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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MUKC

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00049

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245491**

2. STATE VENDOR OR MEDICAID NO. (L2) **857637200**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA MERCY CARE CENTER**
(L4) **710 SOUTH KENWOOD AVENUE**
(L5) **MOOSE LAKE, MN** (L6) **55767**

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) **09/01/2010**

6. DATE OF SURVEY **05/21/2018** (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) **09/30**

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

12. Total Facility Beds **72** (L18)

13. Total Certified Beds **72** (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 |
|---|---|---|---|---|
| | 72 | | | |
| (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:
Teresa Ament, Unit Supervisor — 06/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Michaelyn Bruer, Enforcement Specialist — 06/15/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CMS Certification Number (CCN): 245491

June 15, 2018

Ms. Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

Dear Ms. Peterson:

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 May 4, 2018 the above facility is certified for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 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,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

Electronically delivered

June 15, 2018

Ms. Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: Project Numbers S5491027, H5491019, H5491020

Dear Ms. Peterson:

On April 6, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 11, 2018. (42 CFR 488.422)

In addition, on April 6, 2018, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018. (42 CFR 488.417 (a))

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on March 16, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 17, 2018, we informed you that the following Category 1 enforcement remedy would remain in effect:

- State Monitoring effective April 11, 2018. (42 CFR 488.422)

In addition, on April 17, 2018, we informed you that the following enforcement remedy would remain in effect:

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018. (42 CFR 488.417 (a))

This was based on the deficiencies cited by the Minnesota Departments of Health and Public Safety for a standard survey was completed at your facility on March 29, 2018 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 were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F).

On May 10, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal

certification deficiencies issued pursuant to abbreviated standard survey completed on March 16, 2018. On May 21, 2018, the Minnesota Department of Health completed a PCR by review of your plan of correction and on May 18, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey, completed on March 16, 2018, and pursuant to our standard survey, completed on March 29, 2018, effective May 4, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 4, 2018.

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

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018, be rescinded effective May 4, 2018. (42 CFR 488.417 (a))

In our letter of April 6, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 4, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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

Electronically delivered

June 15, 2018

Ms. Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

Re: Reinspection Results - Complaint Numbers H5491019 and H5491020

Dear Ms. Peterson:

On May 10, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on March 16, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MUKC
Facility ID: 00049

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245491**

2. STATE VENDOR OR MEDICAID NO. (L2) **857637200**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA MERCY CARE CENTER**
(L4) **710 SOUTH KENWOOD AVENUE**
(L5) **MOOSE LAKE, MN** (L6) **55767**

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) **09/01/2010**

6. DATE OF SURVEY **03/29/2018** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **72** (L18)

13. Total Certified Beds **72** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 72 | | | |
| (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 :
Elizabeth Silkey, HFE NE II 05/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/17/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
April 17, 2018

Ms. Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: Project Numbers S5491027, H5491019, H5491020

Dear Ms. Peterson:

On April 6, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 11, 2018. (42 CFR 488.422)

In addition, on April 6, 2018, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018. (42 CFR 488.417 (a))

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on March 16, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 29, 2018, 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 were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of the survey findings that your facility is not in substantial compliance, the following Category 1 enforcement remedy will remain in effect:

- State Monitoring effective April 11, 2018. (42 CFR 488.422)

In addition, as a result of the survey findings that your facility is not in substantial compliance, the following enforcement remedy will remain in effect:

• Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018. (42 CFR 488.417 (a))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 4, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Augustana Mercy Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 4, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

**Teresa Ament, Unit Supervisor**
**Duluth Survey Team**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**Duluth Technology Village**
**11 East Superior Street, Suite 290**
**Duluth, Minnesota 55802-2007**
**Email: teresa.ament@state.mn.us**
**Phone: (218) 302-6151**
**Fax: (218) 723-2359**

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

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 September 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.

**APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver

along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

**INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

Questions regarding all documents submitted electronically as a response to the Life Safety Code

deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

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 |
|---|---|---|---|
| | 245491 | A. BUILDING ______ B. WING ______ | 03/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AUGUSTANA MERCY CARE CENTER** | **710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767** |

| (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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 3/26/18, through 3/29/18, during a recertification survey.<br><br>The facility was found to be in compliance with Appendix Z. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On March 26, 2018, through March 29, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>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.<br><br>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 561 SS=E | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) | F 561 | | 5/4/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/25/2018

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

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| | 245491 | A. BUILDING ______ B. WING ______ | 03/29/2018 |

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| AUGUSTANA MERCY CARE CENTER | 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767 |

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| F 561 | Continued From page 1<br>(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure resident choices and preferences were honored for 4 of 5 residents (R12, R13, R15 and R56) who expressed desire to have two baths weekly. In addition, the facility failed to comprehensively assess and afford choices for bathing schedule(s) for 1 of 5 residents (R62) reviewed for choices and who desired additional bathing during the week.<br><br>Findings include:<br><br>R12's annual Minimum Data Set (MDS) dated 12/29/17, indicated she was cognitively intact, did | F 561 | It is the policy of Augustana Care Moose Lake Health and Rehabilitation to ensure that residents have the right to self-determination. Augustana Care Moose Lake Health and Rehabilitation strives to allow resident choice and inclusion in decisions made regarding activities, schedules, interests and their plan of care. As noted during the annual survey the facility Quality Assurance Performance Improvement Committee had been working on resident bathing preferences as part of a facility wide quality improvement project. Residents | |

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| F 561 | Continued From page 2<br>not reject cares, and required staff assistance with bathing.<br><br>R12's care plan dated 1/1/18, indicated staff were to provide assistance in and out of shower room and assistance/supervision for shower. R12's undated nursing assistant worksheet indicated she was to receive a shower on Wednesdays and an extra shower on Saturdays.<br><br>When interviewed on 3/27/18, at 9:55 a.m. R12 stated the staff, "Work short." R12 expressed concern that not all cares are being provided due to this. When interviewed on 3/2/18, at 10:10 a.m. R12 stated she has told the staff she would like to have a bath twice a week, but this rarely happens.<br><br>R12's January 2018, Point of Care History report indicated one out of the five Wednesday baths had been missed, and the facility did not provide any report for the Saturday baths.<br><br>R12's February 2018, Point of Care History report indicated three out of the four weekly baths were provided on Wednesdays, and three out of four were provided on Saturdays.<br><br>R12's March 2018, Point of Care History report indicated two out of the four Wednesdays she had received a bath. A handwritten undated, untitled sheet of paper indicated R12 had received one out of four Saturday baths.<br><br>R13's annual MDS dated 12/30/17, included he was cognitively intact, did not reject cares, and was totally dependent upon staff to bathe. R13's care plan dated 11/4/15, indicated he required extensive assistance for bathing. An undated | F 561 | R12, R13, R15 and R56 were interviewed regarding their bathing preferences in relation to frequency and confirmed bathing schedule preferences. In addition all residents in the facility were interviewed regarding their bathing preferences and placed into a new schedule that honors their choices for bathing frequency. The facility policy and procedure for bathing was reviewed and updated. The policy entitled resident preferences was reviewed and updated. All residents will be interviewed regarding their preferences including bathing upon admission, quarterly and with significant change. All nursing staff will be re-educated regarding need to ensure resident bathing preferences are met. Baths completed will be reviewed every week day at stand up meeting. Any resident who misses a bath regardless of reason will have the bath rescheduled to the next day. The DON or designee will audit three resident records for bathing preferences per week x4 weeks then monthly x3 months. Results will be reviewed by the facility QAPI committee. Corrected by: 5/4/18. | |

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| F 561 | Continued From page 3 | F 561 | | |

nursing assistant worksheet indicated R13 should be assisted with a bath on Wednesdays and a second bath on Saturdays. R13's Care Conference Summary dated 1/11/18, indicated a preference for two baths per week.

When interviewed on 3/26/18, at 1:10 p.m. R13 stated he was supposed to get a bath twice a week, but there was not enough staff working. R13 stated even if there was a bath aide working, they get pulled from giving baths much of the time to do other things. R13 stated he knew he missed a bath last week, this happened quite often, but had not kept track of when he had or had not received his scheduled bath.

R13's Point of Care History report for January 2018, showed he had received all scheduled baths on Wednesdays, but no documentation of Saturday baths were provided.

R13's Point of Care History report for February 2018, showed R13 had missed one out of four scheduled Wednesday baths, and no Saturday baths were documented.

R13's Point of Care History report for March 2018, showed he had received two out of four Wednesday baths, and no full baths on Saturdays, with two "partial bed bath" documented.

R15's quarterly MDS dated 1/2/18, indicated moderate cognitive impairment, did not reject cares, and was totally dependent upon staff for bathing. R15's care plan directed staff to provide two baths per week. An undated nursing assistant care sheet indicated R15 was to be bathed every Wednesday, and given an extra bath on

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F 561 Continued From page 4 F 561

Saturdays.

When interviewed on 3/27/18, at 2:19 a.m. R15 stated he had concerns over not having enough staff available.

R15's Point of Care History report for January 2018, indicated he had received three of the five Wednesday baths and none of the Saturday baths.

R15's Point of Care History report for February 2018, indicated he had received three of the four Wednesday baths and none of the Saturday baths, documentation indicated R15 refused once.

R15's Point of Care History report for March 2018, indicated he had received one Wednesday and one Saturday bath month. An undated, untitled copy with handwriting indicated R15 had received another bath on on 3/3/18, 3/7/18 and 3/9/18.

R56's quarterly MDS dated 3/5/18, indicated she was cognitively intact, did not refuse cares, and required physical help in part of bathing. R56's care plan dated 5/13/15, directed staff to assist with bathing twice a week on Fridays and Mondays. An undated nursing assistant worksheet directed staff to assist with bathing on Wednesdays, with an extra bath on Saturdays. R56's Care Conference Summary dated 3/8/18, indicated a preference for two baths per week.

When interviewed on 3/26/18, at 11:22 a.m. R56 stated they are "short of help for aides, some bath days will come and go without a bath." R56 stated baths do not get "made up" if missed, and

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| F 561 | Continued From page 5<br>this was distressing to her.<br><br>R56's Point of Care History report for January 2018, indicated she had received five of five Wednesday baths, and two of four Saturday baths.<br><br>R56's Point of Care History report for February 2018, indicated she had received three of four Wednesday baths, and two of four Saturday baths.<br><br>R56's Point of Care History report for March 2018, indicated she had received two of four Wednesday baths, and no Saturday baths. An undated, untitled form indicated she had received a Thursday bath on 3/15/18.<br><br>When interviewed on 3/27/18, at 3:47 p.m. nursing assistant (NA)-B stated they are often short staffed and the bath aide gets pulled to work on the floor doing nurse aide duties, and the baths do not get done. NA-B continued to state the nursing assistants are not able to do the baths, and they get missed.<br><br>When interviewed on 3/27/18, at 3:54 p.m. NA-C stated bath aide gets pulled, "a lot," and they will try and get the baths done the next day, but it usually does not happen.<br><br>When interviewed on 3/27/18, on 3:59 p.m. NA-A stated they do not have a bath aide on the afternoon shift, and they are unable to get baths done if they did not get done on the day shift.<br><br>When interviewed on 3/27/19, at 4:02 p.m. NA-D stated baths do not always get done, and they don't have time to catch up on them. | F 561 | | |

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| F 561 | Continued From page 6 | F 561 | | |

When interviewed on 3/28/18, at 7:05 a.m. NA-G stated they can usually get the work done but it is a struggle, the baths do not always get done.

When interviewed on 3/28/18, at 7:57 a.m. NA-H stated the bath aide had called in for the day, and baths would not get done that day.

When interviewed on 3/28/18, at 9:22 a.m. NA-I stated she had offered to do baths today for her group, if no one volunteers, "They will get done tomorrow."

When interviewed on 3/29/18, at 7:39 a.m. NA-F stated she is often the assigned bath aide but gets pulled very frequently. She can't get baths done and meet the resident's other needs.

When interviewed on 3/29/18, at 10:40 a.m. licensed practical nurse (LPN)-A stated she is unable to assist the nurse aides with bathing as she is too busy herself.

When interviewed on 3/29/18, at 7:56 a.m. NA-K stated they pull the bath aide at least weekly, and there is no way to catch up on the baths. NA-K stated sometimes she is asked to stay late to catch up, but not very often.

When interviewed on 3/29/18, at 8:01 a.m. registered nurse (RN)-A stated if they have a nursing assistant call in, they will pull the bath aide from doing baths to replace them. If this happens, the nursing assistants working should do all the baths. They do not always report when the baths have not been completed. Occasionally, a nursing assistant will report a bath had not been completed, and she reports

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| F 561 | Continued From page 7<br>this to the afternoon shift so that they can try and do it. This is not followed up on to see if the resident actually received a bath on the evening shift.<br><br>When interviewed on 3/28/18, at 9:48 a.m. the administrator stated the facility was aware of baths not always getting done, they are currently addressing the issue in their quality assessment and assurance (QAA) committee. The director of nursing (DON) stated they are still working on it, they try to get an extra person in if they do not have a bath aide, or will try and get someone to stay late and try to get the baths done.<br><br>A facilty policy entitled Apollo Tub, Basic Nursing Care dated 7/15, directed the frequency of bath/shower will be weekly or as requested by each resident, to meet the hygiene needs of each resident.<br><br>R62's 14-day MDS dated 3/14/18, identified R62 had moderate cognitive impairment, required extensive assistance with transfers, and total assistance with bathing.<br><br>During interview on 3/26/18, at 1:04 p.m. R62 explained she enjoyed having a bath and wished she could have more than one per week, however, "Everybody gets it that way." R62 stated she would like to have two baths per week, but nobody had ever asked or questioned her about her bathing preferences since she came to the nursing home.<br><br>R62's Point of Care History report printed 3/28/18, identified R62's completed bath(s) for the past weeks. R62 had a bath completed only on a weekly basis. Further, R62's Resident | F 561 | | |

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| F 561 | Continued From page 8<br>Preference Sheet signed 2/28/18, directed staff to ask her preference between a bath or shower when completing one for R62, however, lacked any assessment or input on R62's choice or preference for bathing. A section labeled, "Other," was left blank.<br><br>R62's medical record was reviewed and lacked evidence R62 had been assessed or afforded input on her bathing schedule(s) since admitting to the nursing home.<br><br>On 3/28/18, at 12:21 p.m. registered nurse (RN)-A was interviewed about the facility process for bathing schedules. RN-A stated when a resident admits to the nursing home, they are added to the bathing schedule for "at least once a week" and should be asked about their preferences for additional bathing using a preference sheet (Resident Preference Sheet). RN-A reviewed R62's completed sheet and stated preferences for bathing usually would be recorded on it adding it should say how many times she desired a bath during the week.<br><br>A facility Resident Preferences policy dated 8/2013, directed all residents of the nursing home " ... are provided with choices regarding their preferences." A procedure was listed which directed, "On admission[,] all residents will be asked questions regarding their preferences for sleep [and] wake times, bathing and activities schedules." These preferences were then to be incorporated into their plan of care. | F 561 | | |
| F 677 SS=E | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry | F 677 | | 5/4/18 |

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| F 677 | Continued From page 9<br>out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide routine bathing/showering assistance for 7 of 11 residents (R3, R5, R13, R15, R38, R56 and R60) and personal grooming for 1 of 11 residents (R214) reviewed for activities of daily living, and who were dependent on staff for assistance.<br><br>Findings include:<br><br>R3's admission Minimum Data Set (MDS) dated 12/18/17, indicated R3 was cognitively intact, did not refuse cares, and was totally dependent upon two staff to bathe. R3's care plan dated 12/12/17, directed staff to provide physical assistance with showers. An undated nursing assistant worksheet directed staff to assist R3 with a shower weekly on Fridays.<br><br>When interviewed on 3/26/18, at 3:05 p.m. R3 stated, "They are always short of staff," and indicated she does not even get a weekly shower which was upsetting to her.<br><br>R3's Point of Care History report for January 2018, indicated staff should have assisted R3 with a shower on 1/5/18, 1/12/18, 1/19/18, and 1/26/18. However, the 1/12/18, bath was not signed off as given, and the 1/19/18, bath was noted to be, "Not Done." Therefore, R3 went for a 21 day period without a shower.<br><br>R3's Point of Care History report for February 2018, indicated R3 had received a weekly shower | F 677 | It is the policy of Augustana Care Moose Lake Health and Rehabilitation to ensure that residents who are unable to carry out activities of daily living receive the necessary services to ensure good nutrition, grooming, personal and oral hygiene. As noted during the annual survey the facility Quality Assurance Performance Improvement Committee had been working on resident bathing preferences as part of a facility wide quality improvement project. Resident R3 has been discharged from the facility. Resident R5 is noted to frequently refuse bathing her care plan was updated to include approaches for staff to use when resident refuses bathing in addition she was interviewed regarding her bathing preferences along with resident's;R13, R15, R38 and R56 and new bathing schedules were developed. Resident R60 is noted to have a diagnosis of aphasia and is not interview able; her family was interviewed regarding her past routines. In addition all residents in the facility were interviewed regarding their bathing preferences and placed into a new schedule that honors their choices regarding the frequency of baths. The facility policy and procedure for bathing was reviewed and updated. The policy titled resident preferences was reviewed and updated. All residents will be interviewed regarding their preferences | |

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in February 2018.

R3's Point of Care History report for March 2018, indicated staff should have assisted R3 with a shower on 3/2/18, 3/9/18, 3/16/18, and 3/23/18. However, the shower was not signed off as being provided on 3/2/18, or 3/23/18.

R5's quarterly MDS dated 12/19/17, indicated R5 was cognitively intact, did not reject cares and required total staff assistance with bathing. R5's care plan dated 10/21/16, indicated she required total assist of 2 for bathing. An undated nursing assistant worksheet directed a tub bath every Monday.

When interviewed on 3/26/18, at 11:58 a.m. R5 stated she typically does not like to bathe, and is fussy about who gives her a bath, but that there is often not enough staff available to give her a weekly bath. R5 stated she has a rash in her abdominal folds and under her breasts, and that she needs to be kept clean or the rash, "Gets really bad."

R5's Point of Care History report for January 2018, indicated R3 should have received a bath on 1/1/18, 1/8/18, 1/15/18, 1/22/18, and 1/29/18. However, the report indicated R5 had only received one bath the entire month on 1/15/18. The other dates were either not answered, or marked as, "Not Done-Resident Refused."

R5's Point of Care History report for February 2018, indicated R5 should have been assisted with a bath on 2/5/18, 2/12/18, 2/19/18, and 2/26/18. Two of those dates were marked as not done, one not marked at all. R5 had only received one bath in February on 2/19/18.

F 677

including bathing upon admission, quarterly, and with significant change. All nursing staff will be re-educated regarding need to ensure resident bathing preferences are met and baths are completed as scheduled. Baths completed will be reviewed each week day at stand up meeting. Any resident who misses a bath regardless of reason will have a bath rescheduled to the next day. The facility policy and procedure for bathing was reviewed and updated this policy includes shaving of both male and female residents and was provided to the survey team during the survey process. The policy entitled resident preferences was reviewed and updated to include resident grooming/shaving preferences. The facility policy on Shaving was reviewed and remains current. All residents will be interviewed regarding their preferences including bathing and grooming upon admission, quarterly and with significant change. Resident R214 was interviewed regarding her shaving preferences and declined shaving, R214 has been discharged from the facility. All nursing staff will be re-educated regarding need to ensure resident bathing preferences are met and all residents who require assistance with bathing are provided a bath per their preference. In addition residents who wish to be shaved will have this completed as necessary. Any resident who misses a bath regardless of reason will have the bath rescheduled to the next week day. The DON or designee will audit three resident records per week x4 weeks then monthly

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| F 677 | Continued From page 11<br><br>R5's Point of Care History report for March 2018, indicated R5 should have been assisted with a bath on 3/5/18, 3/12/18, 3/19/18, and 3/26/18. Two of those dates were marked as not done, one was not answered. R5 had only received a bath on 3/5/18.<br><br>R13's annual MDS dated 12/30/17, included he was cognitively intact, did not reject cares, and was totally dependent upon staff to bathe. R13's care plan dated 11/4/15, indicated he required extensive assistance for bathing. An undated nursing assistant worksheet indicated R13 should be assisted with a bath on Wednesdays and a second bath on Saturdays.<br><br>When interviewed on 3/26/18, at 1:10 p.m. R13 stated he is supposed to get a bath twice a week, but there is not enough staff on to do this. R13 stated even if there is a bath aide on, they get pulled from giving baths much of the time to do other things. R13 stated he knew he missed a bath last week, this happens quite often, but had not kept track of when he had, or had not received the scheduled bath.<br><br>R13's Point of Care History report for January 2018, indicated he had received all scheduled baths on Wednesdays, but no documentation of Saturday baths was provided.<br><br>R13's Point of Care History report for February 2018, indicated R13 had missed one out of four scheduled Wednesday baths, and no Saturday baths were documented.<br><br>R13's Point of Care History report for March 2018, indicated he had received two out of four | F 677 | x3 months to ensure bathing and shaving are completed per care plan. In addition the DON or designee will audit three residents per week weekly x4 weeks then monthly x 3 months to ensure shaving is completed per the care plan. Results will be reviewed by the facility QAPI committee. Corrected by 5/4/2018. | |

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| F 677 | Continued From page 12<br>Wednesday baths, and no full baths on Saturdays, with two "partial bed bath" documented.<br><br>R15's quarterly MDS dated 1/2/18, indicated R15 had moderate cognitive impairment, did not reject cares, and was totally dependent upon staff for bathing. R15's care plan directed staff to provide two baths per week. An undated nursing assistant care sheet indicated R15 was to be bathed every Wednesday, and an extra bath on Saturdays.<br><br>When interviewed on 3/27/18, at 2:19 a.m. R15 stated he had concerns over not having enough staff available.<br><br>R15's Point of Care History report for January 2018, indicated he had received only three of the five Wednesday baths,and none of the Saturday baths.<br><br>R15's Point of Care History report for February 2018, indicated he had only received three of the four Wednesday baths and none of the Saturday baths, indicating he had refused once.<br><br>R15's Point of Care History report for March 2018, indicated he had received only one Wednesday and one Saturday bath this month. An undated, untitled copy with handwriting indicated R15 had received another bath on on 3/3/18, 3/7/18, and 3/9/18.<br><br>R38's significant change MDS dated 2/4/18, indicated R38 had severe cognitive impairment, did not refuse cares, and required total assistance from staff for bathing. R38's care plan dated 1/17/18, directed staff to assist with | F 677 | | |

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| F 677 | Continued From page 13 | F 677 | | |

bathing. An undated nursing assistant worksheet indicated R38 should be assisted with bathing on Wednesdays.

When interviewed on 3/26/18, at 1:59 p.m. R38 stated she did not feel there was enough staff available to meet her needs. R38 did not know how often she received a bath, but didn't think it was very often.

R38's January 2018, Point of Care History report indicated she had received one of two scheduled baths, and had refused the other.

R38's February 2018, indicated R38 had received two out of four scheduled baths.

R38's March 2018, Point of Care History report indicated she had received two out of four scheduled baths, and refused one.

R56's quarterly MDS dated 3/5/18, indicated R56 was cognitively intact, did not refuse cares, and required physical help in part of bathing. R38's care plan dated 5/13/15, directed staff to assist with bathing twice a week on Fridays and Mondays. An undated nursing assistant worksheet directed staff to assist with bathing on Wednesdays with an extra bath on Saturdays.

When interviewed on 3/26/18, at 11:22 a.m. R56 stated they are, "Short of help for aides, some bath days will come and go without a bath." R56 stated baths do not get, "Made up," if missed, and this was distressing to her.

R56's Point of Care History report for January 2018, indicated she had received five of five Wednesday baths, and two of four Saturday

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baths.

R56's Point of Care History report for February 2018, indicated she had received three of four Wednesday baths and two of four Saturday baths.

R56's Point of Care History report for March 2018, indicated she had received two of four Wednesday baths, and no Saturday baths. An undated, untitled form indicated she had received a Thursday bath on 3/15/18.

R60's annual MDS dated 3/2/18, indicated R60 had severe cognitive impairment, did not refuse cares, and required total staff assistance for bathing. R60's care plan directed staff to provide extensive assistance with bathing on Tuesdays. An undated nursing assistant worksheet directed staff to bath R60 on Tuesdays.

When interviewed on 3/27/18, at 11:03 a.m. R60 stated the staff is, "Really short," and she used to get a bath on Tuesday, then they would come in and set her hair after breakfast. R60 stated they pull the bath aide if someone calls in sick. R60 stated today is Tuesday, and no bath yet, and she had just found out they did not have anyone to give baths today. R60 stated she does not feel good when she doesn't get a bath at least every week.

R60's Point of Care History report for January 2018, identified she had received a bath three out of the five Tuesdays, missing a bath for twenty-one days between 1/9/18, and 1/30/18.

R60's Point of Care History report for February 2018, identified she had received a bath three out

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| F 677 | Continued From page 15<br>of four Tuesdays, one she had refused.<br><br>R60's Point of Care History report for March 2018, identified she had received an ordered bath on 3/3/18, and 3/4/18, due to scheduled surgery. However, there was no Point of Care History report identifying any other baths. A Master Bath list dated 3/26/18, identified R60 had received one bath on 3/27/18. No time was identified.<br><br>The facility's Resident Council Meeting Notes dated February 28, 2018, noted a concern over baths being missed due to staff shortages.<br><br>When interviewed on 3/27/18, at 3:47 p.m. nursing assistant (NA)-B stated they are often short staffed, the bath aide gets pulled to work on the floor doing nursing assistant duties, and then the baths do not get done. The nursing assistants are not able to do them, and the baths get missed.<br><br>When interviewed on 3/27/18, at 3:54 p.m. NA-C stated the bath aide gets pulled, "A lot," and they will try and get the baths done the next day, but it usually does not happen.<br><br>When interviewed on 3/27/18, on 3:59 p.m. .NA-A stated they do not have a bath aide on the afternoon shift, and they are unable to get baths done if they did not get done on the day shift.<br><br>When interviewed on 3/27/19, at 4:02 p.m. NA-D stated baths do not always get done, and they don't have time to catch up on them.<br><br>When interviewed on 3/28/18, at 7:05 a.m. NA-G stated they can usually get the work done but it is a struggle, the baths do not always get done. | F 677 | | |

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When interviewed on 3/28/18, at 7:57 a.m. NA-H stated the bath aide had called in for the day, and baths would not get done that day.

When interviewed on 3/28/18, at 9:22 a.m. NA-I stated she had offered to do baths today for her group, if no one volunteers, "They will get done tomorrow."

When interviewed on 3/29/18, at 7:39 a.m. NA-F stated she is often the assigned bath aide, but gets pulled very frequently. NA-F stated she can't get baths done and meet everyone's other needs.

When interviewed on 3/29/18, at 10:40 a.m. licensed practical nurse (LPN)-A stated she is unable to assist the nursing assistants with bathing as she is too busy herself.

When interviewed on 3/29/18, at 7:56 a.m. NA-K stated they pull the bath aide at least weekly. NA-K stated there was no way to catch up on them. NA-K stated sometimes she is asked to stay late to catch up, but not very often.

When interviewed on 3/29/18, at 8:01 a.m. registered nurse (RN)-A stated if they have a nursing assistant call in, they will pull the bath aide from doing baths to replace them. If this happens the nursing assistants working should do all the baths. They do not always report when the baths have not been completed. Occasionally, a nursing assistant will report a bath had not been completed, and she reports this to the afternoon shift so that they can try and do it. This is not followed up on to see if the resident actually received a bath.

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| F 677 | Continued From page 17<br>When interviewed on 3/28/18, at 9:48 a.m. the administrator stated the facility was aware of baths not always getting done, they are currently addressing the issue in their quality assessment and assurance (QAA) committee. The director of nursing (DON) stated they are still working on it, they try to get an extra person in if they do not have a bath aide, or will try and get someone to stay late and try to get the baths done.<br><br>A facility policy entitled Apollo Tub, Basic Nursing Care dated 7/15, directed the frequency of bath/shower will be weekly or as requested by each resident, to meet the hygiene needs of each resident.<br><br>R214's 14-day MDS dated 3/5/18, identified R214 had severe cognitive impairment, and required extensive assistance with personal hygiene.<br><br>R214's Social Services assessment completed 2/21/18, identified R214 with personal characteristic(s) including, "Resident takes pride in her appearance. Staff assist with ADLs [activities of daily living]." Further, R214's care plan dated 3/9/18, identified R216 required total assistance for dressing, bathing, and grooming.<br><br>On 3/26/18, at 3:54 p.m. R214 was observed to have numerous, visible white colored hairs present on her chin which extended down her neck line. During subsequent observations on 3/27/18, at 7:23 p.m. and 3/28/18, at 7:16 a.m. R214 continued to have visible, white colored facial hair present on her chin and extending down her neck line. | F 677 | | |

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| F 677 | Continued From page 18<br>When interviewed on 3/28/18, at 9:41 a.m. NA-A stated staff completed R214's grooming for her as there was a lot R214 can't do for herself. NA-A expressed R214 typically did not have facial hair, however, observed her and stated there was some there, which should have been removed during her morning cares.<br><br>During interview on 3/28/18, at 1:40 p.m. RN-A stated residents should be shaved on their designated bath day(s). RN-A explained R214 did not have any preferences for facial hair, and it should have been removed as residents, "Need to look appropriate."<br><br>A facility policy on grooming and personal hygiene was not provided. | F 677 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide assessed interventions from occupational therapy (OT) to prevent skin breakdown in a contracted hand for 1 of 5 residents (R214) reviewed for mobility and who had limited range of motion (ROM). | F 684 | It is the policy of Augustana Care Moose Lake Health and Rehabilitation to provide treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan and the resident choices. Resident R 214 received MD orders for OT evaluation for | 5/4/18 |

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| F 684 | Continued From page 19 | F 684 | | |

Findings include:

R214's 14-day Minimum Data Set (MDS) dated 3/5/18, identified R214 had severe cognitive impairment, and required extensive assistance with bed mobility, transfers and personal hygiene. Further, R214 had a functional limitation in ROM on one side with no skin lesions, burns or other non-pressure related wounds.

R214's Therapy to Nursing Communication sheet dated 3/9/18, identified a directive from occupational therapy (OT) for, "Lambs wool to [R214's] [left] hand, daily skin care to be provided to [left] hand." The sheet was signed by occupational therapist (OT)-A. Further, R214's care plan revised 3/28/18, identified an intervention directing, "Apply lambs wool to left hand daily, skin care to be provided to left hand."

During observation on 3/26/18, at 3:54 p.m. R214 was laying in bed in her room. R214 had a visibly contracted left hand (shortening and hardening of muscle) with the fingers turned inward, towards her palm, causing the left hand to appear like a fist. There was no lambs wool visible in R214's left hand.

During subsequent observations on 3/27/18, at 10:19 a.m., 3/27/18, at 7:23 p.m. and 3/28/18, at 7:16 a.m. R214 was again observed to not have any lambs wool inside or on the left hand as directed by the OT recommendation.

On 3/28/18, at 7:55 a.m. nursing assistant (NA)-A and NA-B entered R214's room to provide morning cares. R214 was washed, dressed, and assisted to sit in her wheelchair using a mechanical lift. Neither of the NA staff provided or

**Provider's Plan of Correction (F 684):**

her left hand contracture. Evaluation was completed on 4/23/18, OT recommended trial of palm protector that was to be ordered however resident R214 discharged from the facility on 4/24/18. The facility policy titled Restorative nursing programs (RNP)/Functional maintenance programs (FMP) was reviewed and revised. All residents in the facility who use splinting devices were reviewed for appropriateness. All nursing staff will be re-educated regarding need to ensure devices and splints are on the resident's per their plan of care. The DON or designee will audit three residents who use splinting devices per week to ensure compliance x4 weeks then monthly x3 months. Results of the audits will be reported to the QAPI committee for review. Corrected by: 5/4/18.

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| F 684 | Continued From page 20 | F 684 | | |

applied lambs wool to R214's left hand during these cares, nor when they were completed. R214's left hand was observed and lacked any visible cuts, lesions or skin damage.

When interviewed on 3/28/18, at 9:09 a.m. NA-A stated she was not aware of any splints or lambs wool being used in R214's left hand. NA-A explained she had never seen one used prior, either.

During interview on 3/28/18, at 9:50 a.m. NA-B stated she had never seen lambs wool being used on R214's contracted left hand, however, staff will provide her with a squeeze ball shaped like a lamb, and she will often hold it in her other hand which was not contracted. NA-B stated R214 should be trying to use the squeeze ball in her left, contracted hand. Further, NA-B explained therapy recommendations for splints, devices, and ROM programs would be placed inside a resident's closet door so staff could reference them when caring for a person. At 12:44 p.m. NA-B and the surveyor observed R214's inside closet door, and NA-B verified there were no instructions posted pertaining to the application of lambs wool to R214's left hand.

When interviewed on 3/28/18, at 1:34 p.m. registered nurse (RN)-A explained therapy provides nursing with communication sheets with post-therapy discharge instructions to be implemented by nursing staff. R214's therapy communication (dated 3/9/18, 19 days prior) directed to insert lambs wool into R214's contracted left hand, however, RN-A stated the NA just brought a concern to her today as they were fearful R214 may attempt to eat it. RN-A was unable to answer if lambs wool had ever

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| F 684 | Continued From page 21<br>been used in R214's left hand as had been directed by OT on 3/9/18. Further, RN-A stated the NA staff "have to be accountable" and bring concerns to her sooner so they could be clarified and coordinated with therapy adding, "Then we can have appropriate care for the resident."<br><br>During interview on 3/29/18, at 11:16 a.m. OT-A stated R214 was unable to use a palm protector on the left hand due to the contracture. The lambs wool should have been placed in the left hand for "protecting the skin" and preventing skin breakdown. OT-A explained if staff had concerns with interventions provided by OT, they should notify the department to have them addressed "sooner than that [19 days later]" as their was "always a risk of [further] decline" in ROM and skin breakdown.<br><br>A facility policy on coordination of care with therapies (PT / OT) and/or contracture splint/device use was requested, however, none were provided. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to | F 686 | | 5/4/18 |

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| F 686 | Continued From page 22<br>promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide timely assistance with repositioning to promote healing and prevent development of new pressure ulcers for 1 of 1 (R17) residents reviewed with current pressure ulcers.<br><br>Findings include:<br><br>R17's quarterly Minimum Data Set (MDS) dated 1/5/18, included diagnoses of cardiovascular disease, diabetes mellitus type 2, chronic kidney disease, and peripheral vascular disease. The MDS indicated no cognitive impairment, extensive assistance with activities of daily living (ADLs), no rejection of cares and no pressure ulcers.<br><br>R17's annual MDS dated 7/7/17, indicated no cognitive impairment, extensive assistance with ADLS, no rejection of cares and no pressure ulcers. The Pressure Ulcer Care Area Assessment (CAA) dated 7/14/17, indicated CAA triggered due to extensive assistance with mobility, frequently incontinent of bladder, and at risk for skin alterations. R17 scored 15 on the Braden Scale (tool used to predict pressure ulcer risk) placing resident at risk for pressure ulcers. The CAA also indicated R17 could be non-compliant with repositioning. Staff were to turn and reposition every 2 hours, and provide an air mattress on the bed.<br><br>R17's care plan dated as last reviewed on | F 686 | It is the policy of Augustana Care Moose Lake that a resident entering the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and to provide care and services consistent with professional standards of practice to promote the prevention of pressure injury development, promote the healing of existing pressure injuries and to prevent the development of additional pressure injuries. Resident R17 was noted to be hospitalized from 3/8/18-3/13/18, upon return from the hospital she was noted to have a Stage one pressure injury to her right buttock measuring; 4.5x4.0cm in size this was an area of delayed blanching (redness). In addition she was noted to have two areas of abrasion; one to her right buttocks measuring; 3.0x3.5cm and left buttocks abrasion measuring; 0.5x2.5cm these two areas were not noted to be pressure ulcers. Comprehensive skin assessment was completed upon her hospital return 3/8/18 with interventions put in place to help prevent/heal any skin concerns. The resident is noted to have a history of refusing repositioning while in her w/c or bed, she is noted to have a signed risk versus benefit in her chart that includes the risks of refusing repositioning. Right buttocks abrasion noted to be healed 3/21/18, Left buttocks abrasion healed | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUGUSTANA MERCY CARE CENTER | 710 SOUTH KENWOOD AVENUE<br>MOOSE LAKE, MN 55767 |

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| F 686 | Continued From page 23<br>1/22/18, indicated a potential for alteration in skin integrity related to impaired mobility, diabetes mellitus, history of pressure ulcer, and bladder incontinence. R17 was noted to refuse to reposition at times when in bed and wheelchair. R17 was also noted to have an area of moisture associated skin damage (MASD) to the left lateral gluteal crease. Interventions included: air bed with setting of 6, pressure relieving cushion on her wheelchair, turn and reposition every 2 hours, follow toileting schedules, assess skin folds for moisture, and nurse to complete body audit weekly. The care plan did not address current pressure ulcers to the buttocks.<br><br>On 3/27/18, at 5:20 p.m. R17 was observed in her room next to bed in her wheelchair waiting for supper to arrive. An air mattress was noted on the bed.<br><br>- At 6:19 p.m. R17 was observed eating supper at her bedside.<br>- At 6:40 p.m. continued eating supper.<br>- At 7:04 p.m. R17 had call light on. A nurse answered the light and shut door behind her.<br>- At 7:10 p.m. registered nurse/nurse manager (RN)-B came out of R17's room and began wheeling her down the hall. RN-B stated she was taking R17 for a ride.<br>- At 7:30 p.m. RN-B wheeled R17 back to her room. RN-B stated when she answered the call light she helped with TV channel. No cares were provided.<br>- At 7:38 p.m. nursing assistant (NA)-C answered R17's call light and then went to get standing lift. NA-C stated R17 needed to use the bathroom and she would take her to the toilet. NA-C verified R17 had not been assisted with repositioning since before suppertime. | F 686 | 3/29/18 and stage one pressure ulcer healed 4/3/18. The resident continues to have areas of discolored skin to her buttocks r/t an h/o past pressure ulcers and poor skin integrity. A new comprehensive skin assessment with braden was completed on resident R17 that indicated a change in the repositioning schedule to every 2-3 hours. In addition the residents care plan was updated to indicate refusal of repositioning with interventions for staff to use when the resident refuses. Risk versus benefit for refusal of repositioning was reviewed and signed on 4/22/18. The facility policy and procedure on skin integrity was reviewed and updated. All residents with current pressure ulcers and altered skin integrity were reviewed to ensure appropriate turning and repositioning schedules. All nursing employees will be educated regarding need to follow all care planned repositioning schedules and document all refusals in the resident’s medical record. The DON or designee will audit three residents with altered skin integrity weekly x4 for compliance with turning/repositioning and care planned skin interventions then monthly x3 months. Audits will be completed across a variety of shifts and days to ensure compliance. Results of audits will be reviewed by the QAPI committee. Corrected by: 5/4/18. | |

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| F 686 | Continued From page 24 | F 686 | | |

On 3/28/18, at 7:07 a.m. R17 was observed in her room next to bed in her wheelchair. R17 stated she was up early around 6:00 a.m. R17 stated she had sores on her bottom, but they were better.

- At 7:20 a.m. R17 was observed in the same position.
- At 7:40 a.m. R17 was in the same position, asleep in her wheelchair.
- At 8:10 a.m. same position.
- At 08:26 a.m. same position. The social worker entered R17's room to notify her of an upcoming dental appointment.
- At 8:30 a.m. R17 was served breakfast in her room. Eating independently.
- At 9:00 a.m. R17 was done with breakfast.
- At 9:20 a.m. NA-H was interviewed regarding when R17 was last assisted with repositioning. NA-H stated the night staff would have repositioned her when they assisted her with morning cares, and transferred her into the wheelchair. NA -H verified she had not checked for toileting or repositioning since she started work at 6:00 a.m.
- At 9:30 a.m. R17 had company visiting, and refused to be repositioned or toileted. NA-H reported to licensed practical nurse (LPN)-B that R17 refused to be repositioned. LPN-B spoke with R17 and R17 continued to refuse. LPN-B added that she explained the importance of off-loading (relieving pressure to an area) but R17 still refused, but may allow at 10:00 a.m.
- 9:40 a.m. NA-H stated R17 can get feisty and will refuse cares. NA-H verified R17 should be toileted and repositioned every 2 hours, and R17 has open areas on her buttocks that are improving. Observations ended.

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| F 686 | Continued From page 25 | F 686 | | |

-At 11:38 a.m. NA-H stated R17 was finally repositioned and toileted at 11:00 a.m. by another NA.

On 3/29/18, at 07:45 a.m. R17 was observed in bed awake. R17 was positioned on her right side with a pillow behind her lower back.

-At 8:01 a.m. observed RN-C/Nurse Educator perform morning cares. RN-C stated she completed R17's skin assessment upon a recent hospital return, and her pressure ulcers were much improved. R17 was turned on side and observed pressure ulcer (PU) to the right buttocks. A very small scabbed open area was observed to the left buttocks. The PU to the right buttocks was healed. R17's wheelchair was observed to have a pressure relieving cushion. RN-C stated the wound nurse would measure the PU today.

R17's Weekly Wound Assessments:
- 03/14/18, Readmission Skin risk assessment completed. Resident scored a 12 on the Braden scale. Resident is noted to have pressure sores on buttocks. Resident is able to make slight movements independently, but does require assistance to make significant repositioning. Elevate HOB [head of bed] as little as possible for sacral, coccyx or buttocks ulcer prevention, minimize time in bed, and moisturize dry/thin skin daily. Pressure reducing cushion on W/C [wheelchair]; pressure redistribution mattress on bed. Continue to follow toileting schedules. Assess skin folds for moisture. Treat as ordered by care provider. Nurse to complete body audit weekly. Complete a new Braden assessment (for pressure areas of concern) and Tissue Tolerance (if appropriate) when areas of concern are noted.

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| F 686 | Continued From page 26<br>Notify MD [medical doctor/NP [nurse practitioner] as appropriate. Continue with plan of care.<br><br>- 03/14/18, able to assess resident's buttocks at this time r/t [related to] indication of open sores r/t readmission following hospitalization r/t cellulitis of LLE [left lower extremity]. Resident is noted to have an area to her right (R) buttock measuring 4.5 cm [centimeters] x 4.0 cm of darkened redness with delayed blanching [Stage 1] with a noted area of abrasion within area measuring 3 cm x 3.5 cm. Area presents with pink/red granulation; no evidence of slough or eschar, no tunneling, undermining, sinus tracts, induration or current s/sx of infection. No exudate noted. Previous other open areas are noted to be scabbed to the superior location of the abrasion area. Left (L) buttocks superior medial location with abrasion area measuring 0.5 cm x 2.5 cm with pink/red granulated tissue. No evidence of undermining, tunneling, sinus tracts or s/sx of infection. Surrounding skin presents with permanent staining of darkened purplish blanchable skin. Resident does not present with pain during assessment. Treatment: wash bilateral buttocks, apply skin prep allow to dry and then apply skin barrier cream. Resident continues to be on ABx [antibiotic] r/t infection.<br><br>- 3/27/18, able to assess resident's buttocks this afternoon. Resident is noted to have an area to her (R) buttock measuring 2.0 cm x 2.0 cm of redness with delayed blanching [stage 1]; abrasion that was previously noted is no longer present to area. Area presents with pink/red granulation; no evidence of slough or eschar, no tunneling, undermining, sinus tracts, induration or current s/sx of infection. No exudate noted. (L) buttocks superior medial location with abrasion | F 686 | | |

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| F 686 | Continued From page 27 | F 686 | | |

area that is now scabbed over measuring 0.8 cm x 1.2 cm. No evidence of undermining, tunneling, sinus tracts or s/sx of infection. Surrounding skin presents with permanent staining of darkened purplish blanchable skin. Resident does not present with pain during assessment. Treatment: wash bilateral buttocks, apply skin prep allow to dry and then apply skin barrier cream.

- 3/29/18, at 1:45 p.m. able to assess resident's buttocks this afternoon. Resident is noted to have an area to her (R) buttock measuring 1.4 cm x 1.4 cm of slight redness with blanching noted [stage 1]; abrasion that was previously noted is no longer present to area. Resident was noted to have area of drying, flaking skin to bilateral buttocks with was easily removed with cleansing of the area. Area presents with pink/red epithelialization; no evidence of slough or eschar, no tunneling, undermining, sinus tracts, induration or current s/sx of infection. No exudate noted. (L) buttocks superior medial location with abrasion area that was previously scabbed over last week is now considered healed with no open areas or scabbing noted to area. Surrounding skin presents with permanent staining of darkened purplish blanchable skin. Resident does not present with pain during assessment. Writer will continue to follow another week, if no changes present to area, will considered healed at that time. Treatment: wash bilateral buttocks, apply skin prep allow to dry and then apply skin barrier cream.

On 3/29/18, at 12:15 p.m. RN-B/Nurse Manager verified the care plan directed staff to assist with repositioning every 2 hours, and she would expect staff to provide that care. RN-B added R17 has a history of pressure ulcers, and

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| F 686 | Continued From page 28<br>developed new pressure ulcers after a recent hospitalization the beginning of March, which are improving.<br><br>A policy on pressure ulcers was requested, but not provided by the facility. | F 686 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to follow care planned interventions to maintain or improve range of motion for 1 of 5 residents (R60) reviewed for range of motion.<br><br>Findings include:<br><br>R60's Face Sheet undated, indicated diagnoses | F 688 | It is the policy of Augustana Care Moose Lake Health and Rehabilitation to ensure that a resident who enters the facility without limited range of motion doesn't experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in a range of motion is unavoidable. In addition it is the policy of Augustana Care Moose Lake | 5/4/18 |

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included aphasia (language impairment affecting the production or comprehension of speech), hemiplegia (paralysis of one side of the body and hemiparesis (weakness of the entire side of the body) following cerebral infarction (stroke).

R60's annual Minimum Data Set (MDS) dated 3/2/18, indicated R60 had no rejection of cares, rarely or never understood, and required extensive assistance for bed mobility, transfers, dressing, and personal hygiene. The MDS also identified functional limitation in range of motion (ROM) of upper (shoulder, elbow, wrist, and hand) and lower extremities (hip, knee, ankle, and foot).

R60's Care Area Assessment (CAA) for ADLs (activities of daily living) dated 3/12/18, indicated R60 required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, grooming, and total assist with bathing. The MDS also indicated R60 required supervision with eating, and directed to proceed to the care plan.

R60's Physician Order Report dated 3/29/18, revealed an order for right hand splint at all times, except during hygiene when needs to be washed, every shift and passive range of motion (PROM) to the right fingers, wrist, elbow and shoulder to patient tolerance 10 repetitions twice a day (days and evenings).

R60's care plan dated 12/01/17, identified a goal to maintain current ROM in upper extremity or increase ROM in right upper extremity. The interventions directed staff to provide gentle PROM to right upper extremity, shoulder, elbow, digits, and to wear splint at all times except for hygiene and when needs to be washed. The care

F 688

Health and Rehabilitation to ensure that residents receive appropriate services and equipment to maintain or improve mobility. Resident R60 was evaluated by Occupational therapy on 4/23/18 with the following recommendations; Palm Protector is recommended for the RUE. Resident R60 has been noted to have a history of refusing to wear her hand splint and throwing it in the garbage. R60s care plan was updated to include refusals to wear the palm protector. Nursing staff will be re-educated on application of splints/braces and need to ensure they are applied per the care plan. The Facility policy and procedure for Restorative nursing programs (RNP)/Functional maintenance programs (FMP) has been reviewed and revised. The facility policy and procedure for PROM and AROM was reviewed and updated. All residents in the facility will be assessed for appropriateness and or need for a range of motion program. In addition all nursing staff will receive training on the policy and procedure PROM and AROM programs. The DON or designee will audit three resident ROM programs weekly x4 weeks then monthly x3 months to ensure compliance. Results of audits will be reviewed by the facility QAPI committee. Corrected by: 5/4/18.

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plan also indicated R60 refused to wear splint frequently.

R60's group sheet (nursing assistant instructions) indicated right hand splint at all times except for hygiene and when needs to be washed, and ROM program: right fingers, wrist, elbow, and shoulders, PROM to tolerance a.m. and p.m., 10 repetitions.

R60's Restorative Nursing records indicated PROM to right fingers, wrist, elbow and shoulder, to tolerance, 10 repetitions twice daily (in a.m. and p.m.) was not consistently provided:
1/1/18- 1/31/18- missed 14 times
2/1/18- 2/28/18- missed 14 times
3/1/18- 3/28/18- missed 6 times

During observation on 3/27/18, at 10:54 a.m. R60 was seated in her wheelchair, visiting with family member (FM)-A. R60 had a visibly contracted right hand (shortening and hardening of muscle) with the fingers turned inward, towards palm, causing left hand to appear like a fist. There was no splint in R60's left hand.

During interview on 3/27/18, at 11:25 a.m. FM-A stated R60 had a stroke and had weakness on the right side, and contracture of the right hand. FM-A further stated R60 had splints for hands but was not always on, "Like now," "Might be refusal."

On 3/28/18, at 8:32 a.m. nursing assistant (NA)-H was observed finishing morning cares for R60. NA-H stated she assisted with putting residents clothes on, washed face, "Basically gave bed bath," and assisted R60 with transferring from bed to wheelchair with mechanical lift. No splint was observed in R60's hand or visible in the

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room. R60 was observed to continue to hold fingers inward towards palm, forming a fist.

During subsequent observation on 3/29/18, at 9:00 a.m. R60 was observed to be up in her wheelchair in her room, no splint was observed on R60's right hand. NA-H was also in the room, NA-H asked R60 is she wore a hand splint, R60 nodded no. NA-H then asked resident if she did not want to wear the splint, and R60 nodded yes.

During interview on 3/29/18, at 9:08 a.m. NA-H stated she consistently works with R60 and does range of motion exercises in the afternoon, as resident lays down after lunch. NA-H further stated she tried to do twice a day ROM, but does at least once a day, and that she just doesn't have time. NA-H stated she had never seen a right hand splint for R60. NA-H proceeded to remove the group sheet from her pocket, and acknowledged the group sheet indicated right hand splint on at all times except for hygiene, and when needs to be washed.

On 3/29/18, at 9:19 a.m. NA-H went into R60's room and attempted to locate the hand splint, but was not able to find splint.

When interviewed on 3/29/18, at 9:29 a.m. registered nurse (RN)-B stated R60 did have a black hand splint. RN-B further explained R60 was hiding or putting the splint in the garbage. RN-B stated, "Staff should be encouraging her to wear it, I know at one point they were putting a washcloth in her right hand because she was accepting a washcloth." RN-B further stated she recently notified the physician on 3/27/18, and requested the physician discontinue the hand splint, as staff reported they did not have the right

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| F 688 | Continued From page 32<br>hand splint. RN-B indicated the right hand splint had been on the care plan since 4/17/17, and was unable to determine how long the splint had been missing. RN-B explained the implementation of the PROM, ROM, and walking programs were evaluated quarterly by the nurse manager. RN-B explained the review process included nursing assistant charting, resident refusals, program implementation frequency, determination if still beneficial for resident, then a summary note was completed. RN-B was unable to find a recent quarterly summary note; the last quarterly note completed was dated 9/14/17, and did not address the right hand splint.<br><br>On 3/29/18, at 1:52 p.m. R60 was observed in her wheelchair in her room. No right splint or washcloth was observed in hand. RN- B attempted to open R60's hand and was only able to partially open it. RN-B asked R60 if she could put a washcloth her hand and R60 nodded yes. RN-B indicated could, "Definitely" put a washcloth in R60's hand.<br><br>The PROM and AROM (active range of motion) policy dated 6/2016, directed staff to identify limitations in functional ability on the resident's plan of care, notify the physician and/or physical therapy as indicated. The policy further directed PROM may be completed by nursing staff as an independent nursing function and/or physician order, perform ROM exercises as ordered or indicated in the restorative nursing program, document PROM done on electronic treatment record, document changes in functional statues, and notify MD. | F 688 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) | F 689 | | 5/4/18 |

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| F 689 | Continued From page 33<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement fall interventions for 1 of 1 residents (R47) reviewed for accidents.<br><br>Findings include:<br><br>R47's Face Sheet undated, identified current diagnoses of peripheral vascular disease (narrowing of arteries in the legs limiting blood flow), type 2 diabetes, hypertension, and history of intertrochanteric fracture of left femur (hip) fracture.<br><br>R47's quarterly Minimum Data Set (MDS) dated 2/21/18, identified R47 as having had two falls with no injury since prior assessment, required limited assistance of one with bed mobility, extensive assistance of one for transferring, lower extremity impairment on one side, and frequently incontinent of urine. The MDS also identified R47 was cognitively intact.<br><br>R47's Care Area Assessment (CAA) for falls dated 6/5/17, indicated R47 was at high risk for falls. The CAA identified R47's risk factors for falls included intermittent confusion and altered cognition, self transfers, resists using the call | F 689 | It is the policy of Augustana Care Moose Lake Health and Rehabilitation to ensure that the resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Resident R47's grip strips were replaced next to her bed as they had been removed during floor maintenance. A new fall risk observation was completed for R47 which indicated that the grip strips remain appropriate to help prevent falls related to slipping. In addition the fall risk observation didn't indicate that the resident needed to be supervised while in the bathroom as she is able to use her call light to call for assist while on the toilet this was removed from her care plan. Augustana policy titled Accident Prevention and Reduction which was not requested during survey was reviewed and remains appropriate. All facility staff will be educated regarding need to ensure that all residents have grip strips in place per care plan. All residents in the facility will be reviewed to ensure fall risk interventions including grip strips remain appropriate and to ensure | |

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| F 689 | Continued From page 34 | F 689 | | |

light, refuses staff assistance, wandering behaviors, occasionally incontinent of bowel and bladder, and requires assistance of one with transfers and all ADLs (activities of daily living), but is known to refuse cares. The CAA indicated R47 required black grip strips to the floor side of bed and in front of toilet, do not leave alone in bathroom, sign in room to remind resident use call light, observe for unsafe actions, remind of restrictions, and directed to proceed to care plan.

R47's care plan dated 3/5/18, indicated R47 was at high risk for falls, and she was noted to have impaired safety awareness. The care plan interventions included black strips added to floor side of bed and in front of toilet (dated 1/27/17), do not leave resident alone in bathroom (dated 3/14/17), place sign on her closet door to encourage use of call light, falling leaf magnet on door frame because resident was at high risk for falls.

R47 group sheet (nursing assistant instructions) undated, indicated for toileting "A-1 [assist of one] ... Do not leave unattended in bathroom."

R47's progress notes indicated resident experienced four falls in the last 6 months:

1. On 12/27/17, staff heard R47 call out, "Help." Upon arrival, R47 was found to be on the floor at the foot of her bed. When asked what happened, R47 said that she was trying to get to the bathroom and lost her balance. R47 was reminded that she needed to use her call light when she needs to get up. R47 said she was going to, but she forgot. R47 stated she did not hit her head, but her bottom hurt. No bumps or bruises were noted. ROM (range of motion) was

compliance. Resident rooms will be audited following unit cleans to ensure grip strips are present along with all other care planned safety interventions. The DON or designee will audit three residents per week x4 then monthly x3 months to ensure compliance with care planned safety interventions. Results of audits will be reported to the facility QAPI committee. Corrected by: 5/4/18.

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| F 689 | Continued From page 35 | F 689 | | |

good, and R47 had no other complaints of pain.
2. On 1/08/18, staff heard R47 yell, and when they went in room, R47 was lying on the floor between her bed and the bedside table. R47 was on her right side/back partially sitting up. R47 complained of pain in her lower back and stated she hit it when she fell, but denied hitting her head. R47 stated she was trying to get to her wheelchair to go to the bathroom. R47 had gripper socks on. R47 had not asked for help, and the call light was not on. ROM was good. Staff reminded R47 to turn on her call light when she needed to get up, or use the bathroom.
3. On 2/22/18, R47 was found sitting on the floor in her room. R47 was on her buttocks with her feet facing her nightstand. R47 stated that she was trying to turn off her light behind the bed. When asked R47 why she didn't call for help, R47 stated she did not know. R47 had no complaints of discomfort or pain, no facial grimacing was noted when repositioning and transferring. ROM in all four extremities was within normal.
4. On 3/3/18, staff witnessed R47 slide out of wheelchair in her room. R47 did have call light on at the time of the fall. R47 was on her buttocks (on right side) against bed with her feet facing the nightstand. R47 stated she was trying to transfer into bed. R47 had no complaints of pain or discomfort. ROM in all four extremities within normal.

During interview on 3/26/18, at 1:39 p.m. R47 stated staff want her to stay in bed and call for help, and make sure the brakes were on wheelchair. R47 pointed to the sign on the closet door that directed "Push Call-light for help !!" R47 indicated she had multiple falls since admission.

During observation on 3/28/18, 9:20 a.m. R47

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| F 689 | Continued From page 36<br>was observed sitting in her wheelchair in the middle of her room, head held down, arms dangling on both sides of wheelchair. No black strips was observed on the floor side next to R47's bed.<br><br>During subsequent observation on 3/28/18, at 9:33 a.m. R47's bathroom call-light was observed to be on. Nursing assistant (NA)-H was observed to enter R47's room. R47 was up in her wheelchair in the bathroom. NA-H asked R47 if she needed to go to the bathroom. NA-H proceeded to assist R47 with transferring from her wheelchair to the toilet. NA-H then closed the door and left the room. At 9:37 a.m. the bathroom call-light was activated. NA-H was standing in the hallway, outside of R47's room, went into R47's room, and assisted R47 to transfer from the toilet to the wheelchair.<br><br>During interview on 3/28/18, at 9:33 a.m. NA-H stated R47 will go in to the bathroom, put herself on the toilet then pull the bathroom light when she is finished. NA-H further indicated R47 often self transferred, staff answer the call-light as soon as the light goes on, and inform R47 to use the call-light and refrain from self transferring.<br><br>On 3/29/18, 8:46 a.m. R47 was not in her room. No black strips was observed on the floor side next to R47's bed.<br><br>When interviewed on 3/29/18, at 9:29 a.m. registered nurse (RN)-B stated R47's level of alertness varies, and R47 often self transferred in and out of bed, will put the call-light on to get onto the toilet, and use the call light when she was done on the toilet. RN-B further stated R47 has not had any falls in the bathroom, they have been | F 689 | | |

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| F 689 | Continued From page 37<br>mostly by her bed. RN-B acknowledged the care plan directed staff to not to leave R47 alone in the bathroom, "Definitely something I need to discuss with the team." RN-B further indicated R47 should have black strips on the floor next to her bed. At 12:27 p.m. R47's room was reviewed, RN-B confirmed there were no black strips on the floor next to R47's bed. RN-B indicated R47 had resided in current room since 4/17.<br><br>A policy regarding fall protocols was requested but not provided. | F 689 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides. | F 725 | | 5/4/18 |

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| F 725 | Continued From page 38<br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure there was enough staff available for 11 of 18 residents (R3, R5, R12, R13, R15, R17, R38, R56, R60, R62, and R265) interviewed who did not receive the assistance they needed, or felt the assistance was often not timely. In addition, 12 of 16 (NA-B, NA-C, NA-A, NA-D, NA-G, NA-H, NA-I, NA-F, LPN-A, NA-K, RN-A, and NA-E) staff members had concerns about not having enough staff to meet residents needs timely.<br><br>Findings include:<br><br>R3's admission Minimum Data Set (MDS) dated 12/18/17, indicated R3 was cognitively intact, did not refuse cares, required extensive assistance with toileting, and was totally dependent upon two staff to bathe. When interviewed on 3/26/18, at 3:05 p.m. R3 stated, "They are always short of staff." R3 went on to say she has had to wait to get up in the morning until more people arrive, this creates a problem when she has to go to the bathroom and can't hold it. She then becomes incontinent which is upsetting to her. R3 also stated there was not enough staff to make sure she gets a bath every week.<br><br>R3's Point of Care History report indicated she had missed four weekly baths since January 1, 2018, going a full 21 days without a bath between 1/5/18, and 1/26/18. | F 725 | It is the policy of Augustana Care Moose Lake Health and Rehabilitation to ensure that the facility employee's sufficient nursing staff with the appropriate competencies and skills to provide nursing services that meet the needs of the resident population. The Facility Wide Resource Assessment was reviewed and updated related to staffing. This staffing plan is noted to be a suggested plan that will be adjusted as needed. Management staff will use a multifactorial approach for staffing that includes review of census, resident acuity, physical plant structure, budget, mix of available staff and meeting the needs of resident care. Staffing will be adjusted to ensure patient centered care by all available staff not limited to nursing assistant and licensed staff but an interdisciplinary approach will be used. Staffing direction will be given by the Administrator/DON or designee in their absence and reviewed on a daily basis and adjusted as needed. Work flows of the building were evaluated regarding bathing and new bath schedules were revised and implanted on a house wide basis. If for any reason, a bath/shower is missed it will be scheduled for the next day to ensure preferences of frequency of baths/showers is attained. The bath aide as a freestanding position will be eliminated and absorbed into the general | |

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R5's quarterly MDS dated 12/19/17, included R5 was cognitively intact, did not reject cares, required extensive assistance from staff for toileting and total staff assistance with bathing. When interviewed on 3/26/18, at 11:48 a.m. R5 stated there was not enough staff to meet her needs timely. She stated in the morning when she wakes up she needs to go to use the commode right away, it often takes 15 to 20 minutes for someone to come, and by then holding in the urine is painful. Once she gets to the commode she then has trouble urinating. R5 also had a concern about not getting a weekly bath, which she stated she typically does not like bathing, but needs to due to skin concerns under breasts and abdominal folds. R5's Point of Care History report indicated she had only received a bath once each month since January 1, 2018. R5 had refused two of the baths which were scheduled weekly for her.

R12's annual MDS dated 12/29/17, indicated she was cognitively intact, did not reject cares, and required one person physical assistance with ambulation and bathing. R12's care plan dated 1/1/18, indicated staff were to ambulate daily, and assist with a shower twice a week. When interviewed on 3/27/18, at 9:55 a.m. R12 stated she has GERD (gastroesophageal reflux disease) and she will put on her call light at night if she needs medication due to, "Stomach stuff," coming up. Staff do not come right away and this is really uncomfortable for her. R12 expressed concern that she was not being assisted with ambulation every day, she is at risk for falling, so needs staff with her. R12 stated this was upsetting to her. R5's Point of Care History Report indicated she had missed 12 of the twice a week baths since January 1, 2018.

F 725

nursing assistant assignment count. All nursing assistants will perform their assigned resident’s baths per revised schedule and resident wishes. All functional maintenance programs (FMPs) were reviewed for appropriateness with a nursing-therapy review as many were no longer pertinent or appropriate of the current resident status. All care plans were updated accordingly. FMPs will be reviewed on an ongoing basis with the quarterly reviews as a focused area. In addition the facility will continue recruitment and retention efforts aimed at attracting and retaining employees as noted below; Our recruitment efforts include:

- Print Ads in the Evergreen and Gazette
- Electronic Ads using Jazz as a localized site that feeds to others
- Sponsored Ads on Indeed.
- High school and college informational visits,
- Job fairs ranging from Duluth/Superior to the Metro
- Retention Bonus up to $3000
- Outside the box events such as job fairs that are a Pizza party or coffee with Chris events at the local coffee shops
- Hired an external recruiter, Hueman, for C.N.A. individuals only. This additional resource was added to attract the passive job seeker.
- Adapting to the job market and understanding it has been a long term effort for Augustan. We have been formally analyzing the workforce since 2014 when we received a workforce grant

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| F 725 | Continued From page 40<br><br>R13's annual MDS dated 12/30/17, indicated he was cognitively intact, did not reject cares, and was totally dependent upon staff to bathe. R13's care plan dated 11/4/15, indicated he required extensive assistance for bathing and extensive assist for dressing, staff were to encourage and praise him for participation in dressing. An undated nursing assistant worksheet indicated R13 should be assisted with a bath twice a week. When interviewed on 3/26/18, at 1:10 p.m. R13 stated he is supposed to get a bath twice a week, but there is not enough staff on. R13 stated even if there is a bath aide on, they get pulled from giving baths much of the time to do other things. R13 stated he knew he missed a bath last week, this happened quite often, but had not kept track of when he had or had not received the scheduled bath. In addition, R13 stated they have been, "Really short of staff," lately sometimes only having one nurse aide for the 22 residents on the wing, usually have two nurse aides and that is not even enough. R13's other concern was that he is capable of dressing self with set up, but staff do it for him as they are in, "Such a hurry." R13's Point of Care History showed he had missed 13 twice a week baths since January 1, 2018.<br><br>R15's quarterly MDS dated 1/2/18, indicated R15 had moderate cognitive impairment, did not reject cares, required extensive assistance for most activities of daily living (ADLs) and was totally dependent upon staff for bathing. R15's care plan directed staff to provide two baths per week. An undated nursing assistant care sheet indicated R15 was to be bathed twice a week. When interviewed on 3/27/18, at 2:19 p.m. R15 stated he had concerns over not having enough | F 725 | from the Northland foundation. Through this project we adopted additional recruitment efforts in different formats, established an on-site C.n.A. training course which eventually resulted in two on-site certified trainers. The 2017 workforce grant from Leading Age has deepened our understanding of our current workforce and how to create a retention driven environment for those we do attract.<br>• We have established partnerships with the area colleges, schools, and health care community. Examples of these partnerships:<br>• Clinical site for FDLC nursing students and East Central C.N.A. class;<br><br>• One of our current C.N.A. instructors is an adjunct instructor for FDLC teaching a site based Health Occupation course/C.N.A class;<br>• Active participant on the Nursing Advisory board and National accreditation for PTCC<br>• Currently speaking with American Red Cross representative to host Northern MN C.N.A. clinical and informational meetings to attacks more individuals to the industry.<br>• Working with and attending Leading Age workshops specific to the C.N.A. shortage.<br>The DON or designee will audit compliance with staffing through use of resident interviews, monthly resident council meetings and family council meetings. The DON or designee will interview three residents per week x4 weeks then monthly x3 months to ensure | |

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| F 725 | Continued From page 41<br>staff available. R15 stated he often had to wait up to an hour for assistance to get out of bed, and at times staff will come in, turn off his light and tell him they will be back in 10 minutes, but no one comes back and he has to turn on his light again. R15 stated this was frustrating for him. R15's Point of Care History Report identified he had missed 16 of the twice weekly scheduled baths.<br><br>R17's quarterly MDS dated 1/5/18, indicated she was cognitively intact, and required extensive staff assistance for most ADLs. When interviewed on 3/27/18, at 12:21 p.m. R17 stated, "They need more people working here." R17 went on to say that she sometimes has to wait over an hour for assistance to get up in the morning, this makes her uncomfortable and her body hurts when she has to wait so long.<br><br>R38's significant change MDS dated 2/4/18, indicated R38 had severe cognitive impairment, did not refuse cares, was always incontinent of urine, and required total assistance from staff for bathing. R38's care plan dated 1/17/18, directed staff to assist with bathing. An undated nursing assistant worksheet indicated R38 should be assisted with bathing on Wednesdays. When interviewed on 3/26/18, at 1:59 p.m. R38 stated she does not feel there is enough staff available to meet her needs. R38 did not know how often she received a bath, but didn't think it was often enough, and certainly not weekly. R38 also had concerns with having to sit in a wet incontinent brief for up to 15 minutes before staff would assist her in cleaning and a dry pad. R38's Point of Care History Report indicated she had missed five scheduled weekly baths since January 1, 2018. | F 725 | compliance with sufficient staffing.<br>Corrected by: 5/4/2018 | |

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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 |
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| F 725 | Continued From page 42<br>R56's quarterly MDS dated 3/5/18, indicated she was cognitively intact, did not refuse cares and required physical help in part of bathing. R38's care plan dated 5/13/15, directed staff to assist with bathing twice a week on Fridays and Mondays. An undated nursing assistant worksheet directed staff to assist with bathing on Wednesdays, with an extra bath on Saturdays. When interviewed on 3/26/18, at 11:22 a.m. R56 stated they are "Short of help for aides, some bath days wills will come and go without a bath." R56 stated baths do not get, "Made up," if missed, and this was distressing to her. R56's Point of Care History report indicated she had missed 10 of the twice weekly baths since January 1, 2018.<br><br>R60's annual MDS dated 3/2/18, included R60 had severe cognitive impairment, did not refuse cares and required total staff assistance for bathing. R60's care plan directed staff to provide extensive assistance with bathing on Tuesdays. An undated nursing assistant worksheet directed staff to bath R60 on Tuesdays. When interviewed on 3/27/18, at 11:03 a.m. R60 stated the staff is really, "Short," she used to get a bath on Tuesday, then they would come in and set her hair after breakfast. R60 stated they pull the bath aide if someone calls in sick. R60 stated today is Tuesday and no bath yet, she had just found out they did not have anyone to give baths today. R60 stated she does not feel good when she doesn't get a bath at least every week, and really likes to get her hair set. R60's Point of Care History Report indicated she had missed four baths since January 1, 2018, once going 21 days without a bath between 1/9/18, and 1/30/18.<br><br>R62's admission MDS dated 3/7/18, indicated | F 725 | | |

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|---|---|---|---|
| | 245491 | A. BUILDING ______ B. WING ______ | 03/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AUGUSTANA MERCY CARE CENTER** | **710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767** |

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| F 725 | Continued From page 43 | F 725 | | |

she was cognitively intact, and required extensive assistance from staff for most ADLs. When interviewed on 3/2/18, at 1:09 p.m. R62 stated she has had to wait on the bed pan for up to 20 minutes after placing the call light on for staff to remove it.

R265 had been recently admitted, and when interviewed on 3/26/18, at 2:24 p.m. she stated she has trouble getting assistance to the bathroom timely, on one occasion she waited an hour for help. R265 stated, "They don't have enough help."

The facility's Resident Council Meeting Notes dated February 28, 2018 noted a concern over baths being missed due to staff shortages. No follow-up was reported to the residents.

When interviewed on 3/27/18, at 3:47 p.m. nursing assistant (NA)-B stated they are often short staffed, the bath aide gets pulled to work on the floor doing nurse aide duties, and then the baths do not get done. The nursing assistants are not able to do them, and the baths get missed.

When interviewed on 3/27/18, at 3:54 p.m. NA-C stated bath aide gets pulled, "A lot," and they will try and get the baths done the next day, but it usually does not happen.

When interviewed on 3/27/18, on 3:59 p.m. NA-A stated they do not have a bath aide on the afternoon shift, and they are unable to get baths done if they did not get done on the day shift.

When interviewed on 3/27/19, at 4:02 p.m. NA-D stated baths do not always get done, and they don't have time to catch up on them.

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| F 725 | Continued From page 44 | F 725 | | |

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When interviewed on 3/28/18, at 7:05 a.m. NA-G stated they can usually get the work done but it is a struggle, the baths do not always get done.

When interviewed on 3/28/18, at 7:57 a.m. NA-H stated the bath aide had called in for the day. Baths would not get done that day.

When interviewed on 3/28/18, at 9:22 a.m. NA-I stated she had offered to do baths today for her group, if no one volunteers, "They will get done tomorrow."

When interviewed on 3/28/18, at 9:48 a.m. the administrator stated the facility was aware of baths not always getting done, they are currently addressing the issue in their quality assessment and assurance (QAA) committee. The director of nursing (DON) stated they are still working on it, they try to get an extra person in if they do not have a bath aide, or will try and get someone to stay late and try to get the baths done.

When interviewed on 3/29/18, at 7:39 a.m. NA-F stated she is often the assigned bath aide but gets pulled very frequently. NA-F stated she can't get baths done and meet everyone's other needs. NA-F became weepy and stated they, "Can't do a good job," because there is not enough nursing assistants to provide all the cares timely.

When interviewed on 3/29/18, at 10:40 a.m. licensed practical nurse (LPN)-A stated she is unable to assist the nurse aides with bathing as she is too busy herself.

When interviewed on 3/29/18, at 7:56 a.m. NA-K stated they pull the bath aide at least weekly.

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| F 725 | | F 725 | | |

Continued From page 45

NA-K stated there is no way to catch up on them, and sometimes she is asked to stay late to catch up, but not very often.

When interviewed on 3/29/18, at 8:01 a.m. registered nurse (RN)-A stated if they have a nursing assistant call in, they will pull the bath aide from doing baths to replace them. If this happens the nursing assistants working should do all the baths. They do not always report when the baths have not been completed. Occasionally, a nursing assistant will report a bath had not been completed, and she reports this to the afternoon shift so that they can try and do it. This is not followed up on to see if the resident actually received a bath.

When interviewed on 3/29/18, at 8:41 a.m. the human resource director (HR) stated they are aware of nursing assistant shortages and are working with a recruiting company as well as the local colleges and nurse aide training program. They have a nurse aide training program themselves offering on-site clinical's to obtain and retain more nursing assistants. HR stated there are not enough nurse aides in the market place.

When interviewed on 3/29/18, at 7:39 a.m. NA-E who works mainly the night shift, stated there is just her and one nurse on at night for both the 300 and 200 wing, and she is unable to answer call lights timely and if residents want up early, she is unable to help them, they have to wait until more staff come on for the day.

When interviewed on 3/29/18, at 7:47 a.m. the nursing staff scheduler (NS)-A stated if nursing assistants call in, they do attempt to cover the shift. They shouldn't, "Pull" the bath aide, if

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| | 245491 | A. BUILDING ______ B. WING ______ | 03/29/2018 |

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| AUGUSTANA MERCY CARE CENTER | 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767 |

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| F 725 | Continued From page 46<br>unable to replace staff would need to reschedule baths to ensure they got done. They have a lot of openings for nursing assistants, and are working with a recruiting agency to secure more. They have hired more nursing assistants, but they are still in training and expect it to get better. NS-A stated she does not update the Augustana Mercy Health Care Center Report on Nursing Staff when there was staff who called in sick and could not be replaced.<br><br>The Facility Wide Resource Assessment dated 11/2017, identified an approach to staffing to ensure sufficient staff were available to meet the needs of residents at any given time. The plan addressed a need for 80 direct care staff (nursing assistants) at 80 hours on the day shift, 60 hours on the afternoon shift and 24 hours on the night shift.<br><br>The Augustana Mercy Health Care Center Report of Nursing Staff from February 28, 2018, to March 28, 2018, identified they had nurse aides scheduled for between 52 and 80 hours each day shift, before call-ins, only meeting the identified 80 hour need on the Resource Assessment four times. The report also identified they had nurse aides scheduled for between 42 and 60 hours on the evening shift, only meeting the identified 60 hour need twice. | F 725 | | |
| F 770 SS=D | Laboratory Services<br>CFR(s): 483.50(a)(1)(i)<br><br>§483.50(a) Laboratory Services.<br>§483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. | F 770 | | 5/4/18 |

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| F 770 | Continued From page 47<br>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure physician ordered laboratory monitoring was completed for 1 of 5 residents (R56) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R56's Face Sheet printed 3/29/18, identified R56 diagnoses included anemia (a lack of healthy red cells in the blood), morbid obesity and hyperlipidemia (condition with high levels of fat particles in the blood).<br><br>R56's most recent signed Physician Order Report dated 3/28/18, identified a laboratory monitoring order for, "Other Test: (Lipids)," to be completed annually in October. A start date for this laboratory monitoring order was listed as 12/3/14. In addition, the report identified R56 currently received several medications which included:<br><br>- Baclofen (an antispastic agent) 5 milligrams (mg) three times a day for multiple sclerosis;<br>- Zocor (used to treat high cholesterol) 20 mg everyday at bedtime for hyperlipidemia;<br>- Hydrochlorothiazide (a diuretic) 25 mg once a day for high blood pressure; and<br>- Zyprexa (an antipsychotic medication) 2.5 mg once a day for psychotic disorder.<br><br>R56's medical record was reviewed, and lacked any evidence a lipid panel (laboratory test | F 770 | It is the policy of Augustana Care Moose Lake Health and Rehabilitation to provide laboratory services that meet the needs of the resident population. The “lipid panel” for R56 was ordered and results were reviewed by the resident’s physician on 4/24/18 with no noted changes to the plan of care. The Augustana policy entitled lab ordering was reviewed and updated. All LN and health information employees will be re-educated on the lab ordering procedure. All residents in the building will have their lab orders reviewed for compliance. DON or Designee will audit two resident records per week x4 weeks then monthly x 3 months to ensure compliance. Results of all audits will be reviewed by the QAPI committee.<br>Corrected by: 5/4/2018. | |

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| F 770 | Continued From page 48<br>completed to screen for abnormalities in the blood lipids, such as cholesterol) had been completed in October 2017, as had been ordered by R56's physician.<br><br>When interviewed on 3/29/18, at 11:27 a.m. registered nurse (RN)-A stated she had reviewed R56's medical record, and contacted the laboratory itself, however, R56 did not have a lipid panel completed in 2017. RN-A explained the laboratory test was not drawn, despite it being a long-standing order for R56 adding, "This one was just missed." Further, RN-A stated ordered laboratory testing should be completed for residents to see if medications needed to be continued or adjusted to avoid adverse effects.<br><br>During interview on 3/29/18, at 12:10 p.m. the consulting pharmacist (CP) stated he had reviewed R56's medical record before and must have missed identifying the lipid panel had not been completed. CP explained if the physician ordered a laboratory test to be completed, "I would expect it to be done," however, "None of us [staff] identified it."<br><br>A facility provided Medication Regimen Review (MMR) policy dated 2/2018, directed the CP would review each resident's medication regimen on a monthly basis for potential irregularities. A listing of these potential irregularities included, "Laboratory results, diagnostic studies, or other medication therapy measurements are obtained by prescribers/staff and acted upon." Further, a provided Clinical Record of Labs policy dated 6/2014, identified a procedure to ensure laboratory results were placed in the medical record, however, lacked any direction or process to ensure they were completed as ordered by the | F 770 | | |

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| F 770 | Continued From page 49 physician. | F 770 | | |

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

F5491028

PRINTED: 05/01/2018
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245491 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **03/28/2018** |

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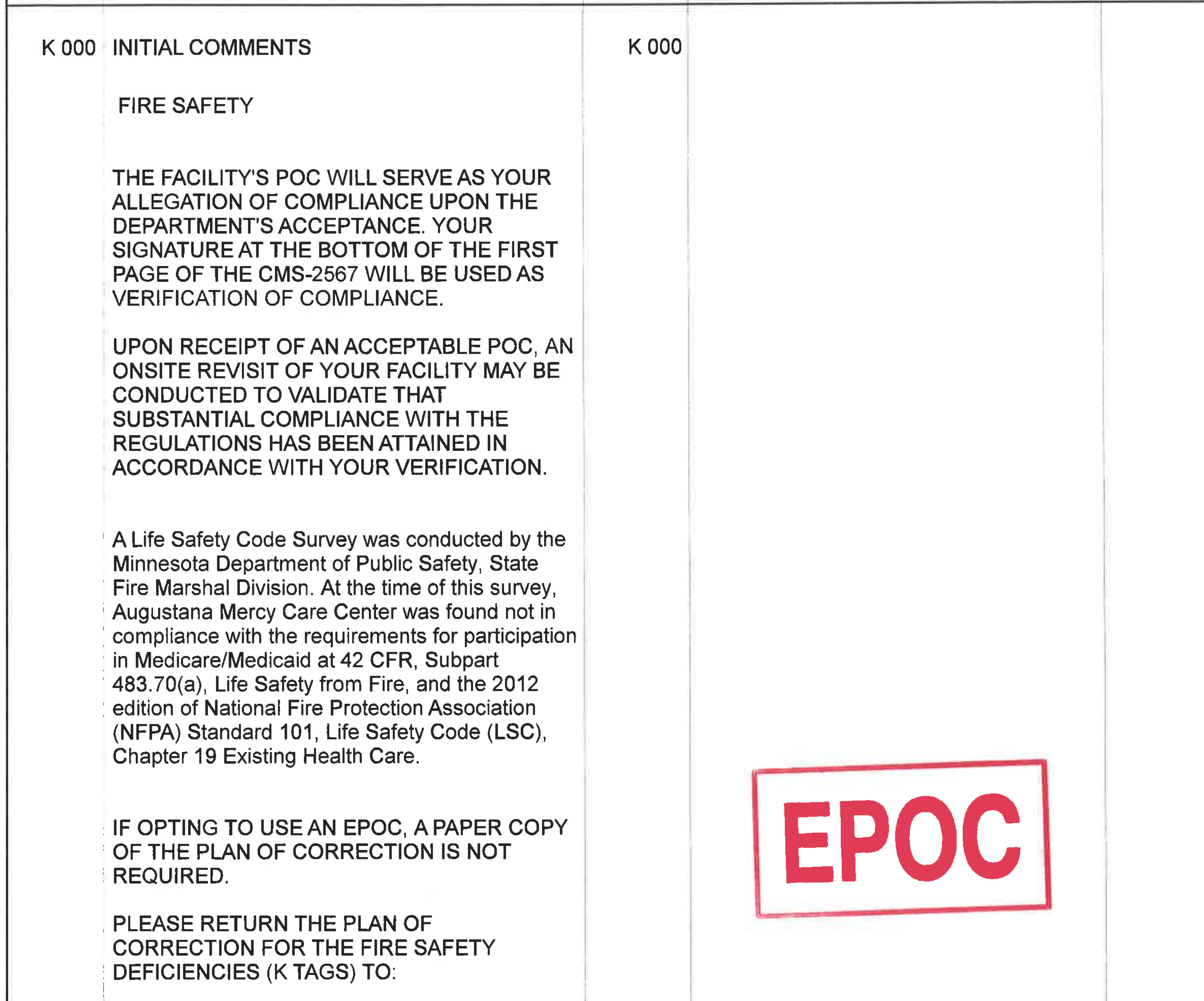
| **AUGUSTANA MERCY CARE CENTER** | **710 SOUTH KENWOOD AVENUE**<br>**MOOSE LAKE, MN 55767** |



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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Augustana Mercy Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 04/25/2018 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245491 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/28/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 000 | Continued From page 1 | K 000 | | |

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Augustana Mercy Care Center is a 1-story building with small partial basement. The original building was constructed in 1964 and additions constructed in 1968 and 1977, all of Type II(111 construction). A single story hospital adjoins the nursing home and is separated by a 4 hour wall. To the south a single story type V(111) assisted living facility also adjoins and is separated by 4 hour construction with a 3 hour rated, self closing door. Therefore, the nursing home was inspected as one building.

The building is fully sprinkler protected. The

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| | 245491 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ____ | **03/28/2018** |

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| K 000 | Continued From page 2<br>facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.<br><br>The facility has a licensed capacity 72 beds and had a census of 64 at the time of the survey.<br><br>The requirement at 42 CFR Subpart 483.70(a) is NOT MET. | K 000 | | |
| K 901<br>SS=F | Fundamentals - Building System Categories<br>CFR(s): NFPA 101<br><br>Fundamentals - Building System Categories<br>Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel.<br>Chapter 4 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 72 of 72 residents, as well as an undetermined number of staff, and visitors.<br><br>Findings include: | K 901 | It is the policy of Augustana Mercy Care to complete a formal and documented risk assessment for building systems, and equipment performed by a qualified staff person.<br>Corrective Action Description:<br>The facility completed an equipment specific risk assessment to record the level of risk determined for all patient care equipment in the facility. The Electrical and Gas Equipment Assessment Tool will | 4/27/18 |

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| K 901 | Continued From page 3<br>On facility tour between 10:30 a.m. to 1:30 p.m. on 03/28/2018, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility's risk assessment document did not account for all of the systems and equipment identified in chapter 10 and 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition.<br><br>This deficient condition was confirmed by the Maintenance Supervisor. | K 901 | be reviewed on an annual basis, and updated at the time of any change or addition of resident care equipment. The current assessment has been attached to this ePOC.<br><br>(DATE Corrected: 4/27/18)<br>Completed by: Jason Johnson<br>Director of Maintenance | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
April 17, 2018

Ms. Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

Re: State Nursing Home Licensing Orders - Project Numbers S5491027, H5491019, H5491020

Dear Ms. Peterson:

The above facility was surveyed on March 26, 2018 through March 29, 2018 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 Teresa Ament, Unit Supervisor, at (218) 302-6151 or teresa.ament@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,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

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 |
|---|---|---|---|
| | 00049 | A. BUILDING: ______ B. WING ______ | 03/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUGUSTANA MERCY CARE CENTER | 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767 |

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| 2 000 | Initial Comments | 2 000 | | |

*****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

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| 2 000 | Continued From page 1<br><br>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.<br><br>On March 26, 2018, through March 29, 2018, 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.<br><br>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.<br><br>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. | 2 000 | | |
| 2 800 | MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements | 2 800 | | 5/4/18 |

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| 2 800 | Continued From page 2<br><br>Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure there was enough staff available for 11 of 18 residents (R3, R5, R12, R13, R15, R17, R38, R56, R60, R62, and R265) interviewed who did not receive the assistance they needed, or felt the assistance was often not timely. In addition, 12 of 16 (NA-B, NA-C, NA-A, NA-D, NA-G, NA-H, NA-I, NA-F, LPN-A, NA-K, RN-A, and NA-E) staff members had concerns about not having enough staff to meet residents needs timely.<br><br>Findings include:<br><br>R3's admission Minimum Data Set (MDS) dated 12/18/17, indicated R3 was cognitively intact, did not refuse cares, required extensive assistance with toileting, and was totally dependent upon two staff to bathe. When interviewed on 3/26/18, at 3:05 p.m. R3 stated, "They are always short of staff." R3 went on to say she has had to wait to get up in the morning until more people arrive, this creates a problem when she has to go to the bathroom and can't hold it. She then becomes incontinent which is upsetting to her. R3 also stated there was not enough staff to make sure she gets a bath every week. | 2 800 | Corrected | |

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R3's Point of Care History report indicated she had missed four weekly baths since January 1, 2018, going a full 21 days without a bath between 1/5/18, and 1/26/18.

R5's quarterly MDS dated 12/19/17, included R5 was cognitively intact, did not reject cares, required extensive assistance from staff for toileting and total staff assistance with bathing. When interviewed on 3/26/18, at 11:48 a.m. R5 stated there was not enough staff to meet her needs timely. She stated in the morning when she wakes up she needs to go to use the commode right away, it often takes 15 to 20 minutes for someone to come, and by then holding in the urine is painful. Once she gets to the commode she then has trouble urinating. R5 also had a concern about not getting a weekly bath, which she stated she typically does not like bathing, but needs to due to skin concerns under breasts and abdominal folds. R5's Point of Care History report indicated she had only received a bath once each month since January 1, 2018. R5 had refused two of the baths which were scheduled weekly for her.

R12's annual MDS dated 12/29/17, indicated she was cognitively intact, did not reject cares, and required one person physical assistance with ambulation and bathing. R12's care plan dated 1/1/18, indicated staff were to ambulate daily, and assist with a shower twice a week. When interviewed on 3/27/18, at 9:55 a.m. R12 stated she has GERD (gastroesophageal reflux disease) and she will put on her call light at night if she needs medication due to, "Stomach stuff," coming up. Staff do not come right away and this is really uncomfortable for her. R12 expressed concern that she was not being assisted with

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ambulation every day, she is at risk for falling, so needs staff with her. R12 stated this was upsetting to her. R5's Point of Care History Report indicated she had missed 12 of the twice a week baths since January 1, 2018.

R13's annual MDS dated 12/30/17, indicated he was cognitively intact, did not reject cares, and was totally dependent upon staff to bathe. R13's care plan dated 11/4/15, indicated he required extensive assistance for bathing and extensive assist for dressing, staff were to encourage and praise him for participation in dressing. An undated nursing assistant worksheet indicated R13 should be assisted with a bath twice a week. When interviewed on 3/26/18, at 1:10 p.m. R13 stated he is supposed to get a bath twice a week, but there is not enough staff on. R13 stated even if there is a bath aide on, they get pulled from giving baths much of the time to do other things. R13 stated he knew he missed a bath last week, this happened quite often, but had not kept track of when he had or had not received the scheduled bath. In addition, R13 stated they have been, "Really short of staff," lately sometimes only having one nurse aide for the 22 residents on the wing, usually have two nurse aides and that is not even enough. R13's other concern was that he is capable of dressing self with set up, but staff do it for him as they are in, "Such a hurry." R13's Point of Care History showed he had missed 13 twice a week baths since January 1, 2018.

R15's quarterly MDS dated 1/2/18, indicated R15 had moderate cognitive impairment, did not reject cares, required extensive assistance for most activities of daily living (ADLs) and was totally dependent upon staff for bathing. R15's care plan directed staff to provide two baths per week.

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An undated nursing assistant care sheet indicated R15 was to be bathed twice a week. When interviewed on 3/27/18, at 2:19 p.m. R15 stated he had concerns over not having enough staff available. R15 stated he often had to wait up to an hour for assistance to get out of bed, and at times staff will come in, turn off his light and tell him they will be back in 10 minutes, but no one comes back and he has to turn on his light again. R15 stated this was frustrating for him. R15's Point of Care History Report identified he had missed 16 of the twice weekly scheduled baths.

R17's quarterly MDS dated 1/5/18, indicated she was cognitively intact, and required extensive staff assistance for most ADLs. When interviewed on 3/27/18, at 12:21 p.m. R17 stated, "They need more people working here." R17 went on to say that she sometimes has to wait over an hour for assistance to get up in the morning, this makes her uncomfortable and her body hurts when she has to wait so long.

R38's significant change MDS dated 2/4/18, indicated R38 had severe cognitive impairment, did not refuse cares, was always incontinent of urine, and required total assistance from staff for bathing. R38's care plan dated 1/17/18, directed staff to assist with bathing. An undated nursing assistant worksheet indicated R38 should be assisted with bathing on Wednesdays. When interviewed on 3/26/18, at 1:59 p.m. R38 stated she does not feel there is enough staff available to meet her needs. R38 did not know how often she received a bath, but didn't think it was often enough, and certainly not weekly. R38 also had concerns with having to sit in a wet incontinent brief for up to 15 minutes before staff would assist her in cleaning and a dry pad. R38's Point of Care History Report indicated she had missed

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five scheduled weekly baths since January 1, 2018.

R56's quarterly MDS dated 3/5/18, indicated she was cognitively intact, did not refuse cares and required physical help in part of bathing. R38's care plan dated 5/13/15, directed staff to assist with bathing twice a week on Fridays and Mondays. An undated nursing assistant worksheet directed staff to assist with bathing on Wednesdays, with an extra bath on Saturdays. When interviewed on 3/26/18, at 11:22 a.m. R56 stated they are "Short of help for aides, some bath days wills will come and go without a bath." R56 stated baths do not get, "Made up," if missed, and this was distressing to her. R56's Point of Care History report indicated she had missed 10 of the twice weekly baths since January 1, 2018.

R60's annual MDS dated 3/2/18, included R60 had severe cognitive impairment, did not refuse cares and required total staff assistance for bathing. R60's care plan directed staff to provide extensive assistance with bathing on Tuesdays. An undated nursing assistant worksheet directed staff to bath R60 on Tuesdays. When interviewed on 3/27/18, at 11:03 a.m. R60 stated the staff is really, "Short," she used to get a bath on Tuesday, then they would come in and set her hair after breakfast. R60 stated they pull the bath aide if someone calls in sick. R60 stated today is Tuesday and no bath yet, she had just found out they did not have anyone to give baths today. R60 stated she does not feel good when she doesn't get a bath at least every week, and really likes to get her hair set. R60's Point of Care History Report indicated she had missed four baths since January 1, 2018, once going 21 days without a bath between 1/9/18, and 1/30/18.

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R62's admission MDS dated 3/7/18, indicated she was cognitively intact, and required extensive assistance from staff for most ADLs. When interviewed on 3/2/18, at 1:09 p.m. R62 stated she has had to wait on the bed pan for up to 20 minutes after placing the call light on for staff to remove it.

R265 had been recently admitted, and when interviewed on 3/26/18, at 2:24 p.m. she stated she has trouble getting assistance to the bathroom timely, on one occasion she waited an hour for help. R265 stated, "They don't have enough help."

The facility's Resident Council Meeting Notes dated February 28, 2018 noted a concern over baths being missed due to staff shortages. No follow-up was reported to the residents.

When interviewed on 3/27/18, at 3:47 p.m. nursing assistant (NA)-B stated they are often short staffed, the bath aide gets pulled to work on the floor doing nurse aide duties, and then the baths do not get done. The nursing assistants are not able to do them, and the baths get missed.

When interviewed on 3/27/18, at 3:54 p.m. NA-C stated bath aide gets pulled, "A lot," and they will try and get the baths done the next day, but it usually does not happen.

When interviewed on 3/27/18, on 3:59 p.m. NA-A stated they do not have a bath aide on the afternoon shift, and they are unable to get baths done if they did not get done on the day shift.

When interviewed on 3/27/19, at 4:02 p.m. NA-D stated baths do not always get done, and they

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don't have time to catch up on them.

When interviewed on 3/28/18, at 7:05 a.m. NA-G stated they can usually get the work done but it is a struggle, the baths do not always get done.

When interviewed on 3/28/18, at 7:57 a.m. NA-H stated the bath aide had called in for the day. Baths would not get done that day.

When interviewed on 3/28/18, at 9:22 a.m. NA-I stated she had offered to do baths today for her group, if no one volunteers, "They will get done tomorrow."

When interviewed on 3/28/18, at 9:48 a.m. the administrator stated the facility was aware of baths not always getting done, they are currently addressing the issue in their quality assessment and assurance (QAA) committee. The director of nursing (DON) stated they are still working on it, they try to get an extra person in if they do not have a bath aide, or will try and get someone to stay late and try to get the baths done.

When interviewed on 3/29/18, at 7:39 a.m. NA-F stated she is often the assigned bath aide but gets pulled very frequently. NA-F stated she can't get baths done and meet everyone's other needs. NA-F became weepy and stated they, "Can't do a good job," because there is not enough nursing assistants to provide all the cares timely.

When interviewed on 3/29/18, at 10:40 a.m. licensed practical nurse (LPN)-A stated she is unable to assist the nurse aides with bathing as she is too busy herself.

When interviewed on 3/29/18, at 7:56 a.m. NA-K stated they pull the bath aide at least weekly.

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NA-K stated there is no way to catch up on them, and sometimes she is asked to stay late to catch up, but not very often.

When interviewed on 3/29/18, at 8:01 a.m. registered nurse (RN)-A stated if they have a nursing assistant call in, they will pull the bath aide from doing baths to replace them. If this happens the nursing assistants working should do all the baths. They do not always report when the baths have not been completed. Occasionally, a nursing assistant will report a bath had not been completed, and she reports this to the afternoon shift so that they can try and do it. This is not followed up on to see if the resident actually received a bath.

When interviewed on 3/29/18, at 8:41 a.m. the human resource director (HR) stated they are aware of nursing assistant shortages and are working with a recruiting company as well as the local colleges and nurse aide training program. They have a nurse aide training program themselves offering on-site clinical's to obtain and retain more nursing assistants. HR stated there are not enough nurse aides in the market place.

When interviewed on 3/29/18, at 7:39 a.m. NA-E who works mainly the night shift, stated there is just her and one nurse on at night for both the 300 and 200 wing, and she is unable to answer call lights timely and if residents want up early, she is unable to help them, they have to wait until more staff come on for the day.

When interviewed on 3/29/18, at 7:47 a.m. the nursing staff scheduler (NS)-A stated if nursing assistants call in, they do attempt to cover the shift. They shouldn't, "Pull" the bath aide, if unable to replace staff would need to reschedule

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| 2 800 | Continued From page 10 | 2 800 | | |

baths to ensure they got done. They have a lot of openings for nursing assistants, and are working with a recruiting agency to secure more. They have hired more nursing assistants, but they are still in training and expect it to get better. NS-A stated she does not update the Augustana Mercy Health Care Center Report on Nursing Staff when there was staff who called in sick and could not be replaced.

The Facility Wide Resource Assessment dated 11/2017, identified an approach to staffing to ensure sufficient staff were available to meet the needs of residents at any given time. The plan addressed a need for 80 direct care staff (nursing assistants) at 80 hours on the day shift, 60 hours on the afternoon shift and 24 hours on the night shift.

The Augustana Mercy Health Care Center Report of Nursing Staff from February 28, 2018, to March 28, 2018, identified they had nurse aides scheduled for between 52 and 80 hours each day shift, before call-ins, only meeting the identified 80 hour need on the Resource Assessment four times. The report also identified they had nurse aides scheduled for between 42 and 60 hours on the evening shift, only meeting the identified 60 hour need twice.

SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure appropriate nursing staffing levels were available to care for the residents. The administrator or designee could develop monitoring systems to ensure ongoing compliance

TIME PERIOD FOR CORRECTION: Twenty-one

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| **AUGUSTANA MERCY CARE CENTER** | **710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767** |

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| 2 800 | Continued From page 11<br>(21) days. | 2 800 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide assessed interventions from occupational therapy (OT) to prevent skin breakdown in a contracted hand for 1 of 5 residents (R214) reviewed for mobility and who had limited range of motion (ROM).<br><br>Findings include:<br><br>R214's 14-day Minimum Data Set (MDS) dated 3/5/18, identified R214 had severe cognitive impairment, and required extensive assistance with bed mobility, transfers and personal hygiene. Further, R214 had a functional limitation in ROM on one side with no skin lesions, burns or other non-pressure related wounds. | 2 830 | Corrected. | 5/4/18 |

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| 2 830 | Continued From page 12 | 2 830 | | |

R214's Therapy to Nursing Communication sheet dated 3/9/18, identified a directive from occupational therapy (OT) for, "Lambs wool to [R214's] [left] hand, daily skin care to be provided to [left] hand." The sheet was signed by occupational therapist (OT)-A. Further, R214's care plan revised 3/28/18, identified an intervention directing, "Apply lambs wool to left hand daily, skin care to be provided to left hand."

During observation on 3/26/18, at 3:54 p.m. R214 was laying in bed in her room. R214 had a visibly contracted left hand (shortening and hardening of muscle) with the fingers turned inward, towards her palm, causing the left hand to appear like a fist. There was no lambs wool visible in R214's left hand.

During subsequent observation(s) on 3/27/18, at 10:19 a.m., 3/27/18, at 7:23 p.m. and 3/28/18, at 7:16 a.m. R214 was again observed to not have any lambs wool inside or on the left hand as directed by the OT recommendation.

On 3/28/18, at 7:55 a.m. nursing assistant (NA)-A and NA-B entered R214's room to provide morning cares. R214 was washed, dressed, and assisted to sit in her wheelchair using a mechanical lift. Neither of the NA staff provided or applied lambs wool to R214's left hand during these cares, nor when they were completed. R214's left hand was observed and lacked any visible cuts, lesions or skin damage.

When interviewed on 3/28/18, at 9:09 a.m. NA-A stated she was not aware of any splints or lambs wool being used in R214's left hand. NA-A explained she had never seen one used prior, either.

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| 2 830 | Continued From page 13 | 2 830 | | |

During interview on 3/28/18, at 9:50 a.m. NA-B stated she had never seen lambs wool being used on R214's contracted left hand, however, staff will provide her with a squeeze ball shaped like a lamb, and she will often hold it in her other hand which was not contracted. NA-B stated R214 should be trying to use the squeeze ball in her left, contracted hand. Further, NA-B explained therapy recommendations for splints, devices, and ROM programs would be placed inside a resident's closet door so staff could reference them when caring for a person. At 12:44 p.m. NA-B and the surveyor observed R214's inside closet door, and NA-B verified there were no instructions posted pertaining to the application of lambs wool to R214's left hand.

When interviewed on 3/28/18, at 1:34 p.m. registered nurse (RN)-A explained therapy provides nursing with communication sheets with post-therapy discharge instructions to be implemented by nursing staff. R214's therapy communication (dated 3/9/18, 19 days prior) directed to insert lambs wool into R214's contracted left hand, however, RN-A stated the NA just brought a concern to her today as they were fearful R214 may attempt to eat it. RN-A was unable to answer if lambs wool had ever been used in R214's left hand as had been directed by OT on 3/9/18. Further, RN-A stated the NA staff "Have to be accountable" and bring concerns to her sooner so they could be clarified and coordinated with therapy adding, "Then we can have appropriate care for the resident."

During interview on 3/29/18, at 11:16 a.m. OT-A stated R214 was unable to use a palm protector on the left hand due to the contracture. The lambs wool should have been placed in the left hand for "protecting the skin" and preventing skin

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| 2 830 | Continued From page 14<br>breakdown. OT-A explained if staff had concerns with interventions provided by OT, they should notify the department to have them addressed "sooner than that [19 days later]" as their was "always a risk of [further] decline" in ROM and skin breakdown.<br><br>A facility policy on coordination of care with therapies (PT / OT) and/or contracture splint/device use was requested, however, none were provided.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and/or review policies and provide education for staff regarding coordination/communication with occupational therapy services related to implementation of resident care intervtions. The DON or designee could conduct random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 2 895 | MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion<br><br>Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>B. a resident with a limited range of motion receives appropriate treatment and services to | 2 895 | | 5/4/18 |

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| 2 895 | Continued From page 15<br>increase range of motion and to prevent further decrease in range of motion.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to follow care planned interventions to maintain or improve range of motion for 1 of 5 residents (R60) reviewed for range of motion.<br><br>Findings include:<br><br>R60's Face Sheet undated, indicated diagnoses included aphasia (language impairment affecting the production or comprehension of speech), hemiplegia (paralysis of one side of the body and hemiparesis (weakness of the entire side of the body) following cerebral infarction (stroke).<br><br>R60's annual Minimum Data Set (MDS) dated 3/2/18, indicated R60 had no rejection of cares, rarely or never understood, and required extensive assistance for bed mobility, transfers, dressing, and personal hygiene. The MDS also identified functional limitation in range of motion (ROM) of upper (shoulder, elbow, wrist, and hand) and lower extremities (hip, knee, ankle, and foot).<br><br>R60's Care Area Assessment (CAA) for ADLs (activities of daily living) dated 3/12/18, indicated R60 required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, grooming, and total assist with bathing. The MDS also indicated R60 required supervision with eating, and directed to proceed to the care plan.<br><br>R60's Physician Order Report dated 3/29/18, | 2 895 | Corrected. | |

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| 2 895 | Continued From page 16 | 2 895 | | |

revealed an order for right hand splint at all times, except during hygiene when needs to be washed, every shift and passive range of motion (PROM) to the right fingers, wrist, elbow and shoulder to patient tolerance 10 repetitions twice a day (days and evenings).

R60's care plan dated 12/01/17, identified a goal to maintain current ROM in upper extremity or increase ROM in right upper extremity. The interventions directed staff to provide gentle PROM to right upper extremity, shoulder, elbow, digits, and to wear splint at all times except for hygiene and when needs to be washed. The care plan also indicated R60 refused to wear splint frequently.

R60's group sheet (nursing assistant instructions) indicated right hand splint at all times except for hygiene and when needs to be washed, and ROM program: right fingers, wrist, elbow, and shoulders, PROM to tolerance a.m. and p.m., 10 repetitions.

R60's Restorative Nursing records indicated PROM to right fingers, wrist, elbow and shoulder, to tolerance, 10 repetitions twice daily (in a.m. and p.m.) was not consistently provided:
1/1/18- 1/31/18- missed 14 times
2/1/18- 2/28/18- missed 14 times
3/1/18- 3/28/18- missed 6 times

During observation on 3/27/18, at 10:54 a.m. R60 was seated in her wheelchair, visiting with family member (FM)-A. R60 had a visibly contracted right hand (shortening and hardening of muscle) with the fingers turned inward, towards palm, causing left hand to appear like a fist. There was no splint in R60's left hand.

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| 2 895 | Continued From page 17 | 2 895 | | |

Continued From page 17

During interview on 3/27/18, at 11:25 a.m. FM-A stated R60 had a stroke and had weakness on the right side, and contracture of the right hand. FM-A further stated R60 had splints for hands but was not always on, "Like now," "Might be refusal".

On 3/28/18, at 8:32 a.m. nursing assistant (NA)-H was observed finishing morning cares for R60. NA-H stated she assisted with putting residents clothes on, washed face, "Basically gave bed bath," and assisted R60 with transferring from bed to wheelchair with mechanical lift. No splint was observed in R60's hand or visible in the room. R60 was observed to continue to hold fingers inward towards palm, forming a fist.

During subsequent observation on 3/29/18, at 9:00 a.m. R60 was observed to be up in her wheelchair in her room, no splint was observed on R60's right hand. NA-H was also in the room, NA-H asked R60 is she wore a hand splint, R60 nodded no. NA-H then asked resident if she did not want to wear the splint, and R60 nodded yes.

During interview on 3/29/18, at 9:08 a.m. NA-H stated she consistently works with R60 and does range of motion exercises in the afternoon, as resident lays down after lunch. NA-H further stated she tried to do twice a day, but does at least once a day, she just doesn't have time. NA-H stated she had never seen a right hand splint for R60. NA-H proceeded to remove the group sheet from her pocket, and acknowledged the group sheet indicated right hand splint on at all times except for hygiene, and when needs to be washed.

On 3/29/18, at 9:19 a.m. NA-H went into R60's room and attempted to locate the hand splint, but was not able to find splint.

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| 2 895 | Continued From page 18 | 2 895 | | |

When interviewed on 3/29/18, at 9:29 a.m. registered nurse (RN)-B stated R60 did have a black hand splint. RN-B further explained R60 was hiding or putting the splint in the garbage. RN-B stated, "Staff should be encouraging her to wear it, I know at one point they were putting a washcloth in her right hand because she was accepting a washcloth." RN-B further stated she recently notified the physician on 3/27/18, and requested the physician discontinue the hand splint, as staff reported they did not have the right hand splint. RN-B indicated the right hand splint had been on the care plan since 4/17/17, and was unable to determine how long the splint had been missing. RN-B explained the implementation of the PROM, ROM, and walking programs were evaluated quarterly by the nurse manager. RN-B explained the review process included nursing assistant charting, resident refusals, program implementation frequency, determination if still beneficial for resident, then a summary note was completed. RN-B was unable to find a recent quarterly summary note; the last quarterly note completed was dated 9/14/17, and did not address the right hand splint.

On 3/29/18, at 1:52 p.m. R60 was observed in her wheelchair in her room. No right splint or washcloth was observed in hand. RN- B attempted to open R60's hand and was only able to partially open it. RN-B asked R60 if she could put a washcloth her hand and R60 nodded yes. RN-B indicated could, "Definitely" put a washcloth in R60's hand.

The PROM and AROM (active range of motion) policy dated 6/2016, directed staff to identify limitations in functional ability on the resident's plan of care, notify the physician and/or physical

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| 2 895 | Continued From page 19<br>therapy as indicated. The policy further directed PROM may be completed by nursing staff as an independent nursing function and/or physician order, perform ROM exercises as ordered or indicated in the restorative nursing program, document PROM done on electronic treatment record, document changes in functional statues, and notify MD.<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and/or review/revise policies and procedures to ensure residents receive range of motion services as determined necessary by their individualized plan of care. The DON or designee could provide education to all appropriate staff on these polices and procedures. The DON or designee could do random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 895 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>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:<br><br>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<br><br>B. a resident who has pressure sores | 2 900 | | 5/4/18 |

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| 2 900 | Continued From page 20<br>receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide timely assistance with repositioning to promote healing and prevent development of new pressure ulcers for 1 of 1 (R17) residents reviewed with current pressure ulcers.<br><br>Findings include:<br><br>R17's quarterly Minimum Data Set (MDS) dated 1/5/18, included diagnoses of cardiovascular disease, diabetes mellitus type 2, chronic kidney disease, and peripheral vascular disease. The MDS indicated no cognitive impairment, extensive assistance with activities of daily living (ADLs), no rejection of cares and no pressure ulcers.<br><br>R17's annual MDS dated 7/7/17, indicated no cognitive impairment, extensive assistance with ADLS, no rejection of cares and no pressure ulcers. The Pressure Ulcer Care Area Assessment (CAA) dated 7/14/17, indicated CAA triggered due to extensive assistance with mobility, frequently incontinent of bladder, and at risk for skin alterations. R17 scored 15 on the Braden Scale (tool used to predict pressure ulcer risk) placing resident at risk for pressure ulcers. The CAA also indicated R17 could be non-compliant with repositioning. Staff were to turn and reposition every 2 hours, and provide an air mattress on the bed. | 2 900 | Corrected | |

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| 2 900 | Continued From page 21 | 2 900 | | |

R17's care plan dated as last reviewed on 1/22/18, indicated a potential for alteration in skin integrity related to impaired mobility, diabetes mellitus, history of pressure ulcer, and bladder incontinence. R17 was noted to refuse to reposition at times when in bed and wheelchair. R17 was also noted to have an area of moisture associated skin damage (MASD) to the left lateral gluteal crease. Interventions included: air bed with setting of 6, pressure relieving cushion on her wheelchair, turn and reposition every 2 hours, follow toileting schedules, assess skin folds for moisture, and nurse to complete body audit weekly. The care plan did not address current pressure ulcers to the buttocks.

On 3/27/18, at 5:20 p.m. R17 was observed in her room next to bed in her wheelchair waiting for supper to arrive. An air mattress was noted on the bed.

- At 6:19 p.m. R17 was observed eating supper at her bedside.
- At 6:40 p.m. continued eating supper.
- At 7:04 p.m. R17 had call light on. A nurse answered the light and shut door behind her.
- At 7:10 p.m. registered nurse/nurse manager (RN)-B came out of R17's room and began wheeling her down the hall. RN-B stated she was taking R17 for a ride.
- At 7:30 p.m. RN-B wheeled R17 back to her room. RN-B stated when she answered the call light she helped with TV channel. No cares were provided.
- At 7:38 p.m. nursing assistant (NA)-C answered R17's call light and then went to get standing lift. NA-C stated R17 needed to use the bathroom and she would take her to the toilet. NA-C verified R17 had not been assisted with repositioning since before suppertime.

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| 2 900 | Continued From page 22 | 2 900 | | |

On 3/28/18, at 7:07 a.m. R17 was observed in her room next to bed in her wheelchair. R17 stated she was up early around 6:00 a.m. R17 stated she had sores on her bottom, but they were better.

- At 7:20 a.m. R17 was observed in the same position.
- At 7:40 a.m. R17 was in the same position, asleep in her wheelchair.
- At 8:10 a.m. same position.
- At 08:26 a.m. same position. The social worker entered R17's room to notify her of an upcoming dental appointment.
- At 8:30 a.m. R17 was served breakfast in her room. Eating independently.
- At 9:00 a.m. R17 was done with breakfast.
-At 9:20 a.m. NA-H was interviewed regarding when R17 was last assisted with repositioning. NA-H stated the night staff would have repositioned her when they assisted her with morning cares, and transferred her into the wheelchair. NA -H verified she had not checked for toileting or repositioning since she started work at 6:00 a.m.
- At 9:30 a.m. R17 had company visiting, and refused to be repositioned or toileted. NA-H reported to licensed practical nurse (LPN)-B that R17 refused to be repositioned. LPN-B spoke with R17 and R17 continued to refuse. LPN-B added that she explained the importance of off-loading (relieving pressure to an area) but R17 still refused, but may allow at 10:00 a.m.
-9:40 a.m. NA-H stated R17 can get feisty and will refuse cares. NA-H verified R17 should be toileted and repositioned every 2 hours, and R17 has open areas on her buttocks that are improving. Observations ended.
-At 11:38 a.m. NA-H stated R17 was finally

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| 2 900 | Continued From page 23<br><br>repositioned and toileted at 11:00 a.m. by another NA.<br><br>On 3/29/18, at 07:45 a.m. R17 was observed in bed awake. R17 was positioned on her right side with a pillow behind her lower back.<br><br>-At 8:01 a.m. observed RN-C/Nurse Educator perform morning cares. RN-C stated she completed R17's skin assessment upon a recent hospital return, and her pressure ulcers were much improved. R17 was turned on side and observed pressure ulcer (PU) to the right buttocks. A very small scabbed open area was observed to the left buttocks. The PU to the right buttocks was healed. R17's wheelchair was observed to have a pressure relieving cushion. RN-C stated the wound nurse would measure the PU today.<br><br>R17's Weekly Wound Assessments:<br>- 03/14/18, Readmission Skin risk assessment completed. Resident scored a 12 on the Braden scale. Resident is noted to have pressure sores on buttocks. Resident is able to make slight movements independently, but does require assistance to make significant repositioning. Elevate HOB [head of bed] as little as possible for sacral, coccyx or buttocks ulcer prevention, minimize time in bed, and moisturize dry/thin skin daily. Pressure reducing cushion on W/C [wheelchair]; pressure redistribution mattress on bed. Continue to follow toileting schedules. Assess skin folds for moisture. Treat as ordered by care provider. Nurse to complete body audit weekly. Complete a new Braden assessment (for pressure areas of concern) and Tissue Tolerance (if appropriate) when areas of concern are noted. Notify MD [medical doctor/NP [nurse practitioner] as appropriate. Continue with plan of care. | 2 900 | | |

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- 03/14/18, able to assess resident's buttocks at this time r/t [related to] indication of open sores r/t readmission following hospitalization r/t cellulitis of LLE [left lower extremity]. Resident is noted to have an area to her right (R) buttock measuring 4.5 cm [centimeters] x 4.0 cm of darkened redness with delayed blanching [Stage 1] with a noted area of abrasion within area measuring 3 cm x 3.5 cm. Area presents with pink/red granulation; no evidence of slough or eschar, no tunneling, undermining, sinus tracts, induration or current s/sx of infection. No exudate noted. Previous other open areas are noted to be scabbed to the superior location of the abrasion area. Left (L) buttocks superior medial location with abrasion area measuring 0.5 cm x 2.5 cm with pink/red granulated tissue. No evidence of undermining, tunneling, sinus tracts or s/sx of infection. Surrounding skin presents with permanent staining of darkened purplish blanchable skin. Resident does not present with pain during assessment. Treatment: wash bilateral buttocks, apply skin prep allow to dry and then apply skin barrier cream. Resident continues to be on ABx [antibiotic] r/t infection.

- 3/27/18, able to assess resident's buttocks this afternoon. Resident is noted to have an area to her (R) buttock measuring 2.0 cm x 2.0 cm of redness with delayed blanching [stage 1]; abrasion that was previously noted is no longer present to area. Area presents with pink/red granulation; no evidence of slough or eschar, no tunneling, undermining, sinus tracts, induration or current s/sx of infection. No exudate noted. (L) buttocks superior medial location with abrasion area that is now scabbed over measuring 0.8 cm x 1.2 cm. No evidence of undermining, tunneling, sinus tracts or s/sx of infection. Surrounding skin

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| 2 900 | Continued From page 25 | 2 900 | | |

presents with permanent staining of darkened purplish blanchable skin. Resident does not present with pain during assessment. Treatment: wash bilateral buttocks, apply skin prep allow to dry and then apply skin barrier cream.

- 3/29/18, at 1:45 p.m. able to assess resident's buttocks this afternoon. Resident is noted to have an area to her (R) buttock measuring 1.4 cm x 1.4 cm of slight redness with blanching noted [stage 1]; abrasion that was previously noted is no longer present to area. Resident was noted to have area of drying, flaking skin to bilateral buttocks with was easily removed with cleansing of the area. Area presents with pink/red epithelialization; no evidence of slough or eschar, no tunneling, undermining, sinus tracts, induration or current s/sx of infection. No exudate noted. (L) buttocks superior medial location with abrasion area that was previously scabbed over last week is now considered healed with no open areas or scabbing noted to area. Surrounding skin presents with permanent staining of darkened purplish blanchable skin. Resident does not present with pain during assessment. Writer will continue to follow another week, if no changes present to area, will considered healed at that time. Treatment: wash bilateral buttocks, apply skin prep allow to dry and then apply skin barrier cream.

On 3/29/18, at 12:15 p.m. RN-B/Nurse Manager verified the care plan directed staff to assist with repositioning every 2 hours, and she would expect staff to provide that care. RN-B added R17 has a history of  pressure ulcers, and developed new pressure ulcers after a recent hospitalization the beginning of March, which are improving.

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| 2 900 | Continued From page 26<br>A policy on pressure ulcers was requested, but not provided by the facility.<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise the current pressure ulcer policies and procedures to ensure all residents receive care and assistance as needed to prevent the development of or further worsening of pressure ulcers. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 900 | | |
| 2 920 | MN Rule 4658.0525 Subp. 6 B Rehab - ADLs<br><br>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide routine bathing/showering assistance for 7 of 11 residents (R3, R5, R13, R15, R38, R56 and R60) and personal grooming for 1 of 11 residents (R214) reviewed for activities of daily living, and who were dependent on staff for assistance. | 2 920 | Corrected. | 5/4/18 |

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Findings include:

R3's admission Minimum Data Set (MDS) dated 12/18/17, indicated R3 was cognitively intact, did not refuse cares, and was totally dependent upon two staff to bathe. R3's care plan dated 12/12/17, directed staff to provide physical assistance with showers. An undated nursing assistant worksheet directed staff to assist R3 with a shower weekly on Fridays.

When interviewed on 3/26/18, at 3:05 p.m. R3 stated, "They are always short of staff," and indicated she does not even get a weekly shower which was upsetting to her.

R3's Point of Care History report for January 2018, indicated staff should have assisted R3 with a shower on 1/5/18, 1/12/18, 1/19/18, and 1/26/18. However, the 1/12/18, bath was not signed off as given, and the 1/19/18, bath was noted to be, "Not Done." Therefore, R3 went for a 21 day period without a shower.

R3's Point of Care History report for February 2018, indicated R3 had received a weekly shower in February 2018.

R3's Point of Care History report for March 2018, indicated staff should have assisted R3 with a shower on 3/2/18, 3/9/18, 3/16/18, and 3/23/18. However, the shower was not signed off as being provided on 3/2/18, or 3/23/18.

R5's quarterly MDS dated 12/19/17, indicated R5 was cognitively intact, did not reject cares and required total staff assistance with bathing. R5's care plan dated 10/21/16, indicated she required total assist of 2 for bathing. An undated nursing assistant worksheet directed a tub bath every

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Monday.

When interviewed on 3/26/18, at 11:58 a.m. R5 stated she typically does not like to bathe, and is fussy about who gives her a bath, but that there is often not enough staff available to give her a weekly bath. R5 stated she has a rash in her abdominal folds and under her breasts, and that she needs to be kept clean or the rash, "Gets really bad."

R5's Point of Care History report for January 2018, indicated R3 should have received a bath on 1/1/18, 1/8/18, 1/15/18, 1/22/18, and 1/29/18. However, the report indicated R5 had only received one bath the entire month on 1/15/18. The other dates were either not answered, or marked as, "Not Done-Resident Refused."

R5's Point of Care History report for February 2018, indicated R5 should have been assisted with a bath on 2/5/18, 2/12/18, 2/19/18, and 2/26/18. Two of those dates were marked as not done, one not marked at all. R5 had only received one bath in February on 2/19/18.

R5's Point of Care History report for March 2018, indicated R5 should have been assisted with a bath on 3/5/18, 3/12/18, 3/19/18, and 3/26/18. Two of those dates were marked as not done, one was not answered. R5 had only received a bath on 3/5/18.

R13's annual MDS dated 12/30/17, included he was cognitively intact, did not reject cares, and was totally dependent upon staff to bathe. R13's care plan dated 11/4/15, indicated he required extensive assistance for bathing. An undated nursing assistant worksheet indicated R13 should be assisted with a bath on Wednesdays and a

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| 2 920 | Continued From page 29<br>second bath on Saturdays.<br><br>When interviewed on 3/26/18, at 1:10 p.m. R13 stated he is supposed to get a bath twice a week, but there is not enough staff on to do this. R13 stated even if there is a bath aide on, they get pulled from giving baths much of the time to do other things. R13 stated he knew he missed a bath last week, this happens quite often, but had not kept track of when he had, or had not received the scheduled bath.<br><br>R13's Point of Care History report for January 2018, indicated he had received all scheduled baths on Wednesdays, but no documentation of Saturday baths was provided.<br><br>R13's Point of Care History report for February 2018, indicated R13 had missed one out of four scheduled Wednesday baths, and no Saturday baths were documented.<br><br>R13's Point of Care History report for March 2018, indicated he had received two out of four Wednesday baths, and no full baths on Saturdays, with two "partial bed bath" documented.<br><br>R15's quarterly MDS dated 1/2/18, indicated R15 had moderate cognitive impairment, did not reject cares, and was totally dependent upon staff for bathing. R15's care plan directed staff to provide two baths per week. An undated nursing assistant care sheet indicated R15 was to be bathed every Wednesday, and an extra bath on Saturdays.<br><br>When interviewed on 3/27/18, at 2:19 a.m. R15 stated he had concerns over not having enough staff available. | 2 920 | | |

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R15's Point of Care History report for January 2018, indicated he had received only three of the five Wednesday baths,and none of the Saturday baths.

R15's Point of Care History report for February 2018, indicated he had only received three of the four Wednesday baths and none of the Saturday baths, indicating he had refused once.

R15's Point of Care History report for March 2018, indicated he had received only one Wednesday and one Saturday bath this month. An undated, untitled copy with handwriting indicated R15 had received another bath on on 3/3/18, 3/7/18, and 3/9/18.

R38's significant change MDS dated 2/4/18, indicated R38 had severe cognitive impairment, did not refuse cares, and required total assistance from staff for bathing. R38's care plan dated 1/17/18, directed staff to assist with bathing. An undated nursing assistant worksheet indicated R38 should be assisted with bathing on Wednesdays.

When interviewed on 3/26/18, at 1:59 p.m. R38 stated she did not feel there was enough staff available to meet her needs. R38 did not know how often she received a bath, but didn't think it was very often.

R38's January 2018, Point of Care History report indicated she had received one of two scheduled baths, and had refused the other.

R38's February 2018, indicated R38 had received two out of four scheduled baths.

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| 2 920 | Continued From page 31<br>R38's March 2018, Point of Care History report indicated she had received two out of four scheduled baths, and refused one.<br><br>R56's quarterly MDS dated 3/5/18, indicated R56 was cognitively intact, did not refuse cares, and required physical help in part of bathing. R38's care plan dated 5/13/15, directed staff to assist with bathing twice a week on Fridays and Mondays. An undated nursing assistant worksheet directed staff to assist with bathing on Wednesdays with an extra bath on Saturdays.<br><br>When interviewed on 3/26/18, at 11:22 a.m. R56 stated they are, "Short of help for aides, some bath days will come and go without a bath." R56 stated baths do not get, "Made up," if missed, and this was distressing to her.<br><br>R56's Point of Care History report for January 2018, indicated she had received five of five Wednesday baths, and two of four Saturday baths.<br><br>R56's Point of Care History report for February 2018, indicated she had received three of four Wednesday baths and two of four Saturday baths.<br><br>R56's Point of Care History report for March 2018, indicated she had received two of four Wednesday baths, and no Saturday baths. An undated, untitled form indicated she had received a Thursday bath on 3/15/18.<br><br>R60's annual MDS dated 3/2/18, indicated R60 had severe cognitive impairment, did not refuse cares, and required total staff assistance for bathing. R60's care plan directed staff to provide extensive assistance with bathing on Tuesdays. | 2 920 | | |

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An undated nursing assistant worksheet directed staff to bath R60 on Tuesdays.

When interviewed on 3/27/18, at 11:03 a.m. R60 stated the staff is, "Really short," and she used to get a bath on Tuesday, then they would come in and set her hair after breakfast. R60 stated they pull the bath aide if someone calls in sick. R60 stated today is Tuesday, and no bath yet, and she had just found out they did not have anyone to give baths today. R60 stated she does not feel good when she doesn't get a bath at least every week.

R60's Point of Care History report for January 2018, identified she had received a bath three out of the five Tuesdays, missing a bath for twenty-one days between 1/9/18, and 1/30/18.

R60's Point of Care History report for February 2018, identified she had received a bath three out of four Tuesdays, one she had refused.

R60's Point of Care History report for March 2018, identified she had received an ordered bath on 3/3/18, and 3/4/18, due to scheduled surgery. However, there was no Point of Care History report identifying any other baths. A Master Bath list dated 3/26/18, identified R60 had received one bath on 3/27/18. No time was identified.

The facility's Resident Council Meeting Notes dated February 28, 2018, noted a concern over baths being missed due to staff shortages.

When interviewed on 3/27/18, at 3:47 p.m. nursing assistant (NA)-B stated they are often short staffed, the bath aide gets pulled to work on the floor doing nursing assistant duties, and then the baths do not get done. The nursing assistants

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are not able to do them, and the baths get missed.

When interviewed on 3/27/18, at 3:54 p.m. NA-C stated the bath aide gets pulled, "A lot," and they will try and get the baths done the next day, but it usually does not happen.

When interviewed on 3/27/18, on 3:59 p.m. .NA-A stated they do not have a bath aide on the afternoon shift, and they are unable to get baths done if they did not get done on the day shift.

When interviewed on 3/27/19, at 4:02 p.m. NA-D stated baths do not always get done, and they don't have time to catch up on them.

When interviewed on 3/28/18, at 7:05 a.m. NA-G stated they can usually get the work done but it is a struggle, the baths do not always get done.

When interviewed on 3/28/18, at 7:57 a.m. NA-H stated the bath aide had called in for the day, and baths would not get done that day.

When interviewed on 3/28/18, at 9:22 a.m. NA-I stated she had offered to do baths today for her group, if no one volunteers, "They will get done tomorrow."

When interviewed on 3/29/18, at 7:39 a.m. NA-F stated she is often the assigned bath aide, but gets pulled very frequently. NA-F stated she can't get baths done and meet everyone's other needs.

When interviewed on 3/29/18, at 10:40 a.m. licensed practical nurse (LPN)-A stated she is unable to assist the nursing assistants with bathing as she is too busy herself.

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUGUSTANA MERCY CARE CENTER | 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767 |

| (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 |
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| 2 920 | Continued From page 34 | 2 920 | | |

Continued From page 34

When interviewed on 3/29/18, at 7:56 a.m. NA-K stated they pull the bath aide at least weekly. NA-K stated there was no way to catch up on them. NA-K stated sometimes she is asked to stay late to catch up, but not very often.

When interviewed on 3/29/18, at 8:01 a.m. registered nurse (RN)-A stated if they have a nursing assistant call in, they will pull the bath aide from doing baths to replace them. If this happens the nursing assistants working should do all the baths. They do not always report when the baths have not been completed. Occasionally, a nursing assistant will report a bath had not been completed, and she reports this to the afternoon shift so that they can try and do it. This is not followed up on to see if the resident actually received a bath.

When interviewed on 3/28/18, at 9:48 a.m. the administrator stated the facility was aware of baths not always getting done, they are currently addressing the issue in their quality assessment and assurance (QAA) committee. The director of nursing (DON) stated they are still working on it, they try to get an extra person in if they do not have a bath aide, or will try and get someone to stay late and try to get the baths done.

A facility policy entitled Apollo Tub, Basic Nursing Care dated 7/15, directed the frequency of bath/shower will be weekly or as requested by each resident, to meet the hygiene needs of each resident.

R214's 14-day MDS dated 3/5/18, identified R214 had severe cognitive impairment, and required extensive assistance with personal hygiene.

R214's Social Services assessment completed

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| 2 920 | Continued From page 35 | 2 920 | | |

2/21/18, identified R214 with personal characteristic(s) including, "Resident takes pride in her appearance. Staff assist with ADLs [activities of daily living]." Further, R214's care plan dated 3/9/18, identified R216 required total assistance for dressing, bathing, and grooming.

On 3/26/18, at 3:54 p.m. R214 was observed to have numerous, visible white colored hairs present on her chin which extended down her neck line. During subsequent observations on 3/27/18, at 7:23 p.m. and 3/28/18, at 7:16 a.m. R214 continued to have visible, white colored facial hair present on her chin and extending down her neck line.

When interviewed on 3/28/18, at 9:41 a.m. NA-A stated staff completed R214's grooming for her as there was a lot R214 can't do for herself. NA-A expressed R214 typically did not have facial hair, however, observed her and stated there was some there, which should have been removed during her morning cares.

During interview on 3/28/18, at 1:40 p.m. RN-A stated residents should be shaved on their designated bath day(s). RN-A explained R214 did not have any preferences for facial hair, and it should have been removed as residents, "Need to look appropriate."

A facility policy on grooming and personal hygiene was not provided.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure residents receive assistance with bathing/showering and grooming as determined necessary by their individualized plan of care.

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| 2 920 | Continued From page 36<br>The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 920 | | |
| 21830 | MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 10. Participation in planning treatment; notification of family members.<br><br>(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.<br>(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family | 21830 | | 5/4/18 |

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| 21830 | Continued From page 37 | 21830 | | |

member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:
(1) examining the personal effects of the resident;
(2) examining the medical records of the resident in the possession of the facility;
(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and
(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.
(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated

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| 21830 | Continued From page 38<br>emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure resident choices and preferences were honored for 4 of 5 residents (R12, R13, R15 and R56) who expressed desire to have two baths weekly. In addition, the facility failed to comprehensively assess and afford choices for bathing schedule(s) for 1 of 5 residents (R62) reviewed for choices and who desired additional bathing during the week.<br><br>Findings include:<br><br>R12's annual Minimum Data Set (MDS) dated 12/29/17, indicated she was cognitively intact, did not reject cares, and required staff assistance with bathing.<br><br>R12's care plan dated 1/1/18, indicated staff were | 21830 | Corrected. | |

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to provide assistance in and out of shower room and assistance/supervision for shower. R12's undated nursing assistant worksheet indicated she was to receive a shower on Wednesdays and an extra shower on Saturdays.

When interviewed on 3/27/18, at 9:55 a.m. R12 stated the staff, "Work short." R12 expressed concern that not all cares are being provided due to this. When interviewed on 3/2/18, at 10:10 a.m. R12 stated she has told the staff she would like to have a bath twice a week, but this rarely happens.

R12's January 2018, Point of Care History report indicated one out of the five Wednesday baths had been missed, and the facility did not provide any report for the Saturday baths.

R12's February 2018, Point of Care History report indicated three out of the four weekly baths were provided on Wednesdays, and three out of four were provided on Saturdays.

R12's March 2018, Point of Care History report indicated two out of the four Wednesdays she had received a bath. A handwritten undated, untitled sheet of paper indicated R12 had received one out of four Saturday baths.

R13's annual MDS dated 12/30/17, included he was cognitively intact, did not reject cares, and was totally dependent upon staff to bathe. R13's care plan dated 11/4/15, indicated he required extensive assistance for bathing. An undated nursing assistant worksheet indicated R13 should be assisted with a bath on Wednesdays and a second bath on Saturdays. R13's Care Conference Summary dated 1/11/18, indicated a preference for two baths per week.

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When interviewed on 3/26/18, at 1:10 p.m. R13 stated he was supposed to get a bath twice a week, but there was not enough staff working. R13 stated even if there was a bath aide working, they get pulled from giving baths much of the time to do other things. R13 stated he knew he missed a bath last week, this happened quite often, but had not kept track of when he had or had not received his scheduled bath.

R13's Point of Care History report for January 2018, showed he had received all scheduled baths on Wednesdays, but no documentation of Saturday baths were provided.

R13's Point of Care History report for February 2018, showed R13 had missed one out of four scheduled Wednesday baths, and no Saturday baths were documented.

R13's Point of Care History report for March 2018, showed he had received two out of four Wednesday baths, and no full baths on Saturdays, with two "partial bed bath" documented.

R15's quarterly MDS dated 1/2/18, indicated moderate cognitive impairment, did not reject cares, and was totally dependent upon staff for bathing. R15's care plan directed staff to provide two baths per week. An undated nursing assistant care sheet indicated R15 was to be bathed every Wednesday, and given an extra bath on Saturdays.

When interviewed on 3/27/18, at 2:19 a.m. R15 stated he had concerns over not having enough staff available.

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| 21830 | Continued From page 41<br><br>R15's Point of Care History report for January 2018, indicated he had received three of the five Wednesday baths and none of the Saturday baths.<br><br>R15's Point of Care History report for February 2018, indicated he had received three of the four Wednesday baths and none of the Saturday baths, documentation indicated R15 refused once.<br><br>R15's Point of Care History report for March 2018, indicated he had received one Wednesday and one Saturday bath month. An undated, untitled copy with handwriting indicated R15 had received another bath on on 3/3/18, 3/7/18 and 3/9/18.<br><br>R56's quarterly MDS dated 3/5/18, indicated she was cognitively intact, did not refuse cares, and required physical help in part of bathing. R56's care plan dated 5/13/15, directed staff to assist with bathing twice a week on Fridays and Mondays. An undated nursing assistant worksheet directed staff to assist with bathing on Wednesdays, with an extra bath on Saturdays. R56's Care Conference Summary dated 3/8/18, indicated a preference for two baths per week.<br><br>When interviewed on 3/26/18, at 11:22 a.m. R56 stated they are "Short of help for aides, some bath days will come and go without a bath." R56 stated baths do not get "Made up" if missed, and this was distressing to her.<br><br>R56's Point of Care History report for January 2018, indicated she had received five of five Wednesday baths, and two of four Saturday baths. | 21830 | | |

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R56's Point of Care History report for February 2018, indicated she had received three of four Wednesday baths, and two of four Saturday baths.

R56's Point of Care History report for March 2018, indicated she had received two of four Wednesday baths, and no Saturday baths. An undated, untitled form indicated she had received a Thursday bath on 3/15/18.

When interviewed on 3/27/18, at 3:47 p.m. nursing assistant (NA)-B stated they are often short staffed and the bath aide gets pulled to work on the floor doing nurse aide duties, and the baths do not get done. NA-B continued to state the nursing assistants are not able to do the baths, and they get missed.

When interviewed on 3/27/18, at 3:54 p.m. NA-C stated bath aide gets pulled, "A lot," and they will try and get the baths done the next day, but it usually does not happen.

When interviewed on 3/27/18, on 3:59 p.m. NA-A stated they do not have a bath aide on the afternoon shift, and they are unable to get baths done if they did not get done on the day shift.

When interviewed on 3/27/19, at 4:02 p.m. NA-D stated baths do not always get done, and they don't have time to catch up on them.

When interviewed on 3/28/18, at 7:05 a.m. NA-G stated they can usually get the work done but it is a struggle, the baths do not always get done.

When interviewed on 3/28/18, at 7:57 a.m. NA-H stated the bath aide had called in for the day, and baths would not get done that day.

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| 21830 | Continued From page 43<br><br>When interviewed on 3/28/18, at 9:22 a.m. NA-I stated she had offered to do baths today for her group, if no one volunteers, "They will get done tomorrow."<br><br>When interviewed on 3/29/18, at 7:39 a.m. NA-F stated she is often the assigned bath aide but gets pulled very frequently. She can't get baths done and meet the resident's other needs.<br><br>When interviewed on 3/29/18, at 10:40 a.m. licensed practical nurse (LPN)-A stated she is unable to assist the nurse aides with bathing as she is too busy herself.<br><br>When interviewed on 3/29/18, at 7:56 a.m. NA-K stated they pull the bath aide at least weekly, and there is no way to catch up on the baths. NA-K stated sometimes she is asked to stay late to catch up, but not very often.<br><br>When interviewed on 3/29/18, at 8:01 a.m. registered nurse (RN)-A stated if they have a nursing assistant call in, they will pull the bath aide from doing baths to replace them. If this happens, the nursing assistants working should do all the baths. They do not always report when the baths have not been completed. Occasionally, a nursing assistant will report a bath had not been completed, and she reports this to the afternoon shift so that they can try and do it. This is not followed up on to see if the resident actually received a bath on the evening shift.<br><br>When interviewed on 3/28/18, at 9:48 a.m. the administrator stated the facility was aware of baths not always getting done, they are currently addressing the issue in their quality assessment | 21830 | | |

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| 21830 | Continued From page 44<br><br>and assurance (QAA) committee. The director of nursing (DON) stated they are still working on it, they try to get an extra person in if they do not have a bath aide, or will try and get someone to stay late and try to get the baths done.<br><br>A facilty policy entitled Apollo Tub, Basic Nursing Care dated 7/15, directed the frequency of bath/shower will be weekly or as requested by each resident, to meet the hygiene needs of each resident.<br><br>R62's 14-day MDS dated 3/14/18, identified R62 had moderate cognitive impairment, required extensive assistance with transfers, and total assistance with bathing.<br><br>During interview on 3/26/18, at 1:04 p.m. R62 explained she enjoyed having a bath and wished she could have more than one per week, however, "Everybody gets it that way." R62 stated she would like to have two baths per week, but nobody had ever asked or questioned her about her bathing preferences since she came to the nursing home.<br><br>R62's Point of Care History report printed 3/28/18, identified R62's completed bath(s) for the past weeks. R62 had a bath completed only on a weekly basis. Further, R62's Resident Preference Sheet signed 2/28/18, directed staff to ask her preference between a bath or shower when completing one for R62, however, lacked any assessment or input on R62's choice or preference for bathing. A section labeled, "Other," was left blank.<br><br>R62's medical record was reviewed and lacked evidence R62 had been assessed or afforded input on her bathing schedule(s) since admitting | 21830 | | |

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to the nursing home.

On 3/28/18, at 12:21 p.m. registered nurse (RN)-A was interviewed about the facility process for bathing schedules. RN-A stated when a resident admits to the nursing home, they are added to the bathing schedule for "at least once a week" and should be asked about their preferences for additional bathing using a preference sheet (Resident Preference Sheet). RN-A reviewed R62's completed sheet and stated preferences for bathing usually would be recorded on it adding it should say how many times she desired a bath during the week.

A facility Resident Preferences policy dated 8/2013, directed all residents of the nursing home " ... are provided with choices regarding their preferences." A procedure was listed which directed, "On admission[,] all residents will be asked questions regarding their preferences for sleep [and] wake times, bathing and activities schedules." These preferences were then to be incorporated into their plan of care.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure residents choices are honored. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.