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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MK67

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00893

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245205**
2.STATE VENDOR OR MEDICAID NO.
(L2) **261960100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANOKA REHABILITATION AND LIVING CENTER**
(L4) **3000 4TH AVENUE**
(L5) **ANOKA, MN** (L6) **55303**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2012**

6. DATE OF SURVEY **01/03/2018** (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 **120** (L18)
13.Total Certified Beds **120** (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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Carlene Lange, HFE NE II 03/07/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/07/2018 (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
02/07/1976
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/17/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245205
March 7, 2018

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

Dear Mr. Dolinsky:

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 January 3, 2018 the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2018

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

RE: Project Number S5205028

Dear Mr. Dolinsky:

On December 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 16, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 3, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 23, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 16, 2017, effective January 3, 2018 and therefore remedies outlined in our letter to you dated December 1, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MK67

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(L4) **3000 4TH AVENUE**
(L5) **ANOKA, MN** (L6) **55303**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2012**
6. DATE OF SURVEY **11/16/2017** (L34)
8. ACCREDITATION STATUS: __ (L10)
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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

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From (a) :
To (b) :

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10.THE FACILITY IS CERTIFIED AS:
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___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
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Andera Schmitz, HFE NEII 12/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/11/2018 (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
02/07/1976
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 4, 2017

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation and Living Center
3000 4th Avenue
Anoka, MN 55303

RE: Project Number S5205028

Dear Mr. Dolinsky:

On November 16, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 23, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 16, 2018 (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 May 16, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	**3000 4TH AVENUE ANOKA, MN 55303**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		12/23/17

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

Electronically Signed | 12/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate notification for 1 of 1 resident (R) 176 who experienced a significant weight loss. Findings include: A quarterly Minimum Data Set (MDS) assessment dated 5/24/17, indicated R176 had a score of 7 on a Brief Interview for Mental Status (BIMS) indicating cognitive losses. The	F 157	F000 It is the policy of Anoka Rehabilitation & Living Center to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction will serve as our credible allegation of compliance but does not constitute an admission of deficient practice. F157 It is the policy of ARLC (Anoka	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(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 157	Continued From page 2 assessment also indicated R176 had experienced a significant weight loss. R176's had diagnoses of dementia, depression, high blood pressure, vascular disease, and paralysis on one side of the body. The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds. A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days. The nurse practitioner (NP)-G progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (dementia) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up. A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days and 16.5% loss in 180 days. NP-G noted a discussion with a family member (FM)-B on 11/06/17. Weight loss was discussed along with increasing medications for depression. A nutrition consult was requested. Family member (FM)-B for R176 was interviewed	F 157	Rehabilitation & Living Center) to follow CFR: 483.10(g)(14) as it relates to proper notification. For R176, the family was notified of the weight loss on 11/20/2017 by the dietician. For other residents, who are on comfort care as defined by their POLST and may be affected by this practice, they will be reviewed to ensure proper notification regarding weight loss was done. To ensure correction is achieved and sustained the facility will continue to follow the notification of changes procedure, and will continue to use the tools and resources. The IDT staff were educated on the notification policy on 12/7/17 Audits on notification of weight loss on new and current comfort care residents will be completed weekly for four weeks, monthly for 3 months, and a needed to ensure compliance and the results will be reported to the QAA/QAPI Committee. The committee will then make further recommendations as deemed necessary. Training to staff will be completed by 12/ 18/17. The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 3 on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had only been made aware of the significant weight loss the past week when the nurse practitioner called to discuss medications. The clinical administrator was interviewed on 11/16/2017, at 3:00 p.m. He stated the interdisciplinary team would notify the nurse practitioner in the case of significant health events and it was the expectation that the nurse practitioner would notify the family. He added, the facility does not supervise the nurse practitioners. A policy regarding health care notification was requested but not provided. The policy, Tracking Weight Changes, dated 2017, indicated the individual, family or representative, physician and registered dietitian would be notified of any individual with an unintended significant weight change of 5% in one month, 7.5% in three months or 10% in six months.	F 157		
F 221 SS=D	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 221		12/23/17

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F 221	Continued From page 4 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R260) was free from physical restraints by lowering bed to the floor restraining R260's ability to self transfer out of bed. R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's disease, toxic encephalopathy (disorder of the nervous system caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness.	F 221	F221 It is the policy of ARLC to treat all residents with respect and dignity according to CFR: 483.10(a)(1) and 483.12(a)(2), including the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident□s medical symptoms. For R260, the bed was re-adjusted to the normal bed height upon notification. Staff members were instructed to only use the EZ Stand for transfers in and out of bed and to use the grab bar and assist of one for toileting. The care plan and Kardex were reviewed and revised to reflect his	

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F 221	Continued From page 5 R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit. R260's significant change MDS, dated 10/13/17, indicated R260 required physical assistance of two staff for bed mobility and transfers. R260 also required assistance of one staff to provide physical weight bearing support to walk in the corridor, and his balance during transitions and walking was not steady and only able to stabilize with human assistance of one. R260's significant change Care Area Assessment (CAA) for falls, dated 10/16/17, identified he was at risk for falls due to use of the EZ stand (mechanical sit to stand lift used to help balance a person to standing position) and assist of one to two assist with transfers. R260 had no falls. R260's current care plan, initiated on 9/25/17, identified a fall risk; however, it did not include an intervention of bed placement to the floor. R260's care plan for Incontinence or altered elimination included an intervention dated 9/28/17, directed staff to respond to call light timely; R260 was able to use call light appropriately. R260's current care plan for activities of daily living (ADLs) included an intervention, initiated 9/29/17, directing one staff to assist R260 with EZ stand when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand. R260's nursing assistant group sheet undated,	F 221	transfer method. For other residents who require the use of a mechanical lift or standing device, their assessments and care plans will be reviewed and/or revised to ensure the proper use of devices. The employee who lowered the bed was provided coaching on 12/15/17. Education will be provided to rehab staff, nursing assistants, nurses, and housekeeping staff. Staff members were educated on following the care plan. Random audits regarding proper use of mechanical lifts, stands and appropriate bed height will be completed, weekly x 4 weeks per household, then monthly x 3 months, and as needed to ensure compliance. The results will be shared with the QAA/QAPI Committee for further recommendations as needed. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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directed staff to transfer with the use of the EZ stand, it did not include an intervention of bed placement to the floor.

R260's Physician Order Report, dated 11/15/17, lacked order to lower bed to the floor.

R260's Physical Therapy Discharge Summary, for dates of service of 9/26/17 to 10/11/17, included his baseline ability to ambulate 8 feet (ft) with assistance of two staff on 9/26/17 and 50 ft with assistance of two staff on 10/9/17. R260's discharge note dated 10/11/17, included R260 was variable with ambulation and required minimum to moderate assist of two staff and wheelchair to follow.

During observation on 11/13/17, at 3:14 p.m. R260 was observed resting in bed. R260's bed was in a low position onto to the floor, with mattress one inch off the floor. R260 stated he had not fallen and did not know why the bed was so low. R260 stated he thought it was done so that he did not get up. R260 stated, "They insist I call for help," and reported the bed was not always put to the floor. The bed remote (which controlled the height of the bed) was observed on the floor one foot away from mattress at R260's shoulder level.

During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed and the bed was at knee level height when nursing assistant (NA)-C entered into room, and shut the door. At 3:00 p.m., NA-C left the room and R260 was discovered to have been transferred out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put on the bathroom call light, NA-D entered the room

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and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back.

During interview on 11/14/17, at 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet.

During observation on 11/15/17, at 7:47 a.m. NA-C assisted R260 out of bed. R260 sat at the edge of the bed and kept balance while seated independently without support. R260 maintained balance while seated and assisted with long sleeve shirt and undershirt. NA-C asked R260 to place feet onto the EZ stand foot plates, then placed sling around R260's waist, attached it to the EZ stand lift, and began to lift the arms of the mechanical standing machine. R260 was lifted by machine support to standing for the first twelve inches of the mattress, then R260 was able to stand tall bearing full weight with only the supportive guidance of the machine from bedside to the wheelchair. NA-C stated R260 did well with the EZ stand machine.

During interview on 11/15/17, at 8:09 a.m. NA-C stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing, in the mornings mostly, and that the EZ stand was used during those times. NA-C verified the groups sheets did not direct staff to use the EZ stand as needed. NA-C stated the bed had been lowered to the floor when R260 was in bed because he liked to

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self transfer. NA-C stated she puts the bed to the floor when she works. NA-C stated R260 would try to self transfer but when the bed is low, R260 would just be able to hang bottom half of body off the side of the bed onto floor.

During interview on 11/15/17, at 8:57 a.m. R260 stated it bothered him that the bed was put down that low. R260 reported it did not happen often but it bothered him because its too hard to get up. R260 stated he lost his patience sometimes and got up by himself but usually would call for help. R260 stated if he had to, he would and could get out of bed, when it wasn't placed so low to the floor. R260 stated he can't get out of bed when it was low to the floor.

During interview on 11/15/17, at 12:09 p.m. NA-E stated the bed was down to the floor as R260 is a fall risk when he tried to get out of bed. When the bed was low, he was only able to just get his feet over the edge of the bed. NA-E worked with R260 once a week.

During interview on 11/15/17, from 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers out of bed using the EZ stand and using the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any deviation from the care planned intervention was needed. LPN- A stated if R260's bed was low or to the floor, it should only have been by R260's preference. LPN-A further stated R260 would not get up independently and usually calls for help. LPN-A was not aware the bed was placed to the floor by staff and verified it was not care planned to be that way. LPN-A reported the bed should not have been to the floor. LPN- A stated R260

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had never fallen out of bed, and NA-C needed education regarding the bed placement on the floor.

During interview on 11/15/17, at 12:31 p.m. the director of nursing (DON) stated she expected staff to follow the care plan and the bed was not care planned to be placed on the floor. The DON verified R260 had no history of falls and education was needed to ensure staff did not place anyone's bed on the floor if not care planned. The DON stated that there was no one in the facility who had a care planned for a bed placement to the floor, further stating it would be care planned and explained why that resident may need the intervention. The DON stated staff are expected to follow the care plan with transfers and that they can only upgrade the transfer mode if needed but never transfer with less than care planned.

During interview on 11/16/17, at 2:55 p.m. the clinical administrator reported the facility was a restraint-free facility, and the facility was working towards that goal of eliminating all restraints, even the Wanderguards. The clinical administrator was unaware of the low bed before that week, stating the low bed "came out of nowhere," further stating it was "a no no." The clinical administrator further reported it was not the facility's policy to keep someone in bed, especially with no history of falling. The clinical administrator had educated all staff last evening and that day they came to work about the use of restraints.

The facility's policy for Physical Device Data Collection and Evaluation dated, 10/2011, stated that physical restraints are defined as any manual

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F 221	Continued From page 10 method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual can not remove easily which restricts freedom of movement. The policy directs staff to identify the rationale for the use of a potential restraint. The policy stated a restraint of any type would not be used as a substitute for more effective nursing care or for convenience of staff. The policy directs the staff with the procedure for documentation, assessment and use of any potential restraint use.	F 221		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (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	F 225		12/23/17

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F 225	Continued From page 11 actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance 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.	F 225		

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F 225	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations involving abuse were immediately reported, not exceeding two hours, to the state agency (SA) and administrator for 2 of 4 residents (R273, R137) reviewed for physical abuse. Findings include: R273's significant change Minimum Data Set (MDS), dated 10/14/17, identified no cognitive impairment and required extensive assistance to total dependence from staff for ADLs (activities of daily living). R273's current care plan, dated 10/27/17, noted his vulnerability to abuse related to depression, above the knee amputation, and long-term care placement. The care plan further directed to provide a safe environment and remove R273 from "potentially abusive situations." During interview on 11/14/17, at 9:27 a.m. R273 alleged physical abuse by the nursing staff. R237 reported the evening nursing assistant seemed mad when answering his call light and was disrespectful to him. R273 stated it rose to abuse when the staff would "flip me" to his side when performing peri cares, noting rough treatment with cares. R273 could not identify the staff, but reported he was not afraid of the staff, further stating he had not reported the incident to the facility. During interview on 11/14/17, at 10:03 a.m. the facility was made aware by this surveyor, of R273's allegation of abuse, and the assistant	F 225	F225 It is the policy of ARLC to investigate and reports allegations according to CFR: 483.12(a)(3)(4)(c)(1)-(4). For R273 and R 137, identified in the statement of deficiency for the allegation of abuse were reviewed and investigated. The allegation was reported to the administrator and to the state agency, investigation was reviewed and completed, and the care plan was reviewed and updated. All staff will be educated by 12/ 18 /17 on mandated reporting, and protocols for response to allegations of abuse/neglect, including ensuring the allegation is immediately reported to the administrator and to the state agency and thorough investigation is completed according to policy Residents potentially affected by the practice as outlined in the statement of deficiency will be identified through resident interview/audits, to be completed by 12/ 18/17. Identified allegations for abuse, neglect, and misappropriation of property will be reported immediately to the administrator and state agency, and thoroughly investigated according to policy. Nursing and/or designee will implement measures to ensure that this practice does not recur, including: review of the Resident Protection/Freedom from abuse	

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F 225	Continued From page 13 executive director (AED) reported the facility would begin their process of risk management. R273's Post Incident Review noted the alleged abuse occurred on 11/13/17, at 8:00 p.m. The Incident Review further identified the executive director/administrator had been notified timely of the allegation, on 11/14/17, at 10:30 a.m. The Incident Review prompted staff to answer if immediate notification of the allegation was made to the state agency or OHFC (office of health facility complaints). The Review indicated a report had been made but did not indicate the time the report had been made. R273's Incident Report Summary by MDH (Minnesota department of health) identified the allegation of physical abuse had been reported to the state agency on 11/14/17, at 2:58 p.m., nearly five hours after it was initially reported. The report further identified R273 had alleged the evening nursing assistant was rough with him during cares and the investigation was in progress. Although the administrator was notified timely, the allegation of abuse was not reported within two hours. R137's admission MDS, dated 10/31/17, identified no cognitive impairment, required limited assistance with ADLs, and needed physical assistance from staff with bathing. R137's current care plan, dated 10/30/17, noted her vulnerability to abuse related to transitional care/rehab placement. The care plan further directed to provide a safe environment and remove R137 from "potentially abusive situations."	F 225	policies, including review that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion, utilization of resident protection and process and forms and staff interview audits. Management staff involved with investigations will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures on resident protection. Training to staff will be completed by 12/18/17. Audits will be completed on OHFC reporting times weekly for four weeks, monthly for three months, and as needed to ensure compliance. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provide as derived from the reviews. The results will be shared with the QAA/QAPI Committee for follow up and further recommendations if needed. To ensure correction is achieved and sustained the facility will continue to follow the resident protection procedure, and will continue to use the tools and resources. The Social Services Director or designee will be responsible for compliance. The facility alleges it will be in substantial compliance with the standard indicated by	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 14 R137's Post Incident Review noted an incident of alleged abuse, rough cares with an evening shower, occurred on 11/10/17, at 9:00 p.m. The Incident Review identified the nursing supervisor had been notified of the abuse allegation via R137's daughter on 11/11/17, at 11:00 a.m. The Incident Review further identified the executive director/administrator had been notified of the allegation of 11/11/17, at 5:35 p.m., over six hours after the initial notification. The Incident Review indicated notification of the allegation was made to the stage agency/OHFC, but did not indicate the time. R137's Incident Report Summary by MDH identified the allegation of physical abuse had been reported to the state agency on 11/11/17, at 6:59 p.m., nearly eight hours after it was initially reported. The report further identified R137 had alleged the evening bath aide was rough during cares while assisting R137 with her shower. The report indicated the nursing assistant had been suspended while the investigation was in progress. Although the allegation of abuse was reported, it was not reported within two hours, to the administrator and state agency. The facility failed to be in compliance with the federal regulation changes, as of November 2016, which directs allegations of abuse be reported immediately and not exceeding two hours. During interview on 11/16/17, at 7:43 a.m. registered nurse (RN)-C stated nursing supervisors and leadership had access to the state agency/OHFC reporting web site and were responsible for reporting allegations of abuse.	F 225	12/ 23/17. Date of Correction: 12/23/17	

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	245205	A. BUILDING _____ B. WING _____	11/16/2017

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F 225	Continued From page 15	F 225		

RN-C stated, when he worked as a floor nurse, he would report allegations to the nursing supervisor on at the time. RN-C further stated, when he worked as a nursing supervisor, he would first interview the resident about the allegation and depending on what the resident said,would get the risk management procedure going, which included to call the administrator, director of nursing (DON), and social services (SS). RN-C stated he would make sure the resident was safe by removing the alleged perpetrator, and if the alleged perpetrator was a staff member would suspend him or her. RN-C stated, as a nursing supervisor, he would complete the initial report to the state agency on the off hours, and social services would complete the report if it was during the day. RN-C thought they had twenty four hours to report, unless there was suspicion of a crime or bodily injury, then they reported in two hours.

During interview on 11/16/17, at 9:05 a.m. RN-B stated all allegations of abuse and bodily harm were reported to the state agency. RN-B reported nursing managers, supervisors, and leadership reported allegations of abuse to the state agency. RN-B stated allegations were reported to the nurse supervisor during off hours, who was responsible for determining if something was reportable, and if the nursing supervisor was unsure of whether or not to report, they could talk to social services. RN-B stated, when an allegation was made, the nurse supervisor would interview the resident and begin the risk management procedure. RN-B further stated after interviewing the resident, the administrator would be notified and determine if a report should be filed to the state agency. RN-B acknowledged the allegation had to be validated and confirmed

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F 225	Continued From page 16 with the resident before calling the administrator, and once the alleged abuse was confirmed, would notify the administrator immediately. RN-B stated their policy did not indicate a timeframe in which to report allegations of abuse, stating she thought they had twenty four hours to report. During interview on 11/16/17, at 11:59 a.m. the director of social services (DSS) stated their number one concern with allegations of abuse was to protect the resident. The DSS stated nursing supervisors were responsible for reporting allegations during off hours, while she reported allegations during the weekdays. The DSS reported the allegations of abuse were reported to the administrator first, as well as the DON and herself. The DSS reported the regulation was not to exceed twenty four hours for reporting, and allegations of rough cares would be treated like physical abuse. She further stated, in cases like R273 and R137, the residents and staff were interviewed prior to reporting the allegations to find out what had occurred and who the perpetrator was, so the alleged perpetrator could be suspended pending the investigation, making sure the situation is safe. The DSS acknowledged that the investigation began as soon as the allegation was made, and that there was investigation going on prior to reporting the allegations, as she attempted to talk with staff right away. The DSS stated she would re-interview staff during the five day investigation depending on the situation, if more questions came up. The DSS was not aware of the federal regulation change requiring allegations of abuse to be reported no later than two hours, stating their policy did not specify a time in hours, but did follow an immediate abuse reporting policy.	F 225		

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F 225	Continued From page 17	F 225		

During interview on 11/16/17, at 2:07 p.m. the DON stated everyone was a mandated reporter, the administrator was notified immediately, and the state agency was notified the same day as the allegation was made. The DON stated nurse managers, supervisors, and social services all had access to report to the state agency. The DON was not aware of the new regulatory guidelines for reporting allegations of abuse within two hours, referencing the facility's abuse policy was a corporate policy, revised last November of 2016.

During interview on 11/16/17, at 2:55 p.m. the clinical administrator stated the facility's quality assurance (QA) committee discussed abuse reporting and completed abuse training house wide a couple months prior, stating it was a number one priority for them. The clinical administrator stated they reported everything in the building. The clinical administrator further stated they might report allegations over two hours or might miss them by two to three hours, but they were very consistent with reporting. The clinical administrator was not aware of the regulatory changes to reporting time frames for allegations of abuse, stating he sat on a regulatory committee and did not know how that was missed.

The facility's Resident/Client/Participant/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure, revised 11/16, directed, "The Executive Director/ or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect." The policy further directed

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F 225	Continued From page 18 suspicions of abuse would be reported to the state agency, "in accordance with state law," noting that "Immediate reporting pertains to Long Term Care."	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse	F 226		12/23/17

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F 226	Continued From page 19 prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their vulnerable adult policy to ensure all alleged violations involving abuse were immediately reported to the administrator and the state agency and failed to re-vise their vulnerable adult policy to reflect the updated federal reporting timeframe of no later than two hours for 2 of 4 residents (R273, R137) reviewed. Findings include: The facility's Resident/Client/Participant/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure, revised 11/16, directed, "The Executive Director/ or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect." The policy further directed suspicions of abuse would be reported to the state agency, "in accordance with state law," noting that "Immediate reporting pertains to Long Term Care." During interview on 11/14/17, at 9:27 a.m. R273 alleged physical abuse by the nursing staff, reporting rough cares from an unknown nursing staff. R273 stated he was not afraid, but had not reported the allegation to the facility. The facility was made aware of the allegation by the state surveyor on 11/14/17, at 10:03 a.m. R273's Incident Report Summary by MDH (Minnesota department of health) identified an	F 226	F 226 It is the policy of ARLC to develop and implement written policies and procedures according to CFR: 483.12(b)(1)-(3) and 483.95(c)(1)-(3) regarding abuse, neglect, and exploitation of residents and misappropriation of resident property, establish policies and procedures to investigate any such allegations and include training as required . For R273 and R137, identified in the statement of deficiency for the incidents for the allegation of abuse were reviewed and investigated. The allegation was reported to the administrator and to the state agency, investigations were reviewed and completed and care plans were reviewed and updated. All staff will be educated by 12/18/17 on mandated reporting, and protocols for response to allegations of abuse/neglect, including ensuring the allegation is immediately reported to the administrator and to the state agency and thorough investigation is completed according to policy Identified allegations for abuse/neglect and misappropriation of property will be reported immediately to the administrator and state agency, and thoroughly investigated per policy.	

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F 226	Continued From page 20 allegation of physical abuse had been reported to the state agency on 11/14/17, at 2:58 p.m., over four hours after it was initially reported. The allegation of abuse was not reported timely, nor was it reported within two hours. R137's Post Incident Review noted, on 11/11/17 at 11:00 a.m., her daughter had reported an allegation of abuse with rough cares during the evening shower. The executive director/administrator was not notified of the allegation until 11/11/17, at 5:35 p.m., over six hours after the initial notification. R137's Incident Report Summary by MDH identified an allegation of physical abuse had been reported to the state agency on 11/11/17, at 6:59 p.m., almost eight hours after it was initially reported. The allegation of abuse was not reported timely, nor was it reported within two hours, to the administrator and state agency. The facility failed to be in compliance with the federal regulation changes, as of November 2016, which directs allegations of abuse be reported immediately and not exceeding two hours. During interview on 11/16/17, at 9:05 a.m. registered nurse (RN)-B stated all allegations of abuse and bodily harm were reported to the state agency. RN-B stated after interviewing the resident, the administrator would be notified and determine if a report should be filed to the state agency. RN-B further stated their policy did not indicate a timeframe in which to report allegations of abuse, stating she thought they had twenty four hours to report.	F 226	Audits will be completed on OHFC reporting times weekly for four weeks, monthly for three months, and as needed to ensure compliance. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provide as derived from the reviews. The results will be shared with the QAA/QAPI Committee for follow up and further recommendations if needed. The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: review of the Resident Protection/Freedom from abuse policies, including review that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion, utilization of resident protection and process and forms and staff interview audits. Management staff involved with investigations will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures on resident protection. Training to staff will be completed by 12/18/17. To ensure correction is achieved and sustained the facility will continue to follow the resident protection procedure, and will continue to use the tools and resources.	

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F 226	Continued From page 21 During interview on 11/16/17, at 11:59 a.m. the director of social services (DSS) stated allegations of abuse were reported to the administrator first, as well as the DON and herself. The DSS reported the regulation was not to exceed twenty four hours for reporting, and allegations of rough cares would be treated like physical abuse. She further stated, in cases like R273 and R137, the residents and staff were interviewed prior to reporting the allegations to find out what had occurred and who the perpetrator was, so the alleged perpetrator could be suspended pending the investigation, making sure the situation is safe. The DSS was not aware of the federal regulation change requiring allegations of abuse to be reported no later than two hours, stating their policy did not specify a time in hours, but did follow an immediate abuse reporting policy. During interview on 11/16/17, at 2:07 p.m. the DON stated the administrator was notified immediately, and the state agency was notified the same day as the allegation was made. The DON was not aware of the new regulatory guidelines for reporting allegations of abuse within two hours, referencing the facility's abuse policy was a corporate policy, revised last November of 2016. During interview on 11/16/17, at 2:55 p.m. the clinical administrator stated they reported everything in the building. The clinical administrator further stated they might report allegations over two hours or might miss them by two to three hours, but they were very consistent with reporting. The clinical administrator was not aware of the regulatory changes to reporting time frames for allegations of abuse, stating he sat on	F 226	The facility alleges it will be in substantial compliance with the standard indicated by 12/23/17. The Social Service Director or designee will be responsible for compliance Date of Correction: 12/23/17	

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F 226	Continued From page 22 a regulatory committee and did not know who that was missed.	F 226		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279		12/23/17

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F 279	Continued From page 23 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan with interventions to address new urinary incontinence or maintain as much urinary continence to the greatest degree for 1 of 3 residents (R273) reviewed for urinary incontinence. Findings Include: R273's admission Minimum Data Set (MDS), dated 9/1/17, identified no cognitive impairment and was always continent of urine.	F 279	F279 It is the policy of ARLC to develop comprehensive care plans according to CFR: 483.20(d) and 483.21(b)(1). For R273, the care plan was updated to include needed assistance with the urinal, bed pan, brief, pericare after each incontinent episode including the application of barrier cream as ordered. The barrier cream was added to the care plan and kardex on 11/27/17. The updated care plan and kardex was	

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F 279	Continued From page 24 R273's significant change MDS, dated 10/14/17, identified no cognitive impairment, was dependent on staff for toileting, and was frequently incontinent of urine. R273's Bladder and Bowel Data Collection, dated 10/11/17, noted he was frequently incontinent of urine and would sometimes leak urine. The Data Collection further noted R273 was not on a toileting program and had never had a voiding trial, but could identify the urge to void and use the call light. The Data collection identified R273 required a mechanical lift for toileting. R273's significant change Care Area Assessments (CAA), dated 10/20/17, indicated a progressive decline since admission, which included a surgery for an above the knee amputation of the right leg and the initiation of dialysis three times a week. The CAA further indicated R273 had little urine output and, "Urinal at bedside to assist with attempt for continence of urine." R273's current Kardex, undated, identified him as occasionally incontinent and needing assistance to transfer on and off the toilet. The Kardex did not include interventions related to assistance with the bedside urinal R273's current care plan, dated 10/7/17, identified a diagnosis of altered elimination with the goal to decrease incontinence episodes. The care plan noted R273 was occasionally incontinent of urine, and lacked any additional interventions to address urinary incontinence such as assistance with bed side urinal or a toileting assistance schedule.	F 279	communicated to staff members 11/27/17 for other residents who are incontinent, their assessments and care plans and kardex will be reviewed for accuracy and updated as needed. They will be reviewed on-going upon admission, quarterly, significant change and annually to reflect their needs. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and care planning procedures, and will continue to use the tools and resources. Care plan and Kardex audits will be completed weekly for four weeks, monthly for three months, and as needed to ensure compliance. The results will be reported to the QAA/QAPI Committee for review and further recommendations as needed. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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F 279	Continued From page 25	F 279		

During interview on 11/15/17, at 9:34 a.m. nursing assistant (NA)-F stated R273 used the urinal at the bedside and needed staff to help position the urinal, stating if it was not in the right spot he would leak. NA-F denied going in to offer the urinal, stating R273 could feel when he had to go and would call in staff.

During interview on 11/15/17, at 2:04 p.m. R273 stated he voided two to three times a day using the urinal at the bedside when he had to void. R273 denied needing assistance to place the urinal, stating if it was hooked on the bedside garbage, he could reach it from where he was lying in the bed. R273 reported he did not use the toilet or go into the bathroom, just used the urinal. R273 denied being incontinent of urine.

During interview on 11/16/17, at 8:27 a.m. registered nurse (RN)-B stated incontinence was assess by the nurse managers on admission by talking with staff, resident, and family, noting that if the resident was not a good historian, then they would look at the charting of incontinence episodes. RN-B stated R273 had contributing factors of kidney failure and dialysis, noting he could use the urinal but could still have bouts of incontinence overnight. RN-B further stated, with the new right leg amputation, R273's mobility was not like it used to be and was requiring more incontinence brief changes at night, accounting for the incontinence. RN-B reported the care plan was suppose to flow from the nurse manager's assessment, noting R273's care plan should consist of more, including the type of the brief he wears for incontinence.

During interview on 11/16/17, at 2:07 p.m. the

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F 279	Continued From page 26 director of nursing (DON) stated the care plan depended on the individual resident, and could not say what would be in the care plan without knowing more about the individual. The DON reported they wanted their rehab residents to be as independent as possible and the care plans were ongoing. A facility policy entitled Care Plan Policy And Procedure, revised 11/16, directed the care team would collect information over a fourteen day course to develop the comprehensive care plan. The policy determined the comprehensive care plan "will describe services to attain or maintain the resident's highest physical .... well-being." The policy further directed interventions would be written to assist in meeting the goal and should be individualized to the resident.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		12/23/17

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F 280	Continued From page 27 (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 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.	F 280		

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F 280	Continued From page 28 (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 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 record review, the facility failed to revise a care plan to include the use of a right heel padded cushion whenever in bed for 1 of 3 residents (R)-86 reviewed for pressure ulcers failed to reassess and revise the care plan for 1 of 1 resident (R)-176 who experienced a significant weight loss. Findings include: R86's annual Minimum Data Set (MDS), dated 5/26/17, identified R86 required assistance of 2+ staff with bed mobility and transfers. R86 required extensive assistance of 1 staff for dressing and personal hygiene. R86 was at risk for pressure	F 280	F280 It is the policy of ARLC to include the resident and/or representative in the care planning process according to CFR: 483.10(c)(2)(i-ii, iv, v)(3), and 483.21b)(2), implementing the plan of care and revising the care plan when necessary. For R86, the care plan was revised on 11/15/17 to include the use of the right heel padded cushion when in bed (not just at night) to prevent pressure ulcers. For other residents at high risk for pressure ulcers per PointRight Quality Measures, their assessments and care plans were reviewed and updated as necessary.	

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F 280	Continued From page 29 ulcers and had one unstageable pressure ulcer. R86 was moderately cognitively impaired. R86's annual Care Area Assessment (CAA), dated 5/26/17, identified R86 was at risk for developing pressure ulcers and currently had one pressure area. R86 had one old scab to right 4th digit toe measuring 0.2 cm x 0.2 cm. "Resident wears padded rt [right] heel boot on at all times when in bed." R86 had a pressure reducing mattress and wheelchair cushion. R86's current physician order's include: -Initiated on 1/10/17, "Please make sure right heel boot is on at HS [bedtime.] -Initiated on 1/12/17, a padded right heel boot on whenever in bed, every shift for skin protection. -Initiated on 5/31/17, to keep shoes off until scab area on right foot has resolved. -initiated on 8/16/17, Apply skin prep to scab on 4th and 5th digit on right foot once daily until resolved. R86's care plan included a problem initiated on 8/15/13, which indicated R86 was at risk for alteration of skin integrity. The problem area was revised on 2/22/17 to include a stage 2 pressure area "scab" on the right foot 4th toe. Interventions included: -A revised 5/2/17 intervention, which directed "padded HEEL boot at night." The care plan did not identify to place the right padded heel boot on whenever in bed as assessed and ordered. -An added 5/2/17 interventions, which indicated R86 was currently wearing gripper socks during the day due to right 4th and 5th toe pressure areas. During observations on 11/13/17, at 2:27 p.m.	F 280	For R176, the care plan was updated to include the weight loss and nutritional recommendations from the RD. For other residents, who are on comfort care as defined by their POLST and may be affected by this practice, their assessments and care plans were reviewed and revised as necessary regarding weight loss. Education was provided for staff members on the updated plans of care. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and care planning procedures, and will continue to use the tools and resources. Care plan audits will be completed weekly for four weeks, monthly for three months, and as needed to ensure compliance. The results will be reported to the QAA/QAPI Committee for review and further recommendations as needed. The Registered Dietician or designee will be responsible for compliance. Date of Correction: 12/23/17	

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R86's was lying on his back in bed. R86 had gripper socks on both feet. R86's heels were resting on the mattress. R86 was not wearing a padded right heel boot as care planned. A padded heel boot was observed laying on the seat of the electric wheelchair in the room.

During an interview on 11/13/17, at 7:09 p.m., R86 stated, "Not sure," when asked when staff apply the heel boot.

During observations on 11/14/17, at 12:46 p.m. nursing assistant (NA)-A and nursing assistant (NA)-B transferred R86 from the wheelchair to bed with a mechanical lift. R86 was wearing gripper socks. NA-A left the room. NA-B provided incontinent cares. After the completion of incontinent cares, NA-B covered R86 with a blanket. R86's heels were resting on the mattress. A padded heel boot was laying on a chair in the room. NA-B left the room without applying the padded heel boot to R86's right foot.

During an interview on 11/16/17, at 10:30 a.m., registered nurse (RN)-A stated she updated R86's care plan on 11/14/17. Review of R86's care plan identified a revised intervention dated 11/14/17, Ten months after the order to place the right heel boot on whenever in bed. The revised care plan intervention directed "Padded boot to right heel whenever resident is in bed. RN-A stated prior to 11/14/17, the care plan and Kardex intervention directed to used a padded heel boot at night.

During an interview on 11/16/17, at 8:40 a.m. the director of nursing (DON) stated the nursing assistant group sheets are used as a resident assignment list, but do not necessarily identify

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interventions. Interventions are documented on the care plan and the Kardex. Interventions are also communicated through report. Staff are to follow the resident's care plan.

The facility's Policy and Procedure for the Prevention and Treatment of Skin Breakdown, revised 8/2011, indicated: "it is the policy of Volunteers of America to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." "The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident."

R176 was observed at breakfast on 11/15/2017, at 8:55 a.m.. R176 had a pureed meal and was assisted to eat. After a few minutes R176 was given the spoon and began to feed herself. At 9:09 a.m., R176 slowed down with eating holding the spoon and looking around; R176 appeared dozy with eyes closed and not eating. At 9:13 a.m. staff encouraged R176 to take a drink of orange juice and began to assist again with eating. At 9:24 a.m. R176 asked to go to the activity room.

R176 was observed at the lunch meal on 11/15/2017, at 12:22 p.m. R176 had the meal in front of her but was not initiating eating. At 12:26 p.m. staff sat with R176 to assist, R176 had started feeding self and drinking independently. R176 continued to feed herself slowly with very small bites. At 1:00 p.m. R176 continued to be assisted by staff to eat. All other residents had finished and left the dining area.

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On 11/16/2017, at 9:19 a.m. Licensed Practical Nurse (LPN)-B stated, R176's intake was variable at 25-75% and often held food in her mouth and needed to be cued to swallow. Also, R176 would say when full.

LPN-C was interviewed on 11/16/2017, at 1:41 p.m. LPN-C said R176 would take any flavor of supplement but preferred strawberry. LPN-C verified the supplements were given between meals, but she would give it after a meal if R 176 had not eaten well. She explained since R176 was a slow eater, she may not be hungry by lunchtime and not eat as well. LPN-C verified the supplements were just three per day, no as needed supplement had been ordered.

The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds.

A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days and was on a nutritional supplement, and had a pureed diet. The nutritional assessment indicated R176 was consuming greater than 75% of calories, 75 grams of protein, and 1500 milliliters (ml) or more for fluid intake. A Minimum Data Set (MDS) assessment dated 5/24/17, indicated a significant loss had occurred.

The nurse practitioner (NP)-C progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (NCD) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was

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weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up.

A nutrition note "dietary eval for weight loss" was completed by RD-E on 7/13/17. The note indicated R176 was on a pureed diet per speech therapy reccommendations, took supplements three times per day, required extensive assitance with meals, and had orders for no tube feeding per physicians orders for life sustaining treatment (POLST). The recommendation was to consider hospice due to, "beyond artificial nutrition which is a contraindicated per POLST wishes, oral interventions are exhausted."

The POLST for R176, dated 10/26/15, indicated, "offer food and liquids by mouth (oral fluids and nutrition must always be offered if medically feasible)"." No tube feeding" was hand written on the form. The form indicated comfort focused care for severe non reversible illness.

A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days and 16.5% loss in 180 days. The estimated intake at meals for R176 was assessed to be approximately 50%. The recommendation was for weekly weight monitoring and continue with nutritional supplement as ordered.

NP-G noted on 11/06/17, a discussion with a family member (FM)-B who acted as the health care agent for R176. Weight loss was discussed along with increasing medications for depression.

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A nutrition consult was requested.

A nutrition note "dietary consult for increased oral calories due to weight loss" was completed on 11/8/17. The note indicated no tube feeding per POLST and consider the possibility for hospice as nutritional interventions are becoming exhausted, resident has a care conference next week.

RD-E was interviewed on 11/15/2017, at 1:25 p.m.. She explained R176 required assist of staff to eat, but could feed herself a bit, intake was variable, and R176 drank the nutritional supplement at near 100%. RD-E said the supplement itself, at three times per day, provided 1050 calories, 39 grams protein. RD-E explained, since meals provided between 1800-2000 calories, at a 50% intake R176 would be consuming approximately 900-1000 calories per day just from meals. Therefore, the combined intake was estimated to be 1950-2150 calories per day. RD-E verified R176's intake appeared to be adequate to meet or exceed assessed needs, but had no explanation why R176 continued to lose weight, and had not assessed if the documented intake was accurate, or other reasons for the weight loss. RD-E also verified, the care plan had not been revised since March, 2017 beyond providing the supplements three times per day. RD-E said she would would review the care plan and consider adding a morning snack. RD-E said she had not increased the amount of supplement offered to try to maximized food intake.

The nutrition care plan, revised on 11/15/17, indicated R176 was at nutritional risk due to weight loss, was on a nutritional supplement and required assistance to eat. The stated goal was

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for R176 to consume 75% or greater of meals and supplements and to maintain weight at 122 pounds. A morning snack of milk or ice cream had been added to the care plan.

Family member (FM)-B for R176 was interviewed on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had not been made aware of the significant weight loss until last week when the nurse practitioner called to discuss medications. FM-B expressed concern with the care at the facility and was worried F176 was not getting as much help as she needed to eat. FM-B said R176 did not like the pureed meal. FM-B stated she knew R176 could feed herself a bit but was very slow, and wanted staff to provide more assistance at meal time. FM-B stated she felt the facility was ignoring R176.

R176 was interviewed 11/16/2017, at 1:47 p.m. R176 did have a diagnosis of dementia, but when asked about the pureed diet she responded negatively and said, "I don't think anyone would like it" R176 said she tried to eat it but couldn't always finish. R176 acknowledged she did like the supplements and would drink what she could. R176 said she was a slow eater and realized she was the last one left in the dining room at times. R176 did not acknowledge losing weight. R176 added that she was comfortable and enjoyed living in the facility.

The Comprehensive Care Plan policy, dated 2017, indicated an individualized care plan would be developed with input from the resident, and/or representative, and be based on a comprehensive assessment and any additional medical nutrition therapy assessments. Additionally, the care plan should address

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F 280	Continued From page 36 identified causes of impaired nutrition status.	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for transfers for 1 of 1 residents (R260) reviewed for potential restraint use. R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's Disease, toxic encephalopathy (disorder of the nervous system caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness. R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit. R260's significant change MDS, dated 10/13/17, indicated he required physical assistance of two staff for bed mobility and transfers. R260 also	F 282	F282 It is the policy of ARLC to provide services by qualified persons per the care plan according to CFR: 483.21(b)(3)(ii). For R260, the bed was re-adjusted to the normal bed height upon notification. Staff members were instructed to only use the EZ Stand for transfers in and out of bed and to use the grab bar and assist of one for toileting. The care plan and Kardex were reviewed and revised to reflect his transfer method. For other residents who require the use of a mechanical lift or standing device, their assessments and care plans will be reviewed and/or revised to ensure the proper use of devices. Staff members were educated on following the care plan. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and care planning procedures, and will continue to use the	12/23/17

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F 282	Continued From page 37 required assistance of one staff to provide physical weight bearing support to walk in the corridor. R260's balance during transitions and walking indicated he was not steady and only able to stabilize with human assistance of one. R260's care plan for activities of daily living (ADLs) included an intervention initiated on 9/29/17, which directed one staff to assist R260 with EZ stand (mechanical sit to stand lift used to help balance a person to standing position) when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand. R260's nursing assistant group sheet, undated, directed staff to transfer with the use of the EZ stand. During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed when nursing assistant (NA)-C entered into room and shut the door. At 3:00 p.m., NA-C left room; R260 was discovered to have been transferred out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put on the bathroom call light, NA-D entered the room and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back. During interview on 11/14/17, 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet.	F 282	tools and resources. The employee who lowered the bed was provided coaching on (11/15/17). Education will be provided to rehab staff, nursing assistants, nurses, and housekeeping staff. Random audits regarding proper use of mechanical lifts, stands and appropriate bed height will be completed, weekly x 4 weeks per household, then monthly x 3 months, and as needed to ensure compliance. The results will be shared with the QAA/QAPI Committee for further recommendations as needed. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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F 282	Continued From page 38 During interview on 11/15/17, at 8:09 a.m. NA-C stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing in the mornings mostly and that the EZ stand was used during those times. NA-C verified the group sheets did not direct staff to use the EZ stand as needed. During interview on 11/15/17, at 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers with use of EZ stand out of bed and used the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any deviation from the care planned intervention was needed. During interview on 11/15/17, at 12:33 p.m. the director of nursing (DON) stated she expected staff to follow the care plan with transfers, stating they can only upgrade the transfer mode if needed but never transfer with less than care planned. The facility's Care Plan Policy and Procedure, dated 11/2016, did not include direction on following the plan of care.	F 282		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and	F 309		12/23/17

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F 309	Continued From page 39 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure care was provided in accordance with resident preferences and to maintain highest physical well-being for 1 of 1 residents (R260) whose care plan was not followed with transfers and whose bed height was adjusted without assessment.	F 309	F309 It is the policy of ARLC to provide care and services for the highest well-being of the residents according to CFR: 483.24 and 483.25(k)(l). For R260, in order to assist in achieving his highest well-being, the bed was	

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F 309	Continued From page 40 Findings include: R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's Disease, toxic encephalopathy (disorder of the nervous system caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness. R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit. R260's significant change MDS, dated 10/13/17, indicated R260 required physical assistance of two staff for bed mobility and transfers. R260 also required assistance of one staff to provide physical weight bearing support to walk in the corridor, and his balance during transitions and walking was not steady and only able to stabilize with human assistance of one. R260's significant change Care Area Assessment (CAA) for falls, dated 10/16/17, identified he was at risk for falls due to use of the EZ stand (mechanical sit to stand lift used to help balance a person to standing position) and assist of one to two assist with transfers. However R260 had no falls. R260's current care plan, initiated on 9/25/17, identified a fall risk; however, it did not include an intervention of bed placement to the floor. R260's care plan for Incontinence or altered	F 309	re-adjusted to the normal bed height upon notification. Staff members were instructed to only use the EZ Stand for transfers in and out of bed and to use the grab bar and assist of one for toileting. The care plan, Kardex, were reviewed and revised to reflect his transfer method. For other residents who require the use of a mechanical lift or standing device, their assessments, care, and kardex will be reviewed and/or revised to ensure the proper use of devices. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and care planning procedures, and will continue to use the tools and resources. The staff members were educated on following the care plan on 11/15/17. Random audits regarding proper use of mechanical lifts, stands and appropriate bed height will be completed, weekly x 4 weeks per household, then monthly x 3 months, and as needed to ensure compliance. The results will be shared with the QAA/QAPI Committee for further recommendations as needed. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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elimination included an intervention dated 9/28/17, directed staff to respond to call light timely; R260 was able to use call light appropriately.

R260's current care plan for activities of daily living (ADLs) included an intervention, initiated 9/29/17, directing one staff to assist R260 with EZ stand when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand.

R260's nursing assistant group sheet, undated, directed staff to transfer with the use of the EZ stand, it did not include an intervention of bed placement to the floor.

During observation on 11/13/17, at 3:14 p.m. R260 was observed resting in bed. R260's bed was in a low position onto to the floor, with mattress one inch off the floor. R260 stated he had not fallen and did not know why the bed was so low. R260 stated he thought it was done so that he did not get up. R260 stated, "They insist I call for help," and reported the bed was not always put to the floor. The bed remote (which controlled the height of the bed) was observed on the floor one foot away from mattress at R260's shoulder level.

During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed and the bed was at knee level height when nursing assistant (NA)-C entered into room, and shut the door. At 3:00 p.m., NA-C left the room and R260 was discovered to have been transferred out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put

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on the bathroom call light, NA-D entered the room and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back.

During interview on 11/14/17, at 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet.

During observation on 11/15/17, at 7:47 a.m. NA-C assisted R260 out of bed. R260 sat at the edge of the bed and kept balance while seated independently without support. R260 maintained balance while seated and assisted with long sleeve shirt and undershirt. NA-C asked R260 to place feet onto the EZ stand foot plates, then placed sling around R260's waist, attached it to the EZ stand lift, and began to lift the arms of the mechanical standing machine. R260 was lifted by machine support to standing for the first twelve inches of the mattress, then R260 was able to stand tall bearing full weight with only the supportive guidance of the machine from bedside to the wheelchair. NA-C stated R260 did well with the EZ stand machine.

During interview on 11/15/17, at 8:09 a.m. NA-C stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing in the mornings mostly and that the EZ stand was used during those times. NA-C verified the groups sheets did not direct staff to use the EZ stand as needed. NA-C stated the bed had been lowered to the

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floor when R260 was in bed because he liked to self transfer. NA-C stated she puts the bed to the floor when she works. NA-C stated R260 would try to self transfer but when the bed is low, R260 would just be able to hang bottom half of body off the side of the bed onto floor.

During interview on 11/15/17, at 8:57 a.m. R260 stated it bothered him that the bed was put down that low. R260 reported it did not happen often but it bothered him because its too hard to get up. R260 stated he lost his patience sometimes and got up by himself but usually would call for help. R260 stated if he had to, he would and could get out of bed. R260 stated he can't get out of bed when it was low to the floor.

During interview on 11/15/17, at 12:09 p.m. NA-E stated the bed was down to the floor as R260 is a fall risk when he tried to get out of bed. When the bed was low, he was only able to just get his feet over the edge of the bed. NA-E worked with R260 once a week.

During interview on 11/15/17, from 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers out of bed using the EZ stand and using the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any deviation from the care planned intervention was needed. LPN- A stated if R260's bed was low or to the floor, it would have been by R260's preference. LPN-A further stated R260 would not get up independently and usually calls for help. LPN-A was not aware the bed was placed to the floor by staff and verified it was not care planned to be that way. LPN-A reported the bed should not have been to the floor. LPN- A stated R260

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had never fallen out of bed, and NA-C needed education regarding the bed placement on the floor.

During interview on 11/15/17, at 12:31 p.m. the director of nursing (DON) stated she expected staff to follow the care plan and the bed was not care planned to be placed on the floor. The DON verified R260 had no history of falls and education was needed to ensure staff did not place anyone's bed on the floor if not care planned. The DON stated that there was no one in the facility who had a care planned for a bed placement to the floor, further stating it would be care planned and explained why that resident may need the intervention. The DON stated staff are expected to follow the care plan with transfers and that they can only upgrade the transfer mode if needed but never transfer with less than care planned.

During interview on 11/16/17, at 2:55 p.m. the clinical administrator was unaware of the low bed before that week, stating the low bed "came out of nowhere," further stating it was "a no no." The clinical administrator further reported it was not the facility's policy to keep someone in bed, especially with no history of falling. The clinical administrator had educated all staff last evening and that day they came to work regarding bed placement.

The facility's policy for Physical Device Data Collection and Evaluation dated, 10/2011, stated that physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual can not remove easily which restricts freedom of movement. The

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F 309	Continued From page 45 policy directs staff to identify the rationale for the use of a potential restraint. The policy stated a restraint of any type would not be used as a substitute for more effective nursing care or for convenience of staff. The policy directs the staff with the procedure for documentation, assessment and use of any potential restraint use.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure interventions to maintain and promote skin integrity were implemented for 1 of 3 residents (R86) reviewed for pressure ulcers, whose padded heel cushion was not consistently implemented as assessed and per physician ordered.	F 314	F314 It is the policy of ARLC to provide treatment and services to prevent or heal pressure sores according to CFR: 483.25(b)(1). For R86, the right heel padded cushion	12/23/17

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F 314	Continued From page 46 Findings include: R86's annual Minimum Data Set (MDS), dated 5/26/17, identified R86 required assistance of 2+ staff with bed mobility and transfers. R86 required extensive assistance of 1 staff for dressing and personal hygiene. R86 was at risk for pressure ulcers and had one unstageable pressure ulcer. R86 was moderately cognitively impaired. R86's annual Care Area Assessment (CAA), dated 5/26/17, identified R86 was at risk for developing pressure ulcers and currently had one pressure area. R86 had one old scab to right 4th digit toe measuring 0.2 cm x 0.2 cm. "Resident wears padded rt [right] heel boot on at all times when in bed." R86 had a pressure reducing mattress and wheelchair cushion. R86's quarterly MDS, dated 8/11/17, continued to identify R86 at risk for pressure ulcers with one unstageable pressure ulcer. R86's current physician order's include: -Initiated on 1/10/17, "Please make sure right heel boot is on at HS [bedtime.] -Initiated on 1/12/17, a padded right heel boot on whenever in bed, every shift for skin protection. -Initiated on 5/31/17, to keep shoes off until scab area on right foot has resolved. -initiated on 8/16/17, Apply skin prep to scab on 4th and 5th digit on right foot once daily until resolved. R86's care plan included a problem initiated on 8/15/13, which indicated R86 was at risk for alteration of skin integrity. The problem area was revised on 2/22/17 to include a stage 2 pressure	F 314	was properly placed upon notification. The care plan was reviewed and revised to reflect that the right heel padded cushion should be on the right foot while the resident is in bed. For other residents who are at high risk for pressure ulcers, their assessments and care plans were reviewed and updated as needed to reflect current physician orders. Education was provided for staff members to ensure they understand and follow the plan of care. Training to staff will be completed by 12/18/17. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and pressure ulcer prevention procedures, and will continue to use the tools and resources. Random audits ensuring the care planned interventions are followed for residents at high risk for pressure ulcers will be completed weekly for four weeks, monthly for three months, and as needed to ensure compliance. The results will be reported to the QAA/QAPI Committee for follow up and further recommendations as needed. The Clinical Administrator or designee will be responsible. Correction Date: 12/23/17	

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area "scab" on the right foot 4th toe. Interventions included:
-A revised 5/2/17 intervention, which directed "padded HEEL boot at night." The care plan did not identify to place the right padded heel boot on whenever in bed as assessed and ordered.
-An added 5/2/17 interventions, which indicated R86 was currently wearing gripper socks during the day due to right 4th and 5th toe pressure areas.

R89's November 2017 treatment record indicated "Padded RIGHT heel boot on whenever is in bed Q [every] SHIFT."

Weekly wound assessment documentation was reviewed. The most recent assessment, dated 11/8/17, identified an unstageable pressure ulcer to the right foot top of 4th digit toe. The area was covered with a "0.5 x 0.5" thin scab. Wound base not viewable, no drainage, no undermining, wound edges intact. Wound stable. Shoes on hold until area is completely healed.

During observations on 11/13/17, at 2:27 p.m. R86's was lying on his back in bed. R86 had gripper socks on both feet. R86's heels were resting on the mattress. R86 was not wearing a padded right heel boot as ordered. A padded heel boot was observed laying on the seat of the electric wheelchair in the room.

During interview on 11/13/17, at 7:09 p.m., R86 stated, "Not sure," when asked when staff apply the heel boot.

During observations on 11/14/17, at 12:46 p.m. nursing assistant (NA)-A and nursing assistant (NA)-B transferred R86 from the wheelchair to

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bed with a mechanical lift. R86 was wearing gripper socks. NA-A left the room. NA-B provided incontinent cares. After the completion of incontinent cares, NA-B covered R86 with a blanket. R86's heels were resting on the mattress. A padded heel boot was laying on a chair in the room. NA-B left the room without applying the padded heel boot to R86's right foot.

During interview on 11/14/17, at 12:56 p.m. NA-B stated she follows a paper group sheet and the Kardex on the computer when completing resident cares. NA-B stated R86 did not wear shoes due to a sore on his toes. When asked about the heel cushion, NA-B stated R86 wears the heel cushion only at night to protect his heel.

Review of the nursing assistant group sheets for R86 identified "In bed after lunch." The group sheet lacked identification or directions for a heel boot.

During interview on 11/14/17, at 2:00 p.m. licensed practical nurse (LPN)-A stated nursing assistants are directed to follow the group sheet for each resident. R86 does not wear shoes, only gripper socks due to a "scab" on his 3rd and 4th toes, which was caused by his shoes. LPN-A stated R86's wears a padded boot on his right heel, because the heel was pretty soft for awhile. LPN-A walked into R86's room. R86's was laying in bed. LPN-A stated R86 was not wearing a heel boot and placed the padded heel boot onto R86's right heel. LPN-A stated the direction to place the heel boot onto R86's heel should be on the nursing assistant's group sheet.

During observations on 11/16/17, at 9:17 a.m. with LPN-A, R86's right heel was clean, dry, intact

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F 314	Continued From page 49 and had no redness. An area on the 4th toe was consistent with the 11/8/17 wound documentation. During interview on 11/16/17, at 10:30 a.m., registered nurse (RN)-A stated she updated R86's care plan on 11/14/17. Review of R86's care plan identified a revised intervention dated 11/14/17, Ten months after the order to place the right heel boot on whenever in bed. The revised care plan intervention directed "Padded boot to right heel whenever resident is in bed. RN-A stated prior to 11/14/17, the care plan and Kardex intervention directed to used a padded heel boot at night. During interview on 11/16/17, at 8:40 a.m. the director of nursing (DON) stated the nursing assistant group sheets are used as a resident assignment list, but do not necessarily identify interventions. Interventions are documented on the care plan and the Kardex. Interventions are also communicated through report. Staff are to follow the resident's care plan. The facility's Policy and Procedure for the Prevention and Treatment of Skin Breakdown, revised 8/2011, indicated: "it is the policy of Volunteers of America to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." "The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident."	F 314		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		12/23/17

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F 315	Continued From page 50 CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 315		

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	245205	A. BUILDING _____ B. WING _____	11/16/2017

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F 315	Continued From page 51 Based on observation, interview, and record review, the facility failed to re-asses and provide neeeded incontinence skin care of new onset bowel incontinence related to Clostridium Difficile (a antibiotic resistant bacteria causing diarrhea, commonly known as C-Diff) for 1 of 3 residents (R273) reviewed for bowel incontinence. Findings include: R273's admission Minimum Data Set (MDS), dated 9/1/17, identified no cognitive impairment and was always continent of bowel. R273's significant change MDS, dated 10/14/17, identified no cognitive impairment, was dependent on staff for toileting, and was always continent of bowel. R273's Bladder and Bowel Data Collection, dated 10/11/17, noted he was always continent of bowel, not needing a toileting program. The Data collection identified R273 required a mechanical lift for toileting. R273's significant change Care Area Assessments (CAA), dated 10/20/17, indicated a progressive decline since admission, which included a surgery for an above the knee amputation of the right leg and the initiation of dialysis three times a week. The CAA further indicated R273 was continent of bowel and was assisted, "to the toilet per his choice." R273's current Kardex, undated, identified him as continent of bowel and needing assistance to transfer on and off the toilet. R273's current care plan, dated 10/7/17, identified	F 315	F315 It is the policy of ARLC to prevent UTI, maintain or restore bowel or bladder function if possible, and not place a catheter unless a justifiable condition warrants placement according to CFR: 483.25(e)(1)-(3). For R273, the care plan was updated to reflect the C-Diff on 11/12/17. An order for barrier cream was obtained due to the red area on the coccyx from the recent hospital stay (which was healed on 10/29/17. The assessment, care plan, and kardex were reviewed and revised as necessary to reflect the current bowel incontinence due to C-Diff. For new and existing residents with C-Diff. that have been assessed for incontinence, their assessments and care plans will be reviewed and revised as necessary. The nursing assistants were educated on the care plan and Kardex changes. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and Infection Prevention and Control procedures, and will continue to use the tools and resources. Care plan and kardex audits will be completed on residents who are incontinent weekly for four weeks, monthly for three months, and as necessary to ensure compliance. The results will be reported to the QAA/QAPI Committee for review and further recommendations as needed. The Clinical Administrator or designee will	

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F 315	Continued From page 52 a diagnosis of altered elimination with the goal to decrease urinary incontinence episodes, noting R273 was continent of bowel, needed two staff and full body lift to transfer, and needed assistance to transfer on/off the toilet. The care plan was revised on 11/12/17, noting a new diagnosis of C-Diff and directing staff to observed and report loose stools. In addition, the care plan indicated R273 had a coccyx wound from his last hospitalization and directed to observe the skin daily. The care plan did not direct staff to apply any barrier creams to the peri area. R273's current physician orders, dated 11/1/617, indicated R273 had been diagnosed with a C-Diff infection on 10/25/17 and had been started on infection monitoring and a fourteen day course of Vancomycin (an antibiotic). During observation of cares on 11/15/17, at 7:04 a.m. nursing assistant (NA)-F was observed to assist R273 with a bed bath. After washing R273's upper body, NA-F proceed to R273's lower half and completed peri cares. R273 was observed to be incontinent with soft bowel movement noted in his brief and smeared on the linens directly underneath him. NA-F changed R273's soiled incontinence product and linens, noting that R273's inner buttocks appeared reddened. NA-F asked R273 if the buttocks hurt, to which R273 replied it did, and NA-F left the room, returning with registered nurse (RN)-F. RN-F proceeded to take off R273's foam dressing, which was over his coccyx wound, and assessed his reddened buttocks, again asking R273 if it hurt, to which R273 replied that the area itched more than it hurt. RN-F directed NA-F to cover R273 with a brief while she went to see if RN-C wanted to measure the coccyx wound and	F 315	be responsible for compliance. Date of Correction: 12/23/17	

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assess the area. RN-F returned to the room, stating RN-C was busy and proceeded to measure and apply a clean foam dressing over the coccyx wound, stating she did not want to put cream on the area until RN-C assessed it. NA-F then assisted in applying the new brief, and finished dressing R273. R273 was transferred into a broda chair and left the facility at 8:41 a.m. for an appointment.

During observation on 11/15/17, at 11:32 a.m. R273 returned to the facility from his appointment and remained sitting up in the broda chair, eating lunch, until 1:26 p.m., when NA-F and RN-C transferred him back into bed. At that time, R273 was observed to have a large unformed incontinent stool in his brief. NA-F performed peri care, first wiping the stool away with bath tissue, then using a wet washcloth to clean the area. R273's buttock remained reddened, and RN-C took off the soiled coccyx dressing, reporting the slit-like coccyx wound underneath was moisture related and had started due to the C-Diff. RN-C did not reapply the coccyx dressing and did not apply any cream, reporting they were getting an order for a cream from the physician.

During interview on 11/15/17, at 9:34 a.m. NA-F acknowledged R273 had an incontinent stool that morning, noting his bottom had been red and had a little open area on the coccyx. NA-F stated R273 had loose stools with the C-Diff, reporting R273 would usually ask for the bed pan and could feel when he had to go prior to the C-Diff; however, with the C-Diff the stool would just come and did not think R273 knew when he stooled. NA-F reported R273 preferred to use the bedpan and did not want to go into the bathroom since his leg was amputated.

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During interview on 11/15/17, at 11:20 a.m. RN-F stated R273 would usually ask for the bedpan, stating she was updated of the incontinent episode that morning, and thought he might have had the bowel movement overnight. RN-F reported R273's bowel continence varied with the C-Diff, and had changed to more incontinence with the C-Diff. RN-F further stated R273 was not transferred to the toilet due to hypotension (lower blood pressure) episodes and for safety with those episodes, noting R273 blood pressure medications had been altered as a result. RN-F reported the hypotension had been going on for about three weeks and had gotten better.

During interview on 11/15/17, at 2:04 p.m. R273 stated he was not incontinent and could control his bowel movements before having C-Diff. R273 reported he either could not feel when he had to have a bowel movement or the bowel movement came quick, further noting the bowel movements were a lot more frequent. R273 stated he had used the bed pan twice since his stay at the facility, noting other times staff changed his brief. R273 reported he wanted to use the toilet, "like a normal human being," and had been talking to staff about using it for two weeks.

During interview on 11/16/17, at 7:38 a.m. RN-C stated R273 came with the reddened bottom from the hospital, noting it was blanchable. RN-C reported a cream had been ordered that day (11/16/17) for R273's buttocks, but there had been nothing prior. RN-C reported R273 had been admitted to the facility with bowel incontinence, stating R273's wife reported R273 was incontinent of bowel and bladder at home. RN-C stated R273 had used the bed pan once;

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however, mostly just went in his brief, further stating R273 never used the toilet, even at home. RN-C stated incontinence was assessed by the nurse managers on admission and the assessment flowed onto the care plan. RN-C was unable to find the toileting intervention at the time of the interview.

During interview on 11/16/17, at 8:27 a.m. RN-B stated incontinence was assess by the nurse managers on admission by talking with staff, resident, and family, noting that if the resident was not a good historian, then they would look at the charting of incontinence episodes. RN-B acknowledged R273's admission bowel assessment from the MDS noted always continent; however, stated the MDS assessment and the nurse managers assessment may conflict with one another because the MDS assessment counted actual episodes of incontinence whereas the nurse manger's assessment did not account for that. RN-B reported the rehab did not have bowel programs because that would be to address a chronic long term issue. RN-B stated they had bowel plans, but for R273 the C-Diff was a temporary issue that would resolved itself and then R273's bowel continence would be back to normal. RN-B further stated R273's care plan was not revised because the C-Diff and associated incontinence was a short term issue, and they would not go back in and revise the care plan for short term problems because his goal was to get better, and nursing assistants were made aware of residents who were incontinent through verbal report. RN-B reported R273's skin was being monitored weekly by nursing staff and they had obtained a physician order for cream to be applied to the buttocks yesterday. RN-B further reported prior to yesterday the nursing assistants

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were verbally told in report to provide barrier cream with incontinence episodes, as a facility standard.

During interview on 11/16/17, at 10:19 a.m. RN-E stated the MDS assessment data was pulled over to the care plan on admission. RN-E stated the MDS nurses were focused on revising the care plans with the comprehensive and quarterly assessment time frames. RN-E reported changes and care plan revisions occurring outside of the MDS time frames were the responsibility of the nurse managers and floor nurses.

During interview on 11/16/17, at 2:07 p.m. the director of nursing (DON) stated the care plan depended on the individual resident and most in the rehab would be alert and able to say when they had to go to the bathroom. The DON stated the care plan was ongoing, and if a resident was now using a brief for example, could be updated. The DON reported, with their rehab residents, the goal was to get them as independent as possible, with a goal to wear regular underwear. The DON reported, for someone with C-Diff, the resident would be provided the appropriate products to use, would assess them for a week to be sure of the change, and then go back to the main goal of getting back to normal.

A facility policy entitled Care Plan Policy And Procedure, revised 11/16, directed the care plan was to be "changed and updated as the care changes for the resident and as the resident changes." The policy noted that any temporary changes would be added to the comprehensive care plan after 30 days. The policy further directed the care plan was to be current at all times.

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F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively evaluate the nutritional care needs for 1 of 1 resident (R)-176 who experienced an unplanned significant weight loss. Findings include: R176 had diagnoses that included high blood pressure, peripheral vascular disease, dementia and depression. R176 had paralysis on one side of her body from a stroke two years ago. R176 was on a pureed diet due to swallowing difficulties from the stroke. R176 was observed at breakfast on 11/15/2017,	F 325	F325 It is the policy of ARLC to assist the resident in maintaining their nutritional status unless their condition deems the decline unavoidable according to CFR: 483.25(g)(1)(3). For R176, a nutritional assessment was completed and the care plan updated on 11/15/17 to reflect the assessment results. The RD and interdisciplinary team met to investigate why the resident may be losing weight and revised the care plan. The RD also completed an audit to determine if the documentation was accurate regarding the weight loss. For other	12/23/17

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F 325	Continued From page 58 at 8:55 a.m.. R176 had a pureed meal and was assisted to eat. After a few minutes R176 was given the spoon and began to feed herself. At 9:09 a.m., R176 slowed down with eating holding the spoon and looking around; R176 appeared dozy with eyes closed and not eating. At 9:13 a.m. staff encouraged R176 to take a drink of orange juice and began to assist again with eating. At 9:24 a.m. R176 asked to go to the activity room. She had eaten about 50%. R176 was observed at the lunch meal on 11/15/2017, at 12:22 p.m. R176 had the meal in front of her but was not initiating eating. At 12:26 p.m. staff sat with R176 to assist, R176 then started feeding self and drinking independently. R176 continued to feed herself slowly with very small bites. At 1:00 p.m. R176 continued to be assisted by staff to eat and had consumed about 50% by that time. All other residents had finished and left the dining area. On 11/16/2017, at 9:19 a.m. Licensed Practical Nurse (LPN)-B stated, R176's intake was variable at 25-75% and often held food in her mouth and needed to be cued to swallow. Also, R176 would say when she was full. LPN-C was interviewed on 11/16/2017, at 1:41 p.m. LPN-C stated R176 would take any flavor of supplement but preferred strawberry. LPN-C verified the supplements were given between meals, but she would give it after a meal if R 176 had not eaten well. She explained since R176 was a slow eater, she may not be hungry by lunchtime and not eat as well. LPN-C verified the supplements were just three per day, no as needed supplement had been ordered.	F 325	residents who are on comfort care, their assessments, care plans, and weight documentation will be reviewed and revised as necessary. IDT staff members were educated on evaluating, assessing, and documenting nutritional status. To ensure correction is achieved and sustained the facility will continue to follow the nutritional services procedures, and will continue to use the tools and resources. Nutritional audits on weight loss on new and current comfort care residents will be completed weekly for four weeks, monthly for 3 months, and a needed to ensure compliance and the results will be reported to the QAA/QAPI Committee. The committee will then make further recommendations as deemed necessary. Training to staff will be completed by 12/18/17 The Registered Dietician or designee will be responsible for compliance. Date of Correction: 12/23/17	

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The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds.

A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days and was on a nutritional supplement, and had a pureed diet. The nutritional assessment indicated R176 was consuming greater than 75% of calories, 75 grams of protein, and 1500 milliliters (ml) or more for fluid intake. A quarterly Minimum Data Set (MDS) assessment dated 5/24/17, indicated a significant loss had occurred.

The nurse practitioner (NP)-G progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (dementia) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up.

A nutrition note "dietary eval for weight loss" was completed by RD-E on 7/13/17. The note indicated R176 was on a pureed diet per speech therapy reccommendations, took supplements three times per day, required extensive assitance with meals, and had orders for no tube feeding per physicians orders for life sustaining treatment (POLST). The recommendation was to consider hospice due to, "beyond artificial nutrition which is a contraindicated per POLST wishes, oral interventions are exhausted."

The POLST for R176, dated 10/26/15, indicated, "offer food and liquids by mouth (oral fluids and nutrition must always be offered if medically

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F 325	Continued From page 60 feasible)"." No tube feeding" was hand written on the form. The form indicated comfort focused care for severe non reversible illness. A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days and 16.5% loss in 180 days. The estimated intake at meals for R176 was assessed to be approximately 50%. The recommendation was for weekly weight monitoring and continue with nutritional supplement as ordered. NP-G noted on 11/06/17, a discussion with a family member (FM)-B who acted as the health care agent for R176. Weight loss was discussed along with increasing medications for depression. A nutrition consult was requested. A nutrition note "dietary consult for increased oral calories due to weight loss" was completed on 11/8/17. The note indicated no tube feeding per POLST and consider the possibility for hospice as nutritional interventions are becoming exhausted, resident has a care conference next week. RD-E was interviewed on 11/15/2017, at 1:25 p.m.. She explained R176 required assist of staff to eat, but could feed herself a bit, intake was variable, and R176 drank the nutritional supplement at near 100%. RD-E said the supplement itself, at three times per day, provided 1050 calories, 39 grams protein. RD-E explained, since meals provided between 1800-2000 calories, at a 50% intake R176 would	F 325		

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be consuming approximately 900-1000 calories per day just from meals. Therefore, the combined intake was estimated to be 1950-2150 calories per day. RD-E verified R176's intake appeared to be adequate to meet or exceed assessed needs, but had no explanation why R176 continued to lose weight, and had not assessed if the documented intake was accurate, or other reasons for the weight loss. RD-E also verified, the care plan had not been revised since March, 2017 beyond providing the supplements three times per day. RD-E said she would review the care plan and consider adding a morning snack. RD-E said she had not increased the amount of supplement offered to try to maximized food intake. RD-E verified the interdisciplinary team reviewed all incidents of significant weight loss to discuss care plan development.

The nutrition care plan, revised on 11/15/17, indicated R176 was at nutritional risk due to weight loss, was on a nutritional supplement and required assistance to eat. The stated goal was for R176 to consume 75% or greater of meals and supplements and to maintain weight at 122 pounds. A morning snack of milk or ice cream had been added to the care plan.

Family member (FM)-B for R176 was interviewed on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had not been made aware of the significant weight loss until last week when the nurse practitioner called to discuss medications. FM-B expressed concern with the care at the facility and was worried F176 was not getting as much help as she needed to eat. FM-B said R176 did not like the pureed meal. FM-B stated she knew R176 could feed herself a bit but was very slow, and wanted staff

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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 325	Continued From page 62 to provide more assistance at meal time. FM-B stated she felt the facility was ignoring R176. R176 was interviewed 11/16/2017, at 1:47 p.m. R176 did have a diagnosis of dementia, but when asked about the pureed diet she responded negatively and said, "I don't think anyone would like it" R176 said she tried to eat it but couldn't always finish. R176 acknowledged she did like the supplements and would drink what she could. R176 said she was a slow eater and realized she was the last one left in the dining room at times. R176 did not acknowledge losing weight. R176 added that she was comfortable and enjoyed living in the facility. The Nutritional Assessment Policy and Procedure (not dated) indicated the clarification of nutritional issues, needs and goals was accomplished by using observation, and gathering and considering relevant information. The procedure directed staff to interview the individual and/or representative and review information from other sources. The facility was to develop a clear and specific statement that provides the basis for interventions.	F 325		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441		12/23/17

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	245205	A. BUILDING _____ B. WING _____	11/16/2017

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F 441	Continued From page 63 communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 441		

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F 441	Continued From page 64 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the appropriate disinfectant bleach wipes, effective against clostridium difficile (drug resistant bacteria commonly known a C-Diff) were accessible to staff, and failed to keep designated resident care equipment in an isolation precautions room for 1 of 2 residents (R273) reviewed for contact isolation precautions. Findings include: R273's significant change Minimum Data Set (MDS), dated 10/14/17, identified no cognitive impairment. R273's current physician orders, dated 11/1/617, indicated he had been diagnosed with C-Diff infection on 10/25/17 and had been started on infection monitoring and a fourteen day course of Vancomycin (an antibiotic).	F 441	F441 It is the policy of ARLC to maintain and infection control and prevention program according to CFR: 483.80(a)(1)(2)(4)(e)(f). For R273, the correct bleach wipes were provided to the staff member caring for the resident with C-Diff to wipe down surfaces and devices. The staff members were educated on making sure the sling for a resident with precautions is kept in the room and not put with the mechanical lift. The staff were also educated on where bleach- containing wipes can be found if not available in the room. For other residents on transmission precautions, their assessments and care plans were reviewed and staff educated on the proper wipes to use and leaving slings in rooms if a mechanical lift is	

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F 441	Continued From page 65 R273's current care plan, dated 11/12/17, identified the diagnosis of C-Diff, with the following interventions: contact isolation for diarrhea, "Cleaning of room and surrounding area daily as per facility protocol/policy, and "Dedicate equipment for resident only." During observation of cares on 11/15/17, at 7:04 a.m. a plastic container with drawers was observed outside of R273's room, containing isolation gowns and gloves, and a sign on R273's door instructing to see the nurse before entering the room. Nursing assistant (NA)-F entered the room, greeted R273, donned clean gloves and went into R273's bathroom to fill a plastic basin with soapy water. NA-F left the basin of water in the bathroom sink, used hand sanitizer, donned new gloves, and proceeded to assist R273 in deciding what clothes to wear for the day. She then proceeded to walk to the top left cabinet, located above R273's entry way sink, and grabbed a container of Super Sani-Cloth disposable wipes with the purple top (which did not contain bleach). After grabbing a few wipes, NA-F cleaned R273's bedside table top, his television remote control, and grabber tool, which were on the table. NA-F pushed the bedside table from the left side of the bed to the right, and grabbed the basin of water and towels. NA-F proceed to don a gown and new gloves, and completed R273's bed bath and peri cares. R273 was observed to be incontinent with soft bowel movement noted in his brief and smeared on the linens directly underneath him. NA-F changed R273's soiled incontinence product and linens; R273 was observed using the bilateral grab bars and overhead trapeze to assist with turning during cares. After completing cares, NA-F emptied the	F 441	required. To ensure correction is achieved and sustained the facility will continue to follow the Infection Prevention and Control procedures, and will continue to use the tools and resources. Audits for proper infection control with residents on transmission precautions will be completed weekly for four weeks, monthly for three months, and as necessary to ensure compliance. The results will be reported to the QAA/QAPI Committee for review and further recommendations as necessary. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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water basin in R273's bathroom, went to the cabinet and grabbed more Super Sani-Cloth wipes from the purple top container. Using the wipes, she cleaned R273's grab bars, overhead trapeze, and remote control for the bed. At that time, registered nurse (RN)-F entered the room to take R273's blood pressure and assess his coccyx wound. RN-F was observed to open and take out a container of Sani-Cloth Bleach disposable wipes with an orange top from the locked medication cabinet, located in the top right cabinet opposite of the entry way sink. RN-F proceeded to clean the blood pressure cuff with the Sani-Cloth Bleach wipes.

During observation on 11/15/17, at 8:06 a.m. NA-F brought the full body lift into R273's room. NA-F and occupational therapist (OT)-A were observed to place a full body lift sling underneath R273 and proceeded to transfer him to a broda chair (specialized wheelchair which can tilt and recline). NA-F took the sling out from underneath R273, taking the full body lift and sling into R273's bathroom, then brought it out to the floor and parked it in an alcove in the hallway. The used sling was observed sitting in the front storage pouch of the full body lift, outside R273's room.

The lift and the sling were stored there untouched until 8:56 a.m., when NA-G took the full body lift to transfer R379, who was also on contact isolation for C-Diff. When asked about the cleaning of the sling and lift, NA-F stopped NA-G in the hallway outside of R379's room, stating she had cleaned the lift with the Sani-Cloth Bleach wipes in R273's bathroom, but had placed the sling in the storage pouch by mistake. Both NA-F and NA-G stated each resident had their own full body sling, and R379's individual sling was noted

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in her room. NA-F was observed to take R273's sling out of the pouch and placed the sling back in R273's bathroom, over his geri chair.

During interview on 11/15/17, at 9:34 a.m. NA-F opened R273's top left cupboard containing both a container of Super Sani-Cloth wipes and a container of Sani-Cloth Bleach wipes. NA-F stated she had used the purple top Super Sani-Cloth wipes to clean R273's bedside table and grab bars because she could not find the orange top Sani-Cloth Bleach wipes. NA-F stated usually the Sani-Cloth Bleach wipes were stored in the locked medication cabinet, and she did not have a key. NA-F reported she could use either type of wipe to clean R273's room, but liked to use the Sani-Cloth Bleach wipes because they were stronger with bleach. NA-F further reported R273's full body sling was usually kept in his room, acknowledging she mistakenly took it out that morning due to the commotion of everything going on.

During interview on 11/15/17, at 11:20 a.m. RN-F verified the Sani-Cloth Bleach wipes had been locked in the medication cabinet that morning, further reporting the Sani-Cloth Bleach wipes were available in the locked medication rooms, which the nurses had access to. RN-F stated the purple top Super Sani-Cloth wipes had a longer wet time of four minutes and were used to wipe down glucometers; however, the orange top Sani-Cloth Bleach wipes had a shorter wet time of two minutes and would be used to wipe down the full body lift. When asked which wipes were used for R273, RN-F stated the orange top Sani-Cloth Bleach wipes were specific to C-Diff; however, it would depend on the situation. RN-F further stated she would use the Sani-Cloth

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Bleach wipes with R273 because he liked to dig and scratch himself, noting she had observed a dark substance under his nails, which she assumed was feces, and had cut his fingernails a couple of weeks ago because of it. RN-F stated R273 had his own full body sling, which was kept in the room.

During interview on 11/16/17, at 8:08 a.m. RN-B stated the facility had different types of Sani-Cloth brand wipes, but used the Sani-Cloth Bleach wipes strictly for C-Diff precautions. RN-B stated the purple top Super Sani-Cloth wipes should not be in R273 room, further stating the only reason the orange top Sani-Cloth Bleach wipes would be locked in the cabinet was if the resident had dementia. RN-B stated staff would still have access to the Sani-Cloth Bleach wipes, as they were available in the clean utility room. RN-B reported if a resident has a lift sling and are on isolation precautions for C-Diff, the sling is kept in the resident's room.

During interview on 11/16/17, at 10:30 a.m. RN-D and RN-G, who were in charge of infection control, stated the facility had special chemicals just for C-Diff, including the orange top Sani-Cloth Bleach wipes, which had a wet time of four minutes. RN-G stated the Sani-Cloth Bleach wipes were the only wipes used with C-Diff that would kill the bacteria. RN-G stated the Sani-Cloth Bleach wipes were kept in the clean utility rooms on the units and the nursing assistants had keys to those rooms. RN-D and RN-G expected nursing assistants to doff their protective personal equipment (PPE), grab a few wipes from the clean utility room, don their PPE and re-enter the room with the wipes. RN-G stated once a container of wipes was brought into

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F 441	Continued From page 69	F 441		

the room, the container had to stay in the room because of the isolation precautions. RN-D and RN-G reported the Sani-Cloth Bleach wipes were locked in resident rooms because they were a chemical, and because they were a chemical, had to be out of reach of residents who may have dementia. In addition, RN-D and RN-G stated they did not like to keep the wipes in the room because the nursing assistants might mistakenly use them for peri care. RN-D stated the full body slings were resident dedicated, meaning R273 would have his own sling, because it wrapped around his bottom, further stating the sling should stay in his room.

The facility's Infection Prevention and Control Manual: Antibiotic Stewardship and MDROs (Multi Drug Resistant Organisms), dated 2017, specifically directed regarding C-Diff, common use equipment should be dedicated to the individual, not shared. In addition, it directed the environment should be cleaned at least daily with "special attention to those items likely to be contaminated with feces, i.e., bed rails," recommending the use of a bleach disinfectant.

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		12/23/17

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

Electronically Signed | 12/08/2017

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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate notification for 1 of 1 resident (R) 176 who experienced a significant weight loss. Findings include: A quarterly Minimum Data Set (MDS) assessment dated 5/24/17, indicated R176 had a score of 7 on a Brief Interview for Mental Status (BIMS) indicating cognitive losses. The	F 157	F000 It is the policy of Anoka Rehabilitation & Living Center to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction will serve as our credible allegation of compliance but does not constitute an admission of deficient practice. F157 It is the policy of ARLC (Anoka	

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F 157	Continued From page 2 assessment also indicated R176 had experienced a significant weight loss. R176's had diagnoses of dementia, depression, high blood pressure, vascular disease, and paralysis on one side of the body. The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds. A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days. The nurse practitioner (NP)-G progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (dementia) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up. A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days and 16.5% loss in 180 days. NP-G noted a discussion with a family member (FM)-B on 11/06/17. Weight loss was discussed along with increasing medications for depression. A nutrition consult was requested. Family member (FM)-B for R176 was interviewed	F 157	Rehabilitation & Living Center) to follow CFR: 483.10(g)(14) as it relates to proper notification. For R176, the family was notified of the weight loss on 11/20/2017 by the dietician. For other residents, who are on comfort care as defined by their POLST and may be affected by this practice, they will be reviewed to ensure proper notification regarding weight loss was done. To ensure correction is achieved and sustained the facility will continue to follow the notification of changes procedure, and will continue to use the tools and resources. The IDT staff were educated on the notification policy on 12/7/17 Audits on notification of weight loss on new and current comfort care residents will be completed weekly for four weeks, monthly for 3 months, and a needed to ensure compliance and the results will be reported to the QAA/QAPI Committee. The committee will then make further recommendations as deemed necessary. Training to staff will be completed by 12/ 18/17. The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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F 157	Continued From page 3 on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had only been made aware of the significant weight loss the past week when the nurse practitioner called to discuss medications. The clinical administrator was interviewed on 11/16/2017, at 3:00 p.m. He stated the interdisciplinary team would notify the nurse practitioner in the case of significant health events and it was the expectation that the nurse practitioner would notify the family. He added, the facility does not supervise the nurse practitioners. A policy regarding health care notification was requested but not provided. The policy, Tracking Weight Changes, dated 2017, indicated the individual, family or representative, physician and registered dietitian would be notified of any individual with an unintended significant weight change of 5% in one month, 7.5% in three months or 10% in six months.	F 157		
F 221 SS=D	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 221		12/23/17

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F 221	Continued From page 4 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R260) was free from physical restraints by lowering bed to the floor restraining R260's ability to self transfer out of bed. R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's disease, toxic encephalopathy (disorder of the nervous system caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness.	F 221	F221 It is the policy of ARLC to treat all residents with respect and dignity according to CFR: 483.10(a)(1) and 483.12(a)(2), including the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident□s medical symptoms. For R260, the bed was re-adjusted to the normal bed height upon notification. Staff members were instructed to only use the EZ Stand for transfers in and out of bed and to use the grab bar and assist of one for toileting. The care plan and Kardex were reviewed and revised to reflect his	

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	245205	A. BUILDING _____ B. WING _____	11/16/2017

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F 221	Continued From page 5 R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit. R260's significant change MDS, dated 10/13/17, indicated R260 required physical assistance of two staff for bed mobility and transfers. R260 also required assistance of one staff to provide physical weight bearing support to walk in the corridor, and his balance during transitions and walking was not steady and only able to stabilize with human assistance of one. R260's significant change Care Area Assessment (CAA) for falls, dated 10/16/17, identified he was at risk for falls due to use of the EZ stand (mechanical sit to stand lift used to help balance a person to standing position) and assist of one to two assist with transfers. R260 had no falls. R260's current care plan, initiated on 9/25/17, identified a fall risk; however, it did not include an intervention of bed placement to the floor. R260's care plan for Incontinence or altered elimination included an intervention dated 9/28/17, directed staff to respond to call light timely; R260 was able to use call light appropriately. R260's current care plan for activities of daily living (ADLs) included an intervention, initiated 9/29/17, directing one staff to assist R260 with EZ stand when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand. R260's nursing assistant group sheet undated,	F 221	transfer method. For other residents who require the use of a mechanical lift or standing device, their assessments and care plans will be reviewed and/or revised to ensure the proper use of devices. The employee who lowered the bed was provided coaching on 12/15/17. Education will be provided to rehab staff, nursing assistants, nurses, and housekeeping staff. Staff members were educated on following the care plan. Random audits regarding proper use of mechanical lifts, stands and appropriate bed height will be completed, weekly x 4 weeks per household, then monthly x 3 months, and as needed to ensure compliance. The results will be shared with the QAA/QAPI Committee for further recommendations as needed. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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directed staff to transfer with the use of the EZ stand, it did not include an intervention of bed placement to the floor.

R260's Physician Order Report, dated 11/15/17, lacked order to lower bed to the floor.

R260's Physical Therapy Discharge Summary, for dates of service of 9/26/17 to 10/11/17, included his baseline ability to ambulate 8 feet (ft) with assistance of two staff on 9/26/17 and 50 ft with assistance of two staff on 10/9/17. R260's discharge note dated 10/11/17, included R260 was variable with ambulation and required minimum to moderate assist of two staff and wheelchair to follow.

During observation on 11/13/17, at 3:14 p.m. R260 was observed resting in bed. R260's bed was in a low position onto to the floor, with mattress one inch off the floor. R260 stated he had not fallen and did not know why the bed was so low. R260 stated he thought it was done so that he did not get up. R260 stated, "They insist I call for help," and reported the bed was not always put to the floor. The bed remote (which controlled the height of the bed) was observed on the floor one foot away from mattress at R260's shoulder level.

During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed and the bed was at knee level height when nursing assistant (NA)-C entered into room, and shut the door. At 3:00 p.m., NA-C left the room and R260 was discovered to have been transferred out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put on the bathroom call light, NA-D entered the room

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and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back.

During interview on 11/14/17, at 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet.

During observation on 11/15/17, at 7:47 a.m. NA-C assisted R260 out of bed. R260 sat at the edge of the bed and kept balance while seated independently without support. R260 maintained balance while seated and assisted with long sleeve shirt and undershirt. NA-C asked R260 to place feet onto the EZ stand foot plates, then placed sling around R260's waist, attached it to the EZ stand lift, and began to lift the arms of the mechanical standing machine. R260 was lifted by machine support to standing for the first twelve inches of the mattress, then R260 was able to stand tall bearing full weight with only the supportive guidance of the machine from bedside to the wheelchair. NA-C stated R260 did well with the EZ stand machine.

During interview on 11/15/17, at 8:09 a.m. NA-C stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing, in the mornings mostly, and that the EZ stand was used during those times. NA-C verified the groups sheets did not direct staff to use the EZ stand as needed. NA-C stated the bed had been lowered to the floor when R260 was in bed because he liked to

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self transfer. NA-C stated she puts the bed to the floor when she works. NA-C stated R260 would try to self transfer but when the bed is low, R260 would just be able to hang bottom half of body off the side of the bed onto floor.

During interview on 11/15/17, at 8:57 a.m. R260 stated it bothered him that the bed was put down that low. R260 reported it did not happen often but it bothered him because its too hard to get up. R260 stated he lost his patience sometimes and got up by himself but usually would call for help. R260 stated if he had to, he would and could get out of bed, when it wasn't placed so low to the floor. R260 stated he can't get out of bed when it was low to the floor.

During interview on 11/15/17, at 12:09 p.m. NA-E stated the bed was down to the floor as R260 is a fall risk when he tried to get out of bed. When the bed was low, he was only able to just get his feet over the edge of the bed. NA-E worked with R260 once a week.

During interview on 11/15/17, from 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers out of bed using the EZ stand and using the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any deviation from the care planned intervention was needed. LPN- A stated if R260's bed was low or to the floor, it should only have been by R260's preference. LPN-A further stated R260 would not get up independently and usually calls for help. LPN-A was not aware the bed was placed to the floor by staff and verified it was not care planned to be that way. LPN-A reported the bed should not have been to the floor. LPN- A stated R260

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had never fallen out of bed, and NA-C needed education regarding the bed placement on the floor.

During interview on 11/15/17, at 12:31 p.m. the director of nursing (DON) stated she expected staff to follow the care plan and the bed was not care planned to be placed on the floor. The DON verified R260 had no history of falls and education was needed to ensure staff did not place anyone's bed on the floor if not care planned. The DON stated that there was no one in the facility who had a care planned for a bed placement to the floor, further stating it would be care planned and explained why that resident may need the intervention. The DON stated staff are expected to follow the care plan with transfers and that they can only upgrade the transfer mode if needed but never transfer with less than care planned.

During interview on 11/16/17, at 2:55 p.m. the clinical administrator reported the facility was a restraint-free facility, and the facility was working towards that goal of eliminating all restraints, even the Wanderguards. The clinical administrator was unaware of the low bed before that week, stating the low bed "came out of nowhere," further stating it was "a no no." The clinical administrator further reported it was not the facility's policy to keep someone in bed, especially with no history of falling. The clinical administrator had educated all staff last evening and that day they came to work about the use of restraints.

The facility's policy for Physical Device Data Collection and Evaluation dated, 10/2011, stated that physical restraints are defined as any manual

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F 221	Continued From page 10 method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual can not remove easily which restricts freedom of movement. The policy directs staff to identify the rationale for the use of a potential restraint. The policy stated a restraint of any type would not be used as a substitute for more effective nursing care or for convenience of staff. The policy directs the staff with the procedure for documentation, assessment and use of any potential restraint use.	F 221		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (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	F 225		12/23/17

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actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance 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.

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F 225	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations involving abuse were immediately reported, not exceeding two hours, to the state agency (SA) and administrator for 2 of 4 residents (R273, R137) reviewed for physical abuse. Findings include: R273's significant change Minimum Data Set (MDS), dated 10/14/17, identified no cognitive impairment and required extensive assistance to total dependence from staff for ADLs (activities of daily living). R273's current care plan, dated 10/27/17, noted his vulnerability to abuse related to depression, above the knee amputation, and long-term care placement. The care plan further directed to provide a safe environment and remove R273 from "potentially abusive situations." During interview on 11/14/17, at 9:27 a.m. R273 alleged physical abuse by the nursing staff. R237 reported the evening nursing assistant seemed mad when answering his call light and was disrespectful to him. R273 stated it rose to abuse when the staff would "flip me" to his side when performing peri cares, noting rough treatment with cares. R273 could not identify the staff, but reported he was not afraid of the staff, further stating he had not reported the incident to the facility. During interview on 11/14/17, at 10:03 a.m. the facility was made aware by this surveyor, of R273's allegation of abuse, and the assistant	F 225	F225 It is the policy of ARLC to investigate and reports allegations according to CFR: 483.12(a)(3)(4)(c)(1)-(4). For R273 and R 137, identified in the statement of deficiency for the allegation of abuse were reviewed and investigated. The allegation was reported to the administrator and to the state agency, investigation was reviewed and completed, and the care plan was reviewed and updated. All staff will be educated by 12/ 18 /17 on mandated reporting, and protocols for response to allegations of abuse/neglect, including ensuring the allegation is immediately reported to the administrator and to the state agency and thorough investigation is completed according to policy Residents potentially affected by the practice as outlined in the statement of deficiency will be identified through resident interview/audits, to be completed by 12/ 18/17. Identified allegations for abuse, neglect, and misappropriation of property will be reported immediately to the administrator and state agency, and thoroughly investigated according to policy. Nursing and/or designee will implement measures to ensure that this practice does not recur, including: review of the Resident Protection/Freedom from abuse	

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F 225	Continued From page 13 executive director (AED) reported the facility would begin their process of risk management. R273's Post Incident Review noted the alleged abuse occurred on 11/13/17, at 8:00 p.m. The Incident Review further identified the executive director/administrator had been notified timely of the allegation, on 11/14/17, at 10:30 a.m. The Incident Review prompted staff to answer if immediate notification of the allegation was made to the state agency or OHFC (office of health facility complaints). The Review indicated a report had been made but did not indicate the time the report had been made. R273's Incident Report Summary by MDH (Minnesota department of health) identified the allegation of physical abuse had been reported to the state agency on 11/14/17, at 2:58 p.m., nearly five hours after it was initially reported. The report further identified R273 had alleged the evening nursing assistant was rough with him during cares and the investigation was in progress. Although the administrator was notified timely, the allegation of abuse was not reported within two hours. R137's admission MDS, dated 10/31/17, identified no cognitive impairment, required limited assistance with ADLs, and needed physical assistance from staff with bathing. R137's current care plan, dated 10/30/17, noted her vulnerability to abuse related to transitional care/rehab placement. The care plan further directed to provide a safe environment and remove R137 from "potentially abusive situations."	F 225	policies, including review that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion, utilization of resident protection and process and forms and staff interview audits. Management staff involved with investigations will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures on resident protection. Training to staff will be completed by 12/18/17. Audits will be completed on OHFC reporting times weekly for four weeks, monthly for three months, and as needed to ensure compliance. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provide as derived from the reviews. The results will be shared with the QAA/QAPI Committee for follow up and further recommendations if needed. To ensure correction is achieved and sustained the facility will continue to follow the resident protection procedure, and will continue to use the tools and resources. The Social Services Director or designee will be responsible for compliance. The facility alleges it will be in substantial compliance with the standard indicated by	

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F 225	Continued From page 14 R137's Post Incident Review noted an incident of alleged abuse, rough cares with an evening shower, occurred on 11/10/17, at 9:00 p.m. The Incident Review identified the nursing supervisor had been notified of the abuse allegation via R137's daughter on 11/11/17, at 11:00 a.m. The Incident Review further identified the executive director/administrator had been notified of the allegation of 11/11/17, at 5:35 p.m., over six hours after the initial notification. The Incident Review indicated notification of the allegation was made to the stage agency/OHFC, but did not indicate the time. R137's Incident Report Summary by MDH identified the allegation of physical abuse had been reported to the state agency on 11/11/17, at 6:59 p.m., nearly eight hours after it was initially reported. The report further identified R137 had alleged the evening bath aide was rough during cares while assisting R137 with her shower. The report indicated the nursing assistant had been suspended while the investigation was in progress. Although the allegation of abuse was reported, it was not reported within two hours, to the administrator and state agency. The facility failed to be in compliance with the federal regulation changes, as of November 2016, which directs allegations of abuse be reported immediately and not exceeding two hours. During interview on 11/16/17, at 7:43 a.m. registered nurse (RN)-C stated nursing supervisors and leadership had access to the state agency/OHFC reporting web site and were responsible for reporting allegations of abuse.	F 225	12/ 23/17. Date of Correction: 12/23/17	

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RN-C stated, when he worked as a floor nurse, he would report allegations to the nursing supervisor on at the time. RN-C further stated, when he worked as a nursing supervisor, he would first interview the resident about the allegation and depending on what the resident said,would get the risk management procedure going, which included to call the administrator, director of nursing (DON), and social services (SS). RN-C stated he would make sure the resident was safe by removing the alleged perpetrator, and if the alleged perpetrator was a staff member would suspend him or her. RN-C stated, as a nursing supervisor, he would complete the initial report to the state agency on the off hours, and social services would complete the report if it was during the day. RN-C thought they had twenty four hours to report, unless there was suspicion of a crime or bodily injury, then they reported in two hours.

During interview on 11/16/17, at 9:05 a.m. RN-B stated all allegations of abuse and bodily harm were reported to the state agency. RN-B reported nursing managers, supervisors, and leadership reported allegations of abuse to the state agency. RN-B stated allegations were reported to the nurse supervisor during off hours, who was responsible for determining if something was reportable, and if the nursing supervisor was unsure of whether or not to report, they could talk to social services. RN-B stated, when an allegation was made, the nurse supervisor would interview the resident and begin the risk management procedure. RN-B further stated after interviewing the resident, the administrator would be notified and determine if a report should be filed to the state agency. RN-B acknowledged the allegation had to be validated and confirmed

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with the resident before calling the administrator, and once the alleged abuse was confirmed, would notify the administrator immediately. RN-B stated their policy did not indicate a timeframe in which to report allegations of abuse, stating she thought they had twenty four hours to report.

During interview on 11/16/17, at 11:59 a.m. the director of social services (DSS) stated their number one concern with allegations of abuse was to protect the resident. The DSS stated nursing supervisors were responsible for reporting allegations during off hours, while she reported allegations during the weekdays. The DSS reported the allegations of abuse were reported to the administrator first, as well as the DON and herself. The DSS reported the regulation was not to exceed twenty four hours for reporting, and allegations of rough cares would be treated like physical abuse. She further stated, in cases like R273 and R137, the residents and staff were interviewed prior to reporting the allegations to find out what had occurred and who the perpetrator was, so the alleged perpetrator could be suspended pending the investigation, making sure the situation is safe. The DSS acknowledged that the investigation began as soon as the allegation was made, and that there was investigation going on prior to reporting the allegations, as she attempted to talk with staff right away. The DSS stated she would re-interview staff during the five day investigation depending on the situation, if more questions came up. The DSS was not aware of the federal regulation change requiring allegations of abuse to be reported no later than two hours, stating their policy did not specify a time in hours, but did follow an immediate abuse reporting policy.

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During interview on 11/16/17, at 2:07 p.m. the DON stated everyone was a mandated reporter, the administrator was notified immediately, and the state agency was notified the same day as the allegation was made. The DON stated nurse managers, supervisors, and social services all had access to report to the state agency. The DON was not aware of the new regulatory guidelines for reporting allegations of abuse within two hours, referencing the facility's abuse policy was a corporate policy, revised last November of 2016.

During interview on 11/16/17, at 2:55 p.m. the clinical administrator stated the facility's quality assurance (QA) committee discussed abuse reporting and completed abuse training house wide a couple months prior, stating it was a number one priority for them. The clinical administrator stated they reported everything in the building. The clinical administrator further stated they might report allegations over two hours or might miss them by two to three hours, but they were very consistent with reporting. The clinical administrator was not aware of the regulatory changes to reporting time frames for allegations of abuse, stating he sat on a regulatory committee and did not know how that was missed.

The facility's Resident/Client/Participant/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure, revised 11/16, directed, "The Executive Director/ or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect." The policy further directed

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F 225	Continued From page 18 suspicions of abuse would be reported to the state agency, "in accordance with state law," noting that "Immediate reporting pertains to Long Term Care."	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse	F 226		12/23/17

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F 226	Continued From page 19 prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their vulnerable adult policy to ensure all alleged violations involving abuse were immediately reported to the administrator and the state agency and failed to re-vise their vulnerable adult policy to reflect the updated federal reporting timeframe of no later than two hours for 2 of 4 residents (R273, R137) reviewed. Findings include: The facility's Resident/Client/Participant/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure, revised 11/16, directed, "The Executive Director/ or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect." The policy further directed suspicions of abuse would be reported to the state agency, "in accordance with state law," noting that "Immediate reporting pertains to Long Term Care." During interview on 11/14/17, at 9:27 a.m. R273 alleged physical abuse by the nursing staff, reporting rough cares from an unknown nursing staff. R273 stated he was not afraid, but had not reported the allegation to the facility. The facility was made aware of the allegation by the state surveyor on 11/14/17, at 10:03 a.m. R273's Incident Report Summary by MDH (Minnesota department of health) identified an	F 226	F 226 It is the policy of ARLC to develop and implement written policies and procedures according to CFR: 483.12(b)(1)-(3) and 483.95(c)(1)-(3) regarding abuse, neglect, and exploitation of residents and misappropriation of resident property, establish policies and procedures to investigate any such allegations and include training as required . For R273 and R137, identified in the statement of deficiency for the incidents for the allegation of abuse were reviewed and investigated. The allegation was reported to the administrator and to the state agency, investigations were reviewed and completed and care plans were reviewed and updated. All staff will be educated by 12/18/17 on mandated reporting, and protocols for response to allegations of abuse/neglect, including ensuring the allegation is immediately reported to the administrator and to the state agency and thorough investigation is completed according to policy Identified allegations for abuse/neglect and misappropriation of property will be reported immediately to the administrator and state agency, and thoroughly investigated per policy.	

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F 226	Continued From page 20 allegation of physical abuse had been reported to the state agency on 11/14/17, at 2:58 p.m., over four hours after it was initially reported. The allegation of abuse was not reported timely, nor was it reported within two hours. R137's Post Incident Review noted, on 11/11/17 at 11:00 a.m., her daughter had reported an allegation of abuse with rough cares during the evening shower. The executive director/administrator was not notified of the allegation until 11/11/17, at 5:35 p.m., over six hours after the initial notification. R137's Incident Report Summary by MDH identified an allegation of physical abuse had been reported to the state agency on 11/11/17, at 6:59 p.m., almost eight hours after it was initially reported. The allegation of abuse was not reported timely, nor was it reported within two hours, to the administrator and state agency. The facility failed to be in compliance with the federal regulation changes, as of November 2016, which directs allegations of abuse be reported immediately and not exceeding two hours. During interview on 11/16/17, at 9:05 a.m. registered nurse (RN)-B stated all allegations of abuse and bodily harm were reported to the state agency. RN-B stated after interviewing the resident, the administrator would be notified and determine if a report should be filed to the state agency. RN-B further stated their policy did not indicate a timeframe in which to report allegations of abuse, stating she thought they had twenty four hours to report.	F 226	Audits will be completed on OHFC reporting times weekly for four weeks, monthly for three months, and as needed to ensure compliance. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provide as derived from the reviews. The results will be shared with the QAA/QAPI Committee for follow up and further recommendations if needed. The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: review of the Resident Protection/Freedom from abuse policies, including review that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion, utilization of resident protection and process and forms and staff interview audits. Management staff involved with investigations will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures on resident protection. Training to staff will be completed by 12/18/17. To ensure correction is achieved and sustained the facility will continue to follow the resident protection procedure, and will continue to use the tools and resources.	

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F 226	Continued From page 21 During interview on 11/16/17, at 11:59 a.m. the director of social services (DSS) stated allegations of abuse were reported to the administrator first, as well as the DON and herself. The DSS reported the regulation was not to exceed twenty four hours for reporting, and allegations of rough cares would be treated like physical abuse. She further stated, in cases like R273 and R137, the residents and staff were interviewed prior to reporting the allegations to find out what had occurred and who the perpetrator was, so the alleged perpetrator could be suspended pending the investigation, making sure the situation is safe. The DSS was not aware of the federal regulation change requiring allegations of abuse to be reported no later than two hours, stating their policy did not specify a time in hours, but did follow an immediate abuse reporting policy. During interview on 11/16/17, at 2:07 p.m. the DON stated the administrator was notified immediately, and the state agency was notified the same day as the allegation was made. The DON was not aware of the new regulatory guidelines for reporting allegations of abuse within two hours, referencing the facility's abuse policy was a corporate policy, revised last November of 2016. During interview on 11/16/17, at 2:55 p.m. the clinical administrator stated they reported everything in the building. The clinical administrator further stated they might report allegations over two hours or might miss them by two to three hours, but they were very consistent with reporting. The clinical administrator was not aware of the regulatory changes to reporting time frames for allegations of abuse, stating he sat on	F 226	The facility alleges it will be in substantial compliance with the standard indicated by 12/23/17. The Social Service Director or designee will be responsible for compliance Date of Correction: 12/23/17	

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F 226	Continued From page 22 a regulatory committee and did not know who that was missed.	F 226		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279		12/23/17

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F 279	Continued From page 23 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan with interventions to address new urinary incontinence or maintain as much urinary continence to the greatest degree for 1 of 3 residents (R273) reviewed for urinary incontinence. Findings Include: R273's admission Minimum Data Set (MDS), dated 9/1/17, identified no cognitive impairment and was always continent of urine.	F 279	F279 It is the policy of ARLC to develop comprehensive care plans according to CFR: 483.20(d) and 483.21(b)(1). For R273, the care plan was updated to include needed assistance with the urinal, bed pan, brief, pericare after each incontinent episode including the application of barrier cream as ordered. The barrier cream was added to the care plan and kardex on 11/27/17. The updated care plan and kardex was	

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F 279	Continued From page 24 R273's significant change MDS, dated 10/14/17, identified no cognitive impairment, was dependent on staff for toileting, and was frequently incontinent of urine. R273's Bladder and Bowel Data Collection, dated 10/11/17, noted he was frequently incontinent of urine and would sometimes leak urine. The Data Collection further noted R273 was not on a toileting program and had never had a voiding trial, but could identify the urge to void and use the call light. The Data collection identified R273 required a mechanical lift for toileting. R273's significant change Care Area Assessments (CAA), dated 10/20/17, indicated a progressive decline since admission, which included a surgery for an above the knee amputation of the right leg and the initiation of dialysis three times a week. The CAA further indicated R273 had little urine output and, "Urinal at bedside to assist with attempt for continence of urine." R273's current Kardex, undated, identified him as occasionally incontinent and needing assistance to transfer on and off the toilet. The Kardex did not include interventions related to assistance with the bedside urinal R273's current care plan, dated 10/7/17, identified a diagnosis of altered elimination with the goal to decrease incontinence episodes. The care plan noted R273 was occasionally incontinent of urine, and lacked any additional interventions to address urinary incontinence such as assistance with bed side urinal or a toileting assistance schedule.	F 279	communicated to staff members 11/27/17 for other residents who are incontinent, their assessments and care plans and kardex will be reviewed for accuracy and updated as needed. They will be reviewed on-going upon admission, quarterly, significant change and annually to reflect their needs. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and care planning procedures, and will continue to use the tools and resources. Care plan and Kardex audits will be completed weekly for four weeks, monthly for three months, and as needed to ensure compliance. The results will be reported to the QAA/QAPI Committee for review and further recommendations as needed. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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During interview on 11/15/17, at 9:34 a.m. nursing assistant (NA)-F stated R273 used the urinal at the bedside and needed staff to help position the urinal, stating if it was not in the right spot he would leak. NA-F denied going in to offer the urinal, stating R273 could feel when he had to go and would call in staff.

During interview on 11/15/17, at 2:04 p.m. R273 stated he voided two to three times a day using the urinal at the bedside when he had to void. R273 denied needing assistance to place the urinal, stating if it was hooked on the bedside garbage, he could reach it from where he was lying in the bed. R273 reported he did not use the toilet or go into the bathroom, just used the urinal. R273 denied being incontinent of urine.

During interview on 11/16/17, at 8:27 a.m. registered nurse (RN)-B stated incontinence was assess by the nurse managers on admission by talking with staff, resident, and family, noting that if the resident was not a good historian, then they would look at the charting of incontinence episodes. RN-B stated R273 had contributing factors of kidney failure and dialysis, noting he could use the urinal but could still have bouts of incontinence overnight. RN-B further stated, with the new right leg amputation, R273's mobility was not like it used to be and was requiring more incontinence brief changes at night, accounting for the incontinence. RN-B reported the care plan was suppose to flow from the nurse manager's assessment, noting R273's care plan should consist of more, including the type of the brief he wears for incontinence.

During interview on 11/16/17, at 2:07 p.m. the

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F 279	Continued From page 26 director of nursing (DON) stated the care plan depended on the individual resident, and could not say what would be in the care plan without knowing more about the individual. The DON reported they wanted their rehab residents to be as independent as possible and the care plans were ongoing. A facility policy entitled Care Plan Policy And Procedure, revised 11/16, directed the care team would collect information over a fourteen day course to develop the comprehensive care plan. The policy determined the comprehensive care plan "will describe services to attain or maintain the resident's highest physical .... well-being." The policy further directed interventions would be written to assist in meeting the goal and should be individualized to the resident.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		12/23/17

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F 280	Continued From page 27 (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 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.	F 280		

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F 280	Continued From page 28 (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 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 record review, the facility failed to revise a care plan to include the use of a right heel padded cushion whenever in bed for 1 of 3 residents (R)-86 reviewed for pressure ulcers failed to reassess and revise the care plan for 1 of 1 resident (R)-176 who experienced a significant weight loss. Findings include: R86's annual Minimum Data Set (MDS), dated 5/26/17, identified R86 required assistance of 2+ staff with bed mobility and transfers. R86 required extensive assistance of 1 staff for dressing and personal hygiene. R86 was at risk for pressure	F 280	F280 It is the policy of ARLC to include the resident and/or representative in the care planning process according to CFR: 483.10(c)(2)(i-ii, iv, v)(3), and 483.21b)(2), implementing the plan of care and revising the care plan when necessary. For R86, the care plan was revised on 11/15/17 to include the use of the right heel padded cushion when in bed (not just at night) to prevent pressure ulcers. For other residents at high risk for pressure ulcers per PointRight Quality Measures, their assessments and care plans were reviewed and updated as necessary.	

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	245205	A. BUILDING _____ B. WING _____	11/16/2017

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F 280	Continued From page 29 ulcers and had one unstageable pressure ulcer. R86 was moderately cognitively impaired. R86's annual Care Area Assessment (CAA), dated 5/26/17, identified R86 was at risk for developing pressure ulcers and currently had one pressure area. R86 had one old scab to right 4th digit toe measuring 0.2 cm x 0.2 cm. "Resident wears padded rt [right] heel boot on at all times when in bed." R86 had a pressure reducing mattress and wheelchair cushion. R86's current physician order's include: -Initiated on 1/10/17, "Please make sure right heel boot is on at HS [bedtime.] -Initiated on 1/12/17, a padded right heel boot on whenever in bed, every shift for skin protection. -Initiated on 5/31/17, to keep shoes off until scab area on right foot has resolved. -initiated on 8/16/17, Apply skin prep to scab on 4th and 5th digit on right foot once daily until resolved. R86's care plan included a problem initiated on 8/15/13, which indicated R86 was at risk for alteration of skin integrity. The problem area was revised on 2/22/17 to include a stage 2 pressure area "scab" on the right foot 4th toe. Interventions included: -A revised 5/2/17 intervention, which directed "padded HEEL boot at night." The care plan did not identify to place the right padded heel boot on whenever in bed as assessed and ordered. -An added 5/2/17 interventions, which indicated R86 was currently wearing gripper socks during the day due to right 4th and 5th toe pressure areas. During observations on 11/13/17, at 2:27 p.m.	F 280	For R176, the care plan was updated to include the weight loss and nutritional recommendations from the RD. For other residents, who are on comfort care as defined by their POLST and may be affected by this practice, their assessments and care plans were reviewed and revised as necessary regarding weight loss. Education was provided for staff members on the updated plans of care. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and care planning procedures, and will continue to use the tools and resources. Care plan audits will be completed weekly for four weeks, monthly for three months, and as needed to ensure compliance. The results will be reported to the QAA/QAPI Committee for review and further recommendations as needed. The Registered Dietician or designee will be responsible for compliance. Date of Correction: 12/23/17	

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R86's was lying on his back in bed. R86 had gripper socks on both feet. R86's heels were resting on the mattress. R86 was not wearing a padded right heel boot as care planned. A padded heel boot was observed laying on the seat of the electric wheelchair in the room.

During an interview on 11/13/17, at 7:09 p.m., R86 stated, "Not sure," when asked when staff apply the heel boot.

During observations on 11/14/17, at 12:46 p.m. nursing assistant (NA)-A and nursing assistant (NA)-B transferred R86 from the wheelchair to bed with a mechanical lift. R86 was wearing gripper socks. NA-A left the room. NA-B provided incontinent cares. After the completion of incontinent cares, NA-B covered R86 with a blanket. R86's heels were resting on the mattress. A padded heel boot was laying on a chair in the room. NA-B left the room without applying the padded heel boot to R86's right foot.

During an interview on 11/16/17, at 10:30 a.m., registered nurse (RN)-A stated she updated R86's care plan on 11/14/17. Review of R86's care plan identified a revised intervention dated 11/14/17, Ten months after the order to place the right heel boot on whenever in bed. The revised care plan intervention directed "Padded boot to right heel whenever resident is in bed. RN-A stated prior to 11/14/17, the care plan and Kardex intervention directed to used a padded heel boot at night.

During an interview on 11/16/17, at 8:40 a.m. the director of nursing (DON) stated the nursing assistant group sheets are used as a resident assignment list, but do not necessarily identify

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interventions. Interventions are documented on the care plan and the Kardex. Interventions are also communicated through report. Staff are to follow the resident's care plan.

The facility's Policy and Procedure for the Prevention and Treatment of Skin Breakdown, revised 8/2011, indicated: "it is the policy of Volunteers of America to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." "The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident."

R176 was observed at breakfast on 11/15/2017, at 8:55 a.m.. R176 had a pureed meal and was assisted to eat. After a few minutes R176 was given the spoon and began to feed herself. At 9:09 a.m., R176 slowed down with eating holding the spoon and looking around; R176 appeared dozy with eyes closed and not eating. At 9:13 a.m. staff encouraged R176 to take a drink of orange juice and began to assist again with eating. At 9:24 a.m. R176 asked to go to the activity room.

R176 was observed at the lunch meal on 11/15/2017, at 12:22 p.m. R176 had the meal in front of her but was not initiating eating. At 12:26 p.m. staff sat with R176 to assist, R176 had started feeding self and drinking independently. R176 continued to feed herself slowly with very small bites. At 1:00 p.m. R176 continued to be assisted by staff to eat. All other residents had finished and left the dining area.

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On 11/16/2017, at 9:19 a.m. Licensed Practical Nurse (LPN)-B stated, R176's intake was variable at 25-75% and often held food in her mouth and needed to be cued to swallow. Also, R176 would say when full.

LPN-C was interviewed on 11/16/2017, at 1:41 p.m. LPN-C said R176 would take any flavor of supplement but preferred strawberry. LPN-C verified the supplements were given between meals, but she would give it after a meal if R 176 had not eaten well. She explained since R176 was a slow eater, she may not be hungry by lunchtime and not eat as well. LPN-C verified the supplements were just three per day, no as needed supplement had been ordered.

The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds.

A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days and was on a nutritional supplement, and had a pureed diet. The nutritional assessment indicated R176 was consuming greater than 75% of calories, 75 grams of protein, and 1500 milliliters (ml) or more for fluid intake. A Minimum Data Set (MDS) assessment dated 5/24/17, indicated a significant loss had occurred.

The nurse practitioner (NP)-C progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (NCD) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was

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weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up.

A nutrition note "dietary eval for weight loss" was completed by RD-E on 7/13/17. The note indicated R176 was on a pureed diet per speech therapy reccommendations, took supplements three times per day, required extensive assitance with meals, and had orders for no tube feeding per physicians orders for life sustaining treatment (POLST). The recommendation was to consider hospice due to, "beyond artificial nutrition which is a contraindicated per POLST wishes, oral interventions are exhausted."

The POLST for R176, dated 10/26/15, indicated, "offer food and liquids by mouth (oral fluids and nutrition must always be offered if medically feasible)"." No tube feeding" was hand written on the form. The form indicated comfort focused care for severe non reversible illness.

A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days and 16.5% loss in 180 days. The estimated intake at meals for R176 was assessed to be approximately 50%. The recommendation was for weekly weight monitoring and continue with nutritional supplement as ordered.

NP-G noted on 11/06/17, a discussion with a family member (FM)-B who acted as the health care agent for R176. Weight loss was discussed along with increasing medications for depression.

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A nutrition consult was requested.

A nutrition note "dietary consult for increased oral calories due to weight loss" was completed on 11/8/17. The note indicated no tube feeding per POLST and consider the possibility for hospice as nutritional interventions are becoming exhausted, resident has a care conference next week.

RD-E was interviewed on 11/15/2017, at 1:25 p.m.. She explained R176 required assist of staff to eat, but could feed herself a bit, intake was variable, and R176 drank the nutritional supplement at near 100%. RD-E said the supplement itself, at three times per day, provided 1050 calories, 39 grams protein. RD-E explained, since meals provided between 1800-2000 calories, at a 50% intake R176 would be consuming approximately 900-1000 calories per day just from meals. Therefore, the combined intake was estimated to be 1950-2150 calories per day. RD-E verified R176's intake appeared to be adequate to meet or exceed assessed needs, but had no explanation why R176 continued to lose weight, and had not assessed if the documented intake was accurate, or other reasons for the weight loss. RD-E also verified, the care plan had not been revised since March, 2017 beyond providing the supplements three times per day. RD-E said she would would review the care plan and consider adding a morning snack. RD-E said she had not increased the amount of supplement offered to try to maximized food intake.

The nutrition care plan, revised on 11/15/17, indicated R176 was at nutritional risk due to weight loss, was on a nutritional supplement and required assistance to eat. The stated goal was

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for R176 to consume 75% or greater of meals and supplements and to maintain weight at 122 pounds. A morning snack of milk or ice cream had been added to the care plan.

Family member (FM)-B for R176 was interviewed on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had not been made aware of the significant weight loss until last week when the nurse practitioner called to discuss medications. FM-B expressed concern with the care at the facility and was worried F176 was not getting as much help as she needed to eat. FM-B said R176 did not like the pureed meal. FM-B stated she knew R176 could feed herself a bit but was very slow, and wanted staff to provide more assistance at meal time. FM-B stated she felt the facility was ignoring R176.

R176 was interviewed 11/16/2017, at 1:47 p.m. R176 did have a diagnosis of dementia, but when asked about the pureed diet she responded negatively and said, "I don't think anyone would like it" R176 said she tried to eat it but couldn't always finish. R176 acknowledged she did like the supplements and would drink what she could. R176 said she was a slow eater and realized she was the last one left in the dining room at times. R176 did not acknowledge losing weight. R176 added that she was comfortable and enjoyed living in the facility.

The Comprehensive Care Plan policy, dated 2017, indicated an individualized care plan would be developed with input from the resident, and/or representative, and be based on a comprehensive assessment and any additional medical nutrition therapy assessments. Additionally, the care plan should address

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F 280	Continued From page 36 identified causes of impaired nutrition status.	F 280		
F 282	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for transfers for 1 of 1 residents (R260) reviewed for potential restraint use. R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's Disease, toxic encephalopathy (disorder of the nervous system caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness. R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit. R260's significant change MDS, dated 10/13/17, indicated he required physical assistance of two staff for bed mobility and transfers. R260 also	F 282	F282 It is the policy of ARLC to provide services by qualified persons per the care plan according to CFR: 483.21(b)(3)(ii). For R260, the bed was re-adjusted to the normal bed height upon notification. Staff members were instructed to only use the EZ Stand for transfers in and out of bed and to use the grab bar and assist of one for toileting. The care plan and Kardex were reviewed and revised to reflect his transfer method. For other residents who require the use of a mechanical lift or standing device, their assessments and care plans will be reviewed and/or revised to ensure the proper use of devices. Staff members were educated on following the care plan. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and care planning procedures, and will continue to use the	12/23/17

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F 282	Continued From page 37 required assistance of one staff to provide physical weight bearing support to walk in the corridor. R260's balance during transitions and walking indicated he was not steady and only able to stabilize with human assistance of one. R260's care plan for activities of daily living (ADLs) included an intervention initiated on 9/29/17, which directed one staff to assist R260 with EZ stand (mechanical sit to stand lift used to help balance a person to standing position) when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand. R260's nursing assistant group sheet, undated, directed staff to transfer with the use of the EZ stand. During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed when nursing assistant (NA)-C entered into room and shut the door. At 3:00 p.m., NA-C left room; R260 was discovered to have been transferred out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put on the bathroom call light, NA-D entered the room and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back. During interview on 11/14/17, 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet.	F 282	tools and resources. The employee who lowered the bed was provided coaching on (11/15/17). Education will be provided to rehab staff, nursing assistants, nurses, and housekeeping staff. Random audits regarding proper use of mechanical lifts, stands and appropriate bed height will be completed, weekly x 4 weeks per household, then monthly x 3 months, and as needed to ensure compliance. The results will be shared with the QAA/QAPI Committee for further recommendations as needed. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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F 282	Continued From page 38 During interview on 11/15/17, at 8:09 a.m. NA-C stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing in the mornings mostly and that the EZ stand was used during those times. NA-C verified the group sheets did not direct staff to use the EZ stand as needed. During interview on 11/15/17, at 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers with use of EZ stand out of bed and used the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any deviation from the care planned intervention was needed. During interview on 11/15/17, at 12:33 p.m. the director of nursing (DON) stated she expected staff to follow the care plan with transfers, stating they can only upgrade the transfer mode if needed but never transfer with less than care planned. The facility's Care Plan Policy and Procedure, dated 11/2016, did not include direction on following the plan of care.	F 282		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and	F 309		12/23/17

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F 309	Continued From page 39 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure care was provided in accordance with resident preferences and to maintain highest physical well-being for 1 of 1 residents (R260) whose care plan was not followed with transfers and whose bed height was adjusted without assessment.	F 309	F309 It is the policy of ARLC to provide care and services for the highest well-being of the residents according to CFR: 483.24 and 483.25(k)(l). For R260, in order to assist in achieving his highest well-being, the bed was	

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F 309	Continued From page 40 Findings include: R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's Disease, toxic encephalopathy (disorder of the nervous system caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness. R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit. R260's significant change MDS, dated 10/13/17, indicated R260 required physical assistance of two staff for bed mobility and transfers. R260 also required assistance of one staff to provide physical weight bearing support to walk in the corridor, and his balance during transitions and walking was not steady and only able to stabilize with human assistance of one. R260's significant change Care Area Assessment (CAA) for falls, dated 10/16/17, identified he was at risk for falls due to use of the EZ stand (mechanical sit to stand lift used to help balance a person to standing position) and assist of one to two assist with transfers. However R260 had no falls. R260's current care plan, initiated on 9/25/17, identified a fall risk; however, it did not include an intervention of bed placement to the floor. R260's care plan for Incontinence or altered	F 309	re-adjusted to the normal bed height upon notification. Staff members were instructed to only use the EZ Stand for transfers in and out of bed and to use the grab bar and assist of one for toileting. The care plan, Kardex, were reviewed and revised to reflect his transfer method. For other residents who require the use of a mechanical lift or standing device, their assessments, care, and kardex will be reviewed and/or revised to ensure the proper use of devices. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and care planning procedures, and will continue to use the tools and resources. The staff members were educated on following the care plan on 11/15/17. Random audits regarding proper use of mechanical lifts, stands and appropriate bed height will be completed, weekly x 4 weeks per household, then monthly x 3 months, and as needed to ensure compliance. The results will be shared with the QAA/QAPI Committee for further recommendations as needed. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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elimination included an intervention dated 9/28/17, directed staff to respond to call light timely; R260 was able to use call light appropriately.

R260's current care plan for activities of daily living (ADLs) included an intervention, initiated 9/29/17, directing one staff to assist R260 with EZ stand when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand.

R260's nursing assistant group sheet, undated, directed staff to transfer with the use of the EZ stand, it did not include an intervention of bed placement to the floor.

During observation on 11/13/17, at 3:14 p.m. R260 was observed resting in bed. R260's bed was in a low position onto to the floor, with mattress one inch off the floor. R260 stated he had not fallen and did not know why the bed was so low. R260 stated he thought it was done so that he did not get up. R260 stated, "They insist I call for help," and reported the bed was not always put to the floor. The bed remote (which controlled the height of the bed) was observed on the floor one foot away from mattress at R260's shoulder level.

During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed and the bed was at knee level height when nursing assistant (NA)-C entered into room, and shut the door. At 3:00 p.m., NA-C left the room and R260 was discovered to have been transferred out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put

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on the bathroom call light, NA-D entered the room and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back.

During interview on 11/14/17, at 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet.

During observation on 11/15/17, at 7:47 a.m. NA-C assisted R260 out of bed. R260 sat at the edge of the bed and kept balance while seated independently without support. R260 maintained balance while seated and assisted with long sleeve shirt and undershirt. NA-C asked R260 to place feet onto the EZ stand foot plates, then placed sling around R260's waist, attached it to the EZ stand lift, and began to lift the arms of the mechanical standing machine. R260 was lifted by machine support to standing for the first twelve inches of the mattress, then R260 was able to stand tall bearing full weight with only the supportive guidance of the machine from bedside to the wheelchair. NA-C stated R260 did well with the EZ stand machine.

During interview on 11/15/17, at 8:09 a.m. NA-C stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing in the mornings mostly and that the EZ stand was used during those times. NA-C verified the groups sheets did not direct staff to use the EZ stand as needed. NA-C stated the bed had been lowered to the

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floor when R260 was in bed because he liked to self transfer. NA-C stated she puts the bed to the floor when she works. NA-C stated R260 would try to self transfer but when the bed is low, R260 would just be able to hang bottom half of body off the side of the bed onto floor.

During interview on 11/15/17, at 8:57 a.m. R260 stated it bothered him that the bed was put down that low. R260 reported it did not happen often but it bothered him because its too hard to get up. R260 stated he lost his patience sometimes and got up by himself but usually would call for help. R260 stated if he had to, he would and could get out of bed. R260 stated he can't get out of bed when it was low to the floor.

During interview on 11/15/17, at 12:09 p.m. NA-E stated the bed was down to the floor as R260 is a fall risk when he tried to get out of bed. When the bed was low, he was only able to just get his feet over the edge of the bed. NA-E worked with R260 once a week.

During interview on 11/15/17, from 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers out of bed using the EZ stand and using the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any deviation from the care planned intervention was needed. LPN- A stated if R260's bed was low or to the floor, it would have been by R260's preference. LPN-A further stated R260 would not get up independently and usually calls for help. LPN-A was not aware the bed was placed to the floor by staff and verified it was not care planned to be that way. LPN-A reported the bed should not have been to the floor. LPN- A stated R260

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had never fallen out of bed, and NA-C needed education regarding the bed placement on the floor.

During interview on 11/15/17, at 12:31 p.m. the director of nursing (DON) stated she expected staff to follow the care plan and the bed was not care planned to be placed on the floor. The DON verified R260 had no history of falls and education was needed to ensure staff did not place anyone's bed on the floor if not care planned. The DON stated that there was no one in the facility who had a care planned for a bed placement to the floor, further stating it would be care planned and explained why that resident may need the intervention. The DON stated staff are expected to follow the care plan with transfers and that they can only upgrade the transfer mode if needed but never transfer with less than care planned.

During interview on 11/16/17, at 2:55 p.m. the clinical administrator was unaware of the low bed before that week, stating the low bed "came out of nowhere," further stating it was "a no no." The clinical administrator further reported it was not the facility's policy to keep someone in bed, especially with no history of falling. The clinical administrator had educated all staff last evening and that day they came to work regarding bed placement.

The facility's policy for Physical Device Data Collection and Evaluation dated, 10/2011, stated that physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual can not remove easily which restricts freedom of movement. The

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F 309	Continued From page 45 policy directs staff to identify the rationale for the use of a potential restraint. The policy stated a restraint of any type would not be used as a substitute for more effective nursing care or for convenience of staff. The policy directs the staff with the procedure for documentation, assessment and use of any potential restraint use.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure interventions to maintain and promote skin integrity were implemented for 1 of 3 residents (R86) reviewed for pressure ulcers, whose padded heel cushion was not consistently implemented as assessed and per physician ordered.	F 314	F314 It is the policy of ARLC to provide treatment and services to prevent or heal pressure sores according to CFR: 483.25(b)(1). For R86, the right heel padded cushion	12/23/17

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F 314	Continued From page 46 Findings include: R86's annual Minimum Data Set (MDS), dated 5/26/17, identified R86 required assistance of 2+ staff with bed mobility and transfers. R86 required extensive assistance of 1 staff for dressing and personal hygiene. R86 was at risk for pressure ulcers and had one unstageable pressure ulcer. R86 was moderately cognitively impaired. R86's annual Care Area Assessment (CAA), dated 5/26/17, identified R86 was at risk for developing pressure ulcers and currently had one pressure area. R86 had one old scab to right 4th digit toe measuring 0.2 cm x 0.2 cm. "Resident wears padded rt [right] heel boot on at all times when in bed." R86 had a pressure reducing mattress and wheelchair cushion. R86's quarterly MDS, dated 8/11/17, continued to identify R86 at risk for pressure ulcers with one unstageable pressure ulcer. R86's current physician order's include: -Initiated on 1/10/17, "Please make sure right heel boot is on at HS [bedtime.] -Initiated on 1/12/17, a padded right heel boot on whenever in bed, every shift for skin protection. -Initiated on 5/31/17, to keep shoes off until scab area on right foot has resolved. -initiated on 8/16/17, Apply skin prep to scab on 4th and 5th digit on right foot once daily until resolved. R86's care plan included a problem initiated on 8/15/13, which indicated R86 was at risk for alteration of skin integrity. The problem area was revised on 2/22/17 to include a stage 2 pressure	F 314	was properly placed upon notification. The care plan was reviewed and revised to reflect that the right heel padded cushion should be on the right foot while the resident is in bed. For other residents who are at high risk for pressure ulcers, their assessments and care plans were reviewed and updated as needed to reflect current physician orders. Education was provided for staff members to ensure they understand and follow the plan of care. Training to staff will be completed by 12/18/17. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and pressure ulcer prevention procedures, and will continue to use the tools and resources. Random audits ensuring the care planned interventions are followed for residents at high risk for pressure ulcers will be completed weekly for four weeks, monthly for three months, and as needed to ensure compliance. The results will be reported to the QAA/QAPI Committee for follow up and further recommendations as needed. The Clinical Administrator or designee will be responsible. Correction Date: 12/23/17	

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area "scab" on the right foot 4th toe. Interventions included:
-A revised 5/2/17 intervention, which directed "padded HEEL boot at night." The care plan did not identify to place the right padded heel boot on whenever in bed as assessed and ordered.
-An added 5/2/17 interventions, which indicated R86 was currently wearing gripper socks during the day due to right 4th and 5th toe pressure areas.

R89's November 2017 treatment record indicated "Padded RIGHT heel boot on whenever is in bed Q [every] SHIFT."

Weekly wound assessment documentation was reviewed. The most recent assessment, dated 11/8/17, identified an unstageable pressure ulcer to the right foot top of 4th digit toe. The area was covered with a "0.5 x 0.5" thin scab. Wound base not viewable, no drainage, no undermining, wound edges intact. Wound stable. Shoes on hold until area is completely healed.

During observations on 11/13/17, at 2:27 p.m. R86's was lying on his back in bed. R86 had gripper socks on both feet. R86's heels were resting on the mattress. R86 was not wearing a padded right heel boot as ordered. A padded heel boot was observed laying on the seat of the electric wheelchair in the room.

During interview on 11/13/17, at 7:09 p.m., R86 stated, "Not sure," when asked when staff apply the heel boot.

During observations on 11/14/17, at 12:46 p.m. nursing assistant (NA)-A and nursing assistant (NA)-B transferred R86 from the wheelchair to

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bed with a mechanical lift. R86 was wearing gripper socks. NA-A left the room. NA-B provided incontinent cares. After the completion of incontinent cares, NA-B covered R86 with a blanket. R86's heels were resting on the mattress. A padded heel boot was laying on a chair in the room. NA-B left the room without applying the padded heel boot to R86's right foot.

During interview on 11/14/17, at 12:56 p.m. NA-B stated she follows a paper group sheet and the Kardex on the computer when completing resident cares. NA-B stated R86 did not wear shoes due to a sore on his toes. When asked about the heel cushion, NA-B stated R86 wears the heel cushion only at night to protect his heel.

Review of the nursing assistant group sheets for R86 identified "In bed after lunch." The group sheet lacked identification or directions for a heel boot.

During interview on 11/14/17, at 2:00 p.m. licensed practical nurse (LPN)-A stated nursing assistants are directed to follow the group sheet for each resident. R86 does not wear shoes, only gripper socks due to a "scab" on his 3rd and 4th toes, which was caused by his shoes. LPN-A stated R86's wears a padded boot on his right heel, because the heel was pretty soft for awhile. LPN-A walked into R86's room. R86's was laying in bed. LPN-A stated R86 was not wearing a heel boot and placed the padded heel boot onto R86's right heel. LPN-A stated the direction to place the heel boot onto R86's heel should be on the nursing assistant's group sheet.

During observations on 11/16/17, at 9:17 a.m. with LPN-A, R86's right heel was clean, dry, intact

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F 314	Continued From page 49 and had no redness. An area on the 4th toe was consistent with the 11/8/17 wound documentation. During interview on 11/16/17, at 10:30 a.m., registered nurse (RN)-A stated she updated R86's care plan on 11/14/17. Review of R86's care plan identified a revised intervention dated 11/14/17, Ten months after the order to place the right heel boot on whenever in bed. The revised care plan intervention directed "Padded boot to right heel whenever resident is in bed. RN-A stated prior to 11/14/17, the care plan and Kardex intervention directed to used a padded heel boot at night. During interview on 11/16/17, at 8:40 a.m. the director of nursing (DON) stated the nursing assistant group sheets are used as a resident assignment list, but do not necessarily identify interventions. Interventions are documented on the care plan and the Kardex. Interventions are also communicated through report. Staff are to follow the resident's care plan. The facility's Policy and Procedure for the Prevention and Treatment of Skin Breakdown, revised 8/2011, indicated: "it is the policy of Volunteers of America to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." "The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident."	F 314		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		12/23/17

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F 315	Continued From page 50 CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 315		

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F 315	Continued From page 51 Based on observation, interview, and record review, the facility failed to re-asses and provide neeeded incontinence skin care of new onset bowel incontinence related to Clostridium Difficile (a antibiotic resistant bacteria causing diarrhea, commonly known as C-Diff) for 1 of 3 residents (R273) reviewed for bowel incontinence. Findings include: R273's admission Minimum Data Set (MDS), dated 9/1/17, identified no cognitive impairment and was always continent of bowel. R273's significant change MDS, dated 10/14/17, identified no cognitive impairment, was dependent on staff for toileting, and was always continent of bowel. R273's Bladder and Bowel Data Collection, dated 10/11/17, noted he was always continent of bowel, not needing a toileting program. The Data collection identified R273 required a mechanical lift for toileting. R273's significant change Care Area Assessments (CAA), dated 10/20/17, indicated a progressive decline since admission, which included a surgery for an above the knee amputation of the right leg and the initiation of dialysis three times a week. The CAA further indicated R273 was continent of bowel and was assisted, "to the toilet per his choice." R273's current Kardex, undated, identified him as continent of bowel and needing assistance to transfer on and off the toilet. R273's current care plan, dated 10/7/17, identified	F 315	F315 It is the policy of ARLC to prevent UTI, maintain or restore bowel or bladder function if possible, and not place a catheter unless a justifiable condition warrants placement according to CFR: 483.25(e)(1)-(3). For R273, the care plan was updated to reflect the C-Diff on 11/12/17. An order for barrier cream was obtained due to the red area on the coccyx from the recent hospital stay (which was healed on 10/29/17. The assessment, care plan, and kardex were reviewed and revised as necessary to reflect the current bowel incontinence due to C-Diff. For new and existing residents with C-Diff. that have been assessed for incontinence, their assessments and care plans will be reviewed and revised as necessary. The nursing assistants were educated on the care plan and Kardex changes. To ensure correction is achieved and sustained the facility will continue to follow the resident assessment and Infection Prevention and Control procedures, and will continue to use the tools and resources. Care plan and kardex audits will be completed on residents who are incontinent weekly for four weeks, monthly for three months, and as necessary to ensure compliance. The results will be reported to the QAA/QAPI Committee for review and further recommendations as needed. The Clinical Administrator or designee will	

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F 315	Continued From page 52 a diagnosis of altered elimination with the goal to decrease urinary incontinence episodes, noting R273 was continent of bowel, needed two staff and full body lift to transfer, and needed assistance to transfer on/off the toilet. The care plan was revised on 11/12/17, noting a new diagnosis of C-Diff and directing staff to observed and report loose stools. In addition, the care plan indicated R273 had a coccyx wound from his last hospitalization and directed to observe the skin daily. The care plan did not direct staff to apply any barrier creams to the peri area. R273's current physician orders, dated 11/1/617, indicated R273 had been diagnosed with a C-Diff infection on 10/25/17 and had been started on infection monitoring and a fourteen day course of Vancomycin (an antibiotic). During observation of cares on 11/15/17, at 7:04 a.m. nursing assistant (NA)-F was observed to assist R273 with a bed bath. After washing R273's upper body, NA-F proceed to R273's lower half and completed peri cares. R273 was observed to be incontinent with soft bowel movement noted in his brief and smeared on the linens directly underneath him. NA-F changed R273's soiled incontinence product and linens, noting that R273's inner buttocks appeared reddened. NA-F asked R273 if the buttocks hurt, to which R273 replied it did, and NA-F left the room, returning with registered nurse (RN)-F. RN-F proceeded to take off R273's foam dressing, which was over his coccyx wound, and assessed his reddened buttocks, again asking R273 if it hurt, to which R273 replied that the area itched more than it hurt. RN-F directed NA-F to cover R273 with a brief while she went to see if RN-C wanted to measure the coccyx wound and	F 315	be responsible for compliance. Date of Correction: 12/23/17	

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assess the area. RN-F returned to the room, stating RN-C was busy and proceeded to measure and apply a clean foam dressing over the coccyx wound, stating she did not want to put cream on the area until RN-C assessed it. NA-F then assisted in applying the new brief, and finished dressing R273. R273 was transferred into a broda chair and left the facility at 8:41 a.m. for an appointment.

During observation on 11/15/17, at 11:32 a.m. R273 returned to the facility from his appointment and remained sitting up in the broda chair, eating lunch, until 1:26 p.m., when NA-F and RN-C transferred him back into bed. At that time, R273 was observed to have a large unformed incontinent stool in his brief. NA-F performed peri care, first wiping the stool away with bath tissue, then using a wet washcloth to clean the area. R273's buttock remained reddened, and RN-C took off the soiled coccyx dressing, reporting the slit-like coccyx wound underneath was moisture related and had started due to the C-Diff. RN-C did not reapply the coccyx dressing and did not apply any cream, reporting they were getting an order for a cream from the physician.

During interview on 11/15/17, at 9:34 a.m. NA-F acknowledged R273 had an incontinent stool that morning, noting his bottom had been red and had a little open area on the coccyx. NA-F stated R273 had loose stools with the C-Diff, reporting R273 would usually ask for the bed pan and could feel when he had to go prior to the C-Diff; however, with the C-Diff the stool would just come and did not think R273 knew when he stooled. NA-F reported R273 preferred to use the bedpan and did not want to go into the bathroom since his leg was amputated.

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During interview on 11/15/17, at 11:20 a.m. RN-F stated R273 would usually ask for the bedpan, stating she was updated of the incontinent episode that morning, and thought he might have had the bowel movement overnight. RN-F reported R273's bowel continence varied with the C-Diff, and had changed to more incontinence with the C-Diff. RN-F further stated R273 was not transferred to the toilet due to hypotension (lower blood pressure) episodes and for safety with those episodes, noting R273 blood pressure medications had been altered as a result. RN-F reported the hypotension had been going on for about three weeks and had gotten better.

During interview on 11/15/17, at 2:04 p.m. R273 stated he was not incontinent and could control his bowel movements before having C-Diff. R273 reported he either could not feel when he had to have a bowel movement or the bowel movement came quick, further noting the bowel movements were a lot more frequent. R273 stated he had used the bed pan twice since his stay at the facility, noting other times staff changed his brief. R273 reported he wanted to use the toilet, "like a normal human being," and had been talking to staff about using it for two weeks.

During interview on 11/16/17, at 7:38 a.m. RN-C stated R273 came with the reddened bottom from the hospital, noting it was blanchable. RN-C reported a cream had been ordered that day (11/16/17) for R273's buttocks, but there had been nothing prior. RN-C reported R273 had been admitted to the facility with bowel incontinence, stating R273's wife reported R273 was incontinent of bowel and bladder at home. RN-C stated R273 had used the bed pan once;

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however, mostly just went in his brief, further stating R273 never used the toilet, even at home. RN-C stated incontinence was assessed by the nurse managers on admission and the assessment flowed onto the care plan. RN-C was unable to find the toileting intervention at the time of the interview.

During interview on 11/16/17, at 8:27 a.m. RN-B stated incontinence was assess by the nurse managers on admission by talking with staff, resident, and family, noting that if the resident was not a good historian, then they would look at the charting of incontinence episodes. RN-B acknowledged R273's admission bowel assessment from the MDS noted always continent; however, stated the MDS assessment and the nurse managers assessment may conflict with one another because the MDS assessment counted actual episodes of incontinence whereas the nurse manger's assessment did not account for that. RN-B reported the rehab did not have bowel programs because that would be to address a chronic long term issue. RN-B stated they had bowel plans, but for R273 the C-Diff was a temporary issue that would resolved itself and then R273's bowel continence would be back to normal. RN-B further stated R273's care plan was not revised because the C-Diff and associated incontinence was a short term issue, and they would not go back in and revise the care plan for short term problems because his goal was to get better, and nursing assistants were made aware of residents who were incontinent through verbal report. RN-B reported R273's skin was being monitored weekly by nursing staff and they had obtained a physician order for cream to be applied to the buttocks yesterday. RN-B further reported prior to yesterday the nursing assistants

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were verbally told in report to provide barrier cream with incontinence episodes, as a facility standard.

During interview on 11/16/17, at 10:19 a.m. RN-E stated the MDS assessment data was pulled over to the care plan on admission. RN-E stated the MDS nurses were focused on revising the care plans with the comprehensive and quarterly assessment time frames. RN-E reported changes and care plan revisions occurring outside of the MDS time frames were the responsibility of the nurse managers and floor nurses.

During interview on 11/16/17, at 2:07 p.m. the director of nursing (DON) stated the care plan depended on the individual resident and most in the rehab would be alert and able to say when they had to go to the bathroom. The DON stated the care plan was ongoing, and if a resident was now using a brief for example, could be updated. The DON reported, with their rehab residents, the goal was to get them as independent as possible, with a goal to wear regular underwear. The DON reported, for someone with C-Diff, the resident would be provided the appropriate products to use, would assess them for a week to be sure of the change, and then go back to the main goal of getting back to normal.

A facility policy entitled Care Plan Policy And Procedure, revised 11/16, directed the care plan was to be "changed and updated as the care changes for the resident and as the resident changes." The policy noted that any temporary changes would be added to the comprehensive care plan after 30 days. The policy further directed the care plan was to be current at all times.

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F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively evaluate the nutritional care needs for 1 of 1 resident (R)-176 who experienced an unplanned significant weight loss. Findings include: R176 had diagnoses that included high blood pressure, peripheral vascular disease, dementia and depression. R176 had paralysis on one side of her body from a stroke two years ago. R176 was on a pureed diet due to swallowing difficulties from the stroke. R176 was observed at breakfast on 11/15/2017,	F 325	F325 It is the policy of ARLC to assist the resident in maintaining their nutritional status unless their condition deems the decline unavoidable according to CFR: 483.25(g)(1)(3). For R176, a nutritional assessment was completed and the care plan updated on 11/15/17 to reflect the assessment results. The RD and interdisciplinary team met to investigate why the resident may be losing weight and revised the care plan. The RD also completed an audit to determine if the documentation was accurate regarding the weight loss. For other	12/23/17

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F 325	Continued From page 58 at 8:55 a.m.. R176 had a pureed meal and was assisted to eat. After a few minutes R176 was given the spoon and began to feed herself. At 9:09 a.m., R176 slowed down with eating holding the spoon and looking around; R176 appeared dozy with eyes closed and not eating. At 9:13 a.m. staff encouraged R176 to take a drink of orange juice and began to assist again with eating. At 9:24 a.m. R176 asked to go to the activity room. She had eaten about 50%. R176 was observed at the lunch meal on 11/15/2017, at 12:22 p.m. R176 had the meal in front of her but was not initiating eating. At 12:26 p.m. staff sat with R176 to assist, R176 then started feeding self and drinking independently. R176 continued to feed herself slowly with very small bites. At 1:00 p.m. R176 continued to be assisted by staff to eat and had consumed about 50% by that time. All other residents had finished and left the dining area. On 11/16/2017, at 9:19 a.m. Licensed Practical Nurse (LPN)-B stated, R176's intake was variable at 25-75% and often held food in her mouth and needed to be cued to swallow. Also, R176 would say when she was full. LPN-C was interviewed on 11/16/2017, at 1:41 p.m. LPN-C stated R176 would take any flavor of supplement but preferred strawberry. LPN-C verified the supplements were given between meals, but she would give it after a meal if R 176 had not eaten well. She explained since R176 was a slow eater, she may not be hungry by lunchtime and not eat as well. LPN-C verified the supplements were just three per day, no as needed supplement had been ordered.	F 325	residents who are on comfort care, their assessments, care plans, and weight documentation will be reviewed and revised as necessary. IDT staff members were educated on evaluating, assessing, and documenting nutritional status. To ensure correction is achieved and sustained the facility will continue to follow the nutritional services procedures, and will continue to use the tools and resources. Nutritional audits on weight loss on new and current comfort care residents will be completed weekly for four weeks, monthly for 3 months, and a needed to ensure compliance and the results will be reported to the QAA/QAPI Committee. The committee will then make further recommendations as deemed necessary. Training to staff will be completed by 12/18/17 The Registered Dietician or designee will be responsible for compliance. Date of Correction: 12/23/17	

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The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds.

A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days and was on a nutritional supplement, and had a pureed diet. The nutritional assessment indicated R176 was consuming greater than 75% of calories, 75 grams of protein, and 1500 milliliters (ml) or more for fluid intake. A quarterly Minimum Data Set (MDS) assessment dated 5/24/17, indicated a significant loss had occurred.

The nurse practitioner (NP)-G progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (dementia) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up.

A nutrition note "dietary eval for weight loss" was completed by RD-E on 7/13/17. The note indicated R176 was on a pureed diet per speech therapy reccommendations, took supplements three times per day, required extensive assitance with meals, and had orders for no tube feeding per physicians orders for life sustaining treatment (POLST). The recommendation was to consider hospice due to, "beyond artificial nutrition which is a contraindicated per POLST wishes, oral interventions are exhausted."

The POLST for R176, dated 10/26/15, indicated, "offer food and liquids by mouth (oral fluids and nutrition must always be offered if medically

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feasible)"." No tube feeding" was hand written on the form. The form indicated comfort focused care for severe non reversible illness.

A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days and 16.5% loss in 180 days. The estimated intake at meals for R176 was assessed to be approximately 50%. The recommendation was for weekly weight monitoring and continue with nutritional supplement as ordered.

NP-G noted on 11/06/17, a discussion with a family member (FM)-B who acted as the health care agent for R176. Weight loss was discussed along with increasing medications for depression. A nutrition consult was requested.

A nutrition note "dietary consult for increased oral calories due to weight loss" was completed on 11/8/17. The note indicated no tube feeding per POLST and consider the possibility for hospice as nutritional interventions are becoming exhausted, resident has a care conference next week.

RD-E was interviewed on 11/15/2017, at 1:25 p.m.. She explained R176 required assist of staff to eat, but could feed herself a bit, intake was variable, and R176 drank the nutritional supplement at near 100%. RD-E said the supplement itself, at three times per day, provided 1050 calories, 39 grams protein. RD-E explained, since meals provided between 1800-2000 calories, at a 50% intake R176 would

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be consuming approximately 900-1000 calories per day just from meals. Therefore, the combined intake was estimated to be 1950-2150 calories per day. RD-E verified R176's intake appeared to be adequate to meet or exceed assessed needs, but had no explanation why R176 continued to lose weight, and had not assessed if the documented intake was accurate, or other reasons for the weight loss. RD-E also verified, the care plan had not been revised since March, 2017 beyond providing the supplements three times per day. RD-E said she would review the care plan and consider adding a morning snack. RD-E said she had not increased the amount of supplement offered to try to maximized food intake. RD-E verified the interdisciplinary team reviewed all incidents of significant weight loss to discuss care plan development.

The nutrition care plan, revised on 11/15/17, indicated R176 was at nutritional risk due to weight loss, was on a nutritional supplement and required assistance to eat. The stated goal was for R176 to consume 75% or greater of meals and supplements and to maintain weight at 122 pounds. A morning snack of milk or ice cream had been added to the care plan.

Family member (FM)-B for R176 was interviewed on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had not been made aware of the significant weight loss until last week when the nurse practitioner called to discuss medications. FM-B expressed concern with the care at the facility and was worried F176 was not getting as much help as she needed to eat. FM-B said R176 did not like the pureed meal. FM-B stated she knew R176 could feed herself a bit but was very slow, and wanted staff

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F 325	Continued From page 62 to provide more assistance at meal time. FM-B stated she felt the facility was ignoring R176. R176 was interviewed 11/16/2017, at 1:47 p.m. R176 did have a diagnosis of dementia, but when asked about the pureed diet she responded negatively and said, "I don't think anyone would like it" R176 said she tried to eat it but couldn't always finish. R176 acknowledged she did like the supplements and would drink what she could. R176 said she was a slow eater and realized she was the last one left in the dining room at times. R176 did not acknowledge losing weight. R176 added that she was comfortable and enjoyed living in the facility. The Nutritional Assessment Policy and Procedure (not dated) indicated the clarification of nutritional issues, needs and goals was accomplished by using observation, and gathering and considering relevant information. The procedure directed staff to interview the individual and/or representative and review information from other sources. The facility was to develop a clear and specific statement that provides the basis for interventions.	F 325		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441		12/23/17

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communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 441	Continued From page 64 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the appropriate disinfectant bleach wipes, effective against clostridium difficile (drug resistant bacteria commonly known a C-Diff) were accessible to staff, and failed to keep designated resident care equipment in an isolation precautions room for 1 of 2 residents (R273) reviewed for contact isolation precautions. Findings include: R273's significant change Minimum Data Set (MDS), dated 10/14/17, identified no cognitive impairment. R273's current physician orders, dated 11/1/617, indicated he had been diagnosed with C-Diff infection on 10/25/17 and had been started on infection monitoring and a fourteen day course of Vancomycin (an antibiotic).	F 441	F441 It is the policy of ARLC to maintain and infection control and prevention program according to CFR: 483.80(a)(1)(2)(4)(e)(f). For R273, the correct bleach wipes were provided to the staff member caring for the resident with C-Diff to wipe down surfaces and devices. The staff members were educated on making sure the sling for a resident with precautions is kept in the room and not put with the mechanical lift. The staff were also educated on where bleach- containing wipes can be found if not available in the room. For other residents on transmission precautions, their assessments and care plans were reviewed and staff educated on the proper wipes to use and leaving slings in rooms if a mechanical lift is	

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	245205	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 65 R273's current care plan, dated 11/12/17, identified the diagnosis of C-Diff, with the following interventions: contact isolation for diarrhea, "Cleaning of room and surrounding area daily as per facility protocol/policy, and "Dedicate equipment for resident only." During observation of cares on 11/15/17, at 7:04 a.m. a plastic container with drawers was observed outside of R273's room, containing isolation gowns and gloves, and a sign on R273's door instructing to see the nurse before entering the room. Nursing assistant (NA)-F entered the room, greeted R273, donned clean gloves and went into R273's bathroom to fill a plastic basin with soapy water. NA-F left the basin of water in the bathroom sink, used hand sanitizer, donned new gloves, and proceeded to assist R273 in deciding what clothes to wear for the day. She then proceeded to walk to the top left cabinet, located above R273's entry way sink, and grabbed a container of Super Sani-Cloth disposable wipes with the purple top (which did not contain bleach). After grabbing a few wipes, NA-F cleaned R273's bedside table top, his television remote control, and grabber tool, which were on the table. NA-F pushed the bedside table from the left side of the bed to the right, and grabbed the basin of water and towels. NA-F proceed to don a gown and new gloves, and completed R273's bed bath and peri cares. R273 was observed to be incontinent with soft bowel movement noted in his brief and smeared on the linens directly underneath him. NA-F changed R273's soiled incontinence product and linens; R273 was observed using the bilateral grab bars and overhead trapeze to assist with turning during cares. After completing cares, NA-F emptied the	F 441	required. To ensure correction is achieved and sustained the facility will continue to follow the Infection Prevention and Control procedures, and will continue to use the tools and resources. Audits for proper infection control with residents on transmission precautions will be completed weekly for four weeks, monthly for three months, and as necessary to ensure compliance. The results will be reported to the QAA/QAPI Committee for review and further recommendations as necessary. Training to staff will be completed by 12/18/17 The Clinical Administrator or designee will be responsible for compliance. Date of Correction: 12/23/17	

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F 441	Continued From page 66	F 441		

water basin in R273's bathroom, went to the cabinet and grabbed more Super Sani-Cloth wipes from the purple top container. Using the wipes, she cleaned R273's grab bars, overhead trapeze, and remote control for the bed. At that time, registered nurse (RN)-F entered the room to take R273's blood pressure and assess his coccyx wound. RN-F was observed to open and take out a container of Sani-Cloth Bleach disposable wipes with an orange top from the locked medication cabinet, located in the top right cabinet opposite of the entry way sink. RN-F proceeded to clean the blood pressure cuff with the Sani-Cloth Bleach wipes.

During observation on 11/15/17, at 8:06 a.m. NA-F brought the full body lift into R273's room. NA-F and occupational therapist (OT)-A were observed to place a full body lift sling underneath R273 and proceeded to transfer him to a broda chair (specialized wheelchair which can tilt and recline). NA-F took the sling out from underneath R273, taking the full body lift and sling into R273's bathroom, then brought it out to the floor and parked it in an alcove in the hallway. The used sling was observed sitting in the front storage pouch of the full body lift, outside R273's room.

The lift and the sling were stored there untouched until 8:56 a.m., when NA-G took the full body lift to transfer R379, who was also on contact isolation for C-Diff. When asked about the cleaning of the sling and lift, NA-F stopped NA-G in the hallway outside of R379's room, stating she had cleaned the lift with the Sani-Cloth Bleach wipes in R273's bathroom, but had placed the sling in the storage pouch by mistake. Both NA-F and NA-G stated each resident had their own full body sling, and R379's individual sling was noted

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F 441	Continued From page 67	F 441		

in her room. NA-F was observed to take R273's sling out of the pouch and placed the sling back in R273's bathroom, over his geri chair.

During interview on 11/15/17, at 9:34 a.m. NA-F opened R273's top left cupboard containing both a container of Super Sani-Cloth wipes and a container of Sani-Cloth Bleach wipes. NA-F stated she had used the purple top Super Sani-Cloth wipes to clean R273's bedside table and grab bars because she could not find the orange top Sani-Cloth Bleach wipes. NA-F stated usually the Sani-Cloth Bleach wipes were stored in the locked medication cabinet, and she did not have a key. NA-F reported she could use either type of wipe to clean R273's room, but liked to use the Sani-Cloth Bleach wipes because they were stronger with bleach. NA-F further reported R273's full body sling was usually kept in his room, acknowledging she mistakenly took it out that morning due to the commotion of everything going on.

During interview on 11/15/17, at 11:20 a.m. RN-F verified the Sani-Cloth Bleach wipes had been locked in the medication cabinet that morning, further reporting the Sani-Cloth Bleach wipes were available in the locked medication rooms, which the nurses had access to. RN-F stated the purple top Super Sani-Cloth wipes had a longer wet time of four minutes and were used to wipe down glucometers; however, the orange top Sani-Cloth Bleach wipes had a shorter wet time of two minutes and would be used to wipe down the full body lift. When asked which wipes were used for R273, RN-F stated the orange top Sani-Cloth Bleach wipes were specific to C-Diff; however, it would depend on the situation. RN-F further stated she would use the Sani-Cloth

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Bleach wipes with R273 because he liked to dig and scratch himself, noting she had observed a dark substance under his nails, which she assumed was feces, and had cut his fingernails a couple of weeks ago because of it. RN-F stated R273 had his own full body sling, which was kept in the room.

During interview on 11/16/17, at 8:08 a.m. RN-B stated the facility had different types of Sani-Cloth brand wipes, but used the Sani-Cloth Bleach wipes strictly for C-Diff precautions. RN-B stated the purple top Super Sani-Cloth wipes should not be in R273 room, further stating the only reason the orange top Sani-Cloth Bleach wipes would be locked in the cabinet was if the resident had dementia. RN-B stated staff would still have access to the Sani-Cloth Bleach wipes, as they were available in the clean utility room. RN-B reported if a resident has a lift sling and are on isolation precautions for C-Diff, the sling is kept in the resident's room.

During interview on 11/16/17, at 10:30 a.m. RN-D and RN-G, who were in charge of infection control, stated the facility had special chemicals just for C-Diff, including the orange top Sani-Cloth Bleach wipes, which had a wet time of four minutes. RN-G stated the Sani-Cloth Bleach wipes were the only wipes used with C-Diff that would kill the bacteria. RN-G stated the Sani-Cloth Bleach wipes were kept in the clean utility rooms on the units and the nursing assistants had keys to those rooms. RN-D and RN-G expected nursing assistants to doff their protective personal equipment (PPE), grab a few wipes from the clean utility room, don their PPE and re-enter the room with the wipes. RN-G stated once a container of wipes was brought into

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F 441	Continued From page 69	F 441		

the room, the container had to stay in the room because of the isolation precautions. RN-D and RN-G reported the Sani-Cloth Bleach wipes were locked in resident rooms because they were a chemical, and because they were a chemical, had to be out of reach of residents who may have dementia. In addition, RN-D and RN-G stated they did not like to keep the wipes in the room because the nursing assistants might mistakenly use them for peri care. RN-D stated the full body slings were resident dedicated, meaning R273 would have his own sling, because it wrapped around his bottom, further stating the sling should stay in his room.

The facility's Infection Prevention and Control Manual: Antibiotic Stewardship and MDROs (Multi Drug Resistant Organisms), dated 2017, specifically directed regarding C-Diff, common use equipment should be dedicated to the individual, not shared. In addition, it directed the environment should be cleaned at least daily with "special attention to those items likely to be contaminated with feces, i.e., bed rails," recommending the use of a bleach disinfectant.

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

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	245205	A. BUILDING **02 - ANOKA CARE & REHAB CENTER** B. WING _____	**11/20/2017**

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ANOKA REHABILITATION AND LIVING CENTE	**3000 4TH AVENUE ANOKA, MN 55303**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 20, 2017. At the time of this survey, Anoka Rehab and Living Center 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. Anoka Rehab & Living Center is a 2- story building with a basement that was built in 2012 and determined to be of Type II(111) construction. The building shares a common wall with an assisted living facility and is separated by 2-hour fire rated construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridor, and resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 111 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.

Electronically delivered
December 1, 2017

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation and Living Center
3000 4th Avenue
Anoka, MN 55303

Re: State Nursing Home Licensing Orders - Project Number S5205028

Dear Mr. Dolinsky:

The above facility was surveyed on November 13, 2017 through November 16, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Kathleen Lucas, Unit Supervisor at (320) 223-7343 or email: kathleen.lucas@state.mn.us**.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	11/16/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On dates November 13, 2017 to November 16, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		12/23/17

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate notification for 1 of 1 resident (R) 176 who experienced a significant weight loss. Findings include: A quarterly Minimum Data Set (MDS) assessment dated 5/24/17, indicated R176 had a score of 7 on a Brief Interview for Mental Status (BIMS) indicating cognitive losses. The assessment also indicated R176 had experienced a significant weight loss. R176's had diagnoses of dementia, depression, high blood pressure, vascular disease, and paralysis on one side of the body. The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds. A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days. The nurse practitioner (NP)-G progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (dementia) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up.	2 265	Corrected	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4 A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days and 16.5% loss in 180 days. NP-G noted a discussion with a family member (FM)-B on 11/06/17. Weight loss was discussed along with increasing medications for depression. A nutrition consult was requested. Family member (FM)-B for R176 was interviewed on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had only been made aware of the significant weight loss the past week when the nurse practitioner called to discuss medications. The clinical administrator was interviewed on 11/16/2017, at 3:00 p.m. He stated the interdisciplinary team would notify the nurse practitioner in the case of significant health events and it was the expectation that the nurse practitioner would notify the family. He added, the facility does not supervise the nurse practitioners. A policy regarding health care notification was requested but not provided. The policy, Tracking Weight Changes, dated 2017, indicated the individual, family or representative, physician and registered dietitian would be notified of any individual with an unintended significant weight change of 5% in one month, 7.5% in three months or 10% in six months.	2 265		

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2 265	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff on examples on when the family should be notified. The DON or designee could perform audits of medical records to determine if the family had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 265		
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R260) was free from physical restraints by lowering bed to the floor restraining R260's ability to self transfer out of bed.	2 530	Corrected	12/23/17

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2 530	Continued From page 6 R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's disease, toxic encephalopathy (disorder of the nervous system caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness. R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit. R260's significant change MDS, dated 10/13/17, indicated R260 required physical assistance of two staff for bed mobility and transfers. R260 also required assistance of one staff to provide physical weight bearing support to walk in the corridor, and his balance during transitions and walking was not steady and only able to stabilize with human assistance of one. R260's significant change Care Area Assessment (CAA) for falls, dated 10/16/17, identified he was at risk for falls due to use of the EZ stand (mechanical sit to stand lift used to help balance a person to standing position) and assist of one to two assist with transfers. R260 had no falls. R260's current care plan, initiated on 9/25/17, identified a fall risk; however, it did not include an intervention of bed placement to the floor. R260's care plan for Incontinence or altered elimination included an intervention dated 9/28/17, directed staff to respond to call light timely; R260 was able to use call light	2 530		

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2 530	Continued From page 7 appropriately. R260's current care plan for activities of daily living (ADLs) included an intervention, initiated 9/29/17, directing one staff to assist R260 with EZ stand when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand. R260's nursing assistant group sheet undated, directed staff to transfer with the use of the EZ stand, it did not include an intervention of bed placement to the floor. R260's Physician Order Report, dated 11/15/17, lacked order to lower bed to the floor. R260's Physical Therapy Discharge Summary, for dates of service of 9/26/17 to 10/11/17, included his baseline ability to ambulate 8 feet (ft) with assistance of two staff on 9/26/17 and 50 ft with assistance of two staff on 10/9/17. R260's discharge note dated 10/11/17, included R260 was variable with ambulation and required minimum to moderate assist of two staff and wheelchair to follow. During observation on 11/13/17, at 3:14 p.m. R260 was observed resting in bed. R260's bed was in a low position onto to the floor, with mattress one inch off the floor. R260 stated he had not fallen and did not know why the bed was so low. R260 stated he thought it was done so that he did not get up. R260 stated, "They insist I call for help," and reported the bed was not always put to the floor. The bed remote (which controlled the height of the bed) was observed on the floor one foot away from mattress at R260's shoulder level.	2 530		

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2 530	Continued From page 8 During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed and the bed was at knee level height when nursing assistant (NA)-C entered into room, and shut the door. At 3:00 p.m., NA-C left the room and R260 was discovered to have been transferred out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put on the bathroom call light, NA-D entered the room and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back. During interview on 11/14/17, at 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet. During observation on 11/15/17, at 7:47 a.m. NA-C assisted R260 out of bed. R260 sat at the edge of the bed and kept balance while seated independently without support. R260 maintained balance while seated and assisted with long sleeve shirt and undershirt. NA-C asked R260 to place feet onto the EZ stand foot plates, then placed sling around R260's waist, attached it to the EZ stand lift, and began to lift the arms of the mechanical standing machine. R260 was lifted by machine support to standing for the first twelve inches of the mattress, then R260 was able to stand tall bearing full weight with only the supportive guidance of the machine from bedside to the wheelchair. NA-C stated R260 did well with the EZ stand machine. During interview on 11/15/17, at 8:09 a.m. NA-C	2 530		

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2 530	Continued From page 9	2 530		

stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing, in the mornings mostly, and that the EZ stand was used during those times. NA-C verified the groups sheets did not direct staff to use the EZ stand as needed. NA-C stated the bed had been lowered to the floor when R260 was in bed because he liked to self transfer. NA-C stated she puts the bed to the floor when she works. NA-C stated R260 would try to self transfer but when the bed is low, R260 would just be able to hang bottom half of body off the side of the bed onto floor.

During interview on 11/15/17, at 8:57 a.m. R260 stated it bothered him that the bed was put down that low. R260 reported it did not happen often but it bothered him because its too hard to get up. R260 stated he lost his patience sometimes and got up by himself but usually would call for help. R260 stated if he had to, he would and could get out of bed, when it wasn't placed so low to the floor. R260 stated he can't get out of bed when it was low to the floor.

During interview on 11/15/17, at 12:09 p.m. NA-E stated the bed was down to the floor as R260 is a fall risk when he tried to get out of bed. When the bed was low, he was only able to just get his feet over the edge of the bed. NA-E worked with R260 once a week.

During interview on 11/15/17, from 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers out of bed using the EZ stand and using the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any deviation from the care planned intervention was

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2 530	Continued From page 10	2 530		

needed. LPN- A stated if R260's bed was low or to the floor, it should only have been by R260's preference. LPN-A further stated R260 would not get up independently and usually calls for help. LPN-A was not aware the bed was placed to the floor by staff and verified it was not care planned to be that way. LPN-A reported the bed should not have been to the floor. LPN- A stated R260 had never fallen out of bed, and NA-C needed education regarding the bed placement on the floor.

During interview on 11/15/17, at 12:31 p.m. the director of nursing (DON) stated she expected staff to follow the care plan and the bed was not care planned to be placed on the floor. The DON verified R260 had no history of falls and education was needed to ensure staff did not place anyone's bed on the floor if not care planned. The DON stated that there was no one in the facility who had a care planned for a bed placement to the floor, further stating it would be care planned and explained why that resident may need the intervention. The DON stated staff are expected to follow the care plan with transfers and that they can only upgrade the transfer mode if needed but never transfer with less than care planned.

During interview on 11/16/17, at 2:55 p.m. the clinical administrator reported the facility was a restraint-free facility, and the facility was working towards that goal of eliminating all restraints, even the Wanderguards. The clinical administrator was unaware of the low bed before that week, stating the low bed "came out of nowhere," further stating it was "a no no." The clinical administrator further reported it was not the facility's policy to keep someone in bed, especially with no history of falling. The clinical

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2 530	Continued From page 11 administrator had educated all staff last evening and that day they came to work about the use of restraints. The facility's policy for Physical Device Data Collection and Evaluation dated, 10/2011, stated that physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual can not remove easily which restricts freedom of movement. The policy directs staff to identify the rationale for the use of a potential restraint. The policy stated a restraint of any type would not be used as a substitute for more effective nursing care or for convenience of staff. The policy directs the staff with the procedure for documentation, assessment and use of any potential restraint use. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure potential restraints are identified, comprehensively assessed and care planned to ensure they are the least restrictive restraints. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 530		

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2 560	Continued From page 12	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan with interventions to address new urinary incontinence or maintain as much urinary continence to the greatest degree for 1 of 3 residents (R273) reviewed for urinary incontinence. Findings Include: R273's admission Minimum Data Set (MDS), dated 9/1/17, identified no cognitive impairment and was always continent of urine. R273's significant change MDS, dated 10/14/17, identified no cognitive impairment, was dependent on staff for toileting, and was frequently incontinent of urine. R273's Bladder and Bowel Data Collection, dated 10/11/17, noted he was frequently incontinent of urine and would sometimes leak urine. The Data Collection further noted R273 was not on a toileting program and had never had a voiding	2 560	Corrected	12/23/17

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2 560	Continued From page 13	2 560		

trial, but could identify the urge to void and use the call light. The Data collection identified R273 required a mechanical lift for toileting.

R273's significant change Care Area Assessments (CAA), dated 10/20/17, indicated a progressive decline since admission, which included a surgery for an above the knee amputation of the right leg and the initiation of dialysis three times a week. The CAA further indicated R273 had little urine output and, "Urinal at bedside to assist with attempt for continence of urine."

R273's current Kardex, undated, identified him as occasionally incontinent and needing assistance to transfer on and off the toilet. The Kardex did not include interventions related to assistance with the bedside urinal

R273's current care plan, dated 10/7/17, identified a diagnosis of altered elimination with the goal to decrease incontinence episodes. The care plan noted R273 was occasionally incontinent of urine, and lacked any additional interventions to address urinary incontinence such as assistance with bed side urinal or a toileting assistance schedule.

During interview on 11/15/17, at 9:34 a.m. nursing assistant (NA)-F stated R273 used the urinal at the bedside and needed staff to help position the urinal, stating if it was not in the right spot he would leak. NA-F denied going in to offer the urinal, stating R273 could feel when he had to go and would call in staff.

During interview on 11/15/17, at 2:04 p.m. R273 stated he voided two to three times a day using the urinal at the bedside when he had to void.

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2 560	Continued From page 14 R273 denied needing assistance to place the urinal, stating if it was hooked on the bedside garbage, he could reach it from where he was lying in the bed. R273 reported he did not use the toilet or go into the bathroom, just used the urinal. R273 denied being incontinent of urine. During interview on 11/16/17, at 8:27 a.m. registered nurse (RN)-B stated incontinence was assess by the nurse managers on admission by talking with staff, resident, and family, noting that if the resident was not a good historian, then they would look at the charting of incontinence episodes. RN-B stated R273 had contributing factors of kidney failure and dialysis, noting he could use the urinal but could still have bouts of incontinence overnight. RN-B further stated, with the new right leg amputation, R273's mobility was not like it used to be and was requiring more incontinence brief changes at night, accounting for the incontinence. RN-B reported the care plan was suppose to flow from the nurse manager's assessment, noting R273's care plan should consist of more, including the type of the brief he wears for incontinence. During interview on 11/16/17, at 2:07 p.m. the director of nursing (DON) stated the care plan depended on the individual resident, and could not say what would be in the care plan without knowing more about the individual. The DON reported they wanted their rehab residents to be as independent as possible and the care plans were ongoing. A facility policy entitled Care Plan Policy And Procedure, revised 11/16, directed the care team would collect information over a fourteen day course to develop the comprehensive care plan. The policy determined the comprehensive care	2 560		

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2 560	Continued From page 15 plan "will describe services to attain or maintain the resident's highest physical .... well-being." The policy further directed interventions would be written to assist in meeting the goal and should be individualized to the resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could educate staff to develop the resident's care plan to include appropriate interventions for addressing incontinence. A monitoring program could be established in order to assure on going and effective care plan interventions based on audits and observations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for transfers for 1 of 1 residents (R260) reviewed for potential restraint use. R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's Disease, toxic encephalopathy (disorder of the nervous system	2 565	Corrected	12/23/17

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2 565	Continued From page 16	2 565		

caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness.

R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit.

R260's significant change MDS, dated 10/13/17, indicated he required physical assistance of two staff for bed mobility and transfers. R260 also required assistance of one staff to provide physical weight bearing support to walk in the corridor. R260's balance during transitions and walking indicated he was not steady and only able to stabilize with human assistance of one.

R260's care plan for activities of daily living (ADLs) included an intervention initiated on 9/29/17, which directed one staff to assist R260 with EZ stand (mechanical sit to stand lift used to help balance a person to standing position) when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand.

R260's nursing assistant group sheet, undated, directed staff to transfer with the use of the EZ stand.

During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed when nursing assistant (NA)-C entered into room and shut the door. At 3:00 p.m., NA-C left room; R260 was discovered to have been transferred

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2 565	Continued From page 17 out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put on the bathroom call light, NA-D entered the room and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back. During interview on 11/14/17, 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet. During interview on 11/15/17, at 8:09 a.m. NA-C stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing in the mornings mostly and that the EZ stand was used during those times. NA-C verified the group sheets did not direct staff to use the EZ stand as needed. During interview on 11/15/17, at 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers with use of EZ stand out of bed and used the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any deviation from the care planned intervention was needed. During interview on 11/15/17, at 12:33 p.m. the director of nursing (DON) stated she expected staff to follow the care plan with transfers, stating they can only upgrade the transfer mode if needed but never transfer with less than care planned.	2 565		

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2 565	Continued From page 18 The facility's Care Plan Policy and Procedure, dated 11/2016, did not include direction on following the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff to follow each resident's care plan when transferring residents. The DON or designee could then perform random audits to ensure each residents care plan is being followed by all staff. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise a care plan to	2 570	Corrected	12/23/17

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2 570	Continued From page 19 include the use of a right heel padded cushion whenever in bed for 1 of 3 residents (R)-86 reviewed for pressure ulcers failed to reassess and revise the care plan for 1 of 1 resident (R)-176 who experienced a significant weight loss. Findings include: R86's annual Minimum Data Set (MDS), dated 5/26/17, identified R86 required assistance of 2+ staff with bed mobility and transfers. R86 required extensive assistance of 1 staff for dressing and personal hygiene. R86 was at risk for pressure ulcers and had one unstageable pressure ulcer. R86 was moderately cognitively impaired. R86's annual Care Area Assessment (CAA), dated 5/26/17, identified R86 was at risk for developing pressure ulcers and currently had one pressure area. R86 had one old scab to right 4th digit toe measuring 0.2 cm x 0.2 cm. "Resident wears padded rt [right] heel boot on at all times when in bed." R86 had a pressure reducing mattress and wheelchair cushion. R86's current physician order's include: -Initiated on 1/10/17, "Please make sure right heel boot is on at HS [bedtime.] -Initiated on 1/12/17, a padded right heel boot on whenever in bed, every shift for skin protection. -Initiated on 5/31/17, to keep shoes off until scab area on right foot has resolved. -initiated on 8/16/17, Apply skin prep to scab on 4th and 5th digit on right foot once daily until resolved. R86's care plan included a problem initiated on 8/15/13, which indicated R86 was at risk for alteration of skin integrity. The problem area was	2 570		

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revised on 2/22/17 to include a stage 2 pressure area "scab" on the right foot 4th toe. Interventions included:
-A revised 5/2/17 intervention, which directed "padded HEEL boot at night." The care plan did not identify to place the right padded heel boot on whenever in bed as assessed and ordered.
-An added 5/2/17 interventions, which indicated R86 was currently wearing gripper socks during the day due to right 4th and 5th toe pressure areas.

During observations on 11/13/17, at 2:27 p.m. R86's was lying on his back in bed. R86 had gripper socks on both feet. R86's heels were resting on the mattress. R86 was not wearing a padded right heel boot as care planned. A padded heel boot was observed laying on the seat of the electric wheelchair in the room.

During an interview on 11/13/17, at 7:09 p.m., R86 stated, "Not sure," when asked when staff apply the heel boot.

During observations on 11/14/17, at 12:46 p.m. nursing assistant (NA)-A and nursing assistant (NA)-B transferred R86 from the wheelchair to bed with a mechanical lift. R86 was wearing gripper socks. NA-A left the room. NA-B provided incontinent cares. After the completion of incontinent cares, NA-B covered R86 with a blanket. R86's heels were resting on the mattress. A padded heel boot was laying on a chair in the room. NA-B left the room without applying the padded heel boot to R86's right foot.

During an interview on 11/16/17, at 10:30 a.m., registered nurse (RN)-A stated she updated R86's care plan on 11/14/17. Review of R86's care plan identified a revised intervention dated

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2 570	Continued From page 21 11/14/17, Ten months after the order to place the right heel boot on whenever in bed. The revised care plan intervention directed "Padded boot to right heel whenever resident is in bed. RN-A stated prior to 11/14/17, the care plan and Kardex intervention directed to used a padded heel boot at night. During an interview on 11/16/17, at 8:40 a.m. the director of nursing (DON) stated the nursing assistant group sheets are used as a resident assignment list, but do not necessarily identify interventions. Interventions are documented on the care plan and the Kardex. Interventions are also communicated through report. Staff are to follow the resident's care plan. The facility's Policy and Procedure for the Prevention and Treatment of Skin Breakdown, revised 8/2011, indicated: "it is the policy of Volunteers of America to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." "The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident." R176 was observed at breakfast on 11/15/2017, at 8:55 a.m.. R176 had a pureed meal and was assisted to eat. After a few minutes R176 was given the spoon and began to feed herself. At 9:09 a.m., R176 slowed down with eating holding the spoon and looking around; R176 appeared dozy with eyes closed and not eating. At 9:13 a.m. staff encouraged R176 to take a drink of orange juice and began to assist again with	2 570		

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2 570	Continued From page 22 eating. At 9:24 a.m. R176 asked to go to the activity room. R176 was observed at the lunch meal on 11/15/2017, at 12:22 p.m. R176 had the meal in front of her but was not initiating eating. At 12:26 p.m. staff sat with R176 to assist, R176 had started feeding self and drinking independently. R176 continued to feed herself slowly with very small bites. At 1:00 p.m. R176 continued to be assisted by staff to eat. All other residents had finished and left the dining area. On 11/16/2017, at 9:19 a.m. Licensed Practical Nurse (LPN)-B stated, R176's intake was variable at 25-75% and often held food in her mouth and needed to be cued to swallow. Also, R176 would say when full. LPN-C was interviewed on 11/16/2017, at 1:41 p.m. LPN-C said R176 would take any flavor of supplement but preferred strawberry. LPN-C verified the supplements were given between meals, but she would give it after a meal if R 176 had not eaten well. She explained since R176 was a slow eater, she may not be hungry by lunchtime and not eat as well. LPN-C verified the supplements were just three per day, no as needed supplement had been ordered. The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds. A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days and was on a nutritional supplement, and had a pureed diet. The nutritional assessment	2 570		

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indicated R176 was consuming greater than 75% of calories, 75 grams of protein, and 1500 milliliters (ml) or more for fluid intake. A Minimum Data Set (MDS) assessment dated 5/24/17, indicated a significant loss had occurred.

The nurse practitioner (NP)-C progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (NCD) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up.

A nutrition note "dietary eval for weight loss" was completed by RD-E on 7/13/17. The note indicated R176 was on a pureed diet per speech therapy reccommendations, took supplements three times per day, required extensive assitance with meals, and had orders for no tube feeding per physicians orders for life sustaining treatment (POLST). The recommendation was to consider hospice due to, "beyond artificial nutrition which is a contraindicated per POLST wishes, oral interventions are exhausted."

The POLST for R176, dated 10/26/15, indicated, "offer food and liquids by mouth (oral fluids and nutrition must always be offered if medically feasible)"." No tube feeding" was hand written on the form. The form indicated comfort focused care for severe non reversible illness.

A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days

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and 16.5% loss in 180 days. The estimated intake at meals for R176 was assessed to be approximately 50%. The recommendation was for weekly weight monitoring and continue with nutritional supplement as ordered.

NP-G noted on 11/06/17, a discussion with a family member (FM)-B who acted as the health care agent for R176. Weight loss was discussed along with increasing medications for depression. A nutrition consult was requested.

A nutrition note "dietary consult for increased oral calories due to weight loss" was completed on 11/8/17. The note indicated no tube feeding per POLST and consider the possibility for hospice as nutritional interventions are becoming exhausted, resident has a care conference next week.

RD-E was interviewed on 11/15/2017, at 1:25 p.m.. She explained R176 required assist of staff to eat, but could feed herself a bit, intake was variable, and R176 drank the nutritional supplement at near 100%. RD-E said the supplement itself, at three times per day, provided 1050 calories, 39 grams protein. RD-E explained, since meals provided between 1800-2000 calories, at a 50% intake R176 would be consuming approximately 900-1000 calories per day just from meals. Therefore, the combined intake was estimated to be 1950-2150 calories per day. RD-E verified R176's intake appeared to be adequate to meet or exceed assessed needs, but had no explanation why R176 continued to lose weight, and had not assessed if the documented intake was accurate, or other reasons for the weight loss. RD-E also verified, the care plan had not been revised since March, 2017 beyond providing the supplements three times per day. RD-E said she would would

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review the care plan and consider adding a morning snack. RD-E said she had not increased the amount of supplement offered to try to maximized food intake.

The nutrition care plan, revised on 11/15/17, indicated R176 was at nutritional risk due to weight loss, was on a nutritional supplement and required assistance to eat. The stated goal was for R176 to consume 75% or greater of meals and supplements and to maintain weight at 122 pounds. A morning snack of milk or ice cream had been added to the care plan.

Family member (FM)-B for R176 was interviewed on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had not been made aware of the significant weight loss until last week when the nurse practitioner called to discuss medications. FM-B expressed concern with the care at the facility and was worried F176 was not getting as much help as she needed to eat. FM-B said R176 did not like the pureed meal. FM-B stated she knew R176 could feed herself a bit but was very slow, and wanted staff to provide more assistance at meal time. FM-B stated she felt the facility was ignoring R176.

R176 was interviewed 11/16/2017, at 1:47 p.m. R176 did have a diagnosis of dementia, but when asked about the pureed diet she responded negatively and said, "I don't think anyone would like it" R176 said she tried to eat it but couldn't always finish. R176 acknowledged she did like the supplements and would drink what she could. R176 said she was a slow eater and realized she was the last one left in the dining room at times. R176 did not acknowledge losing weight. R176 added that she was comfortable and enjoyed living in the facility.

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2 570	Continued From page 26 The Comprehensive Care Plan policy, dated 2017, indicated an individualized care plan would be developed with input from the resident, and/or representative, and be based on a comprehensive assessment and any additional medical nutrition therapy assessments. Additionally, the care plan should address identified causes of impaired nutrition status. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		12/23/17

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2 830	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure care was provided in accordance with resident preferences and to maintain highest physical well-being for 1 of 1 residents (R260) whose care plan was not followed with transfers and whose bed height was adjusted without assessment. Findings include: R260's Admission record, dated 11/15/17, included diagnoses of Parkinson's Disease, toxic encephalopathy (disorder of the nervous system caused by exposure to heavy metals or toxins), palliative (comfort) care encounter on 10/12/17, history of transient ischemic attack (a stroke that lasts only a few minutes) and cerebral infarction (stroke resulting from a blockage in the blood vessels supplying blood to the brain) without residual deficits and weakness. R260's significant change Minimum Data Set (MDS), dated 9/23/17, identified no cognitive deficit. R260's significant change MDS, dated 10/13/17, indicated R260 required physical assistance of two staff for bed mobility and transfers. R260 also required assistance of one staff to provide physical weight bearing support to walk in the corridor, and his balance during transitions and walking was not steady and only able to stabilize with human assistance of one. R260's significant change Care Area Assessment	2 830	Corrected	

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2 830	Continued From page 28 (CAA) for falls, dated 10/16/17, identified he was at risk for falls due to use of the EZ stand (mechanical sit to stand lift used to help balance a person to standing position) and assist of one to two assist with transfers. However R260 had no falls. R260's current care plan, initiated on 9/25/17, identified a fall risk; however, it did not include an intervention of bed placement to the floor. R260's care plan for Incontinence or altered elimination included an intervention dated 9/28/17, directed staff to respond to call light timely; R260 was able to use call light appropriately. R260's current care plan for activities of daily living (ADLs) included an intervention, initiated 9/29/17, directing one staff to assist R260 with EZ stand when transferred in and out of bed. One staff was directed to assist R260 on and off the toilet and to use the grab bar in the bathroom next to toilet for the transfer or the EZ stand. R260's nursing assistant group sheet, undated, directed staff to transfer with the use of the EZ stand, it did not include an intervention of bed placement to the floor. During observation on 11/13/17, at 3:14 p.m. R260 was observed resting in bed. R260's bed was in a low position onto to the floor, with mattress one inch off the floor. R260 stated he had not fallen and did not know why the bed was so low. R260 stated he thought it was done so that he did not get up. R260 stated, "They insist I call for help," and reported the bed was not always put to the floor. The bed remote (which controlled the height of the bed) was observed on	2 830		

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2 830	Continued From page 29 the floor one foot away from mattress at R260's shoulder level. During observation on 11/14/17, at 2:57 p.m. R260 put the call light on. R260 was in bed and the bed was at knee level height when nursing assistant (NA)-C entered into room, and shut the door. At 3:00 p.m., NA-C left the room and R260 was discovered to have been transferred out of bed and onto toilet. No mechanical lift was observed in R260's room. At 3:12 p.m., R260 put on the bathroom call light, NA-D entered the room and found R260 seated on the toilet. NA-D stated she would return after she got the mechanical lift and would be right back. During interview on 11/14/17, at 3:15 p.m. NA-C stated R260 could be transferred without the EZ stand and that he needs the machine more in the mornings than in the afternoons. NA-C stated R260 was transferred without the EZ stand onto wheelchair from bed prior to transferring onto toilet. During observation on 11/15/17, at 7:47 a.m. NA-C assisted R260 out of bed. R260 sat at the edge of the bed and kept balance while seated independently without support. R260 maintained balance while seated and assisted with long sleeve shirt and undershirt. NA-C asked R260 to place feet onto the EZ stand foot plates, then placed sling around R260's waist, attached it to the EZ stand lift, and began to lift the arms of the mechanical standing machine. R260 was lifted by machine support to standing for the first twelve inches of the mattress, then R260 was able to stand tall bearing full weight with only the supportive guidance of the machine from bedside to the wheelchair. NA-C stated R260 did well with the EZ stand machine.	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 30 During interview on 11/15/17, at 8:09 a.m. NA-C stated R260 was transferred with physical assist of one out of bed, the EZ stand transfer machine was used as needed. NA-C stated R260 was sometimes shaky when standing in the mornings mostly and that the EZ stand was used during those times. NA-C verified the groups sheets did not direct staff to use the EZ stand as needed. NA-C stated the bed had been lowered to the floor when R260 was in bed because he liked to self transfer. NA-C stated she puts the bed to the floor when she works. NA-C stated R260 would try to self transfer but when the bed is low, R260 would just be able to hang bottom half of body off the side of the bed onto floor. During interview on 11/15/17, at 8:57 a.m. R260 stated it bothered him that the bed was put down that low. R260 reported it did not happen often but it bothered him because its too hard to get up. R260 stated he lost his patience sometimes and got up by himself but usually would call for help. R260 stated if he had to, he would and could get out of bed. R260 stated he can't get out of bed when it was low to the floor. During interview on 11/15/17, at 12:09 p.m. NA-E stated the bed was down to the floor as R260 is a fall risk when he tried to get out of bed. When the bed was low, he was only able to just get his feet over the edge of the bed. NA-E worked with R260 once a week. During interview on 11/15/17, from 12:16 p.m. licensed practical nurse (LPN)-A verified R260 was to be assisted with transfers out of bed using the EZ stand and using the grab bar in bathroom when transferring to toilet from wheelchair. LPN-A stated a nurse should be consulted if any	2 830		

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2 830	Continued From page 31 deviation from the care planned intervention was needed. LPN- A stated if R260's bed was low or to the floor, it would have been by R260's preference. LPN-A further stated R260 would not get up independently and usually calls for help. LPN-A was not aware the bed was placed to the floor by staff and verified it was not care planned to be that way. LPN-A reported the bed should not have been to the floor. LPN- A stated R260 had never fallen out of bed, and NA-C needed education regarding the bed placement on the floor. During interview on 11/15/17, at 12:31 p.m. the director of nursing (DON) stated she expected staff to follow the care plan and the bed was not care planned to be placed on the floor. The DON verified R260 had no history of falls and education was needed to ensure staff did not place anyone's bed on the floor if not care planned. The DON stated that there was no one in the facility who had a care planned for a bed placement to the floor, further stating it would be care planned and explained why that resident may need the intervention. The DON stated staff are expected to follow the care plan with transfers and that they can only upgrade the transfer mode if needed but never transfer with less than care planned. During interview on 11/16/17, at 2:55 p.m. the clinical administrator was unaware of the low bed before that week, stating the low bed "came out of nowhere," further stating it was "a no no." The clinical administrator further reported it was not the facility's policy to keep someone in bed, especially with no history of falling. The clinical administrator had educated all staff last evening and that day they came to work regarding bed placement.	2 830		

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2 830	Continued From page 32 The facility's policy for Physical Device Data Collection and Evaluation dated, 10/2011, stated that physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual can not remove easily which restricts freedom of movement. The policy directs staff to identify the rationale for the use of a potential restraint. The policy stated a restraint of any type would not be used as a substitute for more effective nursing care or for convenience of staff. The policy directs the staff with the procedure for documentation, assessment and use of any potential restraint use. METHOD OF CORRECTION: The director of nurse (DON) or designee could update policies related to following the care planned interventions and train staff on the updated policies. The DON or designee could perform random audits to monitor that the updated policies are being implemented by staff. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose	2 840		12/23/17

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2 840	Continued From page 33 condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to re-asses and provide	2 840	Corrected	

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2 840	Continued From page 34	2 840		

neeeded incontinence skin care of new onset bowel incontinence related to Clostridium Difficile (a antibiotic resistant bacteria causing diarrhea, commonly known as C-Diff) for 1 of 3 residents (R273) reviewed for bowel incontinence.

Findings include:

R273's admission Minimum Data Set (MDS), dated 9/1/17, identified no cognitive impairment and was always continent of bowel.

R273's significant change MDS, dated 10/14/17, identified no cognitive impairment, was dependent on staff for toileting, and was always continent of bowel.

R273's Bladder and Bowel Data Collection, dated 10/11/17, noted he was always continent of bowel, not needing a toileting program. The Data collection identified R273 required a mechanical lift for toileting.

R273's significant change Care Area Assessments (CAA), dated 10/20/17, indicated a progressive decline since admission, which included a surgery for an above the knee amputation of the right leg and the initiation of dialysis three times a week. The CAA further indicated R273 was continent of bowel and was assisted, "to the toilet per his choice."

R273's current Kardex, undated, identified him as continent of bowel and needing assistance to transfer on and off the toilet.

R273's current care plan, dated 10/7/17, identified a diagnosis of altered elimination with the goal to decrease urinary incontinence episodes, noting R273 was continent of bowel, needed two staff

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2 840	Continued From page 35 and full body lift to transfer, and needed assistance to transfer on/off the toilet. The care plan was revised on 11/12/17, noting a new diagnosis of C-Diff and directing staff to observed and report loose stools. In addition, the care plan indicated R273 had a coccyx wound from his last hospitalization and directed to observe the skin daily. The care plan did not direct staff to apply any barrier creams to the peri area. R273's current physician orders, dated 11/1/617, indicated R273 had been diagnosed with a C-Diff infection on 10/25/17 and had been started on infection monitoring and a fourteen day course of Vancomycin (an antibiotic). During observation of cares on 11/15/17, at 7:04 a.m. nursing assistant (NA)-F was observed to assist R273 with a bed bath. After washing R273's upper body, NA-F proceed to R273's lower half and completed peri cares. R273 was observed to be incontinent with soft bowel movement noted in his brief and smeared on the linens directly underneath him. NA-F changed R273's soiled incontinence product and linens, noting that R273's inner buttocks appeared reddened. NA-F asked R273 if the buttocks hurt, to which R273 replied it did, and NA-F left the room, returning with registered nurse (RN)-F. RN-F proceeded to take off R273's foam dressing, which was over his coccyx wound, and assessed his reddened buttocks, again asking R273 if it hurt, to which R273 replied that the area itched more than it hurt. RN-F directed NA-F to cover R273 with a brief while she went to see if RN-C wanted to measure the coccyx wound and assess the area. RN-F returned to the room, stating RN-C was busy and proceeded to measure and apply a clean foam dressing over the coccyx wound, stating she did not want to put	2 840		

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2 840	Continued From page 36	2 840		

cream on the area until RN-C assessed it. NA-F then assisted in applying the new brief, and finished dressing R273. R273 was transferred into a broda chair and left the facility at 8:41 a.m. for an appointment.

During observation on 11/15/17, at 11:32 a.m. R273 returned to the facility from his appointment and remained sitting up in the broda chair, eating lunch, until 1:26 p.m., when NA-F and RN-C transferred him back into bed. At that time, R273 was observed to have a large unformed incontinent stool in his brief. NA-F performed peri care, first wiping the stool away with bath tissue, then using a wet washcloth to clean the area. R273's buttock remained reddened, and RN-C took off the soiled coccyx dressing, reporting the slit-like coccyx wound underneath was moisture related and had started due to the C-Diff. RN-C did not reapply the coccyx dressing and did not apply any cream, reporting they were getting an order for a cream from the physician.

During interview on 11/15/17, at 9:34 a.m. NA-F acknowledged R273 had an incontinent stool that morning, noting his bottom had been red and had a little open area on the coccyx. NA-F stated R273 had loose stools with the C-Diff, reporting R273 would usually ask for the bed pan and could feel when he had to go prior to the C-Diff; however, with the C-Diff the stool would just come and did not think R273 knew when he stooled. NA-F reported R273 preferred to use the bedpan and did not want to go into the bathroom since his leg was amputated.

During interview on 11/15/17, at 11:20 a.m. RN-F stated R273 would usually ask for the bedpan, stating she was updated of the incontinent episode that morning, and thought he might have

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2 840	Continued From page 37	2 840		

had the bowel movement overnight. RN-F reported R273's bowel continence varied with the C-Diff, and had changed to more incontinence with the C-Diff. RN-F further stated R273 was not transferred to the toilet due to hypotension (lower blood pressure) episodes and for safety with those episodes, noting R273 blood pressure medications had been altered as a result. RN-F reported the hypotension had been going on for about three weeks and had gotten better.

During interview on 11/15/17, at 2:04 p.m. R273 stated he was not incontinent and could control his bowel movements before having C-Diff. R273 reported he either could not feel when he had to have a bowel movement or the bowel movement came quick, further noting the bowel movements were a lot more frequent. R273 stated he had used the bed pan twice since his stay at the facility, noting other times staff changed his brief. R273 reported he wanted to use the toilet, "like a normal human being," and had been talking to staff about using it for two weeks.

During interview on 11/16/17, at 7:38 a.m. RN-C stated R273 came with the reddened bottom from the hospital, noting it was blanchable. RN-C reported a cream had been ordered that day (11/16/17) for R273's buttocks, but there had been nothing prior. RN-C reported R273 had been admitted to the facility with bowel incontinence, stating R273's wife reported R273 was incontinent of bowel and bladder at home. RN-C stated R273 had used the bed pan once; however, mostly just went in his brief, further stating R273 never used the toilet, even at home. RN-C stated incontinence was assessed by the nurse managers on admission and the assessment flowed onto the care plan. RN-C was unable to find the toileting intervention at the time

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2 840	Continued From page 38 of the interview. During interview on 11/16/17, at 8:27 a.m. RN-B stated incontinence was assess by the nurse managers on admission by talking with staff, resident, and family, noting that if the resident was not a good historian, then they would look at the charting of incontinence episodes. RN-B acknowledged R273's admission bowel assessment from the MDS noted always continent; however, stated the MDS assessment and the nurse managers assessment may conflict with one another because the MDS assessment counted actual episodes of incontinence whereas the nurse manger's assessment did not account for that. RN-B reported the rehab did not have bowel programs because that would be to address a chronic long term issue. RN-B stated they had bowel plans, but for R273 the C-Diff was a temporary issue that would resolved itself and then R273's bowel continence would be back to normal. RN-B further stated R273's care plan was not revised because the C-Diff and associated incontinence was a short term issue, and they would not go back in and revise the care plan for short term problems because his goal was to get better, and nursing assistants were made aware of residents who were incontinent through verbal report. RN-B reported R273's skin was being monitored weekly by nursing staff and they had obtained a physician order for cream to be applied to the buttocks yesterday. RN-B further reported prior to yesterday the nursing assistants were verbally told in report to provide barrier cream with incontinence episodes, as a facility standard. During interview on 11/16/17, at 10:19 a.m. RN-E stated the MDS assessment data was pulled over to the care plan on admission. RN-E stated the	2 840		

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2 840	Continued From page 39 MDS nurses were focused on revising the care plans with the comprehensive and quarterly assessment time frames. RN-E reported changes and care plan revisions occurring outside of the MDS time frames were the responsibility of the nurse managers and floor nurses. During interview on 11/16/17, at 2:07 p.m. the director of nursing (DON) stated the care plan depended on the individual resident and most in the rehab would be alert and able to say when they had to go to the bathroom. The DON stated the care plan was ongoing, and if a resident was now using a brief for example, could be updated. The DON reported, with their rehab residents, the goal was to get them as independent as possible, with a goal to wear regular underwear. The DON reported, for someone with C-Diff, the resident would be provided the appropriate products to use, would assess them for a week to be sure of the change, and then go back to the main goal of getting back to normal. A facility policy entitled Care Plan Policy And Procedure, revised 11/16, directed the care plan was to be "changed and updated as the care changes for the resident and as the resident changes." The policy noted that any temporary changes would be added to the comprehensive care plan after 30 days. The policy further directed the care plan was to be current at all times. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents who require assistance and have a change in bowel incontinece are re-assessed and receive timely services. The director of nursing (DON) or designee could	2 840		

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2 840	Continued From page 40 educate staff as appropriate. The director of nursing (DON) or designee could monitor or audit to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 840		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure interventions to maintain and promote skin integrity were implemented for 1 of 3 residents (R86) reviewed for pressure ulcers, whose padded heel cushion was not consistently implemented as assessed and per physician ordered.	2 900	Corrected	12/23/17

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2 900	Continued From page 41 Findings include: R86's annual Minimum Data Set (MDS), dated 5/26/17, identified R86 required assistance of 2+ staff with bed mobility and transfers. R86 required extensive assistance of 1 staff for dressing and personal hygiene. R86 was at risk for pressure ulcers and had one unstageable pressure ulcer. R86 was moderately cognitively impaired. R86's annual Care Area Assessment (CAA), dated 5/26/17, identified R86 was at risk for developing pressure ulcers and currently had one pressure area. R86 had one old scab to right 4th digit toe measuring 0.2 cm x 0.2 cm. "Resident wears padded rt [right] heel boot on at all times when in bed." R86 had a pressure reducing mattress and wheelchair cushion. R86's quarterly MDS, dated 8/11/17, continued to identify R86 at risk for pressure ulcers with one unstageable pressure ulcer. R86's current physician order's include: -Initiated on 1/10/17, "Please make sure right heel boot is on at HS [bedtime.] -Initiated on 1/12/17, a padded right heel boot on whenever in bed, every shift for skin protection. -Initiated on 5/31/17, to keep shoes off until scab area on right foot has resolved. -initiated on 8/16/17, Apply skin prep to scab on 4th and 5th digit on right foot once daily until resolved. R86's care plan included a problem initiated on 8/15/13, which indicated R86 was at risk for alteration of skin integrity. The problem area was revised on 2/22/17 to include a stage 2 pressure area "scab" on the right foot 4th toe. Interventions	2 900		

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2 900	Continued From page 42 included: -A revised 5/2/17 intervention, which directed "padded HEEL boot at night." The care plan did not identify to place the right padded heel boot on whenever in bed as assessed and ordered. -An added 5/2/17 interventions, which indicated R86 was currently wearing gripper socks during the day due to right 4th and 5th toe pressure areas. R89's November 2017 treatment record indicated "Padded RIGHT heel boot on whenever is in bed Q [every] SHIFT." Weekly wound assessment documentation was reviewed. The most recent assessment, dated 11/8/17, identified an unstageable pressure ulcer to the right foot top of 4th digit toe. The area was covered with a "0.5 x 0.5" thin scab. Wound base not viewable, no drainage, no undermining, wound edges intact. Wound stable. Shoes on hold until area is completely healed. During observations on 11/13/17, at 2:27 p.m. R86's was lying on his back in bed. R86 had gripper socks on both feet. R86's heels were resting on the mattress. R86 was not wearing a padded right heel boot as ordered. A padded heel boot was observed laying on the seat of the electric wheelchair in the room. During interview on 11/13/17, at 7:09 p.m., R86 stated, "Not sure," when asked when staff apply the heel boot. During observations on 11/14/17, at 12:46 p.m. nursing assistant (NA)-A and nursing assistant (NA)-B transferred R86 from the wheelchair to bed with a mechanical lift. R86 was wearing gripper socks. NA-A left the room. NA-B provided	2 900		

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2 900	Continued From page 43	2 900		

incontinent cares. After the completion of incontinent cares, NA-B covered R86 with a blanket. R86's heels were resting on the mattress. A padded heel boot was laying on a chair in the room. NA-B left the room without applying the padded heel boot to R86's right foot.

During interview on 11/14/17, at 12:56 p.m. NA-B stated she follows a paper group sheet and the Kardex on the computer when completing resident cares. NA-B stated R86 did not wear shoes due to a sore on his toes. When asked about the heel cushion, NA-B stated R86 wears the heel cushion only at night to protect his heel.

Review of the nursing assistant group sheets for R86 identified "In bed after lunch." The group sheet lacked identification or directions for a heel boot.

During interview on 11/14/17, at 2:00 p.m. licensed practical nurse (LPN)-A stated nursing assistants are directed to follow the group sheet for each resident. R86 does not wear shoes, only gripper socks due to a "scab" on his 3rd and 4th toes, which was caused by his shoes. LPN-A stated R86's wears a padded boot on his right heel, because the heel was pretty soft for awhile. LPN-A walked into R86's room. R86's was laying in bed. LPN-A stated R86 was not wearing a heel boot and placed the padded heel boot onto R86's right heel. LPN-A stated the direction to place the heel boot onto R86's heel should be on the nursing assistant's group sheet.

During observations on 11/16/17, at 9:17 a.m. with LPN-A, R86's right heel was clean, dry, intact and had no redness. An area on the 4th toe was consistent with the 11/8/17 wound documentation.

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2 900	Continued From page 44 During interview on 11/16/17, at 10:30 a.m., registered nurse (RN)-A stated she updated R86's care plan on 11/14/17. Review of R86's care plan identified a revised intervention dated 11/14/17, Ten months after the order to place the right heel boot on whenever in bed. The revised care plan intervention directed "Padded boot to right heel whenever resident is in bed. RN-A stated prior to 11/14/17, the care plan and Kardex intervention directed to used a padded heel boot at night. During interview on 11/16/17, at 8:40 a.m. the director of nursing (DON) stated the nursing assistant group sheets are used as a resident assignment list, but do not necessarily identify interventions. Interventions are documented on the care plan and the Kardex. Interventions are also communicated through report. Staff are to follow the resident's care plan. The facility's Policy and Procedure for the Prevention and Treatment of Skin Breakdown, revised 8/2011, indicated: "it is the policy of Volunteers of America to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." "The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of	2 900		

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2 900	Continued From page 45 pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively evaluate the nutritional care needs for 1 of 1 resident (R)-176 who experienced an unplanned significant weight loss. Findings include: R176 had diagnoses that included high blood pressure, peripheral vascular disease, dementia and depression. R176 had paralysis on one side of her body from a stroke two years ago. R176 was on a pureed diet due to swallowing difficulties from the stroke.	2 965	Corrected	12/23/17

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2 965	Continued From page 46 R176 was observed at breakfast on 11/15/2017, at 8:55 a.m.. R176 had a pureed meal and was assisted to eat. After a few minutes R176 was given the spoon and began to feed herself. At 9:09 a.m., R176 slowed down with eating holding the spoon and looking around; R176 appeared dozy with eyes closed and not eating. At 9:13 a.m. staff encouraged R176 to take a drink of orange juice and began to assist again with eating. At 9:24 a.m. R176 asked to go to the activity room. She had eaten about 50%. R176 was observed at the lunch meal on 11/15/2017, at 12:22 p.m. R176 had the meal in front of her but was not initiating eating. At 12:26 p.m. staff sat with R176 to assist, R176 then started feeding self and drinking independently. R176 continued to feed herself slowly with very small bites. At 1:00 p.m. R176 continued to be assisted by staff to eat and had consumed about 50% by that time. All other residents had finished and left the dining area. On 11/16/2017, at 9:19 a.m. Licensed Practical Nurse (LPN)-B stated, R176's intake was variable at 25-75% and often held food in her mouth and needed to be cued to swallow. Also, R176 would say when she was full. LPN-C was interviewed on 11/16/2017, at 1:41 p.m. LPN-C stated R176 would take any flavor of supplement but preferred strawberry. LPN-C verified the supplements were given between meals, but she would give it after a meal if R 176 had not eaten well. She explained since R176 was a slow eater, she may not be hungry by lunchtime and not eat as well. LPN-C verified the supplements were just three per day, no as needed supplement had been ordered.	2 965		

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2 965	Continued From page 47 The weight record for R176 indicated a progressive weight loss over eight months. On 3/4/17, R176 weighed 156.8 pounds. By 11/09/17, R176 weighed 122 pounds. A nutrition assessment completed by Registered Dietitian (RD)-E dated 5/22/17, indicated R176 had an unplanned weight loss of 12.7% within 30 days and was on a nutritional supplement, and had a pureed diet. The nutritional assessment indicated R176 was consuming greater than 75% of calories, 75 grams of protein, and 1500 milliliters (ml) or more for fluid intake. A quarterly Minimum Data Set (MDS) assessment dated 5/24/17, indicated a significant loss had occurred. The nurse practitioner (NP)-G progress note dated 7/10/17, indicated R176 had a chronic neurological cognitive disorder (dementia) with no behaviors and weight loss was expected as the disease progressed. Additionally noted was weight loss ongoing with no signs or symptoms of illness and requested a nutrition follow-up. A nutrition note "dietary eval for weight loss" was completed by RD-E on 7/13/17. The note indicated R176 was on a pureed diet per speech therapy reccommendations, took supplements three times per day, required extensive assitance with meals, and had orders for no tube feeding per physicians orders for life sustaining treatment (POLST). The recommendation was to consider hospice due to, "beyond artificial nutrition which is a contraindicated per POLST wishes, oral interventions are exhausted." The POLST for R176, dated 10/26/15, indicated, "offer food and liquids by mouth (oral fluids and nutrition must always be offered if medically	2 965		

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2 965	Continued From page 48 feasible)"." No tube feeding" was hand written on the form. The form indicated comfort focused care for severe non reversible illness. A nutritional assessment dated 8/9/17, indicated R176 was consuming greater than 75% for calories, 75 or more grams of protein and 1500 ml or greater of fluids. R176 was assessed to require 1770 calories, 59 grams of protein, and 1770 ml fluids. The assessment indicated R176 had an unplanned weight loss of 5.7% in 30 days and 16.5% loss in 180 days. The estimated intake at meals for R176 was assessed to be approximately 50%. The recommendation was for weekly weight monitoring and continue with nutritional supplement as ordered. NP-G noted on 11/06/17, a discussion with a family member (FM)-B who acted as the health care agent for R176. Weight loss was discussed along with increasing medications for depression. A nutrition consult was requested. A nutrition note "dietary consult for increased oral calories due to weight loss" was completed on 11/8/17. The note indicated no tube feeding per POLST and consider the possibility for hospice as nutritional interventions are becoming exhausted, resident has a care conference next week. RD-E was interviewed on 11/15/2017, at 1:25 p.m.. She explained R176 required assist of staff to eat, but could feed herself a bit, intake was variable, and R176 drank the nutritional supplement at near 100%. RD-E said the supplement itself, at three times per day, provided 1050 calories, 39 grams protein. RD-E explained, since meals provided between 1800-2000 calories, at a 50% intake R176 would be consuming approximately 900-1000 calories	2 965		

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2 965	Continued From page 49 per day just from meals. Therefore, the combined intake was estimated to be 1950-2150 calories per day. RD-E verified R176's intake appeared to be adequate to meet or exceed assessed needs, but had no explanation why R176 continued to lose weight, and had not assessed if the documented intake was accurate, or other reasons for the weight loss. RD-E also verified, the care plan had not been revised since March, 2017 beyond providing the supplements three times per day. RD-E said she would review the care plan and consider adding a morning snack. RD-E said she had not increased the amount of supplement offered to try to maximized food intake. RD-E verified the interdisciplinary team reviewed all incidents of significant weight loss to discuss care plan development. The nutrition care plan, revised on 11/15/17, indicated R176 was at nutritional risk due to weight loss, was on a nutritional supplement and required assistance to eat. The stated goal was for R176 to consume 75% or greater of meals and supplements and to maintain weight at 122 pounds. A morning snack of milk or ice cream had been added to the care plan. Family member (FM)-B for R176 was interviewed on 11/16/17, at 10:45 a.m. FM-B verified she was the primary contact for R176, and had not been made aware of the significant weight loss until last week when the nurse practitioner called to discuss medications. FM-B expressed concern with the care at the facility and was worried F176 was not getting as much help as she needed to eat. FM-B said R176 did not like the pureed meal. FM-B stated she knew R176 could feed herself a bit but was very slow, and wanted staff to provide more assistance at meal time. FM-B stated she felt the facility was ignoring R176.	2 965		

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2 965	Continued From page 50 R176 was interviewed 11/16/2017, at 1:47 p.m. R176 did have a diagnosis of dementia, but when asked about the pureed diet she responded negatively and said, "I don't think anyone would like it" R176 said she tried to eat it but couldn't always finish. R176 acknowledged she did like the supplements and would drink what she could. R176 said she was a slow eater and realized she was the last one left in the dining room at times. R176 did not acknowledge losing weight. R176 added that she was comfortable and enjoyed living in the facility. The Nutritional Assessment Policy and Procedure (not dated) indicated the clarification of nutritional issues, needs and goals was accomplished by using observation, and gathering and considering relevant information. The procedure directed staff to interview the individual and/or representative and review information from other sources. The facility was to develop a clear and specific statement that provides the basis for interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the registered dietician (RD) could develop, review, and/or revise policies and procedures to ensure a system is in place to decrease the risk of weight loss and to identify weight loss in a timely manner so interventions can be implemented. The DON and RD could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 965		

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21385	Continued From page 51	21385		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the appropriate disinfectant bleach wipes, effective against clostridium difficile (drug resistant bacteria commonly known a C-Diff) were accessible to staff, and failed to keep designated resident care equipment in an isolation precautions room for 1 of 2 residents (R273) reviewed for contact isolation precautions. Findings include: R273's significant change Minimum Data Set (MDS), dated 10/14/17, identified no cognitive impairment. R273's current physician orders, dated 11/1/617, indicated he had been diagnosed with C-Diff infection on 10/25/17 and had been started on infection monitoring and a fourteen day course of Vancomycin (an antibiotic). R273's current care plan, dated 11/12/17, identified the diagnosis of C-Diff, with the following interventions: contact isolation for diarrhea, "Cleaning of room and surrounding area	21385	Corrected	12/23/17

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daily as per facility protocol/policy, and "Dedicate equipment for resident only."

During observation of cares on 11/15/17, at 7:04 a.m. a plastic container with drawers was observed outside of R273's room, containing isolation gowns and gloves, and a sign on R273's door instructing to see the nurse before entering the room. Nursing assistant (NA)-F entered the room, greeted R273, donned clean gloves and went into R273's bathroom to fill a plastic basin with soapy water. NA-F left the basin of water in the bathroom sink, used hand sanitizer, donned new gloves, and proceeded to assist R273 in deciding what clothes to wear for the day. She then proceeded to walk to the top left cabinet, located above R273's entry way sink, and grabbed a container of Super Sani-Cloth disposable wipes with the purple top (which did not contain bleach). After grabbing a few wipes, NA-F cleaned R273's bedside table top, his television remote control, and grabber tool, which were on the table. NA-F pushed the bedside table from the left side of the bed to the right, and grabbed the basin of water and towels. NA-F proceed to don a gown and new gloves, and completed R273's bed bath and peri cares. R273 was observed to be incontinent with soft bowel movement noted in his brief and smeared on the linens directly underneath him. NA-F changed R273's soiled incontinence product and linens; R273 was observed using the bilateral grab bars and overhead trapeze to assist with turning during cares. After completing cares, NA-F emptied the water basin in R273's bathroom, went to the cabinet and grabbed more Super Sani-Cloth wipes from the purple top container. Using the wipes, she cleaned R273's grab bars, overhead trapeze, and remote control for the bed. At that time, registered nurse (RN)-F entered the room to

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take R273's blood pressure and assess his coccyx wound. RN-F was observed to open and take out a container of Sani-Cloth Bleach disposable wipes with an orange top from the locked medication cabinet, located in the top right cabinet opposite of the entry way sink. RN-F proceeded to clean the blood pressure cuff with the Sani-Cloth Bleach wipes.

During observation on 11/15/17, at 8:06 a.m. NA-F brought the full body lift into R273's room. NA-F and occupational therapist (OT)-A were observed to place a full body lift sling underneath R273 and proceeded to transfer him to a broda chair (specialized wheelchair which can tilt and recline). NA-F took the sling out from underneath R273, taking the full body lift and sling into R273's bathroom, then brought it out to the floor and parked it in an alcove in the hallway. The used sling was observed sitting in the front storage pouch of the full body lift, outside R273's room.

The lift and the sling were stored there untouched until 8:56 a.m., when NA-G took the full body lift to transfer R379, who was also on contact isolation for C-Diff. When asked about the cleaning of the sling and lift, NA-F stopped NA-G in the hallway outside of R379's room, stating she had cleaned the lift with the Sani-Cloth Bleach wipes in R273's bathroom, but had placed the sling in the storage pouch by mistake. Both NA-F and NA-G stated each resident had their own full body sling, and R379's individual sling was noted in her room. NA-F was observed to take R273's sling out of the pouch and placed the sling back in R273's bathroom, over his geri chair.

During interview on 11/15/17, at 9:34 a.m. NA-F opened R273's top left cupboard containing both a container of Super Sani-Cloth wipes and a

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21385	Continued From page 54 container of Sani-Cloth Bleach wipes. NA-F stated she had used the purple top Super Sani-Cloth wipes to clean R273's bedside table and grab bars because she could not find the orange top Sani-Cloth Bleach wipes. NA-F stated usually the Sani-Cloth Bleach wipes were stored in the locked medication cabinet, and she did not have a key. NA-F reported she could use either type of wipe to clean R273's room, but liked to use the Sani-Cloth Bleach wipes because they were stronger with bleach. NA-F further reported R273's full body sling was usually kept in his room, acknowledging she mistakenly took it out that morning due to the commotion of everything going on. During interview on 11/15/17, at 11:20 a.m. RN-F verified the Sani-Cloth Bleach wipes had been locked in the medication cabinet that morning, further reporting the Sani-Cloth Bleach wipes were available in the locked medication rooms, which the nurses had access to. RN-F stated the purple top Super Sani-Cloth wipes had a longer wet time of four minutes and were used to wipe down glucometers; however, the orange top Sani-Cloth Bleach wipes had a shorter wet time of two minutes and would be used to wipe down the full body lift. When asked which wipes were used for R273, RN-F stated the orange top Sani-Cloth Bleach wipes were specific to C-Diff; however, it would depend on the situation. RN-F further stated she would use the Sani-Cloth Bleach wipes with R273 because he liked to dig and scratch himself, noting she had observed a dark substance under his nails, which she assumed was feces, and had cut his fingernails a couple of weeks ago because of it. RN-F stated R273 had his own full body sling, which was kept in the room.	21385		

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	00893	A. BUILDING: _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

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21385	Continued From page 55 During interview on 11/16/17, at 8:08 a.m. RN-B stated the facility had different types of Sani-Cloth brand wipes, but used the Sani-Cloth Bleach wipes strictly for C-Diff precautions. RN-B stated the purple top Super Sani-Cloth wipes should not be in R273 room, further stating the only reason the orange top Sani-Cloth Bleach wipes would be locked in the cabinet was if the resident had dementia. RN-B stated staff would still have access to the Sani-Cloth Bleach wipes, as they were available in the clean utility room. RN-B reported if a resident has a lift sling and are on isolation precautions for C-Diff, the sling is kept in the resident's room. During interview on 11/16/17, at 10:30 a.m. RN-D and RN-G, who were in charge of infection control, stated the facility had special chemicals just for C-Diff, including the orange top Sani-Cloth Bleach wipes, which had a wet time of four minutes. RN-G stated the Sani-Cloth Bleach wipes were the only wipes used with C-Diff that would kill the bacteria. RN-G stated the Sani-Cloth Bleach wipes were kept in the clean utility rooms on the units and the nursing assistants had keys to those rooms. RN-D and RN-G expected nursing assistants to doff their protective personal equipment (PPE), grab a few wipes from the clean utility room, don their PPE and re-enter the room with the wipes. RN-G stated once a container of wipes was brought into the room, the container had to stay in the room because of the isolation precautions. RN-D and RN-G reported the Sani-Cloth Bleach wipes were locked in resident rooms because they were a chemical, and because they were a chemical, had to be out of reach of residents who may have dementia. In addition, RN-D and RN-G stated they did not like to keep the wipes in the room because the nursing assistants might mistakenly	21385		

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21385	Continued From page 56 use them for peri care. RN-D stated the full body slings were resident dedicated, meaning R273 would have his own sling, because it wrapped around his bottom, further stating the sling should stay in his room. The facility's Infection Prevention and Control Manual: Antibiotic Stewardship and MDROs (Multi Drug Resistant Organisms), dated 2017, specifically directed regarding C-Diff, common use equipment should be dedicated to the individual, not shared. In addition, it directed the environment should be cleaned at least daily with "special attention to those items likely to be contaminated with feces, i.e., bed rails," recommending the use of a bleach disinfectant. Suggested Method of Correction: The DON or her designee could review policy and procedures regarding infection control and nursing staff access to appropriate cleaning supplies. The DON or her designee could educate nursing staff on the appropriate use of disinfectant wipes wiht C-Diff and dedicated residnets equipement to stay in the room. Time Period for Correction: Twenty One (21) days.	21385		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	21980		12/23/17

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21980	Continued From page 57	21980		

individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of

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21980	Continued From page 58 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations involving abuse were immediately reported to the state agency (SA) and administrator for 2 of 4 residents (R273, R137) reviewed for physical abuse. Findings include: R273's significant change Minimum Data Set (MDS), dated 10/14/17, identified no cognitive impairment and required extensive assistance to total dependence from staff for ADLs (activities of daily living). R273's current care plan, dated 10/27/17, noted his vulnerability to abuse related to depression, above the knee amputation, and long-term care placement. The care plan further directed to provide a safe environment and remove R273 from "potentially abusive situations." During interview on 11/14/17, at 9:27 a.m. R273 alleged physical abuse by the nursing staff. R237 reported the evening nursing assistant seemed mad when answering his call light and was disrespectful to him. R273 stated it rose to abuse when the staff would "flip me" to his side when performing peri cares, noting rough treatment with cares. R273 could not identify the staff, but reported he was not afraid of the staff, further stating he had not reported the incident to the facility. During interview on 11/14/17, at 10:03 a.m. the facility was made aware by this surveyor, of	21980	Corrected	

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21980	Continued From page 59 R273's allegation of abuse, and the assistant executive director (AED) reported the facility would begin their process of risk management. R273's Post Incident Review noted the alleged abuse occurred on 11/13/17, at 8:00 p.m. The Incident Review further identified the executive director/administrator had been notified timely of the allegation, on 11/14/17, at 10:30 a.m. The Incident Review prompted staff to answer if immediate notification of the allegation was made to the state agency or OHFC (office of health facility complaints). The Review indicated a report had been made but did not indicate the time the report had been made. R273's Incident Report Summary by MDH (Minnesota department of health) identified the allegation of physical abuse had been reported to the state agency on 11/14/17, at 2:58 p.m., nearly five hours after it was initially reported. The report further identified R273 had alleged the evening nursing assistant was rough with him during cares and the investigation was in progress. Although the administrator was notified timely, the allegation of abuse was not reported immediately. R137's admission MDS, dated 10/31/17, identified no cognitive impairment, required limited assistance with ADLs, and needed physical assistance from staff with bathing. R137's current care plan, dated 10/30/17, noted her vulnerability to abuse related to transitional care/rehab placement. The care plan further directed to provide a safe environment and remove R137 from "potentially abusive situations."	21980		

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21980	Continued From page 60 R137's Post Incident Review noted an incident of alleged abuse, rough cares with an evening shower, occurred on 11/10/17, at 9:00 p.m. The Incident Review identified the nursing supervisor had been notified of the abuse allegation via R137's daughter on 11/11/17, at 11:00 a.m. The Incident Review further identified the executive director/administrator had been notified of the allegation of 11/11/17, at 5:35 p.m., over six hours after the initial notification. The Incident Review indicated notification of the allegation was made to the stage agency/OHFC, but did not indicate the time. R137's Incident Report Summary by MDH identified the allegation of physical abuse had been reported to the state agency on 11/11/17, at 6:59 p.m., nearly eight hours after it was initially reported. The report further identified R137 had alleged the evening bath aide was rough during cares while assisting R137 with her shower. The report indicated the nursing assistant had been suspended while the investigation was in progress. Although the allegation of abuse was reported, it was not reported immediately, to the administrator and state agency. During interview on 11/16/17, at 7:43 a.m. registered nurse (RN)-C stated nursing supervisors and leadership had access to the state agency/OHFC reporting web site and were responsible for reporting allegations of abuse. RN-C stated, when he worked as a floor nurse, he would report allegations to the nursing supervisor on at the time. RN-C further stated, when he worked as a nursing supervisor, he would first interview the resident about the allegation and depending on what the resident	21980		

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21980	Continued From page 61 said,would get the risk management procedure going, which included to call the administrator, director of nursing (DON), and social services (SS). RN-C stated he would make sure the resident was safe by removing the alleged perpetrator, and if the alleged perpetrator was a staff member would suspend him or her. RN-C stated, as a nursing supervisor, he would complete the initial report to the state agency on the off hours, and social services would complete the report if it was during the day. RN-C thought they had twenty four hours to report, unless there was suspicion of a crime or bodily injury, then they reported in two hours. During interview on 11/16/17, at 9:05 a.m. RN-B stated all allegations of abuse and bodily harm were reported to the state agency. RN-B reported nursing managers, supervisors, and leadership reported allegations of abuse to the state agency. RN-B stated allegations were reported to the nurse supervisor during off hours, who was responsible for determining if something was reportable, and if the nursing supervisor was unsure of whether or not to report, they could talk to social services. RN-B stated, when an allegation was made, the nurse supervisor would interview the resident and begin the risk management procedure. RN-B further stated after interviewing the resident, the administrator would be notified and determine if a report should be filed to the state agency. RN-B acknowledged the allegation had to be validated and confirmed with the resident before calling the administrator, and once the alleged abuse was confirmed, would notify the administrator immediately. RN-B stated their policy did not indicate a timeframe in which to report allegations of abuse, stating she thought they had twenty four hours to report.	21980		

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21980	Continued From page 62 During interview on 11/16/17, at 11:59 a.m. the director of social services (DSS) stated their number one concern with allegations of abuse was to protect the resident. The DSS stated nursing supervisors were responsible for reporting allegations during off hours, while she reported allegations during the weekdays. The DSS reported the allegations of abuse were reported to the administrator first, as well as the DON and herself. The DSS reported the regulation was not to exceed twenty four hours for reporting, and allegations of rough cares would be treated like physical abuse. She further stated, in cases like R273 and R137, the residents and staff were interviewed prior to reporting the allegations to find out what had occurred and who the perpetrator was, so the alleged perpetrator could be suspended pending the investigation, making sure the situation is safe. The DSS acknowledged that the investigation began as soon as the allegation was made, and that there was investigation going on prior to reporting the allegations, as she attempted to talk with staff right away. The DSS stated she would re-interview staff during the five day investigation depending on the situation, if more questions came up. The DSS stated their policy did not specify a time in hours, but did follow an immediate abuse reporting policy. During interview on 11/16/17, at 2:07 p.m. the DON stated everyone was a mandated reporter, the administrator was notified immediately, and the state agency was notified the same day as the allegation was made. The DON stated nurse managers, supervisors, and social services all had access to report to the state agency. During interview on 11/16/17, at 2:55 p.m. the clinical administrator stated the facility's quality	21980		

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21980	Continued From page 63 assurance (QA) committee discussed abuse reporting and completed abuse training house wide a couple months prior, stating it was a number one priority for them. The clinical administrator stated they reported everything in the building. The clinical administrator further stated they might report allegations over two hours or might miss them by two to three hours, but they were very consistent with reporting. The facility's Resident/Client/Participant/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure, revised 11/16, directed, "The Executive Director/ or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect." The policy further directed suspicions of abuse would be reported to the state agency, "in accordance with state law," noting that "Immediate reporting pertains to Long Term Care." SUGGESTED METHOD OF CORRECTION: The social services or designee could development and implement policies and procedures to ensure allegations involving abuse are submitted within the appropriate timeframe. The social services or designee could educate all staff on these policy and procedures. The social services or designee could then monitor and audit to ensure staff adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Seven (21) days	21980		