was reviewed and contained no previous allegations. The ED stated, because of the clientele, the education had to go into the delusion and hallucination piece.

On 1/25/17, at 11:46 a.m., SW-C confirmed she had not followed up with R1 regarding the concerns.

On 1/25/17, at 1:15 p.m., the DNS stated he had reviewed R1's care plan to determine if it was appropriate for staff to encourage her to self-transfer and stated, he had taken notes but "didn't keep them." LPN-B and the ED were also present during the interview. LPN-B stated, "it is not safe for [R1] to self-transfer."

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During interview on 1/25/17, at 2:36 p.m. the HRS stated no one had reviewed NA-AA's employment file for previous allegations or education.

R12's quarterly MDS 12/9/16, identified the resident's diagnoses to include: bipolar disorder, anxiety, schizophrenia, osteogenesis imperfecta and diabetes mellitus obtained. In addition, the MDS indicated R12 had intact cognition and no behavioral symptoms including verbal, physical or refusal/rejection of cares.

During interview with R12 on 1/24/17 at 7:59 a.m., when asked whether staff, a resident or anyone else at the facility had abused him, including verbal, physical or sexual abuse, R12 stated, "Yes." R12 further explained, "Some of them. A few days ago [LPN-E] talked to be like I was her child. She told me I had to go to bed before ten o'clock and I told her I was not going to. She said I had to, and again I told her I was not going to. There was an exchange of words between the two of us and it got verbally abusive from both of us. I told her she was a b***h." I reported it to my social worker [SW-B] and the director came and talked to me and said they were looking into it. I have been abused both verbally and emotionally. I told her [LPN-E] I was old enough to be her father."

R12's CP dated 10/15/13, indicated he was at risk for potential abuse due to his diagnoses including: bipolar disorder, schizoaffective disorder, clavicle fracture, osteogenesis imperfecta and diabetes. In addition, the care plan indicated the resident had a history of being physically, verbally, and sexually abused by his

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father and sometimes struggled with sexual identity issues. The CP directed staff to explain what they were going to do before providing care.

On 1/25/17, at 11:01 a.m. SW-B stated R12 had approached her on 1/17/17, around four o'clock when she was just about to leave and had reported LPN-E had exchanged words with him on 1/16/17 at around 10 o'clock, and that he felt his rights had been violated. SW-B stated she had completed a grievance report and reported the allegation to the DNS and put the report under the DNS office door. SW-B said she did not know whether it had been reported to the State agency as it was the facility management's decision. SW-B stated she had asked R12 whether he felt safe and he had indicated he was, and was able to voice his needs and stand his ground. SW-B stated she had counseled the resident 1:1 and thought LPN-E needed to be talked to about resident rights.

On 1/25/17, at 2:06 p.m. the DNS was requested for the grievance report that had been filed on behalf of R12. DNS stated he had followed up with resident and told him he would follow up with the identified staff.

On 1/25/17, at 3:55 p.m. the DNS approached the surveyor and stated he had looked all over his office and was not able to locate the grievance report. DNS stated he had followed up with the resident and had told R12 he had spoken with LPN-E and had told her R12 would go to bed when he wanted to. DNS stated when he had talked with R12, the resident had not indicated he had been abuse. The DNS said he would go interview R12 about the incident again now.

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On 1/25/17, at 4:07 p.m. the SSD and the surveyor went to speak to R12. R12 stated he had reported to SW-B he had felt verbally and emotionally abused. R12 stated during the follow up with the DNS, the DNS had told him he had spoken with the staff [LPN-E]. R12 then proceeded to report the incident again. He said that on 1/16/17, at 10:10 p.m. LPN-E had approached him and asked him why he was still up, and that LPN-E had said he [R12] needed to go to bed as there was not enough staff to put him to bed during the night. R12 stated he had still been up because he was watching one of his favorite shows, then needed to take his medications, and would then go to bed. R12 stated the nurse had thrown her hand up to his face and stated, "we are not having this conversation right now" and kept threatening him she was going to report him to the supervisor. R12 said he'd told the nurse, "please do so she can witness this." R12 stated LPN-E also kept telling him she was going to call the police on him if he did not leave the area. R12 stated this went on back and forth for about 10-15 minutes and that initially he refused to leave the area, but did eventually. R12 then stated he had told LPN-E "This is my home and I can go to bed anytime." R12 further indicated he had called the nurse a "whore" during the exchange. When asked how the incident had made him feel, R12 stated, "I felt verbally and emotionally abused." During the interview, as he explained the incident, R12 appeared upset and his voice rose. After the interview, the SSD stated she was going to report the incident to the ED, DNS and then report it to the SA.

On 1/25/17, at 5:15 p.m. DNS verified there was no documentation of the incident in R12's medical

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F 225	Continued From page 28 record. DNS stated LPN-E should have gone into the medical record and documented the incident "these are things we are trying to change here. We are trying to get nurses to report incidents of possible abuse and neglect to me and I want to make the decision whether or not to call OHFC [Office of Health Facility Complaints-SA]. Incidents like this have been written on the grievance reports instead of being reported to the SA. We are doing education to better serve the residents we are serving." The DNS further stated the supervisor was supposed to be notified of allegations, and dependent on the incident, nurses were able to report the incidents of abuse. R260 was observed on 1/23/17, at 6:49 p.m. to be sitting on the edge of the bed moving an arm continuously, and changing positions frequently. During interview with R260 on 1/23/17, at 7:00 p.m., when asked whether staff, a resident or anyone else at the facility had abused him, including verbal, physical or sexual abuse, R260 stated "Yes." When asked to explain what happened? R260 said, "I think the word is enough. They don't give a s**t that this has been the worst week of my life." When asked whether any staff had been informed of the alleged abuse, R260 said, "The staff all saw it." On 1/24/17, at 8:00 a.m. after review of R260's chart SW-A was asked whether R260 had reported having been abused. SW-A stated R260 had not made any report of abuse. The surveyor then told SW-A that R260 had indicated during interview that she had been abused. During interview with the ED on 1/25/17, at 2:13	F 225		

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p.m., the ED said, "If it was reported as abuse we should have completed an OHFC report and investigated it."

During interview on 1/25/17, at 2:14 p.m. SW-A verified only an internal investigation had been completed thus far. When asked what time yesterday she had interviewed R260. SW-A said, "I interviewed her at 1:30 p.m." SW-A said "I was not aware an allegation of abuse had to be reported within two hours."

R260's Admission Record dated 1/30/17, indicated R260 had diagnoses including: injuries of right wrist, hand and fingers, bipolar disorder (depression with episodes of mania), post-traumatic stress disorder and borderline personality disorder (abnormal behavior characterized by unstable relationships with others).

R80's family member (F)-A was interviewed at 4:33 p.m. on 1/23/17. F-A reported having been concerned about staff hitting R80. F-A stated the allegtion had been reported to SW-D in November around 11/18/16, but F-A was not sure of exact day.

During an interview with R80 on 1/23/17, at 7:20 p.m., R 80 was observed to have bruising on both hands and wrists. When asked what had happened R80 started crying and said, "They hurt me, they hit me, pinch me and push me around."

On 1/23/17, at 7:56 p.m. NA-A was observed to enter R80's room where R80 lying in bed. NA-A grabbed the R80's blanket and pulled it down, off R80 in a quick manner, indicating peri care was

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going to be provided because R80 was always "digging" and had fecal material under nails. R80 was heard to respond, "What the h**l are you doing, leave me alone."

On 1/23/17, at 8:30 p.m. the DNS was asked whether R80 or her family had ever made a report of staff hitting or abusing R80. The DNS denied being aware of any allegations of abuse have been made by R80 or her family. The DNS further stated no reports had been made to the SA since he started in March 2016. The surveyors informed the DNS of the allegations made by R80 and F-A.

During a follow up interview with R80 on 1/24/17, at 1:47 p.m. R80 said, "Staff hit me, it is mostly the night shift." R80 also stated staff verbally abuse her. R80 stated she had told the nurse, nurse manager and DNS.

R80's annual MDS dated 11/3/16, indicated R80 was moderately cognitively impaired without hallucinations or delusions. R80's MDS indicated R80 had verbal and physical behaviors toward others one to three times in the seven days prior to the MDS. R80's MDS also indicated R80 required assistance with all ADL's except eating, and had diagnosis of Alzheimer's disease, depression and urinary incontinence.

R80's Cognitive Loss/Dementia CAA Worksheet dated 11/14/16, indicated R80 had diagnosis of dementia, but was alert and oriented to self and place with short term and long term memory deficits. In addition, the CAA indicated R80 was at risk for unmet needs and safety deficits. An ADL CAA Worksheet dated 11/14/16, indicated R80 required staff assistance with some ADL and

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F 225	Continued From page 31 cognitive skills. A Behavioral Symptoms CAA Worksheet dated 11/14/16, indicated the CAA had triggered due to R80 scratching a staff member during cares one day. Care plan considerations instructed staff to monitor for signs and symptoms of depression and to make sure R80 was not in pain or uncomfortable. Neither the cognition nor behavioral CAA indicated R80 was an inaccurate reporter or made false allegations against staff. R80's Safety CP revised on 11/16/16, indicated: "My safety is at risk and there is potential for abuse due to diagnosis of dementia, depressive disorder, hypertension, hypothyroidism and decreased physical ability." The interventions instructed staff to explain all cares/procedures prior to beginning them. The safety care plan did not indicate R80 made false allegations against staff. A Physical Functioning Deficit CP revised 11/16/16, indicated R80 had a history of personality disorder with narcissistic traits and could be judgmental and make negative statements regarding cares such as "some of them are awful" and instructed staff to provide dressing assistance and transfer assistance with Hoyer of two caregivers due to false allegations." Bed mobility, personal hygiene, toileting, oral care and locomotion were to be provided by assist of one staff member. The At Risk for Altered Skin Integrity CP revised 11/16/16, did not address presence of bruises. An alteration in mood or behavior care plan revised 11/16/16, did not identify false allegations or inaccurate reporting as a problem but included an intervention initiated 6/21/16, "using 2 persons during care may be needed due to potential for allegations." An undated, unlabeled nursing assistant	F 225		

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F 225	Continued From page 32 assignment sheet for R80, indicated R80 was frequently incontinent of both bowel and bladder and to not apply two incontinence briefs at the same time. No skin issues were identified on the assignment sheet. Staff were instructed to have "2 person care givers at all times." The Behavioral Detail Report for R80 was reviewed from 3/1/16, through 1/25/17. There was documentation that indicated R80 had threatened staff once, hit staff twice, rejected assistance with care six times, scratched staff eight times, and had screamed at staff 13 times. The Behavioral Detail Report contained no documentation of R80 making false allegations about staff during this time period. R80's Physician Progress Notes were reviewed from 4/11/16, through 12/16/16. A 4/11/16, note indicated R80 had dementia with behavior disturbances. Particularly difficult at night, with calling out and does not like Hoyer. The Progress Note for 6/14/16, indicated staff reported no new significant behavioral concerns. The Progress Note for 7/27/16, indicated R80 had told the nurse practitioner staff hit her at night. The nurse practitioner had subsequently documented having discussed with an RN manager, R80's concern of staff hitting her at night. The nurse practitioner had further documented that the RN said the issue had been addressed with R80's daughter. Finally, the progress note indicated there was bruising on top of R80's left hand and included: "RN Manager to address staff issues." Progress note dated 10/4/16, indicated, "Staff reports some continuing issues of complaints about her care and therefore she is always attended by two staff members." Progress note dated 12/16/16, indicated staff had no new concerns and there	F 225		

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F 225	Continued From page 33 were no new behaviors. Review of the facility's reports to OHFC were reviewed from 3/1/16, to time of survey entrance on 1/23/17. The reports indicated on 3/24/16, a resident, no longer in the facility, had reported that a staff member had struck R80 on the face on 3/22/16. The report to the SA indicated the facility had been unable to "substantiate any claims of abuse." There was no report to the SA regarding the incident the nurse practicioner had reported to nursing about R80 having been hit by staff on 7/27/16. A VOI documented report for R80 dated 1/23/17, indicated the ED and SA were notified of an allegation on 1/23/17, at 8:45 p.m. (After the surveyors had reported their concerns from interview). In addition, doucmentation on the VOI dated 1/24/17, indicated, when asked if R80 had ever reported being abused LPN-I said, "I think she has but not anybody specific. It seems more paranoid that people are out to get her. She will say, 'Oh, they are out to get me'.'" In addition, the VOI note dated 1/24/17, indicated when asked about reporting R80 had ever been abused, F-B had said, "there was that incident when we tried to transfer her out and you guys blocked it." The IJ was removed on 1/30/17, at 3:05 p.m., when it could be determined administration had modified their protocol for how to handle grievances, had taken action to investigate employee specific allegations, had provided staff training, and interview with staff could verify implementation of these interventions had occured. Although the IJ was removed, non compliance remained at the lower scope and severity level of E.	F 225		

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R28's significant change MDS dated 12/29/16, indicated she was moderately cognitively impaired and required physical assistance from staff to complete ADL's. R28's care plan dated 1/12/17, identified a potential for abuse.

A facility document titled: Grievance Form, dated 12/6/16 indicated the following concern had been voiced by R28: NA-M said "he was going to kill me because I wouldn't give him the call light." The grievance form identified the following findings: "None of the allegations were substantiated." The findings indicated R28 had a history of making accusations against staff. The attached investigation indicated NA-M denied the allegation of verbal abuse. There was no evidence the allegation was investigated further and the allegation was not reported to the SA.

During an interview with the DNS and ED on 1/25/17, at 4:03 p.m., the DNS stated the allegation should have been reported "because she [the resident] stated he was going to kill her." The ED stated she had been made aware of the report a month later and it had not been the facility's practice to report late if staff had already completed the investigation.

R45's quarterly MDS dated 12/8/16, indicated he was cognitively intact and was independent with all ADLs. His care plan dated 12/6/17 identified a potential for abuse.

A facility document titled: Grievance Form, dated 12/15/16, identified the following concern had been reported by R45 read, "On Saturday

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12/13/16, I was waiting near the nurses' carts to sign out in the book. NA-AA was walking down the hall and as she got closer she took a deliberate step to the side. She [NA-AA] rammed her shoulder into mine on purpose." The grievance form findings indicated the allegation of physical abuse was not substantiated. The attached investigation indicated NA-AA had denied the allegation. No further investigation was completed, nor was the allegation reported to the SA.

R112's quarterly MDS dated 1/3/17, indicated she was cognitively intact and was independent with all ADLs. Her care plan dated 1/3/17, indicated a potential for abuse.

A facility document titled Grievance Form, dated 12/29/16, indicated the following concern had been voiced by R112: NA-O "cusses at her and calls her a liar." R28 had alleged in the grievance that NA-O was rough with her when assisting her to undress. The report indicated an investigation was initiated. A VOI dated 1/6/17, indicated R28 had reported she was "scared" of NA-O. The VOI did not indicate whether the allegation had been substantiated by the facility. The abuse allegation was reported to the State agency on 1/6/17, seven days after the initial report.

R186's quarterly MDS dated 12/27/16, indicated she was cognitively intact and independent with all ADL's. R186's care plan dated 12/22/16 identified a potential for abuse.

A facility document titled Grievance Form, dated 12/26/16, indicated R186 voiced the following concern: Certified Medication Technician

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(CMT)-D began a tirade of shouting and being "threatening" to her. The findings indicated the allegation was not confirmed and indicated instead that R186 had been verbally attacking staff. There was no evidence of an investigation, nor was the allegation of verbal abuse reported to the State agency.

During an interview on 1/25/17, at 4:03 p.m., the DNS confirmed no further investigation had been completed for R186 and stated, "we don't always report everything due to resident behaviors."

R218's discharge MDS dated 11/25/16, indicated she was cognitively intact and independent with ADL's. Her care plan dated 5/4/16, identified a potential for abuse.

A facility document titled Grievance Form, dated 11/18/16, indicated R218 had reported a concern on 11/17/16, that NA- O was rude to her and her roommate. R218 had reported that NA-O opens her curtain after she shuts it, and bumps into her things with the mechanical lift. R218 further reported, NA-O "throws the roommate's call light behind her bed, and when she turns on the call light for her roommate, he [NA-O] tells her not to intervene. The investigative report indicated R218's roommate had confirmed NA-O put her call light behind her bed and also confirmed he'd told R218 not to push her call light for the roommate. The resolution on the grievance form indicated: DNS will follow up with employee to ensure behavior does not occur again.

During an interview on 1/25/17, at 4:03 p.m., the DNS stated when a grievance form is completed, if he and the ED are aware of the information they

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will make the decision if it needs to be reported. He stated if the report occurred on a weekend the supervisor would notify him and he would let the ED know. The DNS stated, "sometimes we don't know what is going on, they [facility staff] are not always telling us." He further stated, "the process is sloppy." At that time, the ED added, that not everything was reported due to resident behaviors. She stated, "I look at the resident's behaviors and look to see if it is a continued behavior. I look to see if it is expected." At 4:48 p.m., the DNS stated when a report is received, the facility does their best to report it. He stated by the time they are aware it may be several days or several weeks. The DNS stated the facility changed their policy in November of 2016 to indicate that all grievances need to be called into the DNS or the ED. The DNS said if it occurred on a weekend, the supervisor needed to be notified immediately and was directed to call himself (DNS) and the ED. He stated he and the ED would determine whether a report needed to be made to the SA. He further stated the social services department had not been reporting to himself or the ED.

R167's diagnoses included major depressive disorder, recurrent severe without psychotic features, borderline personality disorder, anxiety disorder and post-traumatic stress disorder obtained from the quarterly MDS dated 11/28/16. In addition, the MDS indicated resident had intact cognition, had no behavioral symptoms, which included verbal, physical and did not have refusing/rejection of cares.

Review of R167's CP dated 3/23/16, identified R167 had a safety risk and there was a potential

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for abuse due to abdominal pain with fluid collection, chronic pain, foot pain and depression. The CP directed staff "Please don't have me near others who disturb me. Please remove me from potentially dangerous situation..."

Review of Vulnerable Adult (VA) reports identified a report submitted to the SA on 10/31/16. The report included R167's allegation that R105 had threatened to "smash her up against the building." In addition, R167 alleged R105 stated, "You're begging for me to smack the shit out of you, smack you out of your chair, and knock you flat on your ass."

A review of the Disposition Letter for the incident report had been sent to the facility on 12/7/16, by the SA revealed the SA had acknowledged receipt of the incident however the file did not indicate a five day investigation report had been submitted to the SA after the initial report.

During review of the Progress Notes the following was revealed documented in the medical record of the allegation:
-On 10/30/16, at 7:04 a.m. writer had indicated at 12:30 a.m. resident had informed the writer that a resident guy on subacute unit was harassing her. Resident declined to tell who it was. She stated that she was down on the said unit when this resident called her names "you thief, stop coming to this unit, whenever you come here, our stuff get lost." The writer indicated a staff from Subacute stated that resident had been at the unit however did not hear what was going on. At that time resident agreed to talk to the Social worker on Monday. Writer indicated resident had been re-assured she was safe and her concern would be passed on to the social worker.

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F 225	Continued From page 39 Resident also stated she would call police if the guy continued to harass her. -On 10/30/16, at 11:49 a.m. writer indicated resident was upset then over incident with a resident on subacute unit, she was unsure on name. Resident was crying and upset, writer indicated they spent 1:1 with resident, called the supervisor who came to talk to her. -On 10/30/16, at 12:42 p.m. writer indicated resident continued to express anxiety over an occurrence she reported last night. She stated she was on subacute unit and was told to leave, and heard a resident yelling she was going into peoples' rooms and stealing things. She described the person as R105, who resided in the subacute unit. In addition to her earlier report, she had further described she had confronted R105 outside when she was smoking and he stated "You're begging for me to smack the shit out of you, smack you out of your chair, and knock you flat on your ass." Writer asked her if she wanted to report this to the police, but she stated no. Writer reassured her that she was safe on the second floor where she lived. Writer also explained she should not go down to subacute unit because of concerns there with residents from other floors who come down and take food from the unit, and who could possibly enter rooms unauthorized at night. Also writer told resident she should use the smoke room on second floor, and this would make her feel safer as well and reassured resident R105 would be talked to, and reminded to remain in his unit as well. Even though three different nurse staff were made aware and/or had knowledge of the incident, none reported the incident to the ED and/or DNS to determine if the incident was to be reported to the SA. A report was then submitted	F 225		

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F 225	Continued From page 40 to the SA on 10/31/16, by the social worker which was a day later and the ED and DNS were made aware also on the same day. On 1/27/17, at 12:53 p.m. DNS reviewed the initial report submitted to the SA which was dated 10/31/16, he verified there had been three different staff who were knowledgeable of the incident and had written progress notes about the issue and all were aware of the issue and never reported the incident to the ED or himself so they could determine whether they should notify the SA. The DNS also stated the social worker who had completed the report was no longer working at the facility, "we inquire what happened then put in a note depending on the situation." When asked why the report had been submitted a day after the resident had reported the allegation, the DNS stated the report was submitted on 10/31/16, Monday because that was when the social worker heard about the issue. DNS stated RN-F was a nurse manager and had the authority to report the allegation to the SA "I don't know why it was not reported until the 31st but we can say it was reported." A facility policy titled Golden Living Investigation and Reporting of Alleged Violations of Federal and State Laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident' Property, dated 11/18/16, was reviewed. The policy indicated the company would take the following steps to prevent abuse......Incidents identified as potential violations shall be reported as stated in the reporting section of this policy and reviewed by the facility's QAPI (quality assurance performance improvement) for detection of patterns or trends. The policy further indicates The ED (executive	F 225		

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F 225	Continued From page 41 director) shall notify the appropriate State agency and investigate the allegation.A facility policy titled Golden Living Investigation and Reporting of Alleged Violations of Federal and State Laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident' Property, dated 11/18/16, was reviewed. The policy indicated the company would take the following steps to prevent abuse......Incidents identified as potential violations shall be reported as stated in the reporting section of this policy and reviewed by the facility's QAPI (quality assurance performance improvement) for detection of patterns or trends. The policy further indicates The ED (executive director) shall notify the appropriate State agency and investigate the allegation.	F 225		
F 226 SS=K	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	F 226		3/11/17

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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 observation, interview and document review, the facility failed to implement their abuse prohibition policies and procedures related to immediate reporting of alleged abuse/neglect to the administrator and State agency (SA), protecting resident/s from ongoing abuse, and completing a thorough investigation following an allegation of abuse/neglect. This resulted in an immediate jeopardy (IJ) for 6 of 12 residents (R183, R118, R1, R12, R260, R80) due to the residents being afraid of unwanted touch and/or threats of physical harm from staff and other residents. In addition to the residents in IJ, the facility failed to identify, report and thoroughly investigate allegations of abuse that were not an IJ for the other 6 of 12 residents (R28, R45, R112, R186, R218, R167).

The IJ began on 1/22/17, when R118 notified facility staff that a nursing assistant (NA) had threatened to hurt her and the facility failed to intervene. The IJ was identified on 1/26/17 and the executive director (ED) was notified of the IJ

Provider's Plan of Correction:

Golden Living St. Louis Park has policies and procedures in place that prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of property to investigate any such allegations and includes training as required.

R183 and R260 Will meet weekly with the unit social worker to discuss concerns at mutually agreed upon time and any concerns brought forward will be addressed.

Customer service and sensitivity training has been completed for staff.

PHQ9 assessment has been completed on R183 to determine if resident would benefit from medication adjustment.

Pain assessment to be completed on R183 to include direct care observation to ensure comfort with cares.

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F 226	Continued From page 43 at 4:32 p.m. on 1/26/17. The IJ was removed on 1/30/17, at 3:05 p.m., but non-compliance remained at the lower scope and severity level of E. Findings include: A facility policy titled Golden Living Investigation and Reporting of Alleged Violations of Federal and State Laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident' Property, dated 11/18/16, was reviewed. The policy indicated the company would take the following steps to prevent abuse......Incidents identified as potential violations shall be reported as stated in the reporting section of this policy and reviewed by the facility's QAPI (quality assurance performance improvement) for detection of patterns or trends. The policy further indicates The ED (executive director) shall notify the appropriate State agency and investigate the allegation. R183 was interviewed on 1/26/17, at 4:00 p.m. and stated she was aware of the reporting process, but felt it was useless to report, because they were "blaming, and accusing her of making up stories." R183 stated she had tried to report to the nurse on the night shift about an incident that had occurred this past spring (date unncertain). R183 stated, "she [the night nurse] came in and was blaming me, saying '[NA-HH] is just trying to take care of you.' So I told her to get out. I don't trust anyone here. That director of nursing (DNS) came in to talk to me and I told him to get out. I don't trust him." R183 had tears in her eyes and reported that NA-HH had rubbed her arm, and then had moved to her breast area. R183 said she'd yelled at NA-HH, "Stop, what the H**l are	F 226	Night supervisor will complete direct care observation audits weekly to ensure comfort with cares. R118 Concerns brought forward will be addressed R1 Concerns brought forward will be addressed in a timely manner NA-AA received Customer Service Training and was reassigned to a different unit, no further concerns from resident have been reported since transferred to new unit. R12 Nursing Staff have been re-educated on residents rights to make choices including but not limited to choice of bedtime. R80 Staff have been reeducated to explain actions of cares prior to meeting residents needs. Staff have been reeducated to timely report allegations of abuse and neglect to the ED/DNS for further investigations R28, R45, R112, R167, R186 Any concerns of allegations of abuse will be reported to the ED/DNS All staff have been reeducated on Abuse, Neglect, Maltreatment and Misappropriation of resident property, to include what constitutes as abuse and immediate reporting of allegations of	

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F 226	Continued From page 44 you doing?" She further stated, "He then took his finger [demonstrated a circular motion with her index finger] around my anus. I told him to stop, saying 'what the h**l are you doing?', but he didn't stop, so I slapped him [demonstrated a backhanded slapping motion], and he still didn't stop, so I slapped him again." R183 stated NA-HH was still working here, so she had kept a fork on her bedside table for a long time, as defense, but then they took it away with a dinner tray. R183 stated she woke up last week and he [NA-HH] was standing at the end of her bed. She stated, "I picked up my bottle [demonstrated picking up a large glass bottle of hot sauce, with a long thin neck] from my bedside table and threatened to hit him with it if he didn't leave. I had to say I will crack your head open to get him to leave." R183 agreed to speak with licensed practical nurse (LPN)-B, because she felt she could trust her, but said she would not speak with the DNS because she did not trust him at all. At 4:34 p.m. on 1/26/17, LPN-B was asked whether she had noted any changes in R183's behavior or if she had heard any report about R183 having threated to hit a NA-HH. After some thought LPN-B stated, "About three or four months ago, R183 would not let anyone turn her or touch her on the night shift. I asked her if anything was wrong, but she wouldn't tell me." LPN-B added, "I have talked to my nurses, months and months ago, she wouldn't turn in bed, she wouldn't roll over. We have to be careful with her, she makes things up. She has a history of conversion disorder, hallucinations and delusions. I had been asking her what's wrong, and she specifically told me it was ok for NA-HH to take care of her." LPN-B went on to say that R183 was 'tough with mental health, and she tries	F 226	abuse. Weekly audits will be conducted to identify any concerns related to abuse, neglect, maltreatment and misappropriation of resident property. The ED or designee will monitor for compliance QAPI will review audits and actions to provide direction or change as needed.	

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to get people in trouble. A social worker (SW) and I interviewed her, then the DNS comes up and she kicks him out of the room." The surveyor then asked LPN-B whether she'd been awared that R183 had alleged having been touched inappropriately by NA-HH. LPN-B stated she had not be aware, then proceeded to go in to discuss with R183, and following their conversation LPN-B reported the allegation of sexual abuse to the SA.

Acording to her Admission Record, R183 was admitted to the facility on 11/11/14, with diagnoses including psychosis (an abnormal condition of the mind that involves a loss of contact with reality), and major depressive disorder.

A quarterly Minimum Data Set (MDS) dated 9/6/16, indicated R183 was cognitively intact and had no signs or symptoms of delirium or hallucinations. In addition, the MDS indicated R183 did not reject cares and had demonstrated no verbal or physical behaviors towards others. R183 was totally dependent on two staff and utilized a mechanical lift for transfers, required extensive physical assistance of two staff for bed mobility, dressing and toilet use, and did not have antipsychotic or antidepressant medications ordered.

An MDS dated 11/29/16, also indicated R183 was cognitively intact and had no signs or symptoms of delirium or hallucinations. However, the MDS indicated R183 had demonstrated physical behaviors directed towards others during one to three days, verbal behaviors directed towards others on four to six days, and had rejected cares one to three days, all days in reference to the

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F 226	Continued From page 46 MDS look back period. The MDS indicated R183 was totally dependent on two staff and a mechanical lift for transfers, required extensive physical assistance of two staff for bed mobility, dressing and toilet use, and did not have antipsychotic or antidepressant medications ordered. A Care Area Assessment (CAA) dated 6/27/16, indicated R183 had triggered delirium as an area for assessment. The CAA analysis indicated the delirium was due to a decrease in her cognitive score and a recent change in mood; sad or anxious (for example crying, social withdrawal). The Care Plan (CP) dated as far back as 11/14/14, indicated R183 had a potential for abuse due to decreased physical ability, need for care and history of allegations towards staff that were found to be unsubstantiated. The CP dated 6/11/15, indicated behaviors which include shouting, crying and stating "I am not crazy. I have a history of psychiatric disorders and will often state a complaint but change my story which results in an inconsistent reporting history. I sometimes refuse the bedpan when offered. Potential conversion disorder exhibited by: 1) verbalize I am having health issues that are not present upon examination/tests. I have paranoia related to my psychosis diagnosis that staff are listening to my conversations through the doorways and bathrooms. I often have concerns regarding the delivery of my cares. I meet with staff on a regular basis to discuss my concerns and resolutions. I often state the NAR's [nursing assistants/registered] are not helping me when in fact I have refused cares." Although the care plan indicated R183 had identified behaviors, the facility did not thoroughly investigate her	F 226		

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F 226	Continued From page 47 allegations to determine validity of the allegations. An Associated Clinic of Psychology (ACP) note dated 10/11/16, indicated the therapist and R183 had discussed the resident's feelings of anger and distress with staff at the facility, and that R183 had elaborated on three of her concerns regarding staff behavior towards her and how she was not pleased with the follow-up thus far. The ACP note also indicated R183 had reported she had not been sleeping well recently, and that she had been encouraged to watch TV and play games on her phone to keep from being overwhelmed by current situation. The note indicated the resident utilized no known medications (for depression or psychosis). The ACP therapists recommendations included: She had been requesting staff to leave her alone as much as possible while continuing to appropriately address her care needs. She seemed to be in a protective mode at that time and thus staff should be very mindful of their behavior around her which includes the way in which they care for her, what they say to her and their body language in her presence. Ongoing: It may be important for staff to know that she liked people to be straight with her. She reported she will become impatient, and most likely verbally aggressive, if she feels others are not being truthful with her. It is important she feels listened to. Staff trying to make sure she understands what is being asked of her and clarifying information with her will most likely be helpful. A subsequent ACP note dated 10/25/16, included: "In wheelchair in depressed mood with distressed affect. She reported sad and tearful due to family issues and grievances with staff at facility which she discussed in detail. Recent events have challenged her beliefs about staff at facility and	F 226		

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F 226	Continued From page 48 has continued to find concerns that lead her to question their skills. No known medications (for depression or psychosis). Recommendations: Staff will inquire about her willingness to move to a different unit within the facility as she does not trust her current direct care staff and does not feel that relationships can be healed. She remains in protective mode at this time and thus staff should be very mindful of their behavior around her which includes way in which they care for her." An ACP note dated 11/8/16, "In wheelchair in room, dysphoric (state of unease or dissatisfaction) mood and angry affect. Reports progressively becoming more distressed and angry the longer she stays at the facility. She does not trust any staff or their motives. Unable to sleep or eat well because of this. Unrealistic about placement in the community. No known medications (for depression or psychosis). Recommendations: Not open to staff challenging her beliefs regarding her health and perceptions and thus staff should continue to address her care and flow with delusions. She is not open to trying medications that may help to reduce her internal emotional distress as she does not believe that she has any mental health concerns. Staff who interact with her should be mindful to present with a neutral demeanor and facial expression as she does not trust "fake smiles", to improve rapport with her." An ACP note dated 11/15/16, "In bed in room, incident claimed that direct care staff were rough with her. Dysphoric mood with angry affect. Appears she reacted in way she did due to exacerbation of pain that staff caused her when staff assisted in turning her. Vented frustration, does not trust staff. Not able to consider reconciling differences with staff at this time and shared her belief that only option to improve her situation was to leave facility, even	F 226		

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though she has no plans or means to do so. Unit Social worker has initiated process of getting her a relocation worker to help find her appropriate placement in the community. Staff her interact with her should be mindful to present with a neutral demeanor and facial expression as she does not trust "fake smiles", to improve rapport with her." The ACP note dated 11/22/16, R183 sitting in a wheelchair in a slightly euthymic (normal) mood with calm affect. She had developed a technique of refraining from interacting with direct care staff so they have nothing to use against her. Recommendations: Had developed a trust with physical therapist, and would like to work with him to assist her doctors with orders for exercise."

R183's 11/30/16, CP included: "I recently bought a set of ankle weights and have a history of stating that I want to throw things at staff. I will request to have the weights or other objects in my hands while I am worked up. I have a history of swinging out at staff with these objects."

Behavior charting for R183 was reviewed from 7/31/16 through 1/27/17:

Charting from 9/24/16, at 10:24 a.m. alleged R183 cursed (no further description) at NA-P, a female staff on the day shift.
On 10/4/16, at 9:54 p.m. R183 rejected assistance of dressing and personal hygiene (no further description) from male staff NA-JJ.
On 10/30/16, at 8:33 p.m. R183 had behaviors not directed towards others (no further description) from male staff NA-LL.
On 11/10/16, at 8:34 a.m. R183 rejected care (no further description) from female staff NA-P.
On 11/12/16, at 1:12 a.m. R183 had behaviors

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not directed towards others "socially inappropriate behavior", male staff NA-LL.
On 11/14/16, at 4:03 p.m. R183 had behavior not directed towards others "socially inappropriate behaviors", male staff NA-LL.
On 11/26/16, at 12:49 a.m. R183, rejected care by male staff NA-LL.
On 12/7/16, at 9:23 p.m. R183 had verbal behaviors directed towards others, male staff NA-LL.
On 12/19/16, at 1:58 a.m. rejection of care, assistance dressing and personal hygiene by male staff NA-EE.
On 1/26/16, at 12:32 a.m. behaviors not directed towards others (no further description) male staff NA-LL.
On 1/27/16, at 1:48 a.m. rejection of care, male staff NA-LL.

The facility's Behavior documentation book was reviewed and noted:
On 1/13/17, night shift documented "episode of resistant to cares, redirected."
On 1/14/17, (no shift noted) "resistant to cares, redirected no change."
On 1/15/17, day shift "accusing staff of unsubstantiated things occurred on days, redirected."
On 1/18/17, "resistant to cares on nights, redirected same."
On 1/19/17, "resistant to cares on nights redirected same."
On 1/20/17, (no shift noted) "Resistant to care."
On 1/24/17, "Resistant to cares on night shift redirected."
On 1/26/17, "Resistant to cares on night shift."

Nursing Progress notes reviewed:
On 12/4/16, at 9:16 a.m. R183 requested to

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speak with LPN-B "I am tired. These damn NAs refuse to take care of me and tell me I am trouble. I fell asleep last evening and woke up at midnight, asked to have my food heated and then be cleaned up. No one helped me." "I told them to leave the food tray here so I could show you and you wouldn't think, I was lying." LPN-B documented resident displaying paranoid behaviors, R183 asked the nurse to look into the bathroom to ensure no-one was listening to the conversation. NA-HH (alleged abuser of R183) and NA-LL had worked the night shift prior.

On 12/9/16, at 8:00 a.m., LPN-M wrote a nursing note that R183 said "both PM [afternoon shift] and night aides did not change me all night, I am completely wet." LPN-M documented that she'd stated to R183, "put on your call light when you need help." She further documented that R183 had gotten mad and started to use profanity. "Get the F*** out of my room you B****", LPN-B notified. NA-HH (alleged abuser of R183) and NA-LL had worked the night shift prior.
On 12/9/16 at 8:48 a.m., LPN-B had gone in to see R183 and two NAs were working with her. LPN-B told R183 she would back to get R183's statement about cares when finished with cares and breakfast trays. R183 noted to be incontinent in her brief at that time. R183 stated "you want to see what I'm talking about." LPN-B told R183, she would return when cares were done, and would speak with NA's about what they'd found. Documentation indicated R183 had began yelling and stated "Oh never mind, you don't care anyway. Get the F**k out, all of you just leave me alone...leave me the F**k alone. The note indicated R183 was thrashing in bed while hooked up to mechanical lift (Marissa Lift), and when staff had started to unhook the sling, R183

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F 226	Continued From page 52 had stated, "I didn't tell you to stop, get me up.'" R183 asked to speak to ED, said she was wet all night, and she was not going to ring and tell anyone what to do. "Get out of my room." The author indicated an unidentified SW had been notified. On 12/9/16 at 12:11 p.m. LPN-B documented she had returned to R183's room with unidentified SW, R183 was quiet at first and did not want to talk to staff, then starting stating. "I don't have to put my call light on when I need cares. No one came in to take care of me all night." R183 stated "I'm not crazy, I know you all think I am, but I'm not crazy." DNS knocked and entered to respond to request for ED, R183 told DNS to get out of her room, stated "I can't stand that SOB [curse word], I ain't talking to him, I don't trust him." R183 remained angry and refusing meals... Placed phone calls to the night shift staff and awaiting call back. On 12/9/16 at 3:23 p.m., documentation indicated LPN-B had interviewed night shift aides who stated they had attempted to provide cares twice for R183, but they stated she was asleep and refused cares. However, during the interview with R183, she stated she stayed awake all night to see if anyone would come into her room. On 12/15/16, at 12:45 p.m. "in house LICSW [licensed clinical social worker]" met with resident on 12/13/16, R183 was in dysthymic mood with angry affect, less distressed than past sessions. R183 able to vent about staff with whom she does not work well and the coping skill she has developed where she asks people to leave her room as a means to protect herself. "Staff should continue to be respectful of R183's right to refuse services and reapproach later." NA-SS and NA-OO worked the night shift prior. NA-P, NA-QQ, NA-YY, and NA-AAA worked the day	F 226		

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F 226	Continued From page 53 shift. On 1/11/17, at 8:19 a.m. noted R183 wanting to meet with LPN-B in room, with roommate. Residents are usually conversing and laughing in room. R183 will say to roommate "tell her what happened last night", roommate will not remember and R183 tells her what to say. R183 stated "I'm telling you girl these aides are worthless, and I am going to report that to the state when they get here. R183 refused to meet with DNS." NA-HH (alleged abuser of R183) and NA-LL worked the night shift prior. On 1/14/17, at 2:02 p.m. R183 "had a run in with a NA." Apparently he walked in when she was talking to a different NA, and she felt that was rude. R183 told the unnamed NA to get out. The unnamed NA stated "I don't have to." R183 became very angry and cussed NA out. NA left and registered nurse (RN)-O came in and talked with R183, who calmed down. NA-HH (alleged abuser of R183), NA-SS worked the night shift prior. NA-P, NA-QQ, NA-UU, NA-E worked the day shift. There was no facility documentation that the unnamed NA was investigated for the incident. 1/15/17, at 4:27 a.m. RN-K noted R 183 refused cares that shift, NA attempted two times. RN-K went in and R183 attempted to get roommate to tell RN-K what happened. Roommate didn't quiet [sic] know what to say. R183 was upset at NA and yet refused to talk with them or receive help from them. R183 angrily yelled "no one is going to touch me, I'll hurt somebody." "I will stay like this and I will call the state about it". NA-HH (alleged abuser of R183), NA-VV, and NA-SS worked the night shift. On 1/23/17, at 4:34 p.m. LPN-B noted, early that morning, was notified by NA that R183 asked them to get out of her room when they were attempting to get her up with the Marisa Lift to her chair. NA's reported they did nothing wrong and R183 won't say why she was upset. LPN-B	F 226		

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and an unidentified SW talked with R183, "Get me up, they don't know what they are doing." "They didn't put the sling under me right." NA-HH (alleged abuser of R183), NA-LL, NA-OO worked the night shift prior. NA-F, NA-TT, NA-UU, NA-VV, NA-WW worked the day shift. On 1/24/17, at 11:27 a.m. [unnamed] NA came to SW-D to assist with R183. R183 was in wheelchair (w/c) but was not positioned well. R183 said that one of the NA's helping didn't know what she was doing. SW-D, NA and trainee got resident on lift and repositioned in w/c correctly. Internal investigation began. NA-N, NA-PP, NA-QQ, and NA-RR worked the shift. On 1/26/17, at 6:25 a.m. RN-K noted R183 refused cares that shift, reapproached and continued to refuse. When the day shift NA arrived, R183 allowed cares, was changed and cleaned up. NA-OO and NA-SS worked the night shift. On 1/26/17, at 3:30 p.m. LPN-B stated R183 had been interviewed and NA-HH was going to be suspended.

On 1/27/16, at 6:06 a.m. RN-K noted 15 minute safety checks, slept in room all night and was safe. No concerns noted [no documentation why 15 minute safety checks].
-At 6:16 R183 refused cares this shift, reapproached three times. Risks and benefits explained. Morning staff updated. NA-HH (alleged abuser of R183), NA-LL, NA-OO worked the night shift.
-At 12:00 p.m. LPN-B stated R183 had been put on 15 minute checks, was happy and had no complaints.
-At 1:43 p.m. R183 stated the assistant director of nursing (ADNS) had told her NA-HH was gone.

During seven of the 11 behavior episodes, the

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alleged abuser NA-HH had been working that shift, or the night shift prior. During 9 of 11 behavior episodes, at least one of three NAs consistently working that shift or the prior shift (including NA-HH, NA-LL, and NA-P).

The employee files were reviewed and the following was noted:
NA-HH, hired 6/6/11, undated training in new hire file for abuse/neglect, patient rights. NA-HH was disciplined on 10/18/11, for poor work quality and productivity for leaving a resident in a bed soaked with urine, changed sheets, but immediately wet again, and NA-HH left for day shift. On 1/8/12, NA-HH had left the floor to buy a can of pop for resident, did not ask nurse if resident could have pop. NA-HH did not tell anyone he was leaving the floor. Notice of 2 week voluntary resignation dated 4/9/15, with last day being 4/21/15. NA-HH was rehired 2/24/16. On 11/18/16, Step 1 discipline notice instructed NA-HH to improve getting to work on time.

NA-LL hired 9/12/16, received preventing abuse training on 9/22/16, and Alzheimer's training on 10/26/16.

NA-N, hired 3/20/15, received preventing resident abuse training on 4/7/15, and Alzheimer's training on 10/26/17. Discipline notice on 4/7/15, for failure to perform assigned duties in an appropriate manner or at assigned times. Discipline notice dated 9/25/15 indicated, "staff is loud and demanding when she approaches them [residents]. Makes the resident anxious and sometimes feel intimidated, always provide excellent customer service. Knock before entering and announce self by name and title. Greet all your residents at the beginning of your

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F 226	Continued From page 56 shift to let them know that you are their aide that day. Utilize words such as please and thank you frequently. Ask for resident preference, do not just tell them what to do. Provide explanations and plan ahead with them for them. Approach with calm, patient tone. Not all residents are deaf and speaking louder does not always help. It may seem intimidating if a resident is having a difficult time understanding, always ask for assistance from another staff member. Resident needs always come first. Ask questions." Discipline notice dated 1/25/17, instructed NA-N "customer service: be aware of how you approach a patient, be aware to speak clearly, make sure that if a resident is asking for your help, you are helping them safely. Address all needs while working with a patient. If you feel uncomfortable being the only staff caring for a resident, bring another staff with." The facility failed to fully investigate a change in patient behavior, and rejection of cares. The facility failed to track and trend staffing patterns with R183's behavioral outbursts to identify a potential staff abuse. R118's quarterly MDS dated 12/16/16, indicated she was cognitively intact and required minimal assistance with activities of daily living (ADLs). During interview with R118 at 8:22 a.m. on 1/24/17, the resident stated she had been threatened by NA-BB the week prior. She said the NA had threatened to "knock her head off." R118 further stated she was afraid of NA-BB. R118 stated she had reported the threat to the Alzheimer's Care Director (ACD). R118 stated the ACD had replied, "it was just a joke."	F 226		

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A facility document titled Verification Of Investigation (VOI) dated 1/22/17, was reviewed. The documentation indicated R118 had been interviewed by facility staff regarding the threat by the NA. The VOI included recommendations taken to prevent reoccurrence which included suspension of the employee, and customer service education having been provided to the employee. The recommendations also included re-directing R118 during episodes of inappropriate behaviors, even though the allegation of inappropriate behavior was made by R118. The facility's VOI document indicated abuse had not been substantiated and further indicated, "per investigation there was a misunderstanding by client regarding employee's comment which does not substantiate."

R1's quarterly MDS dated 12/28/16, indicated she was severely cognitively impaired and required extensive assistance with ADLs. The care plan dated 12/26/17, identified R1's potential for abuse. The care plan further identified a physical functioning deficit and directed staff to assist with transfers, toileting and personal hygiene.

During interview on 1/23/17, at 5:01 p.m., R1 stated NA-AA had pushed her. R1 stated NA-AA was "rough" with her. She stated she needed help to get dressed and that she was afraid NA-AA would come to help her and stated, "I don't want to get in trouble." R1 stated she had not reported the incident to the facility.

On 1/23/17, at 5:21 p.m., the allegation of abuse was reported to the DNS. At 6:28 p.m., the DNS reported to the surveyor that NA-AA had been

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sent home pending investigation of the abuse allegation and that the allegation had been reported to the State agency.

The facility had documented a VOI on 1/24/17 for the allegation R1 had made 1/23/17. The VOI indicated R1 had reported to facility staff that when she requests assistance from NA-AA, the staff member tells her, "do it yourself, get into your chair." R1 reported NA-AA is rude to her and always had been. The VOI further identified recommendations/interventions to prevent reoccurrence as follows: NA (AA) suspended pending outcome of investigation, staff encourage R1 to transfer independently which R1 "interprets as being rude." Unable to substantiate allegation of abuse as resident does transfer herself and staff encourage her to promote independence. Customer service education will be given to NA-AA upon her return.

On 1/25/17, NA-AA was observed working the a.m. shift on the unit where R1 resides.

During an interview on 1/25/17, at 10:56 a.m., the social services director (SSD) stated if someone reports an allegation of abuse, she immediately reports it to the DNS and the ED. She stated the DNS and ED make the decision whether or not the allegation gets reported to the State agency. The SSD stated if an allegation is made on the weekend, "it's harder because we're [management] not here so it goes on a grievance and staff would notify the building supervisor." The SSD stated LPN-B had told her about the allegation made by R1 and stated LPN-B and SW-C completed the investigation.

During an interview on 1/25/17, at 11:07 a.m. with

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F 226	Continued From page 59 LPN-B and SW-C, LPN-B stated if a resident reports mistreatment by staff she would immediately report to the ADNS, DNS and ED. LPN-B stated the ED and DNS determine if an allegation is reportable to the State agency. SW-B verified she had assisted with the investigation regarding R1's report to the surveyor. SW-C stated she had not followed up with R1 but stated she had reported the allegation to the social worker from the ACP who was scheduled to see R1 on 1/24/17. SW-C stated she was aware the ACP social worker had spoken to R1 about her report however, SW-C stated she had not read the ACP social worker's report after the visit. She further stated she had not been aware R1 had accused NA-AA of pushing her or being rough with her prior to the investigation. At 11:14 a.m., LPN-B stated the DNS had told her R1 had reported to the surveyor that staff had been rude to her. LPN-B stated she was not aware R1 had reported that a staff member had pushed her or been rough with her and stated the DNS had not told her that. LPN-B stated R1 had told her NA-AA refused to help her. Review of the ACP Progress Note dated 1/24/17, indicated a licensed social worker had visited with R1 that day and identified the following: Staff shared R1 had reported abuse from a direct care worker to the State assessor yesterday. Met with R1, she showed no obvious evidence of any current delusions or hallucinations. When asked, she expressed some anxiety about sharing her concerns to the State worker and reassured her that it was her right to do so and important to keep her safe. R1 was unable to identify any clear reasons why she had not brought up her concerns during her care conference the previous week aside from stating she was awoken to	F 226		

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attend. She (R1) was unable to confidently state that she would feel comfortable reporting similar concerns to the unit nurse manager (LPN-B) or SW-C in the future.

During an interview on 1/25/17, at 11:24 a.m., the DNS stated if the facility received an allegation of abuse he would call the ED and they would report the allegation to the SA. He stated R1's allegation was still being investigated, but stated interviews with staff and other residents had been completed. The DNS stated based on the conclusion of the interview, the facility felt that NA-AA had been trying to promote independence by encouraging R1 to transfer herself and that he interpreted NA-AA's behavior as "rude," and had scheduled her for additional customer service training. He verified NA-AA had not completed the training prior to returning to work on the floor because they "had call-ins." The DNS further stated he did not interview the resident himself and stated the ADNS had interviewed her.

During interview on 1/25/17, at 11:36 a.m., the ADNS stated she had not talked to R1. She stated she talked to the facility's human resource specialist (HRS) who placed modules in NA-AA's bin and stated NA-AA "needed to complete them today."

During a subsequent interview on 1/25/17, at 11:37 a.m., the DNS acknowledged no one had had followed up with R1 after NA-AA returned to work, nor had anyone asked R1 whether any staff had pushed her or been rough with her. He stated SW-C should have done that. In addition, the DNS stated if an employee needs to be educated, "we provide the education". The DNS stated he felt the allegation from R1 was mistaken

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information or a communication issue. At that time, the ED added, if there was a second incident with an employee the suspension could be longer or the employee could be terminated. The DNS stated NA-AA's employment file was reviewed and contained no previous allegations. The ED stated, because of the clientele, the education had to go into the delusion and hallucination piece.

On 1/25/17, at 11:46 a.m., SW-C confirmed she had not followed up with R1 regarding the concerns.

On 1/25/17, at 1:15 p.m., the DNS stated he had reviewed R1's care plan to determine if it was appropriate for staff to encourage her to self-transfer and stated, he had taken notes but "didn't keep them." LPN-B and the ED were also present during the interview. LPN-B stated, "it is not safe for [R1] to self-transfer."

During interview on 1/25/17, at 2:36 p.m. the HRS stated no one had reviewed NA-AA's employment file for previous allegations or education.

R12's CP dated 10/15/13, indicated he was at risk for potential abuse due to his diagnoses including: bipolar disorder, schizoaffective disorder, clavicle fracture, osteogenesis imperfecta and diabetes. In addition, the care plan indicated the resident had a history of being physically, verbally, and sexually abused by his father and sometimes struggled with sexual identity issues. The CP directed staff to explain what they were going to do before providing care.

On 1/25/17, at 11:01 a.m. SW-B stated R12 had

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F 226	Continued From page 62 approached her on 1/17/17, around four o'clock when she was just about to leave and had reported LPN-E had exchanged words with him on 1/16/17 at around 10 o'clock, and that he felt his rights had been violated. SW-B stated she had completed a grievance report and reported the allegation to the DNS and put the report under the DNS office door. SW-B said she did not know whether it had been reported to the State agency as it was the facility management's decision. SW-B stated she had asked R12 whether he felt safe and he had indicated he was, and was able to voice his needs and stand his ground. SW-B stated she had counseled the resident 1:1 and thought LPN-E needed to be talked to about resident rights. On 1/25/17, at 2:06 p.m. the DNS was requested for the grievance report that had been filed on behalf of R12. DNS stated he had followed up with resident and told him he would follow up with the identified staff. On 1/25/17, at 3:55 p.m. the DNS approached the surveyor and stated he had looked all over his office and was not able to locate the grievance report. DNS stated he had followed up with the resident and had told R12 he had spoken with LPN-E and had told her R12 would go to bed when he wanted to. DNS stated when he had talked with R12, the resident had not indicated he had been abuse. The DNS said he would go interview R12 about the incident again now. On 1/25/17, at 4:07 p.m. the SSD and the surveyor went to speak to R12. R12 stated he had reported to SW-B he had felt verbally and emotionally abused. R12 stated during the follow up with the DNS, the DNS had told him he had	F 226		

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F 226	Continued From page 63 spoken with the staff [LPN-E]. R12 then proceeded to report the incident again. He said that on 1/16/17, at 10:10 p.m. LPN-E had approached him and asked him why he was still up, and that LPN-E had said he [R12] needed to go to bed as there was not enough staff to put him to bed during the night. R12 stated he had still been up because he was watching one of his favorite shows, then needed to take his medications, and would then go to bed. R12 stated the nurse had thrown her hand up to his face and stated, "we are not having this conversation right now" and kept threatening him she was going to report him to the supervisor. R12 said he'd told the nurse, "please do so she can witness this." R12 stated LPN-E also kept telling him she was going to call the police on him if he did not leave the area. R12 stated this went on back and forth for about 10-15 minutes and that initially he refused to leave the area, but did eventually. R12 then stated he had told LPN-E "This is my home and I can go to bed anytime." R12 further indicated he had called the nurse a "whore" during the exchange. When asked how the incident had made him feel, R12 stated, "I felt verbally and emotionally abused." During the interview, as he explained the incident, R12 appeared upset and his voice rose. After the interview, the SSD stated she was going to report the incident to the ED, DNS and then report it to the SA. On 1/25/17, at 5:15 p.m. DNS verified there was no documentation of the incident in R12's medical record. DNS stated LPN-E should have gone into the medical record and documented the incident "these are things we are trying to change here. We are trying to get nurses to report incidents of possible abuse and neglect to me and I want to	F 226		

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make the decision whether or not to call OHFC [Office of Health Facility Complaints-SA]. Incidents like this have been written on the grievance reports instead of being reported to the SA. We are doing education to better serve the residents we are serving." The DNS further stated the supervisor was supposed to be notified of allegations, and dependent on the incident, nurses were able to report the incidents of abuse.

R260 was observed on 1/23/17, at 6:49 p.m. to be sitting on the edge of the bed moving an arm continuously, and changing positions frequently.

During interview with R260 on 1/23/17, at 7:00 p.m., when asked whether staff, a resident or anyone else at the facility had abused him, including verbal, physical or sexual abuse, R260 stated "Yes." When asked to explain what happened? R260 said, "I think the word is enough. They don't give a s**t that this has been the worst week of my life." When asked whether any staff had been informed of the alleged abuse, R260 said, "The staff all saw it."

On 1/24/17, at 8:00 a.m. after review of R260's chart SW-A was asked whether R260 had reported having been abused. SW-A stated R260 had not made any report of abuse. The surveyor then told SW-A that R260 had indicated during interview that she had been abused.

During interview with the ED on 1/25/17, at 2:13 p.m., the ED said, "If it was reported as abuse we should have completed an OHFC report and investigated it."

During interview on 1/25/17, at 2:14 p.m. SW-A

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verified only an internal investigation had been completed thus far. When asked what time yesterday she had interviewed R260. SW-A said, "I interviewed her at 1:30 p.m." SW-A said "I was not aware an allegation of abuse had to be reported within two hours."

R260's Admission Record dated 1/30/17, indicated R260 had diagnoses including: injuries of right wrist, hand and fingers, bipolar disorder (depression with episodes of mania), post-traumatic stress disorder and borderline personality disorder (abnormal behavior characterized by unstable relationships with others).

R80's family member (F)-A was interviewed at 4:33 p.m. on 1/23/17. F-A reported having been concerned about staff hitting R80. F-A stated the allegtion had been reported to SW-D in November around 11/18/16, but F-A was not sure of exact day.

During an interview with R80 on 1/23/17, at 7:20 p.m., R 80 was observed to have bruising on both hands and wrists. When asked what had happened R80 started crying and said, "They hurt me, they hit me, pinch me and push me around."

On 1/23/17, at 7:56 p.m. NA-A was observed to enter R80's room where R80 lying in bed. NA-A grabbed the R80's blanket and pulled it down, off R80 in a quick manner, indicating peri care was going to be provided because R80 was always "digging" and had fecal material under nails. R80 was heard to respond, "What the h**l are you doing, leave me alone."

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On 1/23/17, at 8:30 p.m. the DNS was asked whether R80 or her family had ever made a report of staff hitting or abusing R80. The DNS denied being aware of any allegations of abuse have been made by R80 or her family. The DNS further stated no reports had been made to the SA since he started in March 2016. The surveyors informed the DNS of the allegations made by R80 and F-A.

During a follow up interview with R80 on 1/24/17, at 1:47 p.m. R80 said, "Staff hit me, it is mostly the night shift." R80 also stated staff verbally abuse her. R80 stated she had told the nurse, nurse manager and DNS.

R80's annual MDS dated 11/3/16, indicated R80 was moderately cognitively impaired without hallucinations or delusions. R80's MDS indicated R80 had verbal and physical behaviors toward others one to three times in the seven days prior to the MDS. R80's MDS also indicated R80 required assistance with all ADL's except eating, and had diagnosis of Alzheimer's disease, depression and urinary incontinence.

R80's Cognitive Loss/Dementia CAA Worksheet dated 11/14/16, indicated R80 had diagnosis of dementia, but was alert and oriented to self and place with short term and long term memory deficits. In addition, the CAA indicated R80 was at risk for unmet needs and safety deficits. An ADL CAA Worksheet dated 11/14/16, indicated R80 required staff assistance with some ADL and cognitive skills. A Behavioral Symptoms CAA Worksheet dated 11/14/16, indicated the CAA had triggered due to R80 scratching a staff member during cares one day. Care plan considerations instructed staff to monitor for signs

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and symptoms of depression and to make sure R80 was not in pain or uncomfortable. Neither the cognition nor behavioral CAA indicated R80 was an inaccurate reporter or made false allegations against staff.

R80's Safety CP revised on 11/16/16, indicated: "My safety is at risk and there is potential for abuse due to diagnosis of dementia, depressive disorder, hypertension, hypothyroidism and decreased physical ability." The interventions instructed staff to explain all cares/procedures prior to beginning them. The safety care plan did not indicate R80 made false allegations against staff. A Physical Functioning Deficit CP revised 11/16/16, indicated R80 had a history of personality disorder with narcissistic traits and could be judgmental and make negative statements regarding cares such as "some of them are awful" and instructed staff to provide dressing assistance and transfer assistance with Hoyer of two caregivers due to false allegations." Bed mobility, personal hygiene, toileting, oral care and locomotion were to be provided by assist of one staff member. The At Risk for Altered Skin Integrity CP revised 11/16/16, did not address presence of bruises. An alteration in mood or behavior care plan revised 11/16/16, did not identify false allegations or inaccurate reporting as a problem but included an intervention initiated 6/21/16, "using 2 persons during care may be needed due to potential for allegations."

An undated, unlabeled nursing assistant assignment sheet for R80, indicated R80 was frequently incontinent of both bowel and bladder and to not apply two incontinence briefs at the same time. No skin issues were identified on the assignment sheet. Staff were instructed to have

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"2 person care givers at all times."

The Behavioral Detail Report for R80 was reviewed from 3/1/16, through 1/25/17. There was documentation that indicated R80 had threatened staff once, hit staff twice, rejected assistance with care six times, scratched staff eight times, and had screamed at staff 13 times. The Behavioral Detail Report contained no documentation of R80 making false allegations about staff during this time period.

R80's Physician Progress Notes were reviewed from 4/11/16, through 12/16/16. A 4/11/16, note indicated R80 had dementia with behavior disturbances. Particularly difficult at night, with calling out and does not like Hoyer. The Progress Note for 6/14/16, indicated staff reported no new significant behavioral concerns. The Progress Note for 7/27/16, indicated R80 had told the nurse practitioner staff hit her at night. The nurse practitioner had subsequently documented having discussed with an RN manager, R80's concern of staff hitting her at night. The nurse practitioner had further documented that the RN said the issue had been addressed with R80's daughter. Finally, the progress note indicated there was bruising on top of R80's left hand and included: "RN Manager to address staff issues." Progress note dated 10/4/16, indicated, "Staff reports some continuing issues of complaints about her care and therefore she is always attended by two staff members." Progress note dated 12/16/16, indicated staff had no new concerns and there were no new behaviors.

Review of the facility's reports to OHFC were reviewed from 3/1/16, to time of survey entrance on 1/23/17. The reports indicated on 3/24/16, a

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resident, no longer in the facility, had reported that a staff member had struck R80 on the face on 3/22/16. The report to the SA indicated the facility had been unable to "substantiate any claims of abuse." There was no report to the SA regarding the incident the nurse practicioner had reported to nursing about R80 having been hit by staff on 7/27/16.

A VOI documented report for R80 dated 1/23/17, indicated the ED and SA were notified of an allegation on 1/23/17, at 8:45 p.m. (After the surveyors had reported their concerns from interview). In addition, doucmentation on the VOI dated 1/24/17, indicated, when asked if R80 had ever reported being abused LPN-I said, "I think she has but not anybody specific. It seems more paranoid that people are out to get her. She will say, 'Oh, they are out to get me'.'" In addition, the VOI note dated 1/24/17, indicated when asked about reporting R80 had ever been abused, F-B had said, "there was that incident when we tried to transfer her out and you guys blocked it."

The IJ was removed on 1/30/17, at 3:05 p.m., when it could be determined administration had modified their protocol for how to handle grievances, had taken action to investigate employee specific allegations, had provided staff training, and interview with staff could verify implementation of these interventions had occured. Although the IJ was removed, non compliance remained at the lower scope and severity level of E.

R28's significant change MDS dated 12/29/16, indicated she was moderately cognitively impaired and required physical assistance from

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staff to complete ADL's. R28's care plan dated 1/12/17, identified a potential for abuse.

A facility document titled: Grievance Form, dated 12/6/16 indicated the following concern had been voiced by R28: NA-M said "he was going to kill me because I wouldn't give him the call light." The grievance form identified the following findings: "None of the allegations were substantiated." The findings indicated R28 had a history of making accusations against staff. The attached investigation indicated NA-M denied the allegation of verbal abuse. There was no evidence the allegation was investigated further and the allegation was not reported to the SA.

During an interview with the DNS and ED on 1/25/17, at 4:03 p.m., the DNS stated the allegation should have been reported "because she [the resident] stated he was going to kill her." The ED stated she had been made aware of the report a month later and it had not been the facility's practice to report late if staff had already completed the investigation.

R45's quarterly MDS dated 12/8/16, indicated he was cognitively intact and was independent with all ADLs. His care plan dated 12/6/17 identified a potential for abuse.

A facility document titled: Grievance Form, dated 12/15/16, identified the following concern had been reported by R45 read, "On Saturday 12/13/16, I was waiting near the nurses' carts to sign out in the book. NA-AA was walking down the hall and as she got closer she took a deliberate step to the side. She [NA-AA] rammed her shoulder into mine on purpose." The

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grievance form findings indicated the allegation of physical abuse was not substantiated. The attached investigation indicated NA-AA had denied the allegation. No further investigation was completed, nor was the allegation reported to the SA.

R112's quarterly MDS dated 1/3/17, indicated she was cognitively intact and was independent with all ADLs. Her care plan dated 1/3/17, indicated a potential for abuse.

A facility document titled Grievance Form, dated 12/29/16, indicated the following concern had been voiced by R112: NA-O "cusses at her and calls her a liar." R28 had alleged in the grievance that NA-O was rough with her when assisting her to undress. The report indicated an investigation was initiated. A VOI dated 1/6/17, indicated R28 had reported she was "scared" of NA-O. The VOI did not indicate whether the allegation had been substantiated by the facility. The abuse allegation was reported to the State agency on 1/6/17, seven days after the initial report.

R186's quarterly MDS dated 12/27/16, indicated she was cognitively intact and independent with all ADL's. R186's care plan dated 12/22/16 identified a potential for abuse.

A facility document titled Grievance Form, dated 12/26/16, indicated R186 voiced the following concern: Certified Medication Technician (CMT)-D began a tirade of shouting and being "threatening" to her. The findings indicated the allegation was not confirmed and indicated instead that R186 had been verbally attacking staff. There was no evidence of an investigation,

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nor was the allegation of verbal abuse reported to the State agency.

During an interview on 1/25/17, at 4:03 p.m., the DNS confirmed no further investigation had been completed for R186 and stated, "we don't always report everything due to resident behaviors."

R218's discharge MDS dated 11/25/16, indicated she was cognitively intact and independent with ADL's. Her care plan dated 5/4/16, identified a potential for abuse.

A facility document titled Grievance Form, dated 11/18/16, indicated R218 had reported a concern on 11/17/16, that NA- O was rude to her and her roommate. R218 had reported that NA-O opens her curtain after she shuts it, and bumps into her things with the mechanical lift. R218 further reported, NA-O "throws the roommate's call light behind her bed, and when she turns on the call light for her roommate, he [NA-O] tells her not to intervene. The investigative report indicated R218's roommate had confirmed NA-O put her call light behind her bed and also confirmed he'd told R218 not to push her call light for the roommate. The resolution on the grievance form indicated: DNS will follow up with employee to ensure behavior does not occur again.

During an interview on 1/25/17, at 4:03 p.m., the DNS stated when a grievance form is completed, if he and the ED are aware of the information they will make the decision if it needs to be reported. He stated if the report occurred on a weekend the supervisor would notify him and he would let the ED know. The DNS stated, "sometimes we don't know what is going on, they [facility staff] are not

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always telling us." He further stated, "the process is sloppy." At that time, the ED added, that not everything was reported due to resident behaviors. She stated, "I look at the resident's behaviors and look to see if it is a continued behavior. I look to see if it is expected." At 4:48 p.m., the DNS stated when a report is received, the facility does their best to report it. He stated by the time they are aware it may be several days or several weeks. The DNS stated the facility changed their policy in November of 2016 to indicate that all grievances need to be called into the DNS or the ED. The DNS said if it occurred on a weekend, the supervisor needed to be notified immediately and was directed to call himself (DNS) and the ED. He stated he and the ED would determine whether a report needed to be made to the SA. He further stated the social services department had not been reporting to himself or the ED.

R167's diagnoses included major depressive disorder, recurrent severe without psychotic features, borderline personality disorder, anxiety disorder and post-traumatic stress disorder obtained from the quarterly MDS dated 11/28/16. In addition, the MDS indicated resident had intact cognition, had no behavioral symptoms, which included verbal, physical and did not have refusing/rejection of cares.

Review of R167's CP dated 3/23/16, identified R167 had a safety risk and there was a potential for abuse due to abdominal pain with fluid collection, chronic pain, foot pain and depression. The CP directed staff "Please don't have me near others who disturb me. Please remove me from potentially dangerous situation..."

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Review of Vulnerable Adult (VA) reports identified a report submitted to the SA on 10/31/16. The report included R167's allegation that R105 had threatened to "smash her up against the building." In addition, R167 alleged R105 stated, "You're begging for me to smack the shit out of you, smack you out of your chair, and knock you flat on your ass."

A review of the Disposition Letter for the incident report had been sent to the facility on 12/7/16, by the SA revealed the SA had acknowledged receipt of the incident however the file did not indicate a five day investigation report had been submitted to the SA after the initial report.

During review of the Progress Notes the following was revealed documented in the medical record of the allegation:
-On 10/30/16, at 7:04 a.m. writer had indicated at 12:30 a.m. resident had informed the writer that a resident guy on subacute unit was harassing her. Resident declined to tell who it was. She stated that she was down on the said unit when this resident called her names "you thief, stop coming to this unit, whenever you come here, our stuff get lost." The writer indicated a staff from Subacute stated that resident had been at the unit however did not hear what was going on. At that time resident agreed to talk to the Social worker on Monday. Writer indicated resident had been re-assured she was safe and her concern would be passed on to the social worker. Resident also stated she would call police if the guy continued to harass her.
-On 10/30/16, at 11:49 a.m. writer indicated resident was upset then over incident with a resident on subacute unit, she was unsure on

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name. Resident was crying and upset, writer indicated they spent 1:1 with resident, called the supervisor who came to talk to her.
-On 10/30/16, at 12:42 p.m. writer indicated resident continued to express anxiety over an occurrence she reported last night. She stated she was on subacute unit and was told to leave, and heard a resident yelling she was going into peoples' rooms and stealing things. She described the person as R105, who resided in the subacute unit. In addition to her earlier report, she had further described she had confronted R105 outside when she was smoking and he stated "You're begging for me to smack the shit out of you, smack you out of your chair, and knock you flat on your ass." Writer asked her if she wanted to report this to the police, but she stated no. Writer reassured her that she was safe on the second floor where she lived. Writer also explained she should not go down to subacute unit because of concerns there with residents from other floors who come down and take food from the unit, and who could possibly enter rooms unauthorized at night. Also writer told resident she should use the smoke room on second floor, and this would make her feel safer as well and reassured resident R105 would be talked to, and reminded to remain in his unit as well.

Even though three different nurse staff were made aware and/or had knowledge of the incident, none reported the incident to the ED and/or DNS to determine if the incident was to be reported to the SA. A report was then submitted to the SA on 10/31/16, by the social worker which was a day later and the ED and DNS were made aware also on the same day.

On 1/27/17, at 12:53 p.m. DNS reviewed the

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F 226	Continued From page 76 initial report submitted to the SA which was dated 10/31/16, he verified there had been three different staff who were knowledgeable of the incident and had written progress notes about the issue and all were aware of the issue and never reported the incident to the ED or himself so they could determine whether they should notify the SA. The DNS also stated the social worker who had completed the report was no longer working at the facility, "we inquire what happened then put in a note depending on the situation." When asked why the report had been submitted a day after the resident had reported the allegation, the DNS stated the report was submitted on 10/31/16, Monday because that was when the social worker heard about the issue. DNS stated RN-F was a nurse manager and had the authority to report the allegation to the SA "I don't know why it was not reported until the 31st but we can say it was reported."	F 226		
F 241 SS=G	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R26, R80, R165) was treated in a dignified manner during personal cares. R26 sustained emotional harm when the facility failed to provide assistance with care resulting in R26 having fecal incontinence.	F 241	R26 staff have been reeducated to not turn call lights off until residents concerns/needs have been met. Call light audits have been put in place. Staff educated on diagnosis of	3/11/17

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Findings include:

R26, on 1/23/17, at 5:13 p.m. was asked whether she felt staff treated her with respect and dignity. R26 stated, "I just think some of the staff are lazy and I don't want to work with lazy people."

On 1/27/17, at 8:17 a.m. R26 was observed to be in her room and was overheard yelling in a loud tone of voice, "I need to go to bed just do it. Why couldn't you transfer me when I asked you to. Now I am covered in s**t! You keep saying you need two people but you don't do it that way when the State is not here. I told you I needed to go to the bathroom and you know I can't wait. How many times do I have to ask three, four, five? Maybe you should try this." Certified medication technician (CMT)-C came out of R26's room. At 8:19 a.m. CMT-C was standing at the medication cart. When interviewed CMT-C stated, "She [R26] is mad because she wanted to lay down and asked how come I did not do it without a second person. She put her light on again and complained about stomach pain. She said something about going to the bathroom at that point. I cannot do it, she needs a Hoyer [mechanical lift] and staff are in the dining room. The rule is you can not use the Hoyer by yourself. She put her light on again. I told her we would get to her as soon as possible. [Nursing assistant (NA)-E] and I put her in the sling. He put her in bed and he is cleaning her up now. I can't do anything without help to transfer her but she yelled at me."

On 1/27/17, at 8:20 a.m. R26 was observed to be lying on her right side crying. Her shoulders were moving up and down and her upper body was

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gastroparesis to help decrease incontinence.

R80 Staff have been reeducated to explain cares to resident before starting cares.

Staff have been reeducated on the need to observe for signs and symptoms of pain during care delivery and if observed , stop cares immediately and inform nurse.

R165 Discharged from facility on 1/31/17

The DNS or designee will monitor for compliance

QAPI will review audits and actions to provide direction or change as needed.

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shaking due to her crying. R26's pants were observed to be covered with feces.

On 1/27/17, at 8:31 a.m. when NA-E left the room, R26 stated to the surveyor, "They just f*****g made me like this!" At 8:33 a.m. NA-E returned to the room NA-F and hygiene supplies. The nursing assistants proceeded to assist R26 with toileting hygiene.

On 1/27/17, at 9:02 a.m. R26 was interviewed and stated, "I was crying because I was upset. I was in my wheelchair and he [CMT-C] came in. I told him my stomach hurt and I need to go to the bathroom almost before 8 a.m. [CMT-C] did not say anything about needing two people but turned the call light off. I was leaning over and was screaming. He [CMT-C] left and then came back 10-15 minutes and said you need to stop screaming. There is a sick lady out there. Then he left and shut the door. I asked to be put to bed at that time and he said is it because you need to go to the bathroom? I said yes, I've got to go, I need to lay down. He told me the staff were doing breakfast so I'd have to wait until they were done. After 10 minutes I went over to the bed and pushed the button. Because I got tired of waiting and was going in my pants. [CMT-C] then came in with [NA-E]. They transferred me to bed. I had soiled myself. [CMT-C] asked me, 'Why must you yell at me? Look I don't want to hear you. You don't know what it is like.' He kept blabbing on and I told him to leave. [NA-E] put me in bed after [CMT-C] left. R26 stated this experience made her feel very upset and embarrassed. "It made me hurt and I felt hurt by what he [CMT-C] said. It all depends on how fast I go I could not hold this long." R26 further commented, "This happens all the time, every time I ask to lay down they give

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me excuses about not having enough staff, or that I need to wait till someone is free. I get frustrated. I have told people I am tired of talking, they don't listen and they don't care."

On 1/30/17, at 10:29 a.m. a follow up interview was conducted with R26. The resident stated, "I was crying and I felt that only happened one time and that was Friday when I asked to go to bed to have a BM [bowel movement] and didn't get there in time. I use the bedpan here, so they have to transfer me. When I am at home I use the toilet. I don't have that long from the time I feel the urge, maybe 5 minutes. I have had incontinence episodes where I have not been able to ask staff before it happens. It was very upsetting, my feelings got hurt. It made me mad because [CMT-C] knew I had to go, but he shut the call light off and then shut the door. To get some attention, I started yelling. I started yelling before I lost control. When they started the transfer I had already lost control. [NA-E] is fine, he is a good person. If I tell him I need to go to the bathroom he changes what he is doing and takes care of me then."

According the hospital's History and Physical dated 12/11/16, R26 had a diagnosis of gastroparesis (a condition in which the spontaneous movement of the muscles (motility) in the stomach does not function normally) secondary to diabetes. R26 was admitted to the facility on 12/16/16, to the according to the Admission Face Sheet.

A Bowel Assessment dated 12/19/16, indicated R26 was currently incontinent of bowel and that the resident recognized the appropriate time/place to defecate. The resident was able to

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feel the urge and sensation for bowel movement, but was unable to participate in a program due to functional disability and was dependent on staff.

R26's admission Minimum Data Set (MDS) dated 12/23/16, indicated the resident was cognitively intact. The MDS also indicated R26 was dependent upon two staff for transfers, bed mobility, dressing, toileting, hygiene and did not ambulate. The corresponding Care Area Assessment (CAA) for Activities of Daily Living dated 12/29/16, further verified the resident needed extensive assistance of two staff for bed mobility, dressing, toilet use and personal hygiene and did not ambulate at that time.

R26's care plan dated 12/29/16, identified a problem area of UTI's (urinary tract infections) and incontinence. Interventions directed staff to assist with incontinence care as needed. However, the care plan lacked evidence of any interventions for the diagnosis of gastroparesis and R26's urgency with having to defecate.

On 1/27/17, at 9:18 a.m. NA-E was interviewed and stated, "She [R26] was yelling when I came into the room, [CMT-C] was in the room. She was in the chair. I think she was upset and wanted to go to bed, she was upset because she was sitting in BM. [CMT-C] stayed in the room for the transfer. We put the sling on her together and then [CMT-C] stood there and I did the transfer. I went back to the dining room passing breakfast trays. I finished passing the trays then I went back to the room. It took probably 15 minutes." Even though the bowel assessment indicated R26 was incontinent, it also revealed that R26 felt the urge to go and knew when she had use the bedpan for defecation. Staff did not provide her with dignity

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for toileting.

On 1/27/17, at 1:36 p.m. the facility's executive director (ED) was interviewed and verified when a resident needed to use the bathroom there can be urgency in the request. She stated R26 had not been treated with dignity because she had informed the staff she needed to defecate, and because staff did not respond to the request R26 defecated all over herself, which made her emotionally and visibly upset.

R80 was observed on 1/23/17, at 7:56 p.m. NA-A was observed to enter R80's room where R80 laying in bed asleep. NA-A grabbed the blanket and pulled it down and off R80 in a quick manner. NA-A stated they had to provide pericare, because R80 was always digging in the rectal area and R80 had bowel movement material under nails. R80 asked, "What the h**l are you doing, leave me alone." NA-A did not provide R80 with any explanation of what they were doing in the room prior to the start of cares.

On 1/23/17, at 8:30 p.m. surveyor(s) informed the director of nursing services (DNS) observations of cares provided by NA-A.

R80's annual MDS dated 11/3/16, indicated R80 was moderately cognitively impaired. R80's MDS indicated R80 had verbal and physical behaviors toward others on to three times in the seven days prior to the MDS. R80's MDS indicated R80 required assistance with all activities of daily living (ADL) except eating and had diagnosis of Alzheimer's disease, depression and urinary incontinence.

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F 241	Continued From page 82 R80's Cognitive Loss/Dementia CAA Worksheet dated 11/14/16, R80 had diagnosis of dementia and was alert to and oriented to self and place with short term and long term memory deficits. R80 was at risk for unmet needs and safety deficits. ADL CAA Worksheet dated 11/14/16, indicated R80 required staff assistance with some ADL and cognitive skills. Behavioral Symptoms CAA Worksheet dated 11/14/16, indicated CAA was triggered due to R80 scratching a staff member during cares one day. Care plan considerations instructed staff to monitor for signs and symptoms of depression and to make sure R80 was not in pain or uncomfortable. Neither cognition or behavioral CAA indicated R80 was an inaccurate reporter or made false allegations against staff. The Physical Functioning Deficit care plan revised 11/16/16, indicated R80 had a history of personality disorder with narcissistic traits and could be judgmental and make negative statements regarding cares such as "some of them are awful" and instructed staff to provide dressing assistance and transfer assistance with hoyer of two caregivers due to false allegations." Bed mobility, personal hygiene, toileting, oral care and locomotion were to be assist of one staff member. Alteration in mood or behavior care plan revised 11/16/16, did not identify false allegations or inaccurate reporting as a problem but did instruct staff "using 2 persons during care may be needed due to potential for allegations date initiated 6/21/16." Undated, unlabeled nursing assistant assignment sheet instructed staff R80 was frequently incontinent of both bowel and bladder and to not apply two incontinence briefs at the same time.	F 241		

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No skin issues were identified on the assignment sheet and staff were instructed to have "2 person care givers at all times."

R165 was sitting in bed in a hospital gown on 1/23/17, at 4:29 p.m. R165 showed copies of grievances filed with the facility, and showed phone where R165 was documenting stay at facility. R165 said, "I try to journal daily to help me deal with depression. I don't always if I am too angry. I have done so for years."

LTC Professionals Progress Note date 1/2/17, indicated R165 had undergone an anterior fusion (abdominal surgery joining of two or more vertebrae together so motion did not occur) of L5-S1 (Lumber 5-last vertebrae in lower back and sacral 1-first vertebrae at the top of the sacrum on 12/23/16, with resulting retroperitoneal (the space between the back and the lining around the organs of the abdomen) hemorrhage (bleeding) and had ongoing abdominal and back pain.

R165's admission MDS dated 1/5/17, indicated R165 was cognitively intact with signs of depression but no hallucinations, delusions or behaviors. The MDS further indicated R165 required assistance with bed mobility, dressing, toileting, personal hygiene and walking in room or on the unit, and indicated R165 was occasionally incontinent of bladder, had constant pain at 8/10, and had impairment in range of motion for one side upper and lower body. In addition, the MDS indicated R165 had diagnosis of high blood pressure, spinal stenosis (narrowing) and post-acute procedural pain.

R165's ADL Functional /Rehabilitation Potential

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CAA Worksheet dated 1/10/17, indicated R165 required extensive assistance with ADL's with goals minimizing risks and avoiding complications. Urinary Incontinence and Indwelling Catheter CAA Worksheet Dated 1/10/17, indicated R165 was occasionally incontinent of urine. Urinary CAA indicated contributing factors included pain, restricted mobility and urinary urgency. Urinary CAA care plan considerations indicated R165 was frequently incontinent of urine and required assistance of staff with cares. Falls CAA worksheet dated 1/10/17, indicated R165 was at risk for falls and overall decline with difficulty maintaining seated balance and impaired balance when changing positions. Pain CAA worksheet dated 1/10/17, indicated R165 was having pain that put R165 at risk for immobility depression and functional decline.

R165's care plan dated 12/30/16, instructed staff R165 preferred to wear hospital gowns for comfort. R165's pain management care plain instructed staff to implement R165's preferred non-pharmacological pain relief strategies of offering cold pack and to encourage independence with repositioning. R165's care plan lacked specific interventions for ADLs or urinary incontinence.

An undated Subacute NA Assignment Sheet 2, indicated R165 required minimal assist of one with mobility, was independent to assist of one at times for toileting, and had pain in back and leg. The assignment sheet instructed staff to have two staff present with cares and interactions.

A facility document titled Grievance Form, dated 1/11/17, indicated R165 had reported a concern

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F 241	Continued From page 85 on 1/10/16, that on 1/9/17, staff did not answer her call light for 25 minutes, beginning at 10:30 p.m. Thus, R165 reported having been incontinent of urine from having to wait. According to the grievance, R165 reported going to the hallway for help and registered nurtde (RN)-N "laughed at her and said, 'she just needs a Dilaudid'." R165 reported feeling so upset R165 "wanted to go home." The findings section on the Grievance Form, indicated the allegations were not confirmed and indicated R165 put the call light on and one minute later came out of room yelling at staff to 'give a Dilaudid now'. The resolution on the grievance form indicated: Reviewed with staff -prompt responding to call lights and requests and respectful interactions. It also indicated a meeting had been scheduled with the long-term-care Ombudsman for 1/16/17, to discuss concerns and care for R165. The investigation lacked indication of interview with nursing assistants working the unit at time of allegation, but included interviews completed 1/21/17 and 1/22/17, with staff who had not been working the unit at the time of the allegation. This allegation of neglect and verbal/emotional abuse was not reported to the State agency. The grievance form was documented as having been received by the Grievance Official on 1/24/17. Review of R165's Progress Notes from 1/2/17 through 1/26/17 revealed: Progress Note charted 1/9/17, at 11:39 p.m. R165 had call light on one minute and came out screaming, "I need my pain bill (sic) now." Progress Note dated 1/10/17, indicated, "Res (resident) reported last night that she had her call light on 'a long time and nobody was answering it' and 'didn't make it to the bathroom on time.'" The Progress Note also indicated R165 told RN-F,	F 241		

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"She wanted to leave last night because of 'how I felt I was treated.' but ended up deciding to stay." The Progress Note further included: "her report is different than staff report on her behavior."

A Review of R165's Medication Administration Record dated 1/1/2017-1/31/2017, revealed order dated 12/29/16, "Assess pain intensity every shift: 0=no pain 1-4=mild pain 5-7=moderate pain 8-10= excruciating pain. If Pain assessed at moderate to excruciating=document interventions". Level of on 1/9/17 was documented as "8" on the day shift, "7" on evening shift "9" on the night shift. Review of Progress Notes for 1/9/17 did not indicate usage of any nonpharmacological interventions. Review of MMedication Administration Record (MAR) revealed order dated 1/6/17 for Dilaudid tablet 4 mg (milligram) every three hours as needed for pain until 1/9/17 at 23:59 (11:59 p.m.). R165 received Dilaudid 4 mg at 3:25 a.m., 11:00 a.m., and 5:37 p.m. and 11:27 p.m.

During interview on 1/26/17, at 12:20 p.m. R165 said, "I don't have the exact time, I was so upset that I did not make notes. I was in so much pain, I needed help to get to the bathroom. I put on my call light and when no one came I got myself to the bathroom. I had wet on myself. I put the bathroom call light on. It took me 20-25 minutes to clean up. I turned the call light off. I went out into the hall and [RN-N] said hi, what can I do for you? I told her I wanted Dilaudid and she turned to her coworker and said all she wants is her Dilaudid and laughed. I was so humiliated and came back in my room and started packing. I was so upset and angry, I could not respond. [RN-N] tried to talk me into staying. If I had gone out there and yelled not saying that I did I would have

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said please."

During interview on 1/28/17, at 2:32 p.m. NA-EE said, "Sometimes [R165] gets upset at me but she does not yell. [R165] uses the call light. A call light is a means of communication that we answer normally as soon as able." NA-EE stated call lights have two different sounds one for the room and one for the bathroom. NA-EE said, "Someone has to respond immediately to the bathroom call light, it is an emergency call light. Everyone is responsible to answer call lights."

During interview on 1/28/17 at 3:32 p.m. NA-O verified worked the evening shift. NA-O said, "We can have two or three lights going at the same time. The patients do not complain. If there are more than three call lights on we try to let the patients know that if it is not urgent they need to wait. Bathroom lights are very dangerous so we must answer them first. If a patient asks to go to the bathroom that needs to be first priority because if not they will be incontinent and feel so bad it could be humiliating."

On 1/27/17, at 1:36 p.m. the facility's ED was interviewed and stated all residents are to be treated with respect and dignity.

Dignity policy effective date 2/26/15, instructed staff, "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality."

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F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		3/11/17

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F 248	Continued From page 88 (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure activities were offered to 1 of 3 residents (R131) who did not speak English and who was at risk for social isolation reviewed for activities. Findings include: On 1/23/17, at 2:30 p.m. to 8:00 p.m. R131 was observed on multiple times wandering up and down the hallway in and out of room and to the dining room. R131 was never offered or encouraged to attend any activity. During the observations, the resident was observed on multiple times sitting around the dining room and going back and forth into her room. On 1/24/17, at 8:30 a.m. to 1:00 p.m. R131 was never offered or encouraged to attend any activities and was observed again to be wandering around the unit and attempting to speak her language. None of the staff or any of the other residents residing on the unit understood R131. The unit lacked any form of communication tools to aid in communicating with	F 248	R131 Activities are being offered based on her preferences of individual interests. Communication picture boards will be developed to assist with language communication for all residents. Resident's R131 room will be personalized with identified interests with family assistance. ACU/AACU Activity calendars are posted for each unit ACU/AACU resident rooms will reflect an individualized preference relating to the resident. A new attendance sheet is being developed to track attendance of residents individualized interest. Reeducation on care planning, attendance records, communication boards and programming to be provided to the	

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R131.

On 1/25/17, at 11:42 a.m. the director of the Alzheimer's unit-A was observed to approach R131 and handed her a green wash towel to fold. However, the resident threw the wash towel back at her and at the same time resident was overheard speaking some words in another language. As R131 waved her hands about, the staff gestured her to join and fold linens with other residents. R131 then remained in the area looking around for another 15 minutes before she stood and left the dining room.

R131's Care Area Assessments (CAA) completed 10/17/16, revealed the activities CAA did not trigger for further review. The cognitive CAA dated 10/17/16, indicated CAA triggered related to decreased cognition due to dementia and resident was at risk for activities of daily living (ADL) inability, social isolation, and safety issues decline. R131's care plan dated 1/17/17, indicated "I cannot speak English. My primary language is: Cantonese so I would like to participate in activities that don't depend on my needing to speak or understand language such as music, dancing, balloon ball, cleaning, sorting and folding tasks and setting the table."

R131's Activity Participation Review Assessment dated 1/19/17, indicated R131 attended small groups two to three times a week, attended a large group one to two times a month, had family visits two to five times a week, had been identified to only speak a few English phrases; and did not engage in activities requiring verbalization of English or verbal responses, such as trivia. The assessment also indicated the resident enjoyed music programs, singing,

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Alzheimers care Directors and floor staff.

Activity Director or designee will complete weekly audits to ensure activities are occurring as scheduled and activities meet the residents individual needs.

Alzheimers Care Directors and Activity Director is responsible for monitoring compliance

QAPI will review audits and actions to provide direction or change as needed.

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dancing, enjoyed looking at picture books of animals. The family had provided phrases that resident used and their translation and communication with resident was largely non-verbal. R131 enjoyed family visits.

R131's Therapeutic Recreation Attendance Record dated August 2016 through 1/24/17, indicated R131 had attended 102 activities out of 179 days of which 96 coded as "A=active", one coded as "P=passive" and five coded as "P/W =passive wanders in/out." The Attendance Record also revealed there was no attendance log provided by the facility for September 2016. In addition, the Attendance Record revealed the resident attendance had not been reviewed to ensure the interventions were being followed, if there were appropriate for resident, and the record did not indicate what "Independent activity" resident had participated on.

On 1/25/17, at 12:50 p.m. when asked about resident activities the director of the Alzheimer's unit-A stated she was in charge of activities in the adjacent unit however did have an overlap with the other director of the Alzheimer's unit-B who coordinated the activities in the unit. She reviewed the activity logs and verified for the last three months there had not been any planned activities individualized for resident as per the care plan. She acknowledged with resident not able to communicate in English there were no noted activities that were individualized for resident as assessed and the care plan had not been revised for resident activity needs.

On 1/25/17, at 1:11 p.m. when asked how staff communicated with resident both licensed practical nurse (LPN)-F and nursing assistant

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F 248	Continued From page 91 (NA)-K stated the nursing staff had identified her gestures and always anticipate her needs with gestures. Both indicated there were particular words the nursing staff had known of the things she needed like food, and toilet needs. Both stated the resident liked to pound on the surfaces and would sing her language. R131 also liked make and have bracelets and necklaces. R131's family was at the facility almost daily for "only 10-15 minute visits." On 1/25/17, at 1:19 p.m. the director of the Alzheimer's unit-A reviewed the care plan, Progress Notes and activities assessments stated she had completed the most recent assessment and she completed the assessment with most of the same data from the previous one the other director had completed. The director of the Alzheimer's unit-A acknowledged although R131's activities needs had been assessed and a care plan had been developed, the staff were not following the care plan and were not doing any activities with her as identified on the assessment. When asked if she was aware the resident liked to make and have jewelry she stated she did not know that. The director of the Alzheimer's unit-A also acknowledged resident activities needs had not been reviewed and re-evaluated and facility had not looked into getting out resources to involve resident in more activities other than the family visits which lasted 10 to 15 minutes.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility	F 272		3/11/17

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F 272	Continued From page 92 must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct	F 272		

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F 272	Continued From page 93 observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a comprehensive assessment of resident potential restraint use for 1 of 1 resident (R151) reviewed who was newly admitted with and had siderails on the bed. Findings include: R151 was observed on 1/24/17, at 9:47 a.m. R151 was sitting in wheel chair and gave permission to check side rail. The right half side rail was in the down position in middle of the bed and the rail was tight as it did not move from side to side. The left half side rail was in the up position. The left side rail moved side to side. During observation on 1/25/17, at 6:39 a.m. R151 was lying in bed with the call light on, both half side rails were down in the middle of the bed. During observation of morning cares on 1/25/17, at 7:18 a.m. R151 was sitting on edge of the bed. The right half rail was in the down position and left side rail was in the up position. Nursing assistant (NA)-E assisted R151 to stand up. R151 used left side to stand up and the side rail moved. NA-E did a pivot transfer with R151. R151 sat down on wheelchair arm rest. NA-E helped R151 stand back up and sat R151 down in wheelchair. R151 said, "They usually use the EZ [mechanical lift] lift. It is easier, I get stuck on the wheel [wheelchair]." R151's initial care plan dated 12/31/16, did not	F 272	R151 Side rail assessment has been completed, consent obtained, order has been entered and care plan in place. Other residents will be assessed at time of admission, quarterly or with change in condition for utilization of side rails. If side rails are needed a consent, physician order and a care plan will be updated to include adding side rail information to assignment sheets. Maintenance will continue to complete weekly side rail audits as part of the preventative maintenance plan. Nurse Managers will inform maintenance when side rails are no longer needed for removal. Nurse Managers are responsible for monitoring compliance. QAPI will review audits and actions to provide direction or change as needed.	

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address side rail usage until after surveyor asked licensed practical nurse (LPN)-B about R151's activity of daily living (ADL) care plan. Nor did the temporary plan of care address R151 mobility status, transfer status, and recent stroke.

R151's admission comprehensive assessment dated 1/2/17, indicated the resident was a fall risk. The admisssion Physician Orders were reviewed from 1/2/17, going forward and there were no orders for the siderails use.

R151's physical therapy (PT) evaluation dated 1/2/17, did not address side rails or grab bars. PT was working with R151 for bed mobility including side to side turning using minimal assistance and transfers using moderate assistance.

R151's admission MDS dated 1/7/17, indicated R151 was cognitively intact with no behaviors and required assistance with activities of daily living (ADL) including bed mobility and transfers. R151's MDS indicated R151's diagnoses included cerebral vascular accident (stroke) and left sided hemiplegia (weakness). The MDS indicated the resident did not use bedrails or restraints and had not fallen since admit.

R151's Falls CAA Worksheet dated 1/10/17, indicated R151 was at risk for falls with injury related to recent stroke with left sided weakness.

The Subacute NA Assignment Sheet undated did not address side rails or positioning bars use.

On 1/25/17, at 7:25 a.m. NA-E was interviewed. NA-E indicated R151 was a pivot transfer and that R151 used the rails for transferring. NA-E verified the left grab bar could be moved

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approximately 1.5 inches in either direction.

On 1/26/17, at 7:35 a.m. R151's bed rails were observed with the maintenance director. The right side rail was in the down position and did not deviate from side to side. The left side rail was in the up grab bar position. The left side rail moved back and forth approximately 1.5 inches. The maintenance director looked at side rail and verified the left grab bar was loose. The maintenance director stated that side rails were on for preventative maintenance this month and that he would fix the rail. When asked what the process was for preventative maintenance the maintenance director stated he looked at all the bed rails on a weekly basis. He indicated he did not document the rooms as he did all of the rooms. The preventative maintenance was reviewed in the electronic record. The electronic record read check and adjust all side rails set up weekly as preventative maintenance task. It was not room specific which would instruct staff to tighten or replace side rails if not tight or functioning correctly. It was marked as being completed every Thursday.

On 1/27/17, at 8:02 a.m. LPN-D verified the medical record lacked evidence of an assessment for side rails, risk versus benefits explanation, lacked consent, lacked a physician's order, and lacked care planning for the siderails. LPN-D also verified when R151 was in bed, the 1/2 rails are to be in the down position. LPN-D verified the left rail was loose and could be moved approximately 1.5 inches in either direction which made the rail wobbly.

On 1/27/17, at 11:23 a.m. RN-E stated , "I do not think he could get him self up without assist [of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 96 the bedrails] but he could go to the bottom of the bed if the bedrail is in the down position." During interview on 1/27/17, at 1:01 p.m. director of nursing services (DNS) said, "We do not have side rails on the beds, we have railings on bed that are used as assist with bed mobility and turning and repositioning." DNS said, "We do not obtain a consent, because we don't use restraints in the facility." DNS said, "We assess patients upon admission and provide them with the necessary equipment. We do risk and benefits if it is appropriate." During interview on 1/30/17 at 12:10 p.m. DNS indicated the side rails were on the bed when the bed was delivered to the unit. The bed was in the room when resident was admitted and no interventions were documented prior to using the railings. DNS stated the staff were to follow the care plan. The Restraint Evaluation and Utilization Guideline dated 2/4/16, instructed staff The need for the use of restraint will be discussed with the resident and/ or family. The risks and benefits will be explained to the resident and /or family. The facility will obtain a signed consent for the use of the restraint. The center will obtain a physician order for the least restrictive device. The Physician Order must include the medical symptom for which the device is to be used. No consent could located in R151's medical record. In addition, the medical record lacked evidence any interventions tried before applying the bed rails. The MDS 3.0 manual October of 2016 directed the facility MDS coordinator "to record the	F 272		

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F 272	Continued From page 97 frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition." R151 had bilateral siderails on the bed without the use of a comprehensive assessment.	F 272		
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 right to participate in his or her treatment and shall support the resident in this right. The	F 280		3/11/17

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F 280	Continued From page 98 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 and their resident representative is determined not practicable for the development of the	F 280		

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F 280	Continued From page 99 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 ensure the care plan was revised for 1 of 3 residents (R131) who did not speak English and who was at risk for social isolation reviewed for activities. In addition, the facility failed to evaluate and update care planned interventions for 1 of 3 residents (R118) reviewed for falls. Findings include: On 1/23/17, at 2:30 p.m. to 8:00 p.m. resident was observed on multiple times wandering up and down the hallway in and out of room and to the dining room was never offered or encouraged to attend any activity. During the observations resident was observed on multiple times sitting around the dining room and going back and forth into her room. On 1/24/17, at 8:30 a.m. to 1:00 p.m. resident was never offered or encouraged to attend any activities and was observe again wandering around the unit and attempting to speak her language however, nobody staff or any of the resident residing in the unit understood and no staff either used a communication board.	F 280	R131 Residents care plan interventions identifying music, dancing, balloon toss and jewelry making have been added and are part of her activities program. A communication picture board is being developed to assist with communication. R118 Residents care plan for falls interventions have been reviewed and revised to include that she was moved to a room closer to the nursing station, medical director has reviewed her fall history and met with resident to review pain concerns related to not using her walker. PT is working with resident on balance and utilizing her walker. NAR assignment sheet are updated to include the revised falls interventions. New residents will be assessed for falls, communication and activity needs. Care plan developed and reviewed with any change of condition and quarterly. Reeducation of nursing staff will be	

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F 280	Continued From page 100 On 1/25/17, at 11:42 a.m. the director of the Alzheimer's unit-A was observed approach resident and handed her a green wash towel to fold however resident throw the wash towel at her and at the same time resident was heard say some words in another language in a loud voice as she waved her hands out as the staff gestured her to join and fold linens with other residents. Resident then remained in the area looking around for another 15 minutes before she stood and left the dining room. R131's diagnoses included dementia, psychosis, and age-related osteoporosis obtained from the January 2017, Medication Administration Record (MAR). R131's Care Area Assessment (CAA) completed 10/17/16, revealed the activities CAA did not trigger for further review. The cognitive CAA dated 10/17/16, indicated CAA triggered related to decreased cognition due to dementia and resident was at risk for activities of daily living (ADL) inability, social isolation, and safety issues decline. R131's care plan dated 1/17/17, indicated "I cannot speak English. My primary language is: Cantonese so I would like to participate in activities that don't depend on my needing to speak or understand language such as music, dancing, balloon ball, cleaning, sorting and folding tasks and setting the table. R131's Activity Participation Review Assessment dated 1/19/17, indicated resident attended small groups two to three times a week, attended large group one to two times a month, had family visits two to five times a week, had been identified only spoke a few English phrases; and did not engage	F 280	completed on falls, communication, activity needs and care plans. Weekly audits will be completed DNS or designee is responsible for monitoring compliance. QAPI will review audits and actions to provide direction or change as needed	

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in activities requiring verbalization of English or verbal responses, such as trivia. The assessment also indicated resident enjoyed music programs, singing, dancing. Family visits which resident very much enjoyed, enjoyed looking at picture books of animals, the family had provided phrases that resident used and their translation and communication with resident was largely non-verbal.

R131's Therapeutic Recreation Attendance Record dated August 2016, through 1/24/17, indicated R131 had attended 102 activities out of 179 days of which 96 coded as "A=active", one coded as "P=passive" and five coded as "P/W =passive wanders in/out." The attendance record also revealed there was no attendance logged and provided by the facility for September 2016. In addition, the attendance record revealed resident attendance had not been reviewed to ensure the interventions were being followed and if there were appropriate for resident and record did not indicate what "Independent activity" resident had participated on.

On 1/25/17, at 12:50 p.m. when asked about resident activities the director of the Alzheimer's unit-A stated she was in charge of activities in the adjacent unit however did have an over lap with the other director of the Alzheimer's who coordinated the activities in the unit. She reviewed the activity logs and verified for the last three months there had not been any planned activities individualized for resident as per the care plan. She acknowledged with resident not able to communicate in English there were no noted activities individualized for resident as assessed the care plan had not been revised for resident activity needs.

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On 1/25/17, at 1:11 p.m. when asked how staff communicated with resident both licensed practical nurse (LPN)-F and nursing assistant (NA)-K stated the nursing staff had identified her gestures and always anticipate her needs with gestures. Both indicated there were particular words the nursing staff had known of the things she needed like food, and toilet needs. Both stated resident liked to pound on the surface and would sing her language, liked bracelets and necklaces, also resident family was at the facility almost daily for "only 10-15 minute visits."

On 1/25/17, at 1:19 p.m. the director of the Alzheimer's unit-A reviewed the care plan, progress notes and activities assessments stated she had completed the most recent assessment and she completed the assessment with most of the same data from the previous one the other director had completed. The director of the Alzheimer's unit-A acknowledged although resident activities needs had been assessed and a care plan had been developed, the staff were not following the care plan and were not doing any activities with her as identified on the assessment. When asked if she was aware resident liked to make and have jewelry she stated she did not know. The director of the Alzheimer's unit also acknowledged resident activities needs had not been reviewed and re-evaluated and facility had not looked into getting out resources to involve resident in more activities other than the family visits which lasted 10 to 15 minutes.

R118's quarterly Minimum Data Set (MDS) dated 12/16/16 indicated she was cognitively intact and required some limited assistance with activities of

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daily living. The MDS indicated she was occasionally incontinent of bladder.

R118's care plan dated 12/14/17, indicated a risk for falls related to a history of falls in the facility. Care planned interventions dated 5/5/16, included: assess for pain, call light in reach, observe for side effects of medications, therapy referral and use mechanical lift if unable to get up off floor independently. A facility document untitled and undated, (nursing assistant care sheet) identified the following fall intervention: "Sling Size: large sling if falls and unable to self transfer from floor." No other interventions were indicated.

During observation on 1/27/17, at 9:25 a.m., R118 was ambulating independently throughout the unit. She was not using her walker, nor did staff encourage her to use the walker.

A review of R118's GL (Golden Living) - St. Louis Park Progress Notes dated 5/5/16, through 1/27/17 identified the following falls:
On 5/5/16, R118 had an unwitnessed fall in her bathroom. Staff entered room and found her sitting on the floor. R118 stated she had slipped and indicated her socks were slippery. Staff provided R118 with non-slip socks. On 5/9/16, R118 was found on the floor leaning against her walker. On 6/30/16, R118 was heard calling for help at 6:00 p.m., staff responded to find her sitting on the floor in the doorway of her bathroom. A facility document titled Post Fall Analysis/Plan dated 7/7/16, indicated the interdisciplinary team (IDT) reviewed the fall and recommended R118 be reminded to use her walker. On 7/20/16, R118 reported she lost her balance and fell in her room and hit her head. A

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F 280	Continued From page 104 facility document titled Post Fall Analysis/Plan dated 7/21/16 indicated the IDT reviewed the fall and recommended staff encourage R118 to call for assistance and staff to offer assistance. On 8/5/16, R118 was found lying on the floor by her bathroom doorway. On 9/2/16, R118 stated she was trying to find the bathroom and could not find the grab bar. Stated she lost her balance and fell. On 10/7/16, Staff heard R118 calling for help and found her sitting on the floor with her walker next to her. She stated she tripped on her walker. On 10/12/16, staff responded to R118's bathroom light to find her lying on the floor. R118 stated she fell and crawled to the bathroom to call for help. On 10/20/16, Staff heard a loud noise coming from the craft room and responded to find R118 sitting on the floor beside the toilet. On 11/2/16, a housekeeper alerted nursing staff that R118 had fallen. A facility document titled Post Fall Analysis/Plan, dated 11/3/16 indicated the IDT reviewed the fall and indicated R118 was working with physical therapy to increase use of walker. On 11/5/16, R118 was found lying on the floor calling for help. She was on her right side lying across her doorway. R118 stated she was coming from the bathroom and lost her balance and fell. On 11/15/16, staff responded to R118's call light to find her sitting on the floor in the middle of her room. On 12/14/16, R118 was found sitting on the floor, stated she fell after tripping on her walker. On 1/2/17, R118 was found lying on the floor at 7:00 p.m., she stated she had hit her head. No recommendations were identified. On 1/12/17, R118 fell in the dining room. A facility document titled Post Fall Analysis/Plan, dated 1/13/17 indicated the IDT reviewed the fall and recommended staff decorate R118's walker to encourage use. On 1/14/17, R118 was found lying on the floor next to her bed by staff. She	F 280		

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indicated she had slid out of her bed and landed on her bottom. On 1/27/17, R118 was ambulating and lost her balance.

During interview on 1/26/17, at 3:56 p.m. NA-S stated she was unaware of any fall interventions for R118. NA-S reviewed her care sheet and indicated the only intervention was to use a sling if R118 falls and can't get up.

During an interview on 1/26/17, at 3:59 p.m. LPN-G stated R118 has a lot of jerking she is unable to control due to her diagnosis and that it may contribute to her falls. She stated interventions include, encourage her and offer assistance and she makes sure to give R118's meds on time.

During and interview on 1/26/17, at 4:30 p.m., the assistant director of nursing services (ADNS) stated R118 needed a weighted walker due to impaired balance. She stated she would not use it even though staff encourage her. the ADNS stated when a fall was reported the nurse completed an incident report. She stated the falls are discussed at the IDT meetings. The DNS stated the facility has attempted therapy and stated R118 had shoulder pain that was increased with use of her walker. She stated most recently they discussed decorating R118's walker to promote use.

During an interview on 1/30/17, at 9:55 a.m., the director of nursing services (DNS) stated an incident report should be completed for each fall. He stated the IDT reviews each fall and discusses potential interventions to prevent future falls. He stated all of her falls were due to non-compliance with the use of her walker. He

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stated R118 does not always remember her walker and staff will educate her and remind her to use it. He stated R118 has balance problems and has been referred to therapy. He stated when she uses her walker she's fine, even though she had her walker with her during many of her falls. The DNS stated other than therapy referral and reminders to use the walker, they did not implement any other interventions. He stated, "I think we should have looked at other options instead of just what we did." He stated, "we should have looked at her more closely, and we didn't."

While R118 sustained 17 falls in the facility, one of which required an emergency room visit related to a laceration, there was no evidence the facility consistently reviewed R118's falls in an effort to determine causal factors and/or prevent further injury. Further, the staff indicated R118's falls were all related to non-compliance with the use of her walker, however, at least three of R118's falls indicated she was using her walker and there was no evidence these falls were investigated.

A facility policy titled Golden Living post Fall Analysis Summary and Guidelines for Completion, dated 10/11/16, was reviewed and indicated the following:
It is the policy of the living center to completed the Post fall Analysis Summary after every known fall. The IDT team will complete a review of the post fall Analysis within 72 hours. Recommendations implemented shall be recorded on the report and plan of care revised as necessary.

Interdisciplinary Care Plan policy Effective date 4/1/16, instructed staff, "The interdisciplinary care

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F 280	Continued From page 107 plan will be reviewed at least quarterly to evaluate effectiveness and be revised/updated as necessary to address resident needs in accordance with the most current assessment. Interventions that have proved ineffective must be changed on care plans immediately."	F 280		
F 282 SS=E	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 observations, interview and document review, the facility failed to follow the plan of care for 1 of 3 residents (R150) who was dependent for grooming reviewed for activities of daily living (ADL); the facility failed to follow the plan of care for 2 of 3 residents (R260, R119) reviewed for accidents; the facility failed to follow the plan of care for 1 of 2 residents (R26) who requested toileting assistance; and the facility failed to ensure resident's who pain received assistance with ADLs for 1 of 3 residentsa (R165). Findings include: Grooming: R150's diagnoses included unspecified dementia, paranoid schizophrenia and depressive disorder obtained from the quarterly Minimum Data Set (MDS) dated 12/6/16. In addition the MDS	F 282	R150 Nails are being trimmed and cleaned per plan of care. Nails are checked and documented as part his weekly skin assessment. All residents will be assessed for grooming needs at time of admission with weekly skin checks. Care plans are developed to identify grooming needs and will be reviewed quarterly and as needed. R260 A new smoking assessment has been completed and she has been identified as being independent to smoke. The smoking policy has been reviewed and the new policy will identify if residents are assessed to be independent with smoking, they will not have to be	3/11/17

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F 282	Continued From page 108 indicated resident did not exhibit rejection of care and required extensive assistance of one with personal hygiene. R150's ADL Care Area Assessment dated 6/21/16, indicated the CAA triggered related to resident requiring staff assistance and had diagnosis of dementia and paranoid schizophrenia. Care plan dated 12/12/16, indicated "I have a physical functioning deficit related to: Self care impairment, mobility impairment, diagnoses of dementia, paranoid schizophrenia and osteoarthritis pain." Care plan directed staff to turning and position resident per tissue tolerance and provide nail care as needed. On 1/24/17, at 9:39 a.m. during observations R150 was observed seated on wheelchair at the bedside watching television and both hand fingernails were observed to be long approximately one quarter (1/4) inch, jagged edged and had brown matter underneath. During interview at 9:41 a.m., resident stated staff did assist him with nail care. On 1/25/15, at 7:40 a.m. R150 was observed seated on a wheelchair at the dining room table. R150 appeared sleepy at the time however was seated up straight well positioned and was all dressed for the day. When approached and asked how he was doing resident stated "I have pain in my back" when asked if he wanted pain medications R150 stated "please get me a couple." Surveyor approached licensed practical nurse (LPN)-F reported resident pain. R150's fingernails to both hands remained long approximately one quarter (1/4) inch long, jagged edged and with brown matter underneath the nails.	F 282	supervised, they will not have to wear a smoking apron, will be able to keep their smoking materials in their possession. Residents and staff will be educated on the new smoking policy. The supervised smoking room will continue with the existing policy. New resident wishing to smoke will be assessed at time of admission, quarterly or with any significant change in condition. R119 Comprehensive falls assessment identifying the contributing factors and root cause analysis has been completed for falls. Resident has been referred to physical therapy for evaluation and treatment. All residents upon admission will be assessed for fall risk and care plan developed to address fall risk and care plan developed to address fall risk and interventions implemented to to decrease the risk of falls. R26 Care plan was reviewed and revised to include interventions for gastroparesis and urgency with bowel movements. Nursing staff will be educated on including diagnosis of gastroparesis in care plan development. R165 Discharged from facility on 1/31/17	

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F 282	Continued From page 109 -At 8:05 a.m. LPN-F was observed apply R150's hearing aides both hands visible never offered to trim the nails. -At 8:18 a.m. the director of the Alzheimer's unit approached with R150's breakfast, the nails were visible as the resident's hands were on the table and the director never acknowledged or offered to have fingernails trimmed. On 1/25/17, at 11:06 a.m. R150 was observed seated on wheelchair at the dining room table right in front of the nursing station, drinking a pop at the time both hands fingernails were visible from standing 10 feet and nails still noted with brown matter underneath, long and jagged edged. On 1/26/17, at 1:10 p.m. resident was observed seated on wheelchair right next to bed the fingernails to both hands still long, jagged edged and had brown matter underneath them. When approached and asked how he was doing R150 stated "well." When asked about his fingernails resident looked at the nails and stated "they are long." When asked if he would let staff trim them resident stated "no problem." -At 1:10 p.m. LPN-G stated resident was not diabetic and staff was supposed to trim the nails with his shower weekly. LPN-G went to room and she verified the fingernails were long, jagged edged and had brown matter underneath them. -At 1:13 p.m. LPN-G went back to R150's room, approached the resident and asked the resident if she could trim the nails. R150 was observed to stretch his left hand over and LPN-G was observed provide nail care. On 1/26/17, at 1:23 p.m. when approached and asked about resident nail care nursing assistant	F 282	Weekly audits on care plans to be completed on all floors. DNS or designee is responsible for monitoring compliance. QAPI will review audits and action to provide direction or change as needed.	

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(NA)-H stated resident was ate independently and staff was to supposed to assist to clean under his nails as food got into them. NA-H also stated resident liked nail care to be done on the day he got a shower as they were soft under water.

During review of the Weekly Skin Review dated 12/24/16, 12/31/16, 1/7/17, 1/14/17, and 1/21/17, it was revealed the skin had been assessed and indicated as intact however lacked documentation the nail care had been provided or had been offered and refused. During review of Progress Notes dated 12/1/16, through 1/23/17, it was revealed there was no documentation of resident refusing cares.

On 1/27/17, at 8:50 p.m. registered nurse (RN)-H stated nail care was put of the care plan and was to be provided and as needed. RN-H stated the staff was supposed to follow the plan of care.

On 1/27/17, at 1:00 p.m. the director of nursing services (DNS) stated, staff was supposed to follow the care plan.
Accidents:
R260's Smoking Assessment section indicated on 1/12/17, R260 did not have any cigarettes and the smoking policy was explained. On 1/30/17, the Smoking Assessment was updated and indicated R260 did not have cognitive or physical impairment preventing from safely containing ash and extinguishing cigarette after the surveyor brought it to the attention of the facility.

The Immediate Plan of Care Smoking dated 1/12/17, revealed R260 had impaired cognition, hand tremors and was not following smoking policy. The care plan instructed staff, "supervision per policy while resident is smoking."

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The Smoking Care Plan dated 1/13/17, indicated R260 was at risk for smoking related injury related to: "Smokes independently Non-compliant with facility smoking policy. Smokes in undesignated areas at undesignated times, and does not keep smoking materials in locked cart." R260's smoking care plan instructed staff to, "Assure smoking material is extinguished prior to patient leaving smoking area, Observe patient for unsafe smoking behaviors or attempts to obtain smoking material from outside sources, immediately inform facility management. Patient not to have cigarettes or smoking material on person Place patient in position to assure visualization of ashtray, Provide smoking apron while smoking, Storage of smoking materials per Living Center policy."

R260 was observed on 1/24/17, at 9:55 a.m. R260 was observed to put a cigarette out on the sidewalk of the court yard, leaving the smoldering tip of cigarette on the sidewalk. R260 walked into the facility. There were no facility staff observed in the area. The surveyor continued to observe to ensure tip stopped smoldering. During a random observation on 1/25/17, at 9:39 a.m. R260 was smoking in the outside courtyard R260 threw cigarette into the garden without putting it out. There were no facility staff in the common area leading to the outside court yard to supervise the resident while they smoked.

During continuous observation on 1/25/17, from 11:42 a.m. until 12:43 p.m.
- At 11:43 a.m. R260 came walking into common area with a cigarette dangling out of her mouth. R260 went out to the courtyard and said to another resident "no one is in the lunch room so I

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decided to have a cigarette." R260 lit cigarette with lighter and then put the lighter back in her coat pocket.
-At 11:46 a.m. R260 reentered building with cigarette in hand. R260 put cigarette in the left coat pocket. R260 verified she had put cigarette in her pocket and showed surveyor that she had knocked the end off of it and the cigarette was not smoldering. R260 had a pack of Smoky Joe's cigarettes that had 15 cigarettes in it.
-At 12:23 p.m. R260 entered the common area with a cigarette hanging out of her mouth and went out to the courtyard to smoke.
-At 12:25 p.m. R260 went out to the courtyard and lit cigarette then sat on bench. R260 tapped the ash off of the cigarette onto the ground. R260 was holding cigarette in right hand that had a splint and gauze wraps on it.
-At 12:29 p.m. R260 put cigarette out on ground by bench.

During a random observation on 1/28/17, at 2:44 p.m. R260 was outside wearing a white tee shirt and gray sweat pants and boots. R260 was passing a cigarette back and forth with sharing a cigarette with unidentified resident. Temperature at that time was 23 degrees with a wind chill of 11 degrees Fahrenheit.

During interview on 1/26/17, at 7:11 a.m. LPN-B said, "All of our residents who smoke are to go up to second floor. All people there are supervised. There is supposed to be no smoking outside."

During interview on 1/27/17, at 11:57 a.m. RN-E said, "It is impossible to keep the residents who smoke in the courtyard supervised. They do what they want to. We try to keep them in when it is cold but that does not work. She [R260] is not

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F 282	Continued From page 113 safe to smoke in the court yard but insists." R119's nurse was interviewed on 1/24/17, 10:15 a.m. When asked how many falls the resident had in the last 30 days LPN-I stated the resident had a fall on 1/1/17, and had no injuries. On 1/28/17, at 4:20 p.m. to 4:50 p.m. resident was observed wheel self in the first floor of the facility by the subacute unit. Resident was observed wearing a pair of blue gripper socks. When asked about her transfers and the assistance she received, resident stated the staff was supposed to help her however when she needed the assistance it was a while before someone came. When asked about her gait the resident stated "sometimes am just tired like after dialysis." When asked about the falls, the resident stated they happened so fast. During review of the medical record both electronically and the paper chart the following was revealed about the resident falls in the Progress Note: -6/2/16, at 10:45 p.m. indicated the nursing assistant had reported to the writer the resident was on the floor. The writer went into the resident room and found the resident on the floor between the wheelchair and bed crying. When asked what had happened, the resident stated "I was trying to get my chips from the floor" and the resident slip off the wheelchair and had hit her left arm and was complaining of pain. The resident was assessed and transferred using a Hoyer (specialized lift) with two staff and vital signs were noted to be within normal limits. -8/10/16, at 10:20 p.m. the writer indicated the resident had been found on the floor, sitting on	F 282		

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her bottom, denied hitting head and denied pain and had no injuries noted.
-12/23/16, at 8:00 p.m. the resident was found sitting by the bedside. The resident stated she had slid to the floor when trying to transfer self. Denied hitting head. Transferred and denied pain. The note indicated the resident had been asked to use the call light when trying to transfer to avoid falls. During review of the Post Fall Analysis/Plan 12/23/16, it was revealed the interdisciplinary team (IDT) review and recommendation had been made for resident to be referred to physical/occupational/speech therapy for evaluation.
-1/1/17, at 6:56 a.m. note indicated the resident had a fall at 6:20 a.m. and resident had stated "I was grabbing a candy, and fell." The note indicated the resident was assessed, denied, vital signs were obtained, denied hitting her head and no injuries noted.

During further document review, it was revealed there were no Post Fall Analysis/Plan reports were completed for R119 for falls dated 6/2/16, 8/10/16, and 1/1/17. In addition, it was revealed even though the IDT had recommended therapies the recommendation had not been followed on.

R119's care plan dated 1/24/17, indicated resident was at risk for falls related to history of falls, balance impairments, weakness/deconditioning, history of high blood pressures history of low blood sugar. The care plan also indicated R119 was to have therapy as needed. R119 did not receive therapy as recommended and per the plan of care.

On 1/26/17, at 3:01 p.m. the director of nursing

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services (DNS) stated he was not able to pull the actual incident reports and Post Fall Analysis/Plan for R119's falls for the dates 6/2/16, 8/10/16, and 1/1/17. When asked the facility policy for investigating falls aftermath, DNS stated the nurses were supposed to complete both as that was how the IDT followed up all incidences and if there was no incident the falls were not reviewed as they did not generate "Total Events" log for resident.

On 1/30/17, at 9:25 a.m. a therapy staff reviewed the therapy notes and all the episodes R119 stated the last time resident had been seen by physical, occupational and speech therapies was 6/28/16, 9/19/16, and 11/24/16, respectfully. She verified resident had not been seen by either of the therapies even though it had been recommended by the IDT team to be seen following the fall on 12/23/16.

Toileting:
R26 was overheard on 1/27/17, at 8:17 a.m. yelling in a loud tone of voice. R26 was in her room and stating "I need to go to bed just do it. Why couldn't you transfer me when I asked you to? Now I am covered in s**t! You keep saying you need two people but you don't do it that way when the State is not here. I told you I needed to go to the bathroom you know I cannot wait. How many times do I have to ask three, four, five? Maybe you should try this." Certified medication technician (CMT)-C came out of R26's room. At 8:19 a.m. CMT-C was standing at the medication cart. When interviewed CMT-C indicated, "She is mad because she wanted to get laid down and asked how come I did not do it without a second person. She put her light on again and

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F 282	Continued From page 116 complained about stomach pain. She said something about going to the bathroom at this point. I cannot do it. It is a Hoyer and staff are in the dining room. The rule is you cannot use the Hoyer by yourself. She put her light on again. I told her we would get to her as soon as possible. [Nursing assistant (NA)-E] and I put her in the sling. He put her in bed and he is cleaning her up now. I can not do anything without help to transfer her but she yelled at me." On 1/27/17, at 8:20 a.m. R26 was observed to be lying on the right side, crying. Her shoulders were moving up and down and R26's upper body was shaking as R26 was crying. R26's pants were covered with feces. On 1/27/17, at 8:31 a.m. NA-E left the room and the resident stated, "They just f*****g made me like this!" At 8:33 a.m. NA-E returned to the room with more supplies and with NA-F. Both aides assisted R26 with toileting hygiene. On 1/30/17, at 10:29 a.m. R26 indicated, "I was crying and I felt that only happened one time and that was Friday when I asked to go to bed to have a BM [bowel movement] and didn't get there in time. I don't have that long from the time I feel the urge, maybe 5 minutes. I have had incontinence episodes where I have not been able to ask staff before it happens. It was very upsetting, my feelings got hurt. It made me mad because [CMT-C] knew I had to go, but he shut the call light off and then shut the door. To get some attention, I started yelling. I started yelling before I lost control. When they started the transfer I had already lost control. [NA-E] is fine he is a good person. If I tell him I need to go to the bathroom he changes what he is doing and does me then." R26 was admitted to the facility on 12/16/16, with diagnosis of gastroparesis (a condition in which	F 282		

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the spontaneous movement of the muscles (motility) in your stomach does not function normally) secondary to diabetes.

R26's Bowel Assessment dated 12/19/16, read R26 was currently incontinent of bowel and the resident recognized appropriate time/place to defecate. The resident was able to feel the urge and sensation for bowel movement. R26 was unable to participate in a program due to functional disability and was dependent on staff.

R26's admission Minimum Data Set (MDS) dated 12/23/16, indicated the resident was cognitively intact. The MDS dated 12/23/16, also indicated R26 was dependent upon two staff for transfers, bed mobility, dressing, toileting, hygiene and did not ambulate.

R26's Care Area Assessment for Activities of Daily Living dated 12/29/16, triggered due to resident needing extensive assistance of two staff for bed mobility, dressing, toilet use and personal hygiene. Resident did not ambulate at that time.

The care plan dated 12/2916, for UTI's and incontinence directed staff to assist with incontinence care as needed. The care plan lacked evidence of any interventions for the diagnosis of gastroparesis and R26's urgency with having to defecate.

On 1/27/17, at 9:18 a.m. NA-E was interviewed and stated, "She [R26] was yelling when I came into the room, [CMT-C] was in the room. She was in the chair. I think she was upset and wanted to go to bed and was upset as she was sitting on BM. [CMT-C] stayed in the room for the transfer. We put the sling on her together and

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then [CMT-C] stood there and I did the transfer. I back was in the dining room passing breakfast trays. I finished passing the trays then I went back to the room. It took probably 15 minutes. She is normally incontinent of bowel she never uses the bed pan. She does not normally have a bowel movement in the morning. Yesterday around this time she wanted to go to bed to be changed. She had had a bowel movement."

On 1/27/17, at 1:36 p.m. the executive director was interviewed and verified the when a resident needed to use the bathroom there can be urgency in the request. R26 was not treated with dignity as she had informed the staff she needed to defecate and the staff did not respond to the request and therefore R26 defecated all over herself, which made her emotionally and visibly upset.

Pain management:
R165 was sitting in bed in a hospital gown on 1/23/17, at 4:29 p.m. R165 showed copies of grievances filed with the facility, and showed phone where R165 was documenting stay at facility. R165 said, "I try to journal daily to help me deal with depression. I don't always if I am too angry. I have done so for years."

LTC Professionals Progress Note date 1/2/17, indicated R165 had undergone an anterior fusion (abdominal surgery joining of two or more vertebrae together so motion did not occur) of L5-S1 (Lumber 5-last vertebrae in lower back and sacral 1-first vertebrae at the top of the sacrum on 12/23/16, with resulting retroperitoneal (the space between the back and the lining around the organs of the abdomen) hemorrhage (bleeding)

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and had ongoing abdominal and back pain.

R165's ADL Functional /Rehabilitation Potential CAA Worksheet dated 1/10/17, indicated R165 required extensive assistance with ADL's with goals minimizing risks and avoiding complications. Urinary Incontinence and Indwelling Catheter CAA Worksheet Dated 1/10/17, indicated R165 was occasionally incontinent of urine. Urinary CAA indicated contributing factors included pain, restricted mobility and urinary urgency. Urinary CAA care plan considerations indicated R165 was frequently incontinent of urine and required assistance of staff with cares. Falls CAA worksheet dated 1/10/17, indicated R165 was at risk for falls and overall decline with difficulty maintaining seated balance and impaired balance when changing positions. Pain CAA worksheet dated 1/10/17, indicated R165 was having pain that put R165 at risk for immobility depression and functional decline.

R165's care plan dated 1/6/17, for "Pain management and monitoring related to chronic Back pain, Surgical Procedure", instructed staff R165 to administer pain medication as ordered, Evaluate what makes the patients pain worse, implement the patients preferred non-pharmacological pain relief strategies-offer cold pack. R165's care plan lacked specific interventions for ADLs or urinary incontinence. R165's Mood care plan revised 1/16/17, instructed staff to attempt interventions before my behaviors begin validate distress, listen in the moment and help problem solve and to make sure I am not in pain or uncomfortable. These interventions were initiated 12/30/16. R165 did not receive the needed assistance with toileting

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due to pain as the care plan directed.

An undated Subacute NA Assignment Sheet 2, indicated R165 required minimal assist of one with mobility, was independent to assist of one at times for toileting, and had pain in back and leg. The assignment sheet instructed staff to have two staff present with cares and interactions.

A facility document titled Grievance Form, dated 1/11/17, indicated R165 had reported a concern on 1/10/16, that on 1/9/17, staff did not answer her call light for 25 minutes, beginning at 10:30 p.m. Thus, R165 reported having been incontinent of urine from having to wait. According to the grievance, R165 reported going to the hallway for help and RN-N "laughed at her and said, 'she just needs a Dilaudid'." R165 reported feeling so upset R165 "wanted to go home." The findings section on the Grievance Form, indicated the allegations were not confirmed and indicated R165 put the call light on and one minute later came out of room yelling at staff to 'give a Dilaudid now'. The resolution on the grievance form indicated: Reviewed with staff -prompt responding to call lights and requests and respectful interactions. It also indicated a meeting had been scheduled with the long-term-care Ombudsman for 1/16/17, to discuss concerns and care for R165.

Review of R165's Progress Notes from 1/2/17 through 1/26/17 revealed:
Progress Note charted 1/9/17, at 11:39 p.m. R165 had call light on one minute and came out screaming, "I need my pain bill (sic) now."
Progress Note dated 1/10/17, indicated, "Res (resident) reported last night that she had her call light on 'a long time and nobody was answering it'

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and 'didn't make it to the bathroom on time.'" The Progress Note also indicated R165 told RN-F, "She wanted to leave last night because of 'how I felt I was treated.' but ended up deciding to stay." The Progress Note further included: "her report is different than staff report on her behavior."

During interview on 1/26/17, at 12:20 p.m. R165 said, "I don't have the exact time, I was so upset that I did not make notes. I was in so much pain, I needed help to get to the bathroom. I put on my call light and when no one came I got myself to the bathroom. I had wet on myself. I put the bathroom call light on. It took me 20-25 minutes to clean up. I turned the call light off. I went out into the hall and [RN-N] said hi, what can I do for you? I told her I wanted Dilaudid and she turned to her coworker and said all she wants is her Dilaudid and laughed. I was so humiliated and came back in my room and started packing. I was so upset and angry, I could not respond. [RN-N] tried to talk me into staying. If I had gone out there and yelled not saying that I did I would have said please."

During interview on 1/28/17, at 2:32 p.m. NA-EE said, "Sometimes [R165] gets upset at me but she does not yell. [R165] uses the call light. A call light is a means of communication that we answer normally as soon as able." NA-EE stated call lights have two different sounds one for the room and one for the bathroom. NA-EE said, "Someone has to respond immediately to the bathroom call light, it is an emergency call light. Everyone is responsible to answer call lights."

During interview on 1/28/17 at 3:32 p.m. NA-O verified worked the evening shift. NA-O said, "We can have two or three lights going at the same

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time. The patients do not complain. If there are more than three call lights on we try to let the patients know that if it is not urgent they need to wait. Bathroom lights are very dangerous so we must answer them first. If a patient asks to go to the bathroom that needs to be first priority because if not they will be incontinent and feel so bad it could be humiliating."

On 1/27/17, at 1:36 p.m. the facility's executive director was interviewed and stated all residents are to be treated with respect and dignity.

On 1/30/17, at 7:29 a.m. the DNS said, "We have an hour to give scheduled medications. PRN [as needed] medications should be given when requested." DNS stated we have a team of pain physicians that come in and make adjustments. R165 was seen on January 2nd, so when you are getting a lot of PRN's after seven days, we need to follow up with the physician to increase the scheduled medications. When you are working with pain physicians, they say let's give it some time, especially for patients who are narcotic dependent. They (narcotic dependent residents) say, "I want, I want, I want. A knee or a surgical patient has pain." DNS was asked if aware that R165 was admitted to the facility after back surgery with diagnosis of acute post-operative pain. DNS did not answer.

Interdisciplinary Care Plan policy Effective date 4/1/16, instructed staff, "The interdisciplinary care plan is implemented to guide the LivingCenter in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social well being of the resident and to promote the participation of the resident family or legal representative in planning

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F 282	Continued From page 123 care."	F 282		
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 personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to provide grooming/hygiene for 2 of 3 residents (R150, R26) who was dependent for activities of daily living (ADL). Findings include: R150's ADL Care Area Assessment (CAA) dated 6/21/16, indicated the CAA triggered related to resident requiring staff assistance and had diagnosis of dementia and paranoid schizophrenia. R150's diagnoses included unspecified dementia, paranoid schizophrenia and depressive disorder obtained from the quarterly Minimum Data Set (MDS) dated 12/6/16. In addition the MDS indicated resident did not exhibit rejection of care and required extensive assistance of one with personal hygiene. The care plan dated 12/12/16, indicated "I have a physical functioning deficit related to: Self care impairment, mobility impairment, diagnoses of dementia, paranoid schizophrenia and osteoarthritis pain." The care plan directed staff to turning and position resident per tissue tolerance and provide nail care as needed. On 1/24/17, at 9:39 a.m. during observations	F 312	R150 Residents nails will be checked, trimmed and cleaned as needed. Weekly skin checks will include nail care documentation. All residents nail care needs will be assessed at time of admission, quarterly and change in condition. R26 Staff educated on the diagnosis of gastroparesis to include understanding urgency of need to be assisted to bedpan as soon as possible to prevent incontinence. Nursing reeducated on assisting residents with nail care and toileting per residents individual plan of care. Weekly call light audits and care observations to be completed on all floors. DNS or designee is responsible for monitoring compliance on all floors. QAPI will review audits and actions to provide direction or change as needed.	3/11/17

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R150 was observed seated on wheelchair at the bedside watching television and both hand fingernails were observed to be long approximately one quarter (1/4) inch, jagged edged and had brown matter underneath. During interview at 9:41 a.m., the resident stated staff did assist him with nail care.

On 1/25/15, at 7:40 a.m. R150 was observed seated on a wheelchair at the dining room table. R150 appeared sleepy at the time however was seated up straight well positioned and was all dressed for the day. When approached and asked how he was doing resident stated "I have pain in my back" when asked if he wanted pain medications R150 stated "please get me a couple." Surveyor approached licensed practical nurse (LPN)-F reported the resident pain. R150's fingernails to both hands remained long approximately one quarter (1/4) inch long, jagged edged and with brown matter underneath the nails.
-At 8:05 a.m. LPN-F was observed apply R150's hearing aids both hands visible never offered to trim the nails.
-At 8:18 a.m. the director of the Alzheimer's unit approached with R150's breakfast (the nails were visible as resident hands were on the table) never acknowledged or offered to have fingernails trimmed.

On 1/25/17, at 11:06 a.m. R150 was observed seated on wheelchair at the dining room table right in front of the nursing station, drinking a pop at the time both hands fingernails were visible from standing 10 feet and nails still noted with brown matter underneath, long and jagged edged.

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F 312	Continued From page 125 On 1/26/17, at 1:10 p.m. the resident was observed seated on wheelchair right next to bed the fingernails to both hands still long, jagged edged and had brown matter underneath them. When approached and asked how he was doing R150 stated "well." When asked about his fingernails resident looked at the nails and stated "they are long." When asked if he would let staff trim them resident stated "no problem." -At 1:10 p.m. LPN-G stated resident was not diabetic and staff was supposed to trim the nails with his shower weekly. LPN-G went to room and she verified the fingernails were long, jagged edged and had brown matter underneath them. -At 1:13 p.m. LPN-G went back to R150's room, approached resident asked resident if she could trim the nails and R150 was observed stretch his left hand over and LPN-G was observed provide nail care. -At 1:17 p.m. LPN-G approached the nursing station stated "his nails were so brittle that I nipped his skin. Now I have to do an incident report." On 1/26/17, at 1:23 p.m. when approached and asked about resident nail care, nursing assistant (NA)-H stated resident was ate independently and staff was to supposed to assist to clean under his nails as food got into them. NA-H also stated resident liked nail care to be done on the day he got a shower as they were soft under water. During review of the Weekly Skin Review dated 12/24/16, 12/31/16, 1/7/17, 1/14/17, and 1/21/17, it was revealed the skin had been assessed and indicated as intact however lacked documentation the nail care had been provided or had been offered and refused. During review of Interdisciplinary Notes dated 12/1/16, through	F 312		

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1/23/17, it was revealed there was no documentation of resident refusing cares.

On 1/27/17, at 8:50 p.m. registered nurse (RN)-H stated nail care was put of the care plan and was to be provided and as needed. RN-H stated he would expect the staff to offer nail care and provide it resident allowed. RN-H reviewed the medical record verified there was no documentation of resident refusing nail care in the last week or previous dates when showers had been provided.

On 1/27/17, at 1:00 p.m. when asked about nail care and grooming the director of nursing services (DNS) stated, "We are supposed to do nail care with showers and for diabetes the nurse is supposed to do nail care and skin check."

A Bowel Assessment dated 12/19/16, indicated R26 was currently incontinent of bowel and that the resident recognized the appropriate time and place to defecate. The resident was able to feel the urge and sensation for bowel movement, but was unable to participate in an incontinence management program due to R26's functional disability and because R26 was dependent on staff for cares.

R26's admission MDS dated 12/23/16, indicated the resident was cognitively intact. This MDS also indicated R26 was dependent upon two staff for transfers, bed mobility, dressing, toileting, hygiene and did not ambulate. The corresponding CAA for Activities of Daily Living dated 12/29/16, further verified the resident needed extensive assistance of two staff for bed mobility, dressing, toilet use and personal hygiene and did not ambulate at that time.

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R26's care plan dated 12/29/16, identified a problem area of UTI's (urinary tract infections) and incontinence. Interventions directed staff to assist with incontinence care as needed. However, the care plan lacked evidence of any interventions for the diagnosis of gastroparesis and R26's urgency with having to defecate.

On 1/27/17, at 8:17 a.m. R26 was observed to be in her room and was overheard yelling in a loud tone of voice, "I need to go to bed just do it. Why couldn't you transfer me when I asked you to. Now I am covered in s**t! You keep saying you need two people but you don't do it that way when the State is not here. I told you I needed to go to the bathroom and you know I can't wait. How many times do I have to ask three, four, five? Maybe you should try this." Certified medication technician (CMT)-C came out of R26's room. At 8:19 a.m. CMT-C was standing at the medication cart. When interviewed CMT-C stated, "She [R26] is mad because she wanted to lay down and asked how come I did not do it without a second person. She put her light on again and complained about stomach pain. She said something about going to the bathroom at that point. I cannot do it, she needs a Hoyer (mechanical lift) and staff are in the dining room. The rule is you can not use the Hoyer by yourself. She put her light on again. I told her we would get to her as soon as possible. [NA-E] and I put her in the sling. He put her in bed and he is cleaning her up now. I can't do anything without help to transfer her but she yelled at me."

On 1/27/17, at 8:20 a.m. R26 was observed to be lying on her right side crying. R26's pants were observed to be covered with feces.

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At 8:33 a.m. NA-E returned to the room with NA-F and hygiene supplies. The nursing assistants proceeded to assist R26 with toileting hygiene.

On 1/27/17, at 9:02 a.m. R26 was interviewed and stated, "I was crying because I was upset. I was in my wheelchair and he [CMT-C] came in. I told him my stomach hurt and I need to go to the bathroom almost before 8 a.m. [CMT-C] did not say anything about needing two people but turned the call light off. I was leaning over and was screaming. He [CMT-C] left and then came back 10 to 15 minutes and said you need to stop screaming. There is a sick lady out there. Then he left and shut the door. I asked to be put to bed at that time and he said is it because you need to go to the bathroom? I said yes, I've got to go, I need to lay down. He told me the staff were doing breakfast so I'd have to wait until they were done. After 10 minutes I went over to the bed and pushed the button. Because I got tired of waiting and was going in my pants. [CMT-C] then came in with [NA-E]. They transferred me to bed. I had soiled myself. [NA-E] put me in bed after [CMT-C] left.

On 1/30/17, at 10:29 a.m. a follow up interview was conducted with R26. "I use the bedpan here, so they have to transfer me. When I am at home I use the toilet. I don't have that long from the time I feel the urge, maybe five minutes. I have had incontinence episodes where I have not been able to ask staff before it happens."

According the hospital's History and Physical dated 12/11/16, R26 had a diagnosis of gastroparesis (a condition in which the spontaneous movement of the muscles (motility) in the stomach does not function normally)

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secondary to diabetes. R26 was admitted to the facility on 12/16/16, to the Admission Face Sheet.

On 1/27/17, at 9:18 a.m. NA-E was interviewed and stated, "She [R26] was yelling when I came into the room, [CMT-C] was in the room. She was in the chair. I think she was upset and wanted to go to bed, she was upset because she was sitting in BM. [CMT-C] stayed in the room for the transfer. We put the sling on her together and then [CMT-C] stood there and I did the transfer. I went back to the dining room passing breakfast trays. I finished passing the trays then I went back to the room. It took probably 15 minutes." Even though the bowel assessment indicated R26 was incontinent, it also revealed that R26 felt the urge to go and knew when she had use the bedpan for defecation.

On 1/27/17, at 1:20 p.m. when asked about the length of time it takes to put a resident in bed to use a bedpan the director of nurses said, "It depends if there is enough staff to put the resident in bed. If they are supposed to use the Hoyer, we communicate to the resident, as we have to find two staff to help. We provide help as soon as we can. Nursing assistants have six to ten residents in a team and when you are in a room helping another resident and the next resident wants to go to bed someone wil have to wait."

Incontinence care policy was requested but not received.

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F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		3/11/17

(d) Accidents.

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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 review, the facility failed to thoroughly assess residents at risk for falls, and failed to develop and/or implement interventions to prevent further falls for 2 of 3 residents (R118, R119) reviewed. This resulted in actual harm for R118 who sustained a laceration to her arm which required medical intervention. In addition the facility failed to ensure 1 of 3 residents (R151) was safe in bed with rails on the bed and the facility failed to ensure 1 of 1 resident (R260) had appropriate supervision during smoking.

R118 and R119 Comprehensive falls assessment identifying the contributing factors and root cause analysis has been completed.

Unit huddles will include review of falls and accidents, identification of risk and prevention, commitment to safety and other factors that would put residents at risk for falls.

Nursing staff will complete a fall scene investigation form with every fall.

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F 323	Continued From page 131 Findings include: According to R118's record, she sustained 17 falls in the facility, one of which required an emergency room visit related to a laceration. However, there was no evidence the facility consistently reviewed R118's falls in an effort to determine causal factors and/or prevent further injury. Further, the staff indicated R118's falls were all related to non-compliance with the use of her walker, however, at least three of R118's falls indicated she was using her walker and there was no evidence these falls were investigated. R118's quarterly Minimum Data Set (MDS) dated 12/16/16, indicated she was cognitively intact and required limited assistance with activities of daily living. The MDS indicated she was occasionally incontinent of bladder. R118's care plan dated 12/14/16, indicated the resident had a risk for falls related to a history of falls in the facility. Care plan interventions included: assess for pain, call light in reach, observe for side effects of medications, therapy referral and use mechanical lift (Hoyer) if unable to get up off floor independently. A facility document untitled and undated, (nursing assistant care sheet) identified the following fall intervention: "Sling Size: large sling if falls and unable to self transfer from floor." No other interventions were indicated. R118's Progress Notes and corresponding Incident Reports were reviewed from 5/5/16 through 1/27/17. The following fall history was identified: 5/5/16 - R118 had an unwitnessed fall in her	F 323	Immediate, individualized interventions will be put in place and reviewed by the IDT for accidents and falls. Fall risk assessment will be completed at time of admission, quarterly and with an change in condition. All care plans and NAR assignments will be updated as needed. Nursing staff will be educated on the new fall scene investigation form and the huddle process to review falls and accidents. R151 Side rail assessment has been completed, consent obtained, order has been entered and care plan in place. All residents will be assessed at time of admission, quarterly or with change in condition for utilization of side rails. If side rails are needed a consent, order, and a care plan will be updated to include adding side rail information to assignment sheets. Maintenance will continue to complete weekly side rail audits as part of the preventative maintenance plan. Nurse Managers will inform Maintenance when side rails are no longer needed for removal. R260 A new smoking assessment has been completed and she has been	

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F 323	Continued From page 132 bathroom. Staff entered room and found her sitting on the floor. At that time the resident stated she had slipped because her socks were slippery. Although staff provided R118 with non-slip socks, there was no evidence an incident/investigative report had been completed. 5/9/16 - R118 was found on the floor leaning against her walker. She sustained an abrasion to her right foot. There was no evidence an incident/investigative report had been completed. 6/30/16 - R118 was heard calling for help at 6:00 p.m. staff responded to find her sitting on the floor in the doorway of her bathroom. At that time, the resident stated she'd slid to the floor and crawled to the bathroom. A subsequent Progress Note dated 7/5/16, indicated R118 had sustained a bruise to her right knee related to the 6/30/16 fall. A facility document titled Post Fall Analysis/Plan dated 7/7/16, indicated the interdisciplinary team (IDT) had reviewed the fall and recommended R118 be reminded to use her walker. 7/20/16 - R118 reported she lost her balance and fell in her room and hit her head. The resident sustained a cut to her left elbow measuring 0.8 centimeters (cm) x 0.1 cm. A facility document titled Post Fall Analysis/Plan dated 7/21/16, indicated the IDT had reviewed the fall and recommended staff encourage R118 to call for assistance, and for staff to offer assistance. 8/5/16 - R118 was found lying on the floor by her bathroom doorway. There was no evidence an incident/investigative report had been completed. 9/2/16 - R118 stated she was trying to find the bathroom and could not find the grab bar. She	F 323	identified as being independent to smoke. The smoking policy has been reviewed and revised and the new policy will identify if residents are assessed to be independent with smoking, they will not have to be supervised , they will not have to wear a smoking apron and will be able to keep their smoking materials in their possession. Residents and staff will be educated on the new smoking policy. The supervised smoking room will continue with the existing policy. New residents wishing to smoke will be assessed at time of admission, quarterly or with any significant change in condition. Weekly audits on care plans to be completed on all floors. DNS or designee is responsible for monitoring compliance. QAPI will review audits and actions to provide direction or change as needed.	

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told staff she had lost her balance and fallen. There was no evidence an incident/investigative report had been completed.

10/7/16 -Staff heard R118 calling for help and found her sitting on the floor with her walker next to her. The resident told staff she had tripped on her walker. Although R118 sustained three skin tears to her right forearm, there was no evidence an incident/investigative report had been completed.

10/12/16 - Staff responded to R118's bathroom light to find her lying on the floor. R118 stated she'd fallen and crawled to the bathroom to call for help. There was no evidence an incident/investigative report had been completed.

10/20/16 - Staff heard a loud noise coming from the craft room and responded to find R118 sitting on the floor beside the toilet in the craft room bathroom. There was no evidence an incident/investigative report had been completed.

11/2/16 - A housekeeper called nursing staff to report R118 had fallen. The housekeeper had reported R118 had been standing at the door and putting on her sweater when she'd lost her balance and fallen backwards. The resident sustained discomfort and redness to her left elbow. A facility document titled Post Fall Analysis/Plan dated 11/3/16, indicated the IDT had reviewed the fall and that R118 was working with physical therapy to increase/improve use of walker.

11/5/16 - R118 was found lying on the floor calling for help. She was on her right side lying across her doorway. The documentation indicated R118

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had stated she'd been coming from the bathroom, had lost her balance and had fallen. There was no evidence of any further investigation related to the incident.

11/15/16 - Staff responded to R118's call light to find her sitting on the floor in the middle of her room. R118 had sustained a "deep laceration to the elbow." Documentation indicated the laceration measured 4 cm x 2 cm and that R118 went to the emergency room for treatment, returning with staples in her arm to close the wound. Although R118 sustained an injury requiring medical care, there was no evidence of any further investigation related to the fall.

12/14/16 - R118 was found sitting on the floor and stated she'd fallen after tripping on her walker. An Incident Report dated 12/17/16, indicated R118 had a scratch to her left leg and a bruise measuring 6 cm x 3 cm to her right side below her shoulder blade as a result of the 12/14/16 fall. However, there was no evidence the incident was investigated or reviewed by the IDT.

1/2/17 - R118 was found lying on the floor at 7:00 p.m. Documentation indicated she'd reported to staff that she'd hit her head. A facility document titled Post Fall Analysis/Plan dated 1/3/17, indicated the IDT had reviewed the fall and that R118 continued with physical therapy and refused to use the walker. No other recommendations were identified.

1/12/17 - R118 fell in the dining room and was lying on her back. Staff indicated she was ambulating while eating ice cream, lost her balance and fell. A facility document titled Post Fall Analysis/Plan, dated 1/13/17, indicated the

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IDT reviewed the fall and recommended staff try to decorate R118's walker to encourage use.

1/14/17 - R118 was found lying on the floor next to her bed by staff. Documentation indicated R118 had reported to staff she'd slid out of her bed and landed on her bottom. A facility document titled Post Fall Analysis/Plan, dated 1/23/17, indicated the IDT reviewed the fall and recommended continued reminders to use her walker.

1/27/17 - R118 fell while ambulating in the hallway at 3:00 p.m. Documentation indicated she'd reported she'd pivoted too quickly and lost her balance. There was no evidence the IDT reviewed the fall as of 1/30/17, at 4:30 p.m.

During observation on 1/27/17 at 9:25 a.m., R118 was ambulating independently throughout the unit. She was not using her walker. Staff on the unit did not approach R118 with reminders to use her walker.

During interview on 1/26/17 at 3:56 p.m., nursing assistant (NA)-S stated she was unaware of any fall interventions for R118. NA-S reviewed her care sheet and indicated the only intervention was to use a sling if R118 falls and cannot get up.

During an interview on 1/26/17 at 3:59 p.m., licensed practical nurse (LPN)-G stated R118 experiences a lot of jerking she is unable to control due to her medical diagnosis which may contribute to her falls. LPN-G indicated fall interventions for R118 include: encourage her, offer assistance, and to make sure to give R118's meds on time.

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During an interview on 1/26/17 at 4:30 p.m., the assistant director of nursing services (ADNS) stated R118 needs a weighted walker due to impaired balance. She stated R118 will not use the walker even though staff encourage her. The ADNS stated when a fall was reported the nurse was supposed to complete an incident report and that falls are discussed at the IDT meetings. The ADNS stated the facility had attempted physical therapy for R118, however R118 had complained of increased shoulder pain with use of her walker. The ADNS then stated most recently the IDT had discussed decorating R118's walker to promote use.

During an interview on 1/30/17 at 9:55 a.m., the director of nursing services (DNS) stated an incident report should be completed for each fall. He stated the IDT reviews each fall and discusses potential interventions to prevent future falls. In addition, the DNS stated R118's falls were due to non-compliance with the use of her walker. He stated R118 does not always remember her walker and that staff will regularly educate and remind her to use it. He stated R118 has balance problems and has been referred to physical therapy. He stated when she uses her walker she's fine, even though she had her walker with her during many of her falls. The DNS verified other than the physical therapy referral and reminders to use the walker, they had not implemented any other interventions. He acknowledged, "We should have looked at other options instead of just what we did.We should have looked at her more closely, and we didn't."

A facility policy titled Golden Living post Fall Analysis Summary and Guidelines for Completion, dated 10/11/16, was reviewed and

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indicated the following: It is the policy of the living center to complete the Post fall Analysis Summary after every known fall. The IDT team will complete a review of the post fall Analysis within 72 hours. Recommendations implemented shall be recorded on the report and plan of care revised as necessary. A facility Falls Management Guideline, undated, indicated following a resident's fall, appropriate interventions to prevent falls will be implemented.

R119's falls were not thoroughly investigated to identify the root cause.

R119's falls CAA dated 4/20/16, indicated resident was at risk for falls related to weakness and balance instability. In addition the care indicated resident was at risk for fall with potential for fracture and/or serious injury and further debilitation. R119's diagnoses included hypertension and diabetes mellitus with diabetic neuropathy obtained from the quarterly MDS dated 12/7/16. In addition, the MDS indicated resident required extensive physical assistance of one staff with transfers, used a wheelchair for locomotion and was not steady and required human assistance to stabilize when moving from seated to standing position. R119's Clinical Health Status dated 12/21/16, indicated resident had been identified at a high risk for falls. R119's care plan dated 1/24/17, indicated resident was at risk for falls related to history of falls, balance impairments, weakness/deconditioning, history of high blood pressures history of low blood sugar.

On 1/24/17, 10:15 a.m. when asked how many falls had resident had in the last 30 days LPN-I stated resident had a fall on 1/1/17, and had no injuries.

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On 1/28/17, at 4:20 p.m. to 4:50 p.m. resident was observed wheel self in the first floor of the facility by the subacute unit. Resident was observed wearing a pair of blue gripper socks. When asked about her transfers and the assistance she received, resident stated the staff was supposed to help her however when she needed the assistance it was a while before someone came. When asked about her gait the resident stated "sometimes am just tired like after dialysis." When asked about the falls, the resident stated they happened so fast.

During review of the medical record, both electronic and paper, the following was revealed about the resident falls in the Progress Note:
-6/2/16, at 10:45 p.m. indicated a NA had reported to the writer the resident was on the floor. The writer went into the resident room and found the resident on the floor between the wheelchair and bed crying. When asked what had happened, the resident stated "I was trying to get my chips from the floor" and the resident slip off the wheelchair and had hit her left arm and was complaining of pain. The resident was assessed and transferred using a Hoyer with two staff and vital signs were noted to be within normal limits.
-8/10/16, at 10:20 p.m. the writer indicated the resident had been found on the floor, sitting on her bottom, denied hitting head and denied pain and had no injuries noted.
-12/23/16, at 8:00 p.m. the resident was found sitting by the bedside. The resident stated she had slid to the floor when trying to transfer self. Denied hitting head. Transferred and denied pain. The note indicated the resident had been asked to use the call light when trying to transfer to avoid falls. During review of the Post Fall

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F 323	Continued From page 139 Analysis/Plan 12/23/16, it was revealed the interdisciplinary team (IDT) review and recommendation had been made for resident to be referred to physical/occupational/speech therapy for evaluation. -1/1/17, at 6:56 a.m. note indicated the resident had a fall at 6:20 a.m. and resident had stated "I was grabbing a candy, and fell." The note indicated the resident was assessed, denied, vital signs were obtained, denied hitting her head and no injuries noted. During further document review, it was revealed there were no Post Fall Analysis/Plan reports were completed for R119 for falls dated 6/2/16, 8/10/16, and 1/1/17. In addition it was revealed even though the IDT had recommended therapies the recommendation had not been followed on. On 1/26/17, at 3:01 p.m. the director of nursing services (DNS) stated he was not able to pull the actual incident reports and Post Fall Analysis/Plan for R119's falls for the dates 6/2/16, 8/10/16, and 1/1/17. When asked the facility policy for investigating falls aftermath, DNS stated the nurses were supposed to complete both as that was how the IDT followed up all incidences and if there was no incident the falls were not reviewed as they did not generate "Total Events" log for resident. On 1/30/17, at 9:25 a.m. a therapy staff reviewed the therapy notes and all the episodes R119 stated the last time resident had been seen by physical, occupational and speech therapies was 6/28/16, 9/19/16, and 11/24/16, respectfully. She verified resident had not been seen by either of the therapies even though it had been	F 323		

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recommended by the IDT team to be seen following the fall on 12/23/16.

On 1/30/17, at 11:30 a.m. DNS stated the staff was still looking for the Incident reports and would provide them. At 12:54 p.m. DNS approached stated he was not able to find the incident reports for the 6/2/16. He indicated the staff was supposed to fill the incident reports as the IDT team would follow up and identified the root cause of the fall or incident.
R151 was observed on 1/24/17, at 9:47 a.m. R151 was sitting in wheel chair and gave permission to check side rail. The right half side rail was in the down position in middle of the bed and the rail was tight as it did not move from side to side. The left half side rail was in the up position. The left side rail moved side to side. During observation on 1/25/17, at 6:39 a.m. R151 lying in bed with call light on, both half side rails were down in the middle of the bed.

During observation of morning cares on 1/25/17, at 7:18 a.m. R151 was sitting on edge of the bed. The right half rail was in the down position and left side rail was in the up position. NA-E assisted R151 to stand up. R151 used left side to stand up and the side rail moved. NA-E did a pivot transfer with R151. R151 sat down on wheelchair arm rest. NA-E helped R151 stand back up and sat R151 down in wheelchair. R151 said, "They usually use the EZ [mechanical lift] lift. It is easier, I get stuck on the wheel [wheelchair]."

R151's initial care plan dated 12/31/16, did not address side rail usage until after surveyor asked LPN-B about R151's activity of daily living (ADL) care plan. Nor did the temporary plan of care address R151 mobility status, transfer status, and

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recent stroke.

R151's admission comprehensive assessment dated 1/2/17, indicated the resident was a fall risk. The physician admission orders were reviewed from 1/2/17, going forward and there were no orders for the side rails use.

R151's physical therapy (PT) evaluation dated 1/2/17, did not address side rails or grab bars. PT was working with R151 for bed mobility including side to side turning using minimal assistance and transfers using moderate assistance.

R151's admission MDS dated 1/7/17, indicated R151 was cognitively intact with no behaviors and required assistance with ADL including bed mobility and transfers. R151's MDS indicated R151's diagnoses included cerebral vascular accident (stroke) and left sided hemiplegia (weakness). The MDS indicated the resident did not use bedrails or restraints and had not fallen since admit.

R151's Falls CAA Worksheet dated 1/10/17, indicated R151 was at risk for falls with injury related to recent stroke with left sided weakness.

The Subacute NA Assignment Sheet undated did not address side rails or positioning bars use.

On 1/25/17, at 7:25 a.m. NA-E was interviewed. NA-E indicated R151 was a pivot transfer and that R151 used the rails for transferring. NA-E verified the left grab bar could be moved approximately 1.5 inches in either direction.

On 1/26/17, at 7:35 a.m. R151's bed rails were observed with the maintenance director. The right

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side rail was in the down position and did not deviate from side to side. The left side rail was in the up grab bar position. The left side rail moved back and forth approximately 1.5 inches. The maintenance director looked at side rail and verified the left grab bar was loose. The maintenance director stated that side rails were on for preventative maintenance that month and that he would fix the rail. When asked what the process was for preventative maintenance the maintenance director stated he looked at all the bed rails on a weekly basis. He indicated he did not document the rooms as he did all of the rooms. The preventative maintenance was reviewed in the electronic record. The electronic record read check and adjust all side rails set up weekly as preventative maintenance task. It was not room specific which would instruct staff to tighten or replace side rails if not tight or functioning correctly. It was marked as being completed every Thursday.

On 1/27/17, at 8:02 a.m. LPN-D verified the medical record lacked evidence of an assessment for side rails, risk versus benefits explanation, lacked consent, lacked a physician's order, and lacked care planning for the side rail. LPN-D also verified when R151 was in bed, the 1/2 rails are to be in the down position. LPN-D Verified that the left rail was loose and could be moved approximately 1.5 inches in either direction which made the rail wobbly.

On 1/27/17, at 11:23 a.m. RN-E stated, "I do not think he could get himself up without assist [of the bedrails] but he could go to the bottom of the bed if the bedrail is in the down position."

During interview on 1/27/17, at 1:01 p.m. DNS

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said, "We do not have side rails on the beds, we have railings on bed that are used as assist with bed mobility and turning and repositioning." DNS said, "We do not obtain a consent, because we don't use restraints in the facility." DNS said, "We assess patients upon admission and provide them with the necessary equipment. We do risk and benefits if it is appropriate."

During interview on 1/30/17, at 12:10 p.m. DNS indicated the side rails were on the bed when the bed was delivered to the unit. The bed was in the room when resident was admitted and no interventions were documented prior to using the railings. DNS stated the staff were to follow the care plan.

The Restraint Evaluation and Utilization Guideline dated 2/4/16, instructed staff. The need for the use of restraint will be discussed with the resident and/ or family. The risks and benefits will be explained to the resident and /or family. The facility will obtain a signed consent for the use of the restraint. The center will obtain a physician order for the least restrictive device. The Physician Order must include the medical symptom for which the device was to be used. No consent could located in R151's medical record. In addition, the medical record lacked evidence any interventions tried before applying the bed rails.

R260 was observed on 1/24/17, at 9:55 a.m. R260 was observed to put a cigarette out on the sidewalk of the court yard, leaving the smoldering tip of cigarette on the sidewalk. R260 walked into the facility. There were no facility staff observed in the area. Surveyor continued to observe to

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F 323		F 323		

Continued From page 144

ensure tip stopped smoldering. During a random observation on 1/25/17, at 9:39 a.m. R260 was smoking in the outside courtyard R260 threw cigarette into the garden without putting it out. There were no facility staff in the common area leading to the outside court yard.

During continuous observation on 1/25/17, from 11:42 a.m. until 12:43 p.m.
- At 11:43 a.m. R260 came walking into common area with a cigarette dangling out of her mouth. R260 went out to the courtyard and said to another resident "no one is in the lunch room so I decided to have a cigarette." R260 lit cigarette with lighter and then put the lighter back in her coat pocket.
-At 11:46 a.m. R260 reentered building with cigarette in hand. R260 put cigarette in the left coat pocket. R260 verified she had put cigarette in her pocket and showed surveyor that she had knocked the end off of it and the cigarette was not smoldering. R260 had a pack of Smoky Joe's cigarettes that had 15 cigarettes in it.
-At 12:23 p.m. R260 entered the common area with a cigarette hanging out of her mouth and went out to the courtyard to smoke.
-At 12:25 p.m. R260 went out to the courtyard and lit cigarette then sat on bench. R260 tapped the ash off of the cigarette onto the ground. R260 was holding cigarette in right hand that had a splint and gauze wraps on it.
-At 12:29 p.m. R260 put cigarette out on ground by bench.

During a random observation on 1/28/17, at 2:44 p.m. R260 was outside wearing a white tee shirt and gray sweat pants and boots. R260 was passing a cigarette back and forth with sharing a cigarette with unidentified resident. Temperature

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F 323	Continued From page 145 at that time was 23 degrees with a wind chill of 11 degrees Fahrenheit. The Clinical Health Status Form dated 1/12/17, indicated R260 was at risk for elopement due to being cognitively impaired with impaired decision. The Smoking Assessment section indicated on 1/12/17, R260 did not have any cigarettes and the smoking policy was explained. On 1/30/17, the Smoking Assessment was updated and indicated R260 did not have cognitive or physical impairment preventing from safely containing ash and extinguishing cigarette after the surveyor brought it to the attention of the facility. The Immediate Plan of Care Smoking dated 1/12/17, revealed R260 had impaired cognition, hand tremors and was not following smoking policy. The care plan instructed staff, "supervision per policy while resident is smoking." The Smoking Care Plan dated 1/13/17, indicated R260 was at risk for smoking related injury related to: "Smokes independently Non-compliant with facility smoking policy. Smokes in undesignated areas at undesignated times, and does not keep smoking materials in locked cart." R260's smoking care plan instructed staff to, "Assure smoking material is extinguished prior to patient leaving smoking area, Observe patient for unsafe smoking behaviors or attempts to obtain smoking material from outside sources, immediately inform facility management. Patient not to have cigarettes or smoking material on person Place patient in position to assure visualization of ashtray, Provide smoking apron while smoking, Storage of smoking materials per Living Center policy."	F 323		

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The Comprehensive Assessment dated 1/16/17, indicated R260 had diagnoses of borderline personality disorder, bipolar depression with psychosis history of suicide attempts with lethal intent. The Assessment section indicated, "Res. [resident] reported to be a smoker but did not bring in any cigarettes. 2 hours later noted res. To have a cigarette hanging out of her mouth and was asked where she found a cig [cigarette] and res. Stated, 'I found a friend'. Informed of smoking policy and designated times to smoke, place to smoke, and also requiring a smoke eval [evaluation] and supervision. Res agrees with everything staff tell her but then does something different. Was noted to be smoking outdoors with redirection given and res stood and looked at staff and cont. [continues] to smoke. ETOH [alcohol] policy reviewed also."

During interview on 1/26/17, at 7:11 a.m. LPN-B said, "When she first came she did not have cigarettes but she made friends easily. All of our residents who smoke are to go up to second floor. All people there are supervised. There is supposed to be no smoking outside." When asked what you do to keep residents who smoke in the court yard safe, LPN-B said, "Most of the people who smoke outside are pretty safe. They know the policy and choose to smoke outside. It has been a battle. Residents are not compliant with the smoking policy." When told of observations made of R260 smoking outside, LPN-B said, "If someone were to not ash in the receptacle or put their butts into the receptacle that would be unsafe behavior. I have seen her [R260] yesterday up in the smoke room."

During interview on 1/27/17, at 6:50 a.m. housekeeping -A verified there were 32 cigarette

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F 323	Continued From page 147 butts on the ground of the courtyard. Housekeeping-A said, "I clean the butts up two times a day in the morning and again right before two p.m." Housekeeping-A verified there was a cigarette box in the butt can and verified there was no way to call for help if someone started a fire. Housekeeping-A said we have had no fires out here. Housekeeping-A was unable to say where nearest fire extinguisher was. During interview on 1/27/17, at 11:23 a.m. registered nurse (RN)-E reviewed R260's smoking assessment dated 1/13/17, and said, "Social Service [SS]-A did the assessment. We have non complaint patients and we care plan noncompliance. Per care plan she [260] is independent with smoking and is also identified as non-compliant." RN-E said, "I will let [SS-A] know, she will care plan and do the education." When asked, do you notify management every time there is unsafe behavior or a resident borrows smoking materials or other violations of your policy, RN-E said, "It would be daily. We talk about people at morning meetings. We do not have anyone patrolling the court yard." RN-E verified there was no call light in the courtyard or common area to be used in case of an emergency. RN-E verified the closest fire extinguisher was in the hallway on the other side of the common area from the entrance to the courtyard. During interview on 1/27/17, at 11:44 a.m. SS-A said the supervisor who was here on the day a resident is admitted, "watches the resident smoking and writes it down in the nursing packet." SS-A said, basically it was very difficult to tell the independent people what to do. "We cannot force them to come in because they do	F 323		

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F 323	Continued From page 148 not listen. We cannot force them to come inside and take their cigarettes because that would be abuse. All we can do is educate and hope, especially when it is really cold outside. I have never seen it. We are working on coming up with a plan to make the smoking policy work for the independent people. We are waiting to see what the Monarch policy is." SS-A verified R260 was at the facility under a provisional discharge which included a Provisional Discharge Contract dated 1/12/17, that indicated, "I [R260] will maintain my safety and well-being. This involves not doing to harm or threaten others or myself including use of illicit drugs and alcohol." During interview on 1/27/17 at 11:57 a.m. RN-E said, "It is impossible to keep the residents who smoke in the courtyard supervised. They do what they want to. We try to keep them in when it is cold but that does not work. She [R260] is not safe to smoke in the court yard but insists." RN-E verified putting a used cigarette in pocket would be unsafe, knocking the tip off a cigarette would be unsafe, and not putting a cigarette in the trash bin would be unsafe behavior. During interview on 1/27/17, at 1:10 p.m. DNS said, "We do a smoking assessment upon admission. If they wish to smoke and do not have the cigarette we reach out to guardian and POA [power of attorney] as we know resident is going to smoke. All residents smoking in the courtyard are people who have been assessed per facility policy and they go out and smoke. We can take the cigarettes and they have family bring more." When asked, how do you ensure they are safely smoking, the DNS said "The residents are the ones who feel they are independent and ambulate on their own. They say 'no you are not	F 323		

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F 323	Continued From page 149 going to supervise me. We pick our battles." DNS verified the throwing a cigarette was a risky behavior. When asked, how can a resident notify staff if there was a concern, DNS did not answer. DNS said, "We have not had any accidents." During interview on 1/28/17, at 4:50 p.m. DNS verified there were 78 cigarette butts on the ground in the courtyard. DNS verified there was a folded long section of toilet paper in the butt can that had a cigarette burn through several layers. DNS verified the outside weather was 23 degrees and the wind chill was 11 degrees Fahrenheit. During interview on 1/30/17 at 8:36 a.m. Executive Director said, "How do we keep them safe as they will go outside in spite of what we say. They will go out other doors not dressed appropriate for the weather." Smoking and Tobacco Use Guideline dated 9/14/15, indicated "Patients and Residents of Golden Living are permitted to smoke in the designated area only. Each LivingCenter will specify the smoking area. Smoking outside the LivingCenter designated smoking area is strictly prohibited. Patient/Residents may only smoke at the designated times. Each LivingCenter will develop and specify the smoking times. Smoking will be supervised by a staff member. Smoking garments/aprons will be worn by all residents while smoking for safety. The designated smoking area will be equipped with smoking aprons, fire-proof furniture, Fire-proof receptacles and a fire extinguisher. Smoking is not permitted in any other area of the property."	F 323		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		3/11/17

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(d) Influenza and pneumococcal immunizations

(1) Influenza. The facility must develop policies and procedures to ensure that-

(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal

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F 334	Continued From page 151 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer and/or offer influenza and pneumococcal according to the current standards of immunizations for pneumonia and influenza for 1 of 5 residents (R13) whose vaccinations history were reviewed. Findings include: The Center for Disease Control and Prevention identified "Adults 65 years of age or older who	F 334	R13 Resident will be offered the Pneumococcal immunization. All residents will be offered all immunizations upon admission and per the immunization guideline. Weekly audits on care plane to be completed on all floors. Nurse Manager is responsible for	

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F 334	Continued From page 152	F 334		

have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of pneumococcal 13-valent Conjugate Vaccine (PCV13). The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose."

The facility Influenza/Pneumococcal Immunization Guideline revised 5/2/16, directed "LivingCenters will offer and encourage that each resident receive immunization against Influenza annually, as well as lifetime immunization against pneumococcal disease. This immunization will be administered unless it is medically contraindicated, the resident has already been immunized or the resident and/or responsible party refuse the immunization..."

R13's record indicated the 65 year old had resided at the facility since 1/4/17. R13's immunization record revealed resident had not been offered Influenza, PCV13 and PPSV23 since admit to the facility. R13's diagnoses included pneumonia, respiratory failure and hypertension obtained from admission Minimum Data Set (MDS) dated 1/11/17.

On 1/26/17, at 3:27 p.m. the licensed practical nurse (LPN)-J reviewed R13's both electronic and chart medical record and verified resident only had a record of Influenza had last administered on 11/19/11. LPN-J directed surveyor to the MDS coordinator.

On 1/26/17, at 3:39 p.m. the both registered nurses (RN)-D and RN-I both verified R13's most recent MDS indicated resident had "None" and "not offered" for both immunizations. Both

monitoring compliance.
QAPI will review audits and actions to provide direction or change as needed.

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F 334	Continued From page 153 reviewed the medical record and verified there was no Immunization Consent or Declination in the chart. When asked who was responsible for making sure this was completed both stated was the nurse manager's responsibility as the facility had done a facility wide immunization clinic in September 2016. Both acknowledged the unit had a nurse manager who had just started working at the facility that week and she was out ill for the day and prior to that the unit did not have a unit nurse manager. On 1/30/17, at 2:31 p.m. during the quality assurance interview with the director of nursing services (DNS) and the consultant registered nurse when asked what the facility was doing in implementing the recent pneumococcal recommendations, the DNS stated in August or September of last year 2016, the facility had identified a list of resident who required the immunizations and had and had been able to administer appropriate shots. When asked how the facility was ensuring the new admissions received the immunizations and the immunization record was updated, DNS stated "We check MIIC [Minnesota Immunization Information Connection] immunization site, all HUC's [health unit coordinators] have access, and then manager is responsible for making sure it gets done. If HUC doesn't do it, we provide immunizations, but try to verify if they had it." When asked about units where the facility did not have permanent managers, and who covered the role, DNS stated the unit manager for those units had actually left in October 2016, for two North and two South and the assistant director of nursing services was following up on that unit.	F 334		
F 353	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING	F 353		3/11/17

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F 353 SS=F	Continued From page 154	F 353		

STAFF PER CARE PLANS

483.35 Nursing Services

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed

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F 353	Continued From page 155 nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed resident needs for 9 of 26 residents (R165, R151, R71, R252, R54, R26, R118, R243, R183) reviewed for activities of daily living and 13 of 13 staff members (licensed practical nurse (LPN)-H, LPN-L, certified medication technician (CMT)-E, nursing assistant (NA)-BB, LPN-K, NA-CC, LPN-C, NA-DD, NA-FF, NA-GG, LPN-J, NA-I, CMT-B, anonymous nurse, LPN-I, NA-G) felt staffing was insufficient. Findings include: Resident Interview: R165's admission Minimum Data Set (MDS) dated 1/5/17, indicated R165 was cognitively intact with signs of depression but no hallucinations, delusions or behaviors. R165's MDS indicated R165 required assistance with bed mobility, dressing, toileting, personal hygiene and walking in room or on the unit. R165's MDS indicated resident was occasionally incontinent of bladder, had constant pain at 8/10 and had impairment in range of motion for one side upper and lower body. R165's MDS indicated R165 had diagnosis of high blood pressure, spinal stenosis (narrowing) and post-acute procedural pain.	F 353	Facility will provide nursing staffing services according to the residents assessments and plans of care. Nursing staff will be reeducated on the provision of staffing related to the residents needs according to assessments and plan of care. Weekly audits will be completed to ensure quality of care is being delivered. HR and Staff Development will work with corporate recruiter to assist in filling open cores up to and including: attending job fairs, employment advertising, reaching out to Staffing Agency as necessary, offering additional shift bonuses, offering part time employees a signing bonus to take a FT core for the next five months as we continue to recruit. Working with MDH to grant waiver to be a satellite NAR training site. Reaching out to Colleges for a waiver to continue clinical training for professional nurses. Hired 24 hour a week in house RN Staff Developer. Change in DNS and ADNS to provide new leadership and policy and practice	

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F 353	Continued From page 156 During interview on 1/23/17, at 4:44 p.m. R165 said, "I have had four to five grievances surrounding getting pain medication on time sometimes it taken up to one hour or one and a half hours. I think they think I do not need it. We had a meeting today about it. I was told the reason they took so long as they were busy with other residents. I told her [social service (SS)-A] I get that. They could have at least relayed the message." I needed the pain med. R165 said, "Give me the respect of answering the call light. Voice tearful when taking. I feel some of them need sensitivity training. You cannot make a determination about someone else's pain. It should not take more than five to ten minutes. I would be ok even with 20 minutes if I had to, but an hour is way too long to lay in bed in pain. It is more on their time. R165 stated I am taking notes and showed surveyor documentation on R165's phone. R165 said, "On 1/22/17, at 7:20 p.m. I put the call light on about for 10 minutes an aide came and I requested something for pain. I put the call light on from 7:52 p.m. to 7:56 p.m. a person came in and said they would tell the nurse. At 8:15 p.m. had not gotten my prn [as needed] medication. At 8:20 p.m. I put on the call light. At 8:30 p.m. [NA-EE] said did not have an PRN's [as needed medications] due. I was given meds [medications] at 8:45 p.m." R165 said, "On the weekends the call light stays on constantly during the evening and on the weekends the response is very slow. I have been incontinent one to two times after putting on the call light." R151's admission MDS dated 1/7/17, indicated R151 was cognitively intact with no behaviors and required assistance with activities of daily living	F 353	change. HR and Staff Development Nurse are responsible for monitoring compliance. QAPI will review audits and actions a to provide direction or change as needed.	

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(ADL) including bed mobility and transfers. R151's MDS indicated R151's diagnoses included cerebral vascular accident (stroke) and left sided hemiplegia (weakness). During review of the Medication Administration Record (MAR) dated 1/1/17 through 1/31/17, it was revealed R165 had an order for Oxycodone 10 (milligram) mg three times a day as needed for pain with at least three hours between doses. On 1/22/17, the MAR indicated R165 received oxycodone 10 mg at 12:15 a.m. and 8:41 p.m. with a pain rating of 8/10 both times (on a scale of 0 no pain and 10 the most pain).

During interview on 1/24/17, at 9:37 a.m. R151 said, "I have to have a lot of patience in here to get to bed you have to wait a long time before they come some evenings. Sundays are really bad. They are kind of lax about Sunday. There is a lot of waiting here for things. They have other residents, I understand. I sleep with my door open at night and the call lights go all night.

R71's MDS indicated R71 required assistance with bed mobility, transfers, dressing, toileting, and personal hygiene R71's MDS indicated resident was frequently incontinent of bladder, and had occasional pain at 4/10. R71's MDS indicated R71 had diagnoses of diabetes, and chronic kidney disease.

During interview on 1/24/17, at 8:56 a.m. R71 said, "I waited from 3 a.m. to 3:45 a.m. to get back to bed last night. There is a couple times this happens but I report it and the person that has been reported gets back to you." R71's quarterly MDS dated 11/9/16, indicated R71 was cognitively intact with signs of depression but no

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hallucinations, delusions or behaviors.

R252's admission MDS dated 12/29/16, indicated R252 was cognitively intact. R252's MDS indicated R252 was Independent with activities of daily living and received Intravenous medications. R252's MDS indicated R252 had diagnoses of diabetes, and chronic foot ulcer.

During interview on 1/23/17, at 5:38 p.m. R252 said, "Sometimes, I have to wait 45 minutes to an hour to get my IV [intravenous] site flushed."

R54's quarterly MDS dated 1/5/17, indicated R54 had intact cognition and required limited to extensive assistance with ADL's.
On 1/23/17, at 4:46 p.m. when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R54 stated "I wait sometimes a long time. Sometimes 45 minutes to an hour."

R26's 30 day scheduled assessment MDS dated 1/13/17, indicated cognition was intact, required extensive physical assistance of two staff with bed mobility, dressing, toilet use, personal hygiene and used a wheelchair for mobility.

On 1/23/17, at 5:22 a.m. when asked if she felt there was enough staff available to make sure she got the care and assistance she needed without having to wait for a long time R26 stated "they put one staff here some just stand . I can only sit in my chair for 3 hours I ask to be laid down and they say no it is almost supper or lunch

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and I do not get in bed."

R118's quarterly MDS dated 12/16/16, indicated cognition was intact, required supervision to extensive physical assistance of one staff with bed mobility, dressing, toilet use, personal hygiene and used a walker for mobility.

On 1/24/17, at 8:31 a.m. when asked if she felt there was enough staff available to make sure she got the care and assistance she needed without having to wait for a long time R118 stated "I don't get regular baths, I get them when they come and ask if I have had one. They never answer my light. The staff plays a lot too. I have waited up to two hours for my light to be answered. I fell and just laid there and I had the bathroom light on within the last month."

R243's admission MDS dated 1/14/17, indicated cognition was intact, required extensive physical assistance of two staff with bed mobility, dressing, toilet use, personal hygiene and used walker and wheelchair for mobility.

On 1/24/17, at 9:26 a.m. when asked if she felt there was enough staff available to make sure she got the care and assistance she needed without having to wait for a long time R243 stated "many times no. Sometimes long call light waits. Sometimes it takes a while for staff to answer alarm."

R183's quarterly MDS dated 11/29/16, indicated cognition was intact, required total dependence to extensive physical assistance of two staff with

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bed mobility, dressing, toilet use, personal hygiene and used a wheelchair for mobility.

On 1/24/17, at 9:26 a.m. when asked if she felt there was enough staff available to make sure she got the care and assistance she needed without having to wait for a long time R183 stated "I have to wait between 45 minutes and 2 hours for help."

Staff interviews
On 1/25/17, at 6:44 a.m. when asked about staffing level at the facility LPN-H stated the night shift was always short staff and that made it impossible to get the cares done timely and residents had to wait for a while before staff would get to them.

On 1/25/17, at 7:56 a.m. when sitting at the nursing station, NA-J was overheard stated "I don't know how they expect us to do all this 15 minutes checks to all this people when we have all the rest of the work to do."
-At 7:57 a.m. when approached and asked about staffing stated "it's actually okay. I was just joking. I like to give the social worker hard time."

On 1/27/17, at 5:56 a.m. LPN-L said, "This floor is ok but when I work on second floor they always need more staff. Usually on second floor we get the job done but it is straining. Third floor it is a lot of residents who need two to three staff members for turning or transferring. We do the best we are able."

On 1/27/17, at 6:06 a.m. CMT-E said, "I mostly work on 1 North. We have one nurse and one aide, sometime two aides if busy or need more

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help. Staffing is ok we can get our work done. We are not able to supervise those that go outside to smoke because we are busy and cannot hear the call lights on 1 North."
On 1/27/17, at 6:14 a.m. NA-BB said, "There are two of us for all of our residents on the floor. Most of the residents are two people assist or total. Sometimes we have to get the aide from the other floor. I cannot get everything done but I do my best and let the nurse know."

On 1/27/17, at 6:22 a.m. LPN-K stated, "On the night shift I have both the ACU [Alzheimer Care Unit] and the AACU [Advance Alzheimer Care Unit]. I have 46 patients and two aides. I am the third person or we call from other floors. I am also the supervisor usually the two aides can pretty much handle it. They manage. Nights is not busy the residents are sleeping. During the evening shift they need five staff members but except for survey they have three to four staff."

On 1/28/17, at 2:05 a.m. NA-CC said, "Staffing is up and down. When it is up I can get my work done, when it is down I have to let something go."

On 1/28/17, at 2:57 a.m. LPN-C said I have 20 residents. During survey we have three nursing assistants. Normally we have two to two and a half nursing assistants. We are short nurses and aides a lot of the time it is so hard. We do our best.

On 1/28/17, at 3:04 a.m. NA-DD said, "We are always short. If a call light goes off we try to answer right away because we have to know what somebody wants. Sometimes we cannot get to the call lights for 30 minutes."

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On 1/28/17, at 3:11 a.m. NA-FF said, "Most of the time we only have two aides. If we need help, the residents are having to wait, but I don't know how long they wait. I think we have been working short most of the time I have worked here. We are always busy. We are few. I have worked here over year. We always work short. I work nights by myself on ACU [Alzheimer Care Unit]. Some of the residents cannot reposition themselves and need to wait until there is another person. Some resident have to wait 20 minutes to an hour for me to get help to turn them. R26 does not yell, when we are free, we take her and transfer her to the bedpan. Sometimes when I am the only one on the unit she has to wait 30 minutes to go to bed."

On 1/28/17, at 3:20 a.m. NA-GG said, "I am working a double today. I work doubles often because we are short. Third floor needs six people on day shift between both units. It is so hard, we have too many residents do everything. We do what we can but it is not your best. Sometimes we are not on time for repositioning. We cannot come back if they ref something and offer again, like shaving."

On 1/28/17, at 3:44 a.m. when asked about staffing, LPN-J laughed at surveyor and said, "They are trying. I have two nursing assistants and a CMT. We share an aide between 2 South and 2 North." LPN-J said, "No, we do not have enough staff. We make out with what we got. We try, some days it is worse. If we have a call in we keep calling people and hope someone will come in. The residents don't care about others. I have to tell people that someone who is sick is my first priority and that I won't miss a soul but it may take too long. If someone falls, they are first. A fall is a

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F 353	Continued From page 163 priority. I am here at 6:30 a. m. and I am often still here until sometimes 5 or 6 pm. I like the home, but we need more aides. We need a third one in the morning [DNS] said he will initiate a third aide but we have not seen it yet. We have more help during the week than we do on the weekend because the managers work with the aides. On 1/28/17, at 2:19 p.m. when asked about staffing NA-I stated staffing was so bad and the staff was not able to toilet and answer all the call lights timely because there was not enough staff around for all the resident needs. On 1/28/17, at 2:54 p.m. CMT-B stated when asked about staffing "Horrible. We have talked to them about having one [trained medication aide] TMA for each of the units and nothing has been done. Sometimes it's so bad and I have had to work in three units down stairs and up here to help the nurse. We have to do the blood sugar as those have to be done before the meal and are time sensitive and sometimes we are just not able to get everything done. Going between the units is so bad and between doing treatments and passing the medications it's hard to tell you and this is not safe for the residents and for our license or certificate." If we have someone to do checks every 15 minutes this is even another challenge added and to tell you the truth that is when you say I have to choose what to do because there is not enough staff here to do it all." On 1/28/17, at 3:07 p.m. anonymous nurse approached surveyor stated she wanted to have a serious word with this surveyor about the working conditions at the facility. nurse directed surveyor to a room and stated "I want you to tell	F 353		

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F 353	Continued From page 164 me how someone can do this when there is only one nurse at night with two aides and there are four residents who use Hoyer's which need two staff to get the resident in and out of bed. Sometimes when there is a sick resident it is hard to get anything done here because there is only one aide and I have to help them to turn, reposition, toilet residents who need two staff for assist. When someone is sick you know and someone is on the floor after a fall I don't even know what to do because I have to attend to this one who is on distress. There is no cordless phone to call you know 911 and as I am getting this other one off the floor for the supervisor to come help. So they would pull the only other aide from the other unit to help here and guess what unit is left without a staff to monitor or answer the call lights which very dangerous and unsafe. I have told them about this chronic staffing problem and feel like sometimes am being insubordinate to them. When working I have to have residents wait if they need pain medications or need to use the toilet because I have to attend to the one who is in distress because I just can't do it all because there is just not enough staff here. At times the supervisor can help but most times they are busy helping another unit which is in need." As staff spoke with surveyor she started to cry and was shaking stated she was afraid something bad was going to happen with the residents not getting their needs met because of staffing "Please do something." On 1/28/17, at 3:13 p.m. LPN-I when asked about staffing "I have reported the concern about staffing to management several times. There is one TMA between the units and honestly it's just not enough and if one of the residents got sick or there was a fall you feel like you are sinking	F 353		

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because you have to give medications for 27 residents. There was only two aides and they need help. It is not safe at all to the residents because they unit is heavy and residents have huge needs."

On 1/30/17, at 9:45 a.m. when asked about staffing NA-G stated "since you guys came to the facility they have been over staffing the units and today I think people called in because they don't want to work when you are here. We are supposed to have three aides in the unit depending on the census and two in the memory unit. It is hard all the time and we are not able to do everything we are supposed to do for the residents and have to make them wait. I have to take care of myself because I can do so much because we get burned out and they think we can do this all when we are working with less staff. They started the hospitality aide thing and they are supposed to come and help pass the water, and clean out after the meals but that department has huge turnover and most of the times the aide never shows up to the floor to help. Its's hard and staffing is bad here they think we can do it all. The resident don't understand when we are not able to meet their needs because they depend on us to assist them but we are short and don't have enough help."

On 1/26/17, at 8:31 a.m. the nursing department educator stated that new employees orientation was run weekly for the facility, and she worked individually with staff on the floor that required 1:1 hands on training or review.

On 1/30/17, at 1:00 p.m. an interview with human resources (HR) revealed a large number of open positions in the facility. Staffing was based on

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positions listed in FTE (Full Time Equivalent= 40 hours per week, 80 hours per pay period). A 1.4 FTE would fill one 8-hour shift for 14 days, in other words the facility had 32 open positions, and lacked more than 11 full time employees in the nursing department. HR indicated the open positions for the nursing department include:
Registered nurse (RN) supervisors 2.0 FTE = 160 hours per pay period.
Nurses RN or LPN 2.7 FTE 216 hour per pay period
CMT or TMA 1.5 FTE = 120 hours per pay period and
NA 10.5 FTE = 840 hours per pay period.

On 1/30/17, at 2:00 p.m. the staffing coordinator verified it was fair to say the facility occasionally worked short. The staffing coordinator verified that the schedule had only 50% of shifts filled after the posted date of the schedule.

On 1/30/17, at 1:59 p.m. the facility Medical Director (FMD) was interviewed and stated that staffing was discussed in quality meetings in regard to the challenge of having full staffing, a full compliment of staff of board. FMD further stated, trying to retract and retain really good employees in this market was very difficult. When asked if each individual fall was not tracked and discussed in the quality meeting, FMD stated just numbers in a report.

During review of the block scheduling provided when there was multiple grievance reports of staff not providing pain medications timely and call lights not being answered for the following dates 1/5/17, 1/6/17, 1/7/17, and 1/8/17, the block scheduling did not reflect a consistent staffing pattern for the facility on the evening shift. On the

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F 353	Continued From page 167 dates reviewed, it was revealed there was between 13-21 nursing assistants scheduled for the PM shift. During review of actual staffing sheets for assorted days it was revealed on 10/30/16, 11/25/16, 12/10/16, 12/12/16, 12/15/16, 12/29/16, 1/14/17, 1/15/17, and 1.27/17, multiple staff had picked up multiple shifts, worked doubles back to back, staff had been floated between units and there were no replacement for the units they had been moved from and staff had been scheduled but then removed from the schedule without explanation. In addition it was revealed multiple staff had called in sick with no replacements on multiple shifts. A review of the falls indicated 16 falls in the facility within the last 3 months, which had not been tracked or trended by individual resident and most of the falls lacked root cause analysis performed for those with multiple falls. During review of the 13 "call light" audits done between October and December 2016, it was revealed the call light audits were actually for accommodation of needs follow-up from a prior survey, and only answered the following questions: "Is call light within reach", "Does clothing fit properly", d\"Does care plan reflect, follow up needed". The audits did not reflect actual time call light was on, the room number or unit it occurred on and if the need had been met. Refer to F225/F226. The facility failed to identify report and thoroughly investigate allegations of abuse resulting in residents being afraid of unwanted touch, threats of physical harm from staff and other residents and not receiving	F 353		

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F 353 Continued From page 168 F 353

assistance as needed, which resulted to an immediate jeopardy.

Refer to F241. The facility failed to ensure 2 of 2 residents (R26, R80) was treated in a dignified manner during personal cares. R26 sustained emotional harm when the facility failed to provide assistance with care resulting in R26 having fecal incontinence.

Refer to F312. The facility failed to provide assistance with grooming and toileting 2 of 3 residents (R150, R26) who required assistance with activities of daily living.

Refer to F323. the facility failed to thoroughly assess for and implement interventions to prevent falls for 2 of 3 residents (R118, R119) reviewed. This resulted in actual harm for R118 who sustained multiple minor injuries. In addition the facility failed to ensure 1 of 3 residents (R151) was safe in bed with rails on the bed and the facility failed to ensure 1 of 1 resident (R260) had appropriate supervision during smoking.

F 356 SS=C 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION F 356 3/11/17

483.35
(g) Nurse Staffing Information
(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and

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F 356	Continued From page 169 unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to post the required nurse staffing	F 356	New Posted Nursing Hour form has been implemented to reflect daily nursing hours	

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F 356	Continued From page 170 information daily. In addition, nursing hours were counted for staff that were not assigned direct care duties for residents. This had the potential to affect all 177 residents in the facility. Findings include: On 1/30/17, at 2:00 p.m. an interview with the staffing coordinator, director of nursing services (DNS), executive director (ED), and intern was held. During the interview the staffing coordinator was asked if the five registered nurse's (RNs) noted on the day shift staff posting for 1/25/17, included nurse managers in the count, since a review of the actual staffing sheet showed one RN during the day shift. Staffing coordinator and DNS verified that nurse managers were counted in the posted hours. DNS and ED verified the nurse managers do not have a direct patient care assignment. On 2/1/17, at 12:09 p.m. the staffing coordinator stated each staff posting page had three days on it. The nurse staffing posting when posted included the hours for three consecutive days. The facility staffing coordinator was asked who was responsible for updating the staff posting every shift if there were changes, no answer has been received. On 2/6/17, at 12:00 noon the staffing coordinator stated the day shift posting was updated by her every day, but the weekend was posted for the entire three day weekend on Friday and it was up to the nurse supervisors to update the census and staffing on the weekend. The Facility Nurse Staff Hours policy dated 8/14/14, stated nursing staff hours will be posted	F 356	of assigned staff providing direct care 24/7. Staffing coordinator has been educated on new Posted Hour form Weekly audits will be completed Staffing coordinator is responsible for monitoring compliance. QAPI will review audits and actions to provide direction or change as needed.	

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F 356	Continued From page 171 in accordance with state and federal regulations in all facilities. The facility failed to post the nurse staffing hours daily, in addition, the facility failed to update the nurse staff posting every shift which would include only direct care staff hours.	F 356		
F 490 SS=F	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the administrator failed to identify, report and thoroughly investigate allegations of abuse resulting in residents being afraid of unwanted touch, threats of physical harm from staff and other residents and not receiving assistance as needed with toileting for 6 of 12 residents (R183, R1, R80, R12, R118, R260). In addition, the facility failed to to identify, report and thoroughly investigate allegations of abuse for 6 of 12 residents (R165, R112, R186, R145, R218, R28). This had the potential to affect all 177 residents who resided in the facility. Findings include: Grievance Reports and Incident Reports reviews going back six months to July 2016, were completed. The administrator failed to identify a problem with the identifying, reporting and investigating potential abuse. The administrator failed to respond appropriately to address the	F 490	New administration was put in place late November 2016 to ensure policies and procedures regarding quality of life and quality of care were initiated and staff is being held a accountable. New grievance process has been put in place along with training staff on the importance of understanding and reporting grievances in a timely manner along with understanding allegations versus grievances. Executive Director and or designee in her absence reviews all grievances/investigations and gives directions as needed immediately after being notified from mandated reporters who have been reeducated on timely reporting. Please refer to plan of corrections: F241,	3/11/17

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F 490	Continued From page 172 problem. The Administrator Job Description which included an addendum labeled Compliance Liaison Responsibilities updated 10/14/15, noted as follows: "Compliance Liaisons are responsible for: providing leadership and support regarding compliance issues at their operational level and facility levels; distributing written compliance-related materials as necessary; assuring the provision of appropriate training and the proper documentation of such training; assuring the appropriate distribution of internal and external audits reports and monitoring of corrective action related to such reports or other identified compliance related issues; assuring proper reporting and responses to compliance-related functions." The addendum went onto note the administrator was to lead by example, was to monitor the staff training, and was to conduct internal audits for monitoring, identify issues from the audits to ensure corrective action was taken to address the issue, and prevent the issue from re-occurring. On 1/25/17, at 4:04 p.m. during interview with the executive director (ED) and director of nursing services (DNS), the ED stated we do not always get called on grievances. The ED said, "Some of these [grievances] I was not made aware of. We get a report and if we think it is abuse and neglect, we do our best to report it. By the time we became aware of issues, it was several days or several weeks after the event. We were not review grievances at the time they were made. At the end of November, I changed the process for grievances and abuse reporting, when we were talking about a resident to resident." The DNS	F 490	F312, F323 and F497. ED and DNS are responsible for monitoring compliance. QAPI will review audits and actions to provide direction or change as needed.	

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F 490	Continued From page 173 explained the grievance process has been revised. The DNS said, "The plan we have in place now is that every grievance needs to be reported to me, so I and the ED can determine if an OHFC [office of health facility complaints] report is required." The ED said "What we have in place now will allow us to be sure grievance are followed up on and completed thoroughly. Every grievance will be reviewed by the team during stand up meeting. We want to see every grievance. The expectation is whenever there is a concern the supervisor will notify me." Refer to F225/F226. The facility failed to identify report and thoroughly investigate allegations of abuse resulting in residents being afraid of unwanted touch, threats of physical harm from staff and other residents and not receiving assistance as needed, which resulted to an immediate jeopardy. Refer to F241. The facility failed to ensure 1 of 2 residents (R26) was treated in a dignified manner during personal cares. R26 sustained emotional harm when the facility failed to provide assistance with care resulting in R26 having fecal incontinence. Refer to F312. The facility failed to provide assistance with grooming and toileting 2 of 3 resident (R150, R26) who required assistance with activities of daily living. Refer to F323. The facility failed to thoroughly assess for and implement interventions to prevent falls for 2 of 3 residents (R118, R119) reviewed. This resulted in actual harm for R118 who sustained multiple minor injuries.	F 490		

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F 490	Continued From page 174 Refer to F497. The facility failed to complete performance reviews every 12 months and failed to ensure the nursing assistant(s) had completed at least 12 hours of continuing education which would include abuse/neglect training and dementia training for 10 of 10 nursing assistants (NA)-L, NA-P, NA-Q, NA-R, NA-T, NA-U, NA-V, NA-W, NA-X, NA-Y.	F 490		
F 497 SS=F	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete performance reviews every 12 months and failed to ensure the nursing assistant(s) had completed at least 12 hours of continuing education for 10 of 10 nursing assistants (NA)-L, NA-P, NA-Q, NA-R, NA-T, NA-U, NA-V, NA-W, NA-X, NA-Y. This had the potential to affect all 177 residents in the facility. Findings include: Nursing assistant (NA)-L's personnel file was reviewed on 1/27/17, and indicated a hire date of 2/12/07. The personnel file indicated NA-L's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-L's Training Records from 1/1/16 through	F 497	New in house RN Staff Development nurse was hired 2/17/2017 to partner with HR Director to ensure all nursing assistant staff complete the required 12 hours of yearly mandatory training. Any NAR not in yearly compliance by 12/2017 and there after by anniversary date will be removed from schedule until training is completed. The process for annual performance evaluation will be implemented and all staff will be evaluated by 12/2017 and there after on anniversary date. Audits will be completed monthly by Staff Developer and HR Director to ensure compliance of evaluations and continuing	3/11/17

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F 497	Continued From page 175 12/31/16, noted NA-L only had 5.75 hours of continuing education, which only included the dementia training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year. NA-P's personnel file was reviewed on 1/27/17, and indicated a hire date of 12/5/85. The personnel file indicated NA-P's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-P's Training Records from 1/1/16 through 12/31/16, noted NA-P only had 10.25 hours of continuing education, which included the dementia and abuse training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year. NA-Q's personnel file was reviewed on 1/27/17, and indicated a hire date of 4/8/14. The personnel file indicated NA-Q's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-Q's Training Records from 1/1/16 through 12/31/16, noted NA-Q had no documented hours of continuing education, which included abuse and dementia training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year. NA-R's personnel file was reviewed on 1/27/17, and indicated a hire date of 2/9/09. The personnel file indicated NA-R's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-R's Training Records from 1/1/16 through 12/31/16, noted NA-R had no documented hours of continuing education, which included abuse and dementia training. The file lacked evidence of the NA	F 497	education. QAPI will review audits and actions to provide direction or change as needed.	

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F 497		F 497		

Continued From page 176
having completed twelve hours of continuing education in the last year.

NA-T's personnel file was reviewed on 1/27/17, and indicated a hire date of 9/10/12. The personnel file indicated NA-T's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-T's Training Records from 1/1/16 through 12/31/16, noted NA-T had no documented hours of continuing education, which included abuse and dementia training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year.

NA-U's personnel file was reviewed on 1/27/17, and indicated a hire date of 11/21/11. The personnel file indicated NA-U's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-U's Training Records from 1/1/16 through 12/31/16, noted NA-U had no documented hours of continuing education, which included abuse and dementia training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year.

NA-V's personnel file was reviewed on 1/27/17, and indicated a hire date of 11/30/92. The personnel file indicated NA-V's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-V's Training Records from 1/1/16 through 12/31/16, noted NA-V only had 5.75 documented hours of continuing education, which included dementia training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year.

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NA-W's personnel file was reviewed on 1/27/17, and indicated a hire date of 11/6/06. The personnel file indicated NA-W's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-W's Training Records from 1/1/16 through 12/31/16, noted NA-W only had 1.50 documented hours of continuing education, which included dementia training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year.

NA-X's personnel file was reviewed on 1/27/17, and indicated a hire date of 11/3/08. The personnel file indicated NA-X's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-X's Training Records from 1/1/16 through 12/31/16, noted NA-X had no documented hours of continuing education, which included abuse and dementia training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year.

NA-Y's personnel file was reviewed on 1/27/17, and indicated a hire date of 11/5/12. The personnel file indicated NA-Y's void of any evidence that a performance evaluation had been completed at all. In addition, a review of NA-Y's Training Records from 1/1/16 through 12/31/16, noted NA-Y had no documented hours of continuing education, which included abuse and dementia training. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year.

On 1/26/17, at 7:03 a.m. the administrator stated Golden Living did not do evaluations and so they do not have them here.

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F 497	Continued From page 178 The administrator was interviewed on 1/27/17, at 1:07 p.m. and indicated she knew about the lack of training and stated it would be fixed.	F 497		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as	F 520		3/11/17

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F 520	Continued From page 179 such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a quality assessment performace improvement (QAPI) committee that established appropriate plans of action for identified quality deficiencies related to ensure allegations of abuse were thoroughly investigated for 6 of 6 residents (R183, R12, R167, R118, R260, R1) which resulted in extended survey, and then immediate jeopardy for the facility. In addition, the facility failed to ensure staff treated residents with dignity for 2 of 2 residents (R26, R80), incidents and accidents were tracked or trended for patterns, and failed to do root cause analysis for repeated falls for 2 of 3 residents (R118, R119). This had the potential to affect all 177 residents in the facility. Findings include: Refer to F225: The facility failed to report to the administrator and state agency, and investigate, all allegations of staff abuse, neglect, and/ or mistreatment for 6 of 6 residents (R183, R12, R167, R118, R260 and R1) who made allegations of staff maltreatment. The failure of the facility to ensure a system was in place regarding all allegations of staff abuse, neglect, and mistreatment were reported to the administrator and state agency, and were thoroughly	F 520	QAPI will be held quarterly to establish appropriate plans of actions to identify quality deficiencies to ensure plans of correction are developed and met to ensure the well being of resident care, staff development and family/resident satisfaction. QAPI will have adverse event monitoring to systemically identify, report, track, investigate, and analyze such events. Facility will use the data and information relating to adverse events to develop plans to prevent/correct adverse events. Appropriate designated staff will attend QAPI quarterly. QAPI minutes will reflect appropriate plans of action to correct identified quality deficiencies. Staff will be educated on QAPI process. DNS or designee will monitor compliance. QAPI will review and update QAPI process as necessary to meet compliance.	

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F 520	Continued From page 180	F 520		

investigated, resulted in an Immediate Jeopardy (IJ) for all 177 residents currently residing in the facility.

Refer to F226: The facility failed to ensure the abuse prevention policy and procedure was implemented for 6 of 6 residents (R183, R12, R167, R118, R260 and R1) who made allegations of staff abuse, neglect, and/or mistreatment, and the facility failed to report to the State agency (SA), and/or administrator, and did not complete a thorough investigation, resulted in an IJ. This had the potential to affect all 177 residents currently residing in the facility.

Refer to F241: The facility failed to ensure staff treated residents with respect during incontinence cares for 2 of 2 residents R26 and R80 resulting in psychosocial harm for 1 resident (R26).

Refer to F323: The facility failed to track or trend falls for patterns and root cause analysis for 2 of 3 residents (R118, R119) reviewed. This resulted in actual harm for R118 who sustained multiple minor injuries.

Review of QAPI Minutes sign in sheet for the period of March 2016, through December 2016, indicated facility QAPI met monthly. The QAPI Minutes for 7/20/16, 8/17/16, 9/21/16, and 10/19/16, did not indicate the executive director attended the meetings or calling in to the meetings.

During interview on 1/30/17, at 1:59 p.m. medical director indicated he was informed of immediate jeopardy this weekend but no one had requested his input for plan of removal. When asked what the quality assistance and performance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING ______ B. WING ______	C 01/30/2017

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

(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 520	Continued From page 181 improvement (QAPI) committee did in regards to allegations of abuse or neglect toward residents, the medical director stated, "The lead social worker explains what concerns were made and the investigation and what conclusions were made. We look at things like were call lights answered properly, concerns of abuse, staff terminations and what happened and lost items." Medical director was unable to verify if QAPI was tracking or trending timeliness of reporting allegations of abuse to the executive director, or number of abuse allegations that were being reported on grievance forms. The medical director said "My experience about abuse or true neglect was that those were handled much more expeditiously." Medical director indicated the interim executive director was not always at the QAPI meetings and was "hard to touch base with as he was not in the office frequently, when I come in to see patients." When asked if the Executive Director ever called into the QAPI meetings on the phone the medical director said, "No." Medical director indicated Staffing concerns were discussed at the QAPI meetings as it was a challenge to have full staff but he believed they now had a "full complement of staff on board." The medical director stated, "I am not aware of any incidents or accidents related to short staffing." The medical director stated smoking in the courtyard has been a big topic with QAPI over a long period of time. Trying to allow access to smoking but keep it as safe as possible is difficult. Supervised smoking works but you cannot put all the smokers in the smoke room at the same time. We try to discourage it but it is impossible to enforce. When asked about falls the medical director said, "We try to look at how many falls, where they are happening, each individual fall, how do we keep them safe without	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING ______ B. WING ______	C 01/30/2017

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

(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 520	Continued From page 182	F 520		

restraint, individuality and independence." The Medical director was unable to verify if R118's falls were discussed. "[R118] is not my patient. I wouldn't remember names."

During interview on 1/30/17, at 2:31 p.m. the director of nurses (DNS) explained the QAPI process because the Executive Director was new and had only been at the 12/21/16, QAPI meeting. The DNS said, "We have not been reviewing grievances at QAPI. As a team we talk about VOI's [Verification of Investigations] or OHFC [Office of Facility Complaints] reports. I connect with medical director and update him to specific cases." When asked has the QAPI identified the concerns identified during the survey DNS said, "Yes, we have talked a lot about grievances" DNS initially denied knowing there was a was a problem with grievance process and said, "We have a decision tree for what to report" DNS then stated in October or November, we felt the process needed to be looked at and re-evaluated. DNS said, "[QAPI committee] Talked about it [grievance process], but only mentioned in QAPI, that we would look at a grievance process." DNS said we put a new process in place in November. We have made progress, but if it happens on evenings or weekends, we have not heard. Anyone or everyone can complete a grievance form, but communication to get to manager is an issue." DNS said, "We met and review falls, total number of falls compared to individual falls. I have a report that I generate, total falls for March, June, July. We look at time of day, the room, and look at patterns." When asked if this was instead of root cause analysis DNS said, "Yes" DNS was unable to discuss facility fall rate or how it was calculated. This information had been requested

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING ______ B. WING ______	C **01/30/2017**

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

(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 520	Continued From page 183 previously but not provided. Only action plan DNS shared was there had been an action plan for "how to recruit more staff, fill shifts and offer incentives." QAPI Committee Guideline Revised August 2014 instructed staff, "The QAPI Committee monitors and sustains Living Center operational performance in clinical and non-clinical systems through self-identification and improvement in areas where opportunities for improvement (OFIs) have been identified."	F 520		

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

F5148025

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on January 24, 2017. At the time of this survey, Golden Livingcenter St. Louis Park was found 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. Golden Livingcenter St. Louis Park is a 3-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II (222) construction. In 1972 a two- story addition was constructed to the East Wing and determined to be of Type II (222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 208 beds and had a census of 182 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **01/23/17** To F2: **01/30/17**	Extended Survey Date Format: mm/dd/yy From F3: **01/25/17** To F4: **01/30/17**	
Name of Facility: **GOLDEN LIVINGCENTER - ST LOUIS**	Provider Number: **245148**	Fiscal Year ending:
Address: **3201 VIRGINIA AVENUE SOUTH, SAINT LOUIS PARK, HENNEPIN, MN 55426**		
Telephone Number: F6	State/County Code: **MN / HENNEPIN**	State/Region Code: **MN / 05**
~~A. F9 **02 - Nursing Facility (NF) - Medicaid** Participation~~ 03-SNF/NF Medicar/Medicaid B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 **03 - For Profit - Corporation**		
Owned or leased by Multi-Facility Organization: F13 **Yes** Name of Multi-Facility Organization: F14 **Golden Living**		
Dedicated Special Care Units (show number of beds for all that apply)		

AIDS F15 **0**	Alzheimer's Disease F16 **55**
Dialysis F17 **0**	Disabled Child Young Adult F18 **0**
Head Trama F19 **0**	Hospice F20 **0**
Huntington's Disease F21 **0**	Ventilator/Respiratory Care F22 **0**

Other Spec Rehab. F23 **36**	
Does the facility currently have an organized resident group? F24	**Yes**
Does the facility currently have an organized group of family members of residents? F25	**Yes**
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28	Hours waived per week: F29
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30	Hours waived per week: F31

Does the facility currently have an approved nurse aide training and competency program? F32	**Yes**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A			B	C	D
	Tag #	Services Provided 1	2	3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33				**634**	**8**	**0**
Physician Services	F34	**Yes**	**No**	**No**			
Medical Director	F35					**0**	**10**
Other Physician	F36				**0**	**0**	**0**
Physician Extender	F37	**Yes**	**No**	**No**	**0**	**0**	**25**
Nursing Services	F38	**Yes**	**No**	**No**			
RN Director of Nursing	F39				**80**	**0**	**0**

Nurses with Admin Duties	F40		335	0	0
Registered Nurses	F41		1406	259	0
Licensed Practical/ Vocational Nurses	F42		1628	234	0
Certified Nurse Aides	F43		3715	1254	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		215	93	0
Pharmacists	F46	Yes No No	0	0	0
Dietary Services	F47	Yes No No			
Dietitian	F48		144	36	0
Food Service Workers	F49		1309	358	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes Yes No	0	0	185
Occupational Therapy Assistant	F52		0	0	201
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes Yes No	0	0	124
Physical Therapy Assist	F55		0	0	357
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	Yes Yes No	0	0	318
Therapeutic Recreation Spec.	F58	Yes No No	236	41	0
Qualified Activities Prof.	F59	Yes No No	71	0	0
Other Activities Staff	F60	Yes No No	0	0	0
Qualified Social Workers	F61	Yes No No	148	0	48
Other Social Services Staff	F62	Yes No No	0	0	0
Dentists	F63	Yes No No	0	0	0

Podiatrists	F64	**Yes**	**No**	**No**	**0**	**0**	**0**
Mental Health Services	F65	**Yes**	**No**	**No**	**0**	**0**	**62**
Vocational Services	F66	**No**	**No**	**No**			
Clinical Laboratory Services	F67	**Yes**	**No**	**No**			
Diagnostic X-ray Services	F68	**Yes**	**No**	**No**			
Administration Storage of Blood	F69	**No**	**No**	**No**			
Housekeeping Services	F70	**Yes**	**No**	**No**	**0**	**0**	**934**
Other	F71				**668**	**0**	**294**
Name of Person Completing Form: **Laurie A Sykes**							Date: **02/08/17**

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Spotlight

Minnesota eLicensing

Questions?

Please contact our Health Regulation Division: health.fpc-web@state.mn.us or 651-201-4101.

See also > Health Regulation

- Certificates & Records
- Data & Statistics
- Diseases & Conditions
- Emergency Preparedness
- Environments & Your Health
- Facilities & Professions
- Health Care & Coverage
- Injury, Violence & Safety
- Life Stages & Populations
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Minnesota Department of Health
Protecting, maintaining and improving the health of all Minnesotans

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I'm finished and would like to exit the application.	Exit

GOLDEN LIVINGCENTER - ST LOUIS				
Provider No. **245148**	Medicare F75 **15**	Medicaid F76 **139**	Other F77 **23**	Total Residents F78 **177**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **22**	F80 **66**	F81 **89**
Dressing	F82 **21**	F83 **144**	F84 **12**
Transferring	F85 **59**	F86 **95**	F87 **23**
Toilet Use	F88 **27**	F89 **129**	F90 **21**
Eating	F91 **69**	F92 **95**	F93 **13**

A. Bowel/Bladder Status

F94 **8** With indwelling or external catheter.

F95 Of total number of residents with catheters, **6** were present on admission.

F96 **142** Occasionally or frequently incontinent of bladder.

B. Mobility

F100 **4** Bedfast all or most of time..

F101 **116** In chair all or most of time.

F102 **48** Independently ambulatory.

F97 **100** Occasionally or frequently incontinent of bowel.

F98 **0** On individually written bladder training program.

F99 **0** On individually written bowel training program.

F103 **42** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 **30** With contractures.

F107 Of total number of residents with contractures, **26** had contractures on admission.

C. Mental Status

F108 **2** With mental retardation.

F109 **109** With documentation signs and symptoms of depression.

F110 **101** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **69** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **52** With behavioral symptoms.

F113 **33** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

F115 **7** With pressure sores (exclude stage I).

F116 **7** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **162** Receiving preventive skin care.

F118 **0** With rashes.

E. Special Care

F119 **1** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **0** Receiving chemotherapy.

F122 **7** Receiving dialysis.

F127 **1** Receiving suction.

F128 **58** Receiving injections (exclude vitamin B12 injections)

F129 **4** Receiving tube feedings.

F130 **50** Receiving mechanically altered diets including pureed and all chopped food (not only meat).

F123 **1** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion. F124 **17** Receiving respiratory treatment. F125 **1** Receiving tracheostomy care. F126 **2** Receiving ostomy care.	F131 **84** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy). F132 **6** Assistive devices while eating.

F. Medication	**G. Other**
F133 **131** Receiving any psychoactive medication.	F140 **24** With unplanned significant weight loss/gain.
F134 **77** Receiving antipsychotic medications.	F141 **4** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **39** Receiving antianxiety medications.	F142 **0** Who use non-oral communicationdevices.
F136 **92** Receiving antidepressant medications.	F143 **132** With advance directives.
F137 **6** Receiving hypnotic medication.	F144 **117** Received influenza immunization.
F138 **6** Receiving antibiotics.	F145 **128** Received pneumococcal vaccine.
F139 **119** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Samuel Sampson, RN, MSN, PHN	**Director of Nursing Services**	**02/08/2017**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **Yes**
F148 Medication error rate **0%**

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Spotlight

Minnesota eLicensing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245148	GOLDEN LIVINGCNTR ST LOUIS PK

Type of Survey (select all that apply):

A	I				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

	Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.	18623	01-27-2017	01-27-2017	0.00	0.50	3.50	0.00	0.00	1.00
2.	30951	01-25-2017	01-30-2017	0.00	3.50	38.50	0.00	0.00	15.00
3.	32982	01-23-2017	01-30-2017	0.00	5.00	43.75	2.00	0.00	15.00
4.	35569	01-23-2017	01-30-2017	0.00	3.50	48.00	2.00	0.00	26.50
5.	Team Leader 35993	01-23-2017	01-30-2017	2.00	6.50	53.00	2.75	0.00	27.50
6.	37910	01-23-2017	01-30-2017	0.00	5.00	53.00	2.75	0.00	37.00
7.									
8.									
9.									
10.									

Total Supervisory Review Hours 34.75

Total Clerical/Data Entry Hours.. 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

H5148165

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Provider/Supplier Number	Provider/Supplier Name
245148	GOLDEN LIVINGCNTR ST LOUIS PK

Type of Survey (select all that apply):

A					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 32982	01-25-2017	01-26-2017	0.00	0.00	6.00	0.00	0.25	3.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... U

FORM HCFA-670 (12-91)

H5148166

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Provider/Supplier Number	Provider/Supplier Name
245148	GOLDEN LIVINGCNTR ST LOUIS PK

Type of Survey (select all that apply):

A					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

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Please enter the workload information for each surveyor. Use the surveyor's information number.

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1. Team Leader 35993	01-25-2017	01-26-2017	0.00	0.00	1.50	0.00	0.25	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours.. 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... U

FORM HCFA-670 (12-91)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245148	GOLDEN LIVINGCNTR ST LOUIS PK

Type of Survey (select all that apply):

H	I				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 37009	01-24-2017	01-24-2017	1.00	0.00	6.00	0.00	1.50	3.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

FORM HCFA-670 (12-91)

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245148	**GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA**	*K4 **01/24/2017**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [ ] K351: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1 [X] (COMP. WITH ALL PROVISIONS)

A2 [ ] (ACCEPTABLE POC)

A3 [ ] (WAIVERS)

A4 [ ] (FSES)

A5 [ ] (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A. [X] FULLY SPRINKLERED (All required areas are sprinklered)

B. [ ] PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. [ ] NONE (No sprinkler system)

*MANDATORY

S5148026

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for Administrator: LAURIE.Sykes@goldenliving.com

National Provider Identifier (NPI) Number: 1932150380

One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: GOLDEN LIVINGCNTR ST LOUIS PK City: ST LOUIS PARK

Name of Legal Entity Operating Provider: GGNSC MINNEAPOLIS ST LOUIS PARK, LLC

Name and Address of Governing Board President:

Name: SEAN FOSTER

Address: 1000 FIANNA WAY

City/State/Zip: FORT SMITH, MN 72919

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: ______ City: ______

Name of Legal Entity Operating Provider: ______

Name and Address of Governing Board President:

Name: ______

Address: ______

City/State/Zip: ______

SIGNATURE

Completed by: Laurie A Sykes

Title: Executive Director

Date: 1/24/17

April 17, 2017

Randy Snyder, Executive Director
Board of Nursing Home Administrators
Park Plaza Building
2829 University Avenue Southeast, Suite 440
Minneapolis, Minnesota 55414

Dear Mr. Snyder:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the Board of Nursing Home Administrators whenever we determine that substandard quality of care has been provided to residents. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Golden LivingCenter - St Louis Park Plaza, 3201 Virginia Avenue South Saint Louis Park, MN 55426, which was completed on January 30, 2017, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

- **F0225 -- S/S: K -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals;**
- **F0226 -- S/S: K -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implment Abuse/neglect, Etc Policies**

Resident Behavior and Facility Practices (§483.13). Regulations in this area grant residents the right to be free from abuse, mistreatment, and unnecessary physical and chemical restraints.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The administrator is Ms. Laurie Sykes, .

If you have any questions, please feel free to contact me.

Sincerely,

Kamala Fiske-Downing

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

April 17, 2017

Dr. Bernadette Quadling, MD
HCMC-ECD
701 Park Avenue South
Minneapolis, MN 55415

Dear Dr. Quadling:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Golden LivingCenter - St Louis Park Plaza
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Resident Behavior and Facility Practices (§483.13). Regulations in this area grant residents the right to be free from abuse, mistreatment, and unnecessary physical and chemical restraints.

The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility or at the address below.

If you have any questions, please feel free to contact me.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 17, 2017

Shirley Brekken, Executive Director
Board of Nursing
Park Plaza Building
2829 University Avenue Southeast, Suite 500
Minneapolis, Minnesota 55414

Dear Ms. Brekken:

This is relative to a full survey conducted at Golden LivingCenter - St Louis Park Plaza
3201 Virginia Avenue South, Saint Louis Park, MN 55426 and completed on January 30, 2017.

At the time of this survey it was determined that the residents in this facility have received substandard quality of care.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The director of nursing at the time of the survey was Samuel Sampson.

If you have any questions on this matter, please do not hesitate to call me.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 17, 2017

Dr. Mittal Vikas, MD
1675 Village Trail East #6
Maplewood, MN 55109

Dear Dr. Vikas:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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If you have any questions, please feel free to contact me.

Sincerely,

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Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 17, 2017

Dr. Michael Dukinfield, MD
6600 Excelsior Suite 160
St. Louis Park, MN 55426

Dear Dr. Dukinfield:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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Program Assurance Unit
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Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 17, 2017

Dr. Douglas Lowin, MD
3850 Park Nicollet Boulevard
Mailstop 60101A
St. Louis Park, MN 55416

Dear Dr. Lowin:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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

F5148025

2012 LIFE SAFETY CODE
Form Approved OMB Exempt

FIRE SAFETY SURVEY REPORT 2012 CODE – HEALTH CARE Medicare – Medicaid	1. (A) PROVIDER NUMBER 245148 (K1)	1. (B) MEDICAID I.D. NO. (K2)

PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract
OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	K0180
Golden Livingcenter St. Louis Park	A. BUILDING 1 B. WING C. FLOOR K3	3201 Virginia Avenue South St. Louis Park, MN 55426	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system)

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
☑ MEDICARE ☑ MEDICAID	01/24/2017 (K4)	(K6)	5. (●) 2012 EXISTING 6. ( ) 2012 NEW (K7)

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/IID UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. ☑ ENTIRE FACILITY 2. ☐ DISTINCT PART OF (SPECIFY) ____

3. ☐ IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED? a. ☐ YES b. ☑ NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
208		208	208	

7. A (●) THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ☑ COMPLIANCE WITH ALL PROVISIONS 2. ☐ ACCEPTANCE OF A PLAN OF CORRECTION 3. ☐ RECOMMENDED WAIVERS 4. ☐ FSES 5. ☐ PERFORMANCE BASED DESIGN

B ( ) THE FACILITY DOES NOT MEET THE STANDARD

K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
William Abderhalden 999 SURVEYOR ID 37009 (K10)	Deputy State Fire Marshal	State Fire Marshal Division	02/08/2017
FIRE AUTHORITY OFFICIAL *(Signature)* Thomas Linhoff 12424	TITLE Fire Safety Supervisor	OFFICE State Fire Marshal Division	DATE 02-09-2017

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I – NFPA 101 LSC REQUIREMENTS (Items in italics relate to the FSES)				
	SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: • Requirements of Chapter 18 and 19. • Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K112	**Sprinkler Requirements for Major Rehabilitation** If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft² of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	○	○	●	
K131	**Multiple Occupancies – Sections of Health Care Facilities** Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients. • They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623	○	○	●	
K132	**Multiple Occupancies – Contiguous Non-Health Care Occupancies** Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	○	○	●	

<table>
<tr><th>ID PREFIX</th><th></th><th>MET</th><th>NOT MET</th><th>N/A</th><th>REMARKS</th></tr>
<tr><td>K133</td><td>Multiple Occupancies – Construction Type
Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
• The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.
• The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.
18.1.3.5, 19.1.3.5, 8.2.1.3</td><td>○</td><td>○</td><td>◉</td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5
<table>
<tr><th></th><th></th><th>Construction Type</th><th></th></tr>
<tr><td>1</td><td>○</td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td>○</td><td>II (111)</td><td>One story non-sprinklered Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td>○</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered Maximum 2 stories sprinklered</td></tr>
<tr><td>4</td><td>○</td><td>III (211)</td></tr>
<tr><td>5</td><td>○</td><td>IV (2HH)</td></tr>
<tr><td>6</td><td>○</td><td>V (111)</td></tr>
<tr><td>7</td><td>○</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered Maximum 1 story sprinklered</td></tr>
<tr><td>8</td><td>○</td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</td><td>○</td><td>○</td><td>○</td><td>Golden Livingcenter St. Louis Park is a 3-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II (222) construction. In 1972 a two- story addition was constructed to the East Wing and determined to be of Type II (222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.</td></tr>
</table>

ID PREFIX		MET	NOT MET	N/A	REMARKS
K161	2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7 18.1.6.4, 18.1.6.5	◯	◯	◯	
K162	**Roofing Systems Involving Combustibles** 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790	◯	◯	◯	

K161 construction type table:

		Construction Type	
1	◯	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered
2	◯	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered
3	◯	II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered
4	◯	III (211)	
5	◯	IV (2HH)	
6	◯	V (111)	
7	◯	III (200)	Not allowed non-sprinklered
8	◯	V (000)	

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	2012 NEW Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790	○	○	○	
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	◉	○	○	
	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2	◉	○	○	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	**Patient Sleeping Room Doors** Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	◉	○	○	
K222	**Egress Doors** Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: ☐ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 ☐ SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	⬓ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ⬓ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	◉	○	○	
K223	**Doors with Self-Closing Devices** Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no hazards. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	○	○	◉	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	◉	○	○	
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	○	○	◉	
K227	**Ramps and Other Exits** Ramps, exit passageways, fire escape ladders, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	◉	○	○	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	**Aisle, Corridor or Ramp Width** 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	○	○	○	
	2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5	○	○	○	
K233	**Clear Width of Exit and Exit Access Doors** 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7	○	○	○	
	2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7	○	○	○	
K241	**Number of Exits – Story and Compartment** Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	**Dead-End Corridors and Common Path of Travel** 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2	○	○	○	
K251	2012 NEW Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	○	○	○	
K252	**Number of Exits – Corridors** Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	◉	○	○	
K253	**Number of Exits – Patient Sleeping and Non-Sleeping Rooms** Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	◉	○	○	
K254	**Corridor Access** All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4	◉	○	○	
K255	**Suite Separation, Hazardous Content, and Subdivision** All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	**Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2	○	○	◉	
K257	**Non-Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). • Point in a room to room door less than or equal to 50 feet. 18.2.6, 19.2.6	◉	○	○	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38	◉	○	○	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	◉	○	○	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	◉	○	○	
K292	**Life Support Means of Egress** 2012 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K293	**Exit Signage** 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	○	○	○	
	2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	○	○	○	
	SECTION 3 – PROTECTION				
K300	**Protection – Other** List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K311	**Vertical Openings – Enclosure** 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 *If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.* ☐	○	○	○	
	2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	**Hazardous Areas – Enclosure** 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 19.3.2.1	○	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☑	☑	☐
b. Laundries (larger than 100 sq. ft.)	☑	☑	☐
c. Repair, Maintenance, and Paint Shops	☑	☑	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☑	☑	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☑	☑	☐
f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)	☐	☐	☑
g. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☑

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	2012 NEW Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7	○	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☐	☐	☐
b. Laundries (larger than 100 sq. ft.)	☐	☐	☐
c. Repair, Maintenance, and Paint Shops	☐	☐	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☐	☐	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☐	☐	☐
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)	☐	☐	☐
g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)	☐	☐	☐
h. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	**Laboratories** Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC) 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each anesthetizing location for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer’s instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	**Cooking Facilities** Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations*, unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	◉	○	○	
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	**Interior Wall and Ceiling Finish** 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 *Indicate flame spread rating(s).* Class B	○	○	○	
	2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 *Indicate flame spread rating(s).* ____________________	○	○	○	
K332	**Interior Floor Finish** 2012 NEW (Indicate N/A for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	○	○	◉	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5	◉	○	○	
K343	**Fire Alarm – Notification** 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)	○	○	○	
	2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4	○	○	○	
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	◉	○	○	
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	◉	○	○	
K347	**Smoke Detection** 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	◉	○	○	
	2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K351	**Sprinkler System – Installation** 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	◉	○	○	
	2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10	○	○	○	
K352	**Sprinkler System – Supervisory Signals** Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code,* and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 11/11/2016 b) Who provided system test. Summit c) Water system supply source. City Water *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	◉	○	○	
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	◉	○	○	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	**Corridors – Construction of Walls** 2012 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. *If the walls have a fire resistance rating, give the rating _____________ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.* 19.3.6.2, 19.3.6.2.7	◉	○	○	
	2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	**Corridor – Doors** 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 *Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.*	◉	○	○	
	2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with self-latching and positive latching hardware. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 *Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.*	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	**Corridor – Openings** Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in². Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	◉	○	○	
K371	**Subdivision of Building Spaces – Smoke Compartments** 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	◉	○	○	
	2012 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** 2012 EXISTING Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) *Describe any mechanical smoke control system in REMARKS.*	◉	○	○	
	2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 *Describe any mechanical smoke control system in REMARKS.*	○	○	○	
K373	**Subdivision of Building Spaces – Accumulation Space** Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	◉	○	○	
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** 2012 EXISTING Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K374	2012 NEW Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8	○	○	○	
K379	**Smoke Barrier Door Glazing** 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5	●	○	○	
	2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	○	○	○	
K381	**Sleeping Room Outside Windows and Doors** Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485	●	○	○	
	SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** List in the REMARKS section any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	●	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	**High-Rise Buildings** 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2	○	○	◉	
	2012 NEW High-rise buildings comply with section 11.8. 18.4.2	○	○	○	
	SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	◉	○	○	
K521	**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	◉	○	○	
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2,	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)	○	○	◉	
K524	**HVAC – Direct-Vent Gas Fireplaces** Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	○	○	◉	
K525	**HVAC – Solid Fuel-Burning Fireplaces** Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction. • Fireplace complies with 9.2.2. • Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. • Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)	○	○	◉	
K531	**Elevators** 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators*. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3	○	○	○	
K532	**Escalators, Dumbwaiters, and Moving Walks** 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2	○	○	◉	
	2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	◉	○	○	
	2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82	○	○	○	
	SECTION 6 – RESERVED				
	SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	◉	○	○	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	◉	○	○	
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	◉	○	○	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. • The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	◉	○	○	
K771	**Engineer Smoke Control Systems** 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7	○	○	◉	
	2012 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, *Standard for Smoke Control Systems*. Test documentation is maintained on the premises. 18.7.7	○	○	○	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	○	○	◉	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	◉	○	○	
K902	**Gas and Vacuum Piped Systems – Other** List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99)	○	○	◉	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems in which failure is likely to cause major injury or death are designated: ☐ Category 1. Systems in which failure is likely to cause minor injury to patients are designated. ☐ Category 2. Systems in which failure is not likely to cause injury, but can cause discomfort is designated. ☐ Category 3. Deep sedation and general anesthesia are not administered when using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	○	○	◉	
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	○	○	◉	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	○	○	◉	
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	○	○	◉	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	○	○	◉	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	○	○	◉	
K911	**Electrical Systems – Other** List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	○	○	◉	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	○	○	●	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	○	○	●	
K915	**Electrical Systems – Essential Electric System Categories** ○ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ● General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ○ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	●	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	◉	○	○	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	◉	○	○	
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	**Electrical Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 10, *Electrical Equipment*, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)	◉	○	○	
K920	**Electrical Equipment – Power Cords and Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	◉	○	○	
K922	**Gas Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	◉	○	○	
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	◉	○	○	
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	◉	○	○	
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	◉	○	○	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	◉	○	○	
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	◉	○	○	
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	○	○	◉	
K932	**Features of Fire Protection – Other** List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 15 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS

K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms**
	Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers:
	• packaging is non-flammable.
	• applicators are in unit doses.
	• Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify:
	  ○ application site is dry prior to draping and use of surgical equipment.
	  ○ pooling of solution has not occurred or has been corrected.
	  ○ solution-soaked materials have been removed from the OR prior to draping and use of surgical devices.
	  ○ policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use.
	Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually.
	15.13 (NFPA 99)
		○	○	◉	

Name of Facility	2012 LIFE SAFETY CODE

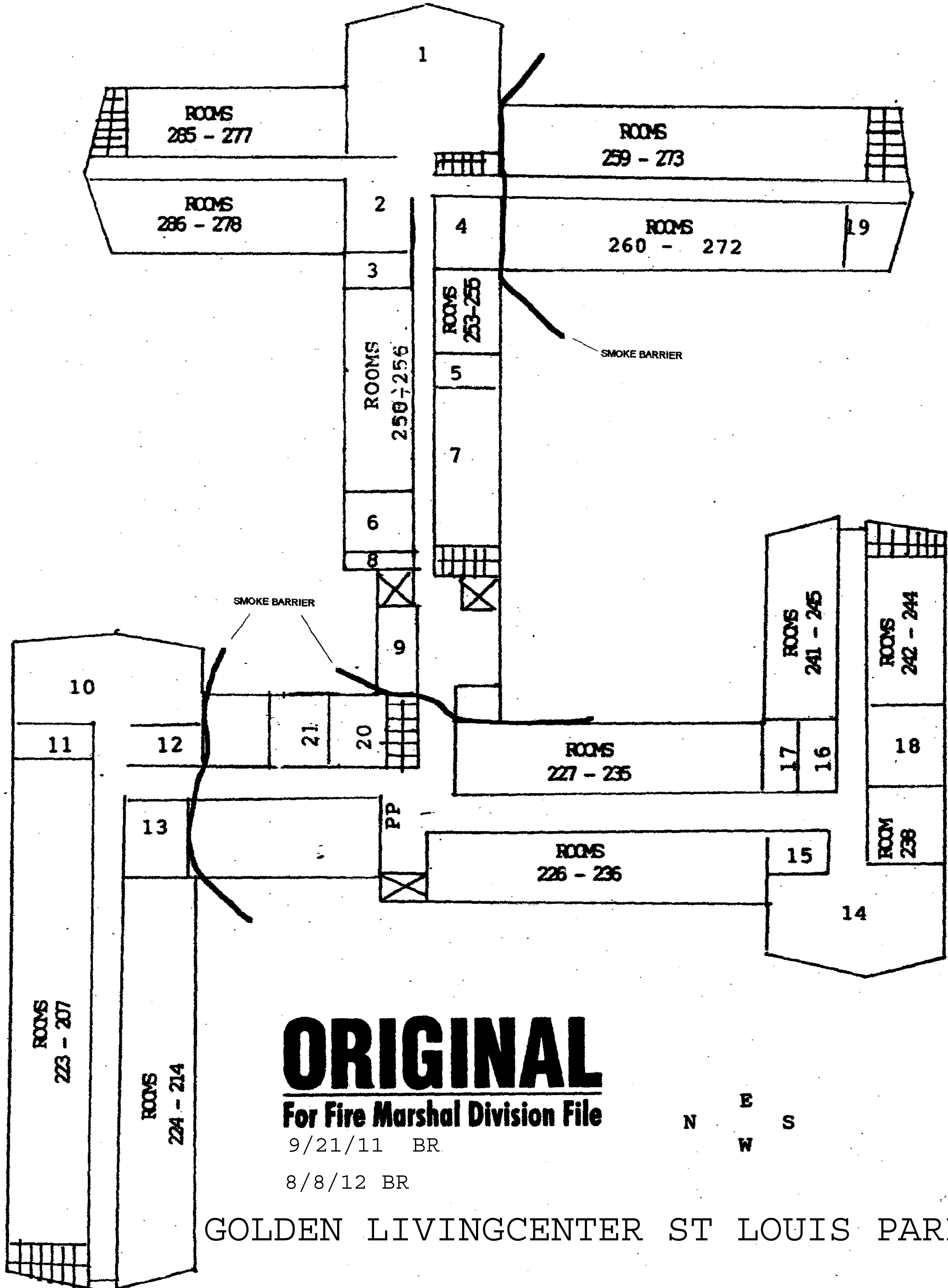
PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

HC140440



ORIGINAL

For Fire Marshal Division File

9/21/11 BR

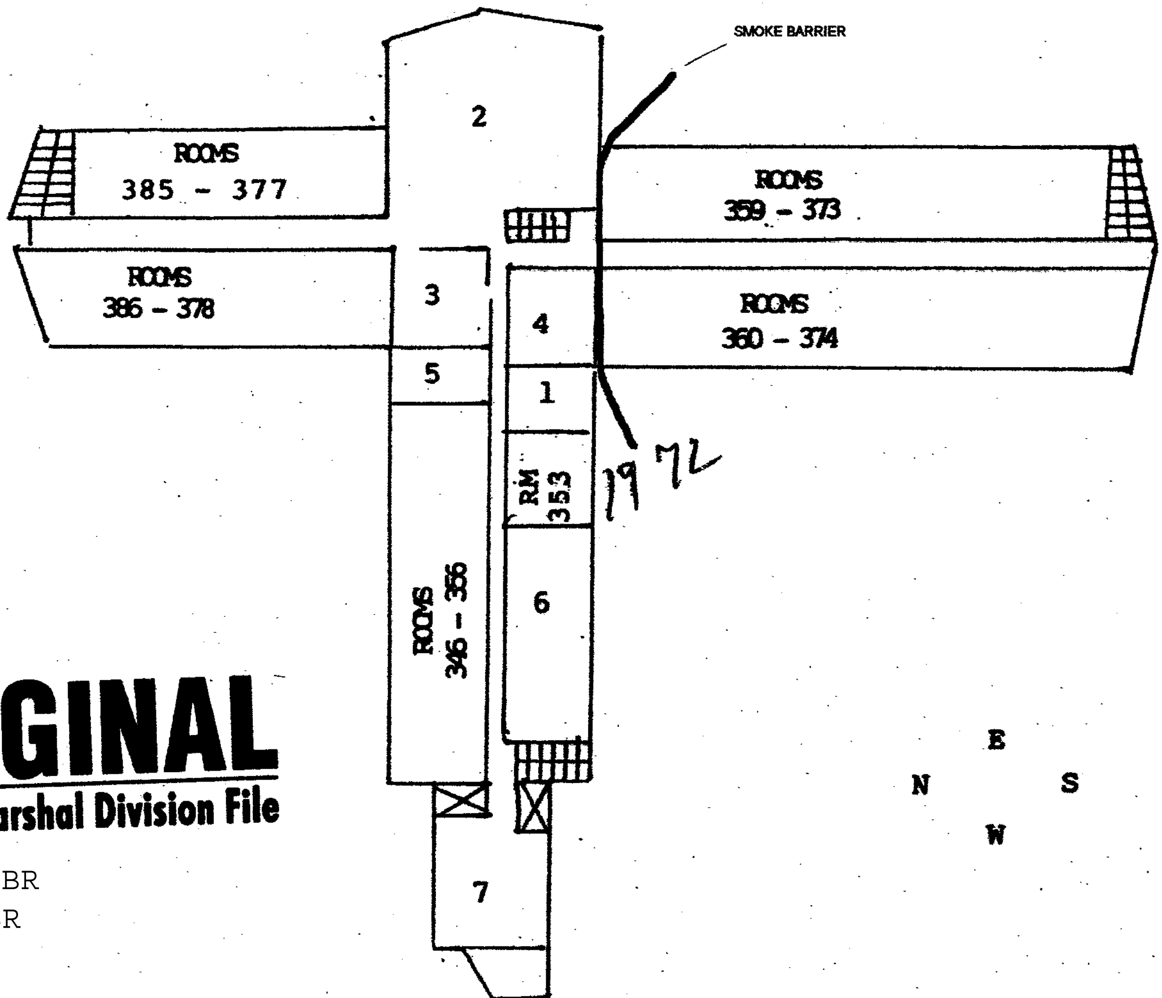
8/8/12 BR

GOLDEN LIVINGCENTER ST LOUIS PARK

HC140440

GOLDEN LIVINGCENTER ST LOUIS PARK

THIRD FLOOR

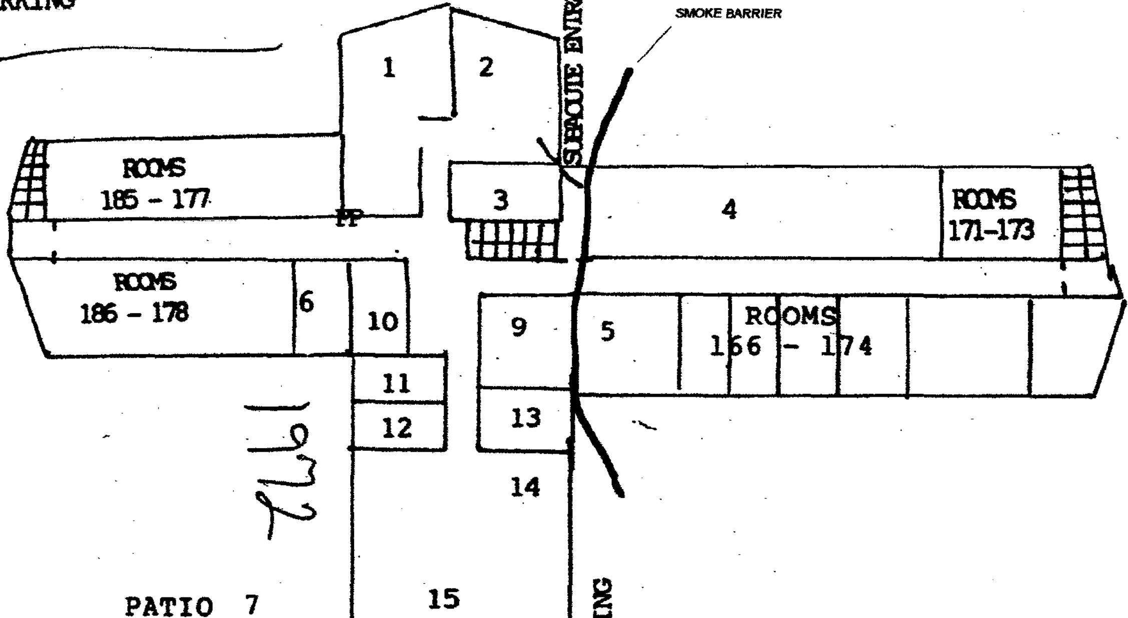


ORIGINAL
For Fire Marshal Division File

9/21/11 BR
8/8/12 BR

HC140440

PARKING



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AMBULANCE
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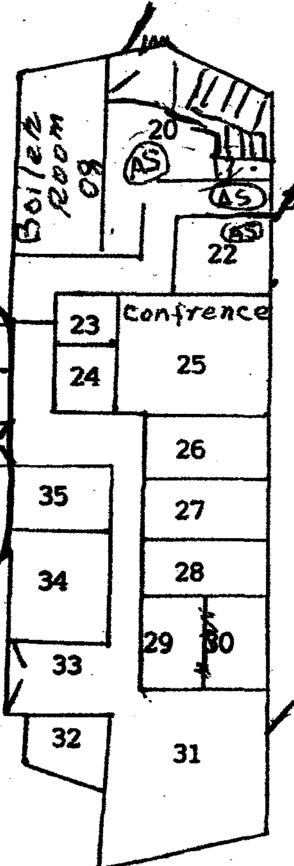

39
40
41
ROOMS
105 - 101
42
ROOMS
106 - 102
18
19
R R
38
37
36
35
34
SMOKE BARRIER
FRONT ENTRANCE
ROOMS
123 - 107
ROOMS
124 - 114

1966

ORIGINAL

For Fire Marshal Division File

9/21/11 BR 8/8/12 BR

GOLDEN LIVINGCENTER ST LOUIS PARK

FIRST FLOOR

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N S
W

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5148025	Golden Livingcenter St. Louis Park	01/24/2017

Administrator: Laurie Sykes

Phone Number: (952) 935-0333

Email address: laurie.sykes@goldenliving.com

State Fire Inspector: William Abderhalden, (507) 361-6204 william.abderhalden@state.mn.us

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

(●) **At the time of this inspection, this facility was found to comply with the requirements of the 2012 Life Safety Code applicable to: [✓] SNF/NF [ ] Hospital [ ] ICFMR [ ] ASC Facilities participating in the Medicare/Medicaid programs.**

( ) **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S — (●) **Draft Summary of Deficiency(ies)** ( ) **Revisit** ( ) **Clearance**

This was an annual federal recertification and state licensing inspection to the standards of the 2012 edition of the Life Safety Code NFPA 101 and the 2012 edition of the Health Care Facilities Code NFPA 99.

This facility meets the requirements.

Transaction Number: 240006559258 **On:** 03/15/2017 **By:**
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Message Detail:

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Message Detail:

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Message Detail:

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