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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N6OT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**
2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **47** (L18)
13.Total Certified Beds **47** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 09/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/30/1991
(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.
09201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/06/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5535

On September 6, 2016, the Minnesota Department of Health completed a revisit to verify the facility corrected the deficiencies reissued at the time of the July 6, 2016 revisit. We presumed, based on the facility's plan of correction, that the facility had corrected these deficiencies as of July 29, 2016. Based on our visit, we have determined that the facility has achieved compliance with the remaining deficiencies. As a result of our finding that your facility has achieved compliance, this Department discontinued the Category 1 remedy of State monitoring as of July 29, 2016.

In addition, we are recommending the following enforcement action to the CMS Region V Office related to the imposed remedies in their letter of September 9, 2016:

- Mandatory Denial of payment for new Medicare and Medicaid admissions (DPNA), effective August 16, 2016, be rescinded.

- Per day civil money penalty, beginning July 6, 2016, be discontinued as of July 29, 2016.

Since Mandatory denial of payment for new Medicare and Medicaid admissions did not go into effect, the facility is not subject to a two year loss of NATCEP that was to begin, August 16, 2016.

Refer to the CMS 2567b form for health only.

Effective July 29, 2016, the facility is certified for 47 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245535

September 21, 2016

Mr. Larry Passel, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

Dear Mr. Passel:

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 July 29, 2016 the above facility is certified for:

47 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 47 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.

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

Sincerely,

Mark Meath

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 13, 2016

Mr. Larry Passel, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535028

Dear Mr. Passel:

On July 20, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 25, 2016. (42 CFR 488.422)

On September 9, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of $450.00, beginning July 6, 2016 and continuing until substantial compliance has been achieved. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 16, 2016. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of September 9, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 16, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on May 16, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on July 6, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On September 6, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 29, 2016. Based on our visit, we have determined that your

facility has corrected the deficiencies issued pursuant to our PCR, completed on July 6, 2016, as of July 29, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of State monitoring effective July 29, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of September 9, 2016:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 16, 2016, be rescinded. (42 CFR 488.417 (b))

- Per day civil money penalty beginning July 6, 2016 be discontinued as of July 29, 2016. (42 CFR 488.430 through 488.444)

Furthermore, CMS advised you in their letter of September 9, 2016, 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 August 16, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 29, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245535		9/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 07/29/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 07/26/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	09/13/2016	33562	09/05/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/16/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N6OT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**

2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **47** (L18)
13.Total Certified Beds **47** (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
	47			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NEII 07/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/31/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/30/1991
(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.
09201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/06/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5535

On July 6, 2016, the Minnesota Department of Health and on July 15, 2016, the Minnesota Department of Public Safety completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 16, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of July 11, 2016. Based on our visit, we have determined that the facility has not achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on May 16, 2016. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

The most serious deficiencies in the facility were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced , whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

State Monitoring effective July 25, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify the facility of the imposition:

Mandatory Denial of payment for new Medicare and Medicaid admissions (DPNA), effective August 16, 2016

Furthermore, based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP beginning August 16, 2016.

Refer to the CMS 2567b forms and CMS 2567 for health only, along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 20, 2016

Mr. Larry Passel, , Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535028

Dear Mr.. Passel:

On June 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 16, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On July 6, 2016, the Minnesota Department of Health and on July 15, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 16, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 11, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on May 16, 2016. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective July 25, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last

day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 16, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 16, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 16, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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, Jourdain Perpich Extended Care Facility is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective August 16, 2016. 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.

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

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

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

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 .

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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 allegation of compliance and/or 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 November 16, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

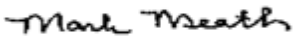
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

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Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 07/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on July 5 & July 6, 2016, to determine compliance with Federal deficiencies issued during a recertification survey exited on May 16, 2016. During this visit the following regulations were determined to be not corrected. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide every one hour repositioning/off-loading assistance as directed by the care plan for 1 of 3 residents (R14) reviewed for pressure ulcer care and prevention.	{F 282}	Immediately upon notification from the survey team, the Charge Nurse (s), Licensed Nurse (s)and Nursing Assistants where re-educated on resident #14 care plan and off loading schedule as	7/29/16

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

Electronically Signed | 07/28/2016

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{F 282}	Continued From page 1 Findings include: R14's care plan dated 7/1/16, indicated R14 had a stage 3 (full thickness tissue loss, may include undermining and tunneling) pressure ulcer and a history of ulcers. R14 refused to be repositioned and would become agitated at times. Interventions directed staff to follow facility policy/procedures for the prevention/treatment of skin breakdown; R14 required assistance to turn/reposition when in bed every two hours and hourly when in R14's wheelchair. In addition, R14's care plan dated 2/10/16, identified a focus are for potential to skin integrity related to R14's history of pressure ulcers. Interventions directed staff to encourage R14 to off-load (relieving the pressure to an area for one full minute) hourly and staff were directed to re-approach if R14 became agitated or refused. On 7/5/16, during continuous observation from 2:51 p.m. until 6:45 p.m. R14 remained calm and cooperative. The following was observed: - At 2:51 p.m. R14 was seated in her wheelchair in the activity room. A ROHO cushion appeared to be in the seat of R14's wheelchair. Activity Director (AD) approached R41 and asked R14 if she had enjoyed the women's group meeting. - At 3:00 p.m. director of nursing (DON) approached R14 and stated to R14 that she knew of someone R14 could visit with. DON proceeded to wheel R14's wheelchair directly into the social worker (SW)-A's office. DON did not offer or	{F 282}	determined by the individual resident Care Plan based on the Braden Scale and Tissue Tolerance Test results. Repositioning schedule has been added to the EMAR for Licensed Nurse to monitor that the repositioning is occurring per the care plan. Licensed staff are signing that repositioning is occurring. Ancillary staff consisting of the Social Worker, Dietary Manager, and Activities Manager were educated on 7-7-16 to check with nursing on resident repositioning schedules. Like residents will be identified by the individualized Braden Score and Tissue Tolerance Test scores found in Point Click Care to determine individualized repositioning and off-loading schedules. C.N.A. Kardex (printed directly from Point Click Care care plan) have been printed and placed in binders on each wing for staff to reference individual resident repositioning and off-loading schedules. Kardex will be reprinted whenever a change occurs for a resident by the MDS nurse. Mandatory re-education was held July 12th, July 13th, and July 14th, 2016 for all nursing staff reviewing how to follow the plan of care, specific emphasis on repositioning and off-loading requirements, and full review of the survey exit citations. Daily visual timed audits will be conducted	

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{F 282}	Continued From page 2 provide assistance for R14 to off-load or be repositioned in R14's wheelchair. R14 remained in SW-A's office with the door open until 3:20 p.m. - At 3:20 p.m. SW-A transported R14 in her wheelchair back to the activity area, where a baseball game was being televised. SW-A remained with R14, seated by R14's side. - At 3:45 p.m. licensed practical nurse (LPN)-A approached R14 and asked R14 if she would like a cup of coffee. LPN-A failed to offer or provide assistance for R14 to off-load or be repositioned in R14's wheelchair. - At 3:58 p.m. DON approached R14 briefly, did not offer or provide R14 an opportunity to be off-loaded or repositioned. - At 4:05 p.m. SW-A left R14's side and R14 remained seated in her wheelchair in the activity room. - At 4:12 p.m. SW-A returned to the activity room and positioned herself beside R14. R14 remained seated in her wheelchair. - At 4:16 p.m. LPN-A brought R14 a cup of coffee. LPN-A did not offer or provide R14 an opportunity to be off-loaded or repositioned. -At 4:22 p.m. SW-A asked R14 if she was finished with her coffee. R14 responded "yes" and SW-A proceeded to take R14's disposable coffee cup and tossed it in the garbage can on her way out of the activity area. -At 4:25 p.m. SW-A returned to the activity area and positioned herself beside R14. During the entire time the SW-A spent with R14; R14 was not offered to be off-loaded or repositioned. - At 4:28 p.m. SW-A proceeded to transport R14 in her wheelchair out of the activity room and into R14's room. The DON approached SW-A when R14 reached her room. SW-A stated to the DON that she was looking for LPN-A so he could give	{F 282}	on any resident with pressure related skin areas to ensure that repositioning and off-loading area performed as the Braden Scale and Tissue Tolerance Test determine as state in the plan of care/Kardex. Supervising Nurse will observe and sign that off loading and repositioning was performed per Care Plan. Daily visual audits will be inclusive or rotating all 3 shifts. Audits will be conducted daily / 2 weeks, weekly/ 4 weeks, and monthly/3 months. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance. Resident # 14 and like residents will have daily audits x 2 week performed. The audits will check that the care plans for Resident # 14 and like residents are being followed for repositioning and off-loading, as well as for all care plan areas. Audits will be conducted as stated above for daily x 2 weeks; then weekly x 4 weeks; then monthly x 3 months. Director of Nursing, MDS Nurse; Infection Control Nurse; and Administrator are responsible to ensure that audits are completed as assigned. Date certain: 7/29/2016.,	

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{F 282}	Continued From page 3	{F 282}		

R14 her medications.
- At 4:31 p.m. R14 remained seated in her wheelchair in her room with SW-A in attendance.
-At 4:40 p.m. (1 hour and 49 minutes) nursing assistant NA-B assisted R14 into her bathroom and transferred R14 onto the toilet. Upon standing and providing peri-care, R14's coccyx dressing came off. NA-B assisted R14 with her brief and pants while following appropriate infection control practices.
- At 4:45 p.m. (start of second observation) NA-B assisted R14 back into her wheelchair. ROHO cushion was in place and inflated in the seat of R14's wheelchair.
- At 4:47 p.m. NA-B stated she was unsure of how long R14 had been seated up in R14's wheelchair as the day shift had gotten R14 up. NA-B stated she was not very familiar with R14's care as she normally worked on the other wing.
- At 5:00 p.m. NA-B made LPN-A aware that R14's coccyx dressing had come off when NA-B had assisted R14 to the bathroom. LPN-A stated he would replace the dressing later. NA-B proceeded to transport R14 in her wheelchair into the dining room.
- At 5:07 p.m. R14 was seated in her wheelchair in the dining room awaiting dinner.
- At 5:42 p.m. R14 remained seated in her wheelchair in the dining room, eating dinner. NA-C was seated adjacent to R14 providing encouragement for R14 to eat and assisting R14's table mate with her dinner.
- At 5:47 p.m. R14 propelled herself about two feet away from her position at the dining room table.
-At 5:42 p.m. NA-C wheeled R14's wheelchair back to R14's position at the dining room table and continued to encourage R14 to eat.
- At 6:07 p.m. LPN-A entered the dining room.

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{F 282}	Continued From page 4 - At 6:14 p.m. LPN-A wheeled R14's wheelchair out of the dining room area and into the common area by the medication cart. LPN-A administered R14 some pain medication (liquid morphine) and brought R14 a glass of apple juice. - At 6:22 p.m. LPN-A took R14's blood pressure as R14 remained in the common area seated in R14's wheelchair. - At 6:25 p.m. LPN-A administered R14 a medicine cup of pills. During this time R14 was not offered or provided assistance to be off-loaded or repositioned by LPN-A. - At 6:30 p.m. LPN-C approached R14 while R14 remained seated in her wheelchair in the common area. - At 6:45 p.m. (2 hours later) LPN-C wheeled R14's wheelchair into the tub room. LPN-A and LPN-B followed R14 into the tub room. LPN-C proceeded to apply a new dressing to R14's pressure ulcer wound while LPN-B and LPN-C assisted R14 to stand while R14 grabbed on to the railing in the tub room. On 7/5/16, at 6:07 p.m. LPN-A stated he was unaware of how long R14 had currently been seated in her wheelchair. LPN-A stated he thought R14 needed to be off-loaded or repositioned every two hours. On 7/6/16, at 8:49 a.m. NA-A stated R14 needed to be repositioned every two hours when R14 was lying in her bed or seated in her wheelchair. On 7/6/16, at 8:52 a.m. NA-D stated R14's repositioning schedule was every two hours no matter if R14 was lying in her bed or seated in her wheelchair. On 7/6/16, at 9:14 a.m. DON confirmed R14 had	{F 282}		

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{F 282}	Continued From page 5 a current stage 3 pressure ulcer on her coccyx. DON verified R14 should be off-loaded or repositioned every one hour as directed by R14's latest tissue tolerance assessment and care plan. DON confirmed it was her expectation that staff followed R14's care plan in regards to repositioning and off-loading. Pressure Ulcer Treatment policy dated 9/2013, indicated the residents care plan should be assessed for any special needs of the resident and the resident's Braden Scale should be reviewed to identify risk for pressure ulcer development. In addition, pressure ulcer treatment should focus on the resident's assessed current status of existing pressure ulcers; pressure ulcer care required; and education provided. Interventions and care strategies required a comprehensive approach and included maximizing the potential for healing.	{F 282}		
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide every one hour	{F 314}	1. Address how corrective action will be accomplished for those residents found to	7/26/16

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{F 314}	Continued From page 6 repositioning assistance in order to promote healing and/or prevent development and subsequent decline of a facility acquired pressure ulcer for 1 of 3 residents (R14) reviewed for pressure ulcer care and prevention. This resulted in actual harm for R14. Findings include: R14's Diagnosis Report dated 7/6/16, identified R14's diagnosis as Alzheimer's, pressure ulcer - stage 3 (a pressure ulcer with full thickness loss of tissue, subcutaneous fat may be visible but bone, tendon or muscle are not, may be tunneled), muscle weakness, diabetes, and anemia. R14's significant change Minimum Data Set (MDS) dated 4/19/16, indicated R14 had severe cognitive impairment, required extensive assist with bed mobility, transfers, and toileting. The MDS indicated R14 utilized a wheelchair for locomotion and R14 had two stage 3 pressure ulcers. The skin and pressure ulcer treatment plan included for R14 to have a pressure reduction device in R14's wheelchair and bed, a turning and repositioning schedule, pressure ulcer care and nutrition or hydration interventions to manage R14's skin problems. R14's Pressure Ulcer Care Area Assessment (CAA) dated 4/26/16, indicated R14 had stage 3 pressure ulcers on the coccyx and right buttock area. R14 had a history of pressure ulcers, had limited mobility and severe cognitive impairment with a history of refusing to be repositioned. R14	{F 314}	have been affected by the deficient practice. Individually reflect each resident cited in the survey results or tag, and respond how you corrected the issue for each resident. Resident # 14: Braden scale was performed on 7-6-2016, and Tissue Tolerance Test performed on 7-8-2016. This was used to determine the frequency of off-loading and repositioning required for the pressure area located in the sacral area. Braden scale and Tissue Tolerance Test will be conducted quarterly, annually, and with any significant change. We also perform these assessments at the time of any admission/readmission for all residents. This is performed for all residents. We have a Primary Care Provider order for resident to remain off wound as much as possible for resident #14. We also have limit w/c use and utilization of an air bed for her bed. We have daily meeting to address resident changes and needs. Resident # 14 ROHO wheelchair cushion was removed on 7/5/2016 and new wheelchair gel-foam cushion was placed in wheel chair as recommended by physical therapy. Resident #14 Care plan was updated on 7-5-2016 to reflect new wheelchair cushion and schedule for repositioning in	

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{F 314}	Continued From page 7 had an air mattress and ROHO (air floatation pressure redistribution cushion) in her wheelchair and was repositioned hourly as resident allowed. R14 was being followed by the wound clinic and treatments were to be provided as ordered. R14's Pain CAA dated 4/26/16, indicated per wound clinic orders R14 was to have limited time in R14's wheelchair in an effort to keep pressure off of R14's coccyx. Per physical therapy, R14 was able to bear weight as tolerated. R14's most recent Braden (tool used to assess a resident's level of risk for development of a pressure ulcer) dated 4/13/16, indicated R14 was at high risk for the development of pressure ulcers due to slightly limited ability to respond meaningfully to pressure related discomfort, skin was occasionally moist, was chairfast due to severely limited or nonexistent ability to walk, had very limited ability to change and control body position, and required moderate to maximum assistance to move/reposition. R14's Tissue Tolerance (assessment utilized to determine the ability of the skin and supporting tissue structure to endure the effects of pressure without adverse effects) dated 5/17/16, indicated R14 was to be turned and repositioned every two hours when lying and repositioned every one hour when seated. R14's Clinical Physician Orders dated 4/2/16, indicated R14 should limit her time in the wheelchair and utilize the air bed. In addition, R14 was to remain off her wound as much as possible. R14's care plan revised on 7/1/16, indicated R14	{F 314}	bed and off-loading in wheelchair when up. C.N.A. Kardex reflects repositioning schedule and off-loading requirement for Resident # 14 to be limited time in wheelchair with 1 hour off-loading schedule in wheelchair and 2 hour repositioning schedule when in bed. Registered Dietician notified on 7-6-2016 of survey exit regarding Resident # 14. Dietician reviews Resident # 14 nutritional data each visit and RD progress note is entered in to the EMR. Weights were increased to bi-weekly on 7-4-2016 due to end stage dementia and poor nutritional intake. Care plan is updated and addressing this need. ie snacks and supplements. SS: Activities; and CDM were verbally educated on Resident # 14 off-loading requirements on 7-7-2016. Ancillary departments will communicate with Nursing whenever Resident # 14 is taken off the unit to be informed of when off-loading and repositioning is next scheduled to be performed. They are also trained to offer offloading to all residents as needed and written in Care Plans. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Your response should state how you will correct the cited area for any other resident with a like deficient practice potential.	

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{F 314}	Continued From page 8 had a stage 3 pressure ulcer and a history of ulcers. The care plan also indicated R14 refused to be repositioned and would become agitated at times. Interventions directed staff to follow facility policy/procedures for the prevention/treatment of skin breakdown, R14 required assistance to turn/reposition when in bed every two hours and hourly when in the wheelchair, and weekly treatment documentation to include wound measurements. In addition, R14's care plan dated 2/10/16, indicated R14 had a potential for impairment of skin integrity related to R14's history of pressure ulcers, diabetes, Alzheimer's and anemia. Interventions directed staff to encourage R14 to off-load hourly and to re-approach if R14 became agitated or refused. On 7/5/16, during continuous observation from 2:51 p.m. until 6:45 p.m. R14 remained calm and cooperative. The following was observed: - At 2:51 p.m. R14 was seated in her wheelchair in the activity room. A ROHO cushion appeared to be in the seat of R14's wheelchair. Activity Director (AD) approached and asked R14 if she had enjoyed the women's group meeting. - At 3:00 p.m. the director of nursing (DON) approached R14 and stated she knew of someone R14 could visit with. The DON proceeded to wheel R14's wheelchair directly into social worker (SW)-A's office. The DON did not offer or provide assistance for R14 to off-load (relieving the pressure to an area for one full minute to allow for tissue reperfusion) nor to reposition the resident in her wheelchair. R14 remained in SW-A's office with the door open until 3:20 p.m. - At 3:20 p.m. SW-A transported R14 in her wheelchair back to the activity area, where a baseball game was being televised. SW-A	{F 314}	What is your facility policy and procedure for the specific deficient practice area? Any resident with a Braden scale of At Risk Category to High Risk Category currently with skin treatment order, will be visually audited daily to ensure repositioning and off-loading as directed by the care plan. Pressure prevention interventions for any resident on the Braden Scale PCC report for at risk to high risk category will have their care plan reviewed to ensure prevention interventions are in place, including visual audit. Wound RN will review the Braden Scale PCC report weekly to ensure residents with at risk to high risk results have pressure prevention measure in place. Policy and Procedure for Prevention of Pressure Ulcers was reviewed, and will be discussed and provided to staff at mandatory education. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Mandatory Nursing department education will be conducted on July 12, 13, 14th, 2016. Education will emphasize basic skin care; skin inspection; pressure prevention interventions, following the plan of care; immediately replacing treatment dressing PRN; and reporting	

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{F 314}	Continued From page 9 remained with R14, seated by R14's side. - At 3:45 p.m. licensed practical nurse (LPN)-A approached R14 and asked her if she would like a cup of coffee. LPN-A did not offer or provide assistance for R14 to off-load nor to reposition the resident in her wheelchair. - At 3:58 p.m. the DON approached R14 briefly, but did not offer or provide R14 an opportunity to be off-loaded or repositioned. - At 4:05 p.m. SW-A left R14's side and R14 remained seated in her wheelchair in the activity room. - At 4:12 p.m. SW-A returned to the activity room and sat beside R14. R14 remained seated in her wheelchair. - At 4:16 p.m. LPN-A brought R14 a cup of coffee. LPN-A did not offer provide R14 an opportunity to be off-loaded or repositioned. -At 4:22 p.m. SW-A asked R14 if she was finished with her coffee. R14 responded "yes" and SW-A took R14's disposable coffee cup and tossed it in the garbage can on her (SW-A) way out of the activity area. -At 4:25 p.m. SW-A returned to the activity area and again sat beside R14. During the entire time SW-A spent with R14, the resident was not offered to be off-loaded or repositioned. - At 4:28 p.m. SW-A proceeded to transport R14 in her wheelchair out of the activity room and into R14's room. The DON approached SW-A when R14 reached her room, SW-A stated to the DON that she was looking for LPN-A so he could give R14 her medications. - At 4:31 p.m. R14 remained seated in her wheelchair in her room with SW-A in attendance. -At 4:40 p.m. (1 hour and 49 minutes being observed in the wheelchair), nursing assistant (NA)-B assisted R14 into her bathroom and transferred R14 onto the toilet. Upon standing	{F 314}	changes in skin condition. All residents will have quarterly; annually; significant change; or admission/readmission Braden Scale assessment and Tissue Tolerance Test assessment as per facility policy and procedure. C.N.A. Kardex (directly from electronic care plan) were printed off for each hallway and accessible for Nursing staff and ancillary departments to follow repositioning schedule and off-loading schedules daily. EMAR will require the licensed nurse to document q shift that any resident with a pressure related area is turned & repositioned and off-loaded as the plan of care directs and will supervise that the C.N.A□s are following the plan of care. In-service training is being scheduled with Sanford Would Clinic for all licensed nurses to be presented at the JPECC facility. 4. 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 corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system Daily visual timed audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 07/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 10 and providing peri-care, R14's coccyx wound dressing came off. NA-B assisted R14 with her brief and pants while following appropriate infection control practices. - At 4:45 p.m. (start of second observation) NA-B assisted R14 back into her wheelchair. A ROHO cushion was in place and inflated in the seat of R14's wheelchair. - At 4:47 p.m. NA-B stated she was unsure of how long R14 had been sitting up in her wheelchair because the day shift had gotten R14 up. NA-B also stated she was not very familiar with R14's care as she normally worked on the other wing. - At 5:00 p.m. twenty minutes later, NA-B made LPN-A aware that R14's coccyx dressing had come off when NA-B had assisted R14 to the bathroom. LPN-A stated he would replace the dressing later. NA-B proceeded to transport R14 in her wheelchair into the dining room. - At 5:07 p.m. R14 was seated in her wheelchair in the dining room awaiting dinner. - At 5:42 p.m. R14 remained seated in her wheelchair in the dining room, eating dinner. NA-C was seated adjacent to R14 providing encouragement for R14 to eat while assisting her table mate with her dinner. - At 5:47 p.m. R14 propelled herself about two feet away from her position at the dining room table. -At 5:42 p.m. NA-C wheeled R14's wheelchair back up to the dining room table and continued to encourage R14 to eat. - At 6:07 p.m. LPN-A entered the dining room. LPN-A stated he was unaware of how long R14 had currently been seated in her wheelchair. LPN-A stated he thought R14 needed to be off-loaded or repositioned every two hours (the care plan intervention indicated 1 hour).	{F 314}	conducted on any resident with pressure related skin areas to ensure that repositioning and off-loading area performed as the Braden Scale and Tissue Tolerance Test determine as state in the plan of care/Kardex. Daily visual audits will be inclusive or rotating all 3 shifts. Audits will be conducted daily / 2 weeks, weekly/ 4 weeks, and monthly/3 months. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance. 5. 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 Resident # 14 and like residents will have daily audits x 2 week performed. The audits will check that the care plans for Resident # 14 and like residents are being followed for repositioning and off-loading, as well as for all care plan areas. Audits will be conducted as stated above for daily x 2 weeks; then weekly x 4 weeks; then monthly x 3 months. Director of Nursing or designee will be responsible to oversee that auditing is performed per audit schedule. Audit results will be presented to QA Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 07/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

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{F 314}	Continued From page 11 - At 6:14 p.m. LPN-A wheeled R14's wheelchair out of the dining room area and into the common area near the medication cart. LPN-A administered R14 some pain medication (liquid morphine) and brought R14 a glass of apple juice. - At 6:22 p.m. LPN-A took R14's blood pressure while R14 remained seated in her wheelchair in the common area. - At 6:25 p.m. LPN-A administered medications to R14. During this time R14 was not offered or provided assistance to be off-loaded or repositioned by LPN-A. - At 6:30 p.m. LPN-C approached R14 while R14 remained seated in her wheelchair in the common area. - At 6:45 p.m. (2 hours of being observed seated in the wheelchair and without wound covering/protection), LPN-C wheeled R14's wheelchair into the tub room. LPN-A and LPN-B followed. LPN-C proceeded to apply a new dressing to R14's pressure ulcer wound while LPN-B and LPN-C assisted R14 to stand. During the observation, R14 grabbed onto the railing in the tub room. R14's bottom was observed to be reddened and ruddy in appearance. The area around the coccyx pressure ulcer was pink, with an opening in the middle which LPN-C packed with gauze after having cleansed the wound. On 7/6/16, at 8:49 a.m. NA-A stated R14 was to be repositioned every two hours while lying in bed, or seated in her wheelchair (the care plan indicated repositioning was required every 1 hour while seated in the wheelchair). On 7/6/16, at 8:52 a.m. NA-D stated R14's repositioning schedule was every two hours no matter whether R14 was lying in her bed or seated in her wheelchair.	{F 314}	for further review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 07/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

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{F 314}	Continued From page 12 R14's Wound-Weekly Observation Assessment dated 6/29/16, indicated the following: - R14 had a stage 3 pressure ulcer on her coccyx which R14 had acquired at the facility on 3/23/16. - R14's pressure ulcer measurements were identified as 3 millimeters (mm) in length by 3 mm in width and 13 mm in depth with 2.4 centimeters (cm) of tunneling or undermining along the 12-3 o'clock border of the pressure ulcer. (When these measurements were placed in R14's electronic health record, the electronic health record automatically converted cm to mm. Hence any wound measurements documented on a paper form or in a progress note were noted to be in cm and the electronic Wound-Weekly Observation Assessments measurements were documented in mm's and should read cm). - Wound progress was noted as being improved since the last visit at the wound clinic and the wound assessment and measurements had been completed at the wound clinic. R14's Wound-Weekly Observation Assessment dated 7/5/16, indicated the following: - R14's stage 3 pressure ulcer on R14's coccyx area measured 3 mm x 3 mm x 17 mm in depth with 2.4 cm of tunneling or undermining along the 12-3 o'clock border of pressure ulcer. - Overall impression of the pressure ulcer was unchanged with the epithelial (outer layer of the skin) tissue was pink, and the pressure ulcer had a scant amount of odorless serosanguinous (yellowish drainage with small amounts of blood) drainage. - Wound progress was noted as the wound being stable, but the depth of the wound and undermining had not changed. - Additional comments indicated R14 was supposed to be encouraged to stay off of the	{F 314}		

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{F 314}	Continued From page 13 wound as much as possible and R14 should be off-loaded and repositioned while seated in her wheelchair. R14's Clinical Referral form for the wound clinic dated 6/28/16, indicated the measurements of the pressure ulcer to be 0.3 cm x 0.3 cm x 1.3 cm in depth with 2.4 cm of undermining present at the 12 -3 o'clock border of the wound. R14's Wound Assessment Progress Report dated 6/29/16, indicated the following: - R14 had a stage 3 pressure ulcer on R14's coccyx area which had been acquired at the facility on 3/23/16. - Measurement indicated 0.3 cm x 0.3 cm x 1.3 cm with 2.4 cm of undermining along the 12-3 o'clock border; surrounding tissue was intact with a small amount of odorless serosanguinous drainage. - Wound status was noted as improved. - Pressure relieving interventions included pressure reduction cushion, encourage R14 to stay off wound as much as possible, R14 should be off-loaded and repositioned while seated in her wheelchair. R14's Wound Assessment Progress Report dated 7/5/16, indicated the following: - R14's stage 3 pressure ulcer measured 0.3 cm x 0.3 cm x 1.7 cm with 2.0 cm of undermining along the 12-3 o'clock border, surround tissue was pink and intact, with a scant amount of odorless serosanguinous drainage. - Wound status was noted as the same. - Pressure reduction interventions remained the same as noted above. R14's progress note (PN) dated 6/28/16, indicated R14 had returned from the wound clinic	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	R 07/06/2016

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{F 314}	Continued From page 14	{F 314}		

appointment. The wound measurement form had been completed by the wound clinic staff and indicated R14's pressure ulcer measured 0.3 cm x 0.3 cm x 1.3 cm with 2.4 cm of undermining at the 12-3 o'clock border of the wound.

R14's PN dated 7/5/16, indicated R14's wound on R14's lower right buttock had healed. R14's wound on her coccyx was a stage 3 pressure ulcer and measured 0.3 cm x 0.3 cm x 1.7 cm with 2 cm of undermining present at the 12-3 o'clock border. The wound had new pink tissue present and the exterior of the wound had decreased in size, however, the depth of the wound had not improved from the week prior.

R14's medication administration record (MAR) for the month of 6/2016, indicated by a check mark at each shift, of each day, that the staff had monitored R14 for being off of her wound as much as possible and that R14 had limited her time in the wheelchair.

On 7/6/16, at 9:14 a.m. director of nursing (DON) confirmed R14 had a current stage 3 pressure ulcer on her coccyx. Registered Nurse consultant (RN)-A and DON confirmed the above noted measurements with acknowledgement that from 6/29/16, to 7/5/16, measurement indicated the depth of R14's pressure ulcer had increased from 13 mm to 17 mm (4 mm). DON verified R14 should be off-loaded or repositioned every one hour as directed by R14's latest tissue tolerance assessment and care plan.

On 7/6/16, at 2:20 p.m. RN-A stated it was good nursing practice for any resident who had a stage 3 pressure ulcer to be on an every one hour repositioning schedule.

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{F 314}	Continued From page 15 Pressure Ulcer Treatment policy dated 9/2013, indicated the resident's care plan should be assessed for any special needs of the resident and the resident's Braden Scale should be reviewed to identify risk for pressure ulcer development. In addition, pressure ulcer treatment should focus on the resident's assessed current status of existing pressure ulcers; pressure ulcer care required; and education provided. Interventions and care strategies required a comprehensive approach and included maximizing the potential for healing. Repositioning Level II policy [undated] indicated repositioning was a common, effective intervention for the prevention of skin breakdown, promoted circulation and provided pressure relief. Repositioning was critical for a resident who was dependent on staff for repositioning. For a resident with a stage 1 or above pressure ulcer, an every two hour repositioning schedule was inadequate and a resident who was in a chair should be on an every one hour repositioning scheduled or as directed by the tissue tolerance test.	{F 314}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245535 Y1	A. Building B. Wing Y2	7/6/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0246	Correction	ID Prefix F0248	Correction	ID Prefix F0280	Correction
Reg. # 483.15(e)(1)	Completed	Reg. # 483.15(f)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	07/06/2016	LSC	07/06/2016	LSC	07/06/2016
ID Prefix F0309	Correction	ID Prefix F0313	Correction	ID Prefix F0318	Correction
Reg. # 483.25	Completed	Reg. # 483.25(b)	Completed	Reg. # 483.25(e)(2)	Completed
LSC	07/06/2016	LSC	07/06/2016	LSC	07/06/2016
ID Prefix F0322	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.25(g)(2)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed
LSC	07/06/2016	LSC	07/06/2016	LSC	07/06/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/06/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	07/20/2016	18619	07/06/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/16/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245535 Y1	A. Building 01 - NURSING HOME B. Wing Y2	7/15/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0022	06/03/2016	LSC	K0025	06/10/2016	LSC	K0050	06/13/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0052	06/10/2016	LSC	K0066	07/11/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	07/20/2016	36536	07/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/10/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: N6OT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**

2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/16/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **47** (L18)

13.Total Certified Beds **47** (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
	47			
(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 :
Jana Bromenshenkel, HFE NEII — 06/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 06/30/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/30/1991
(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.
09201
(L31)

30. REMARKS
Posted 07/06/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 3, 2016

Mr. Delbert Clark, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535028

Dear Mr. Clark:

On May 16, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

.Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 25, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 25, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 16, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 16, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a call light was provided to summon assistance for 1 of 1 resident (R5) who was observed asking for assistance but unable to summon assistance due to not having the call light in reach. Findings include:	F 246	F246 Reasonable Accommodation of Needs/Preferences It is the policy and practice of JPECC to provide all residents with call light accessibility. Policy is that call lights will be within reach for the resident. Resident 5 was immediately provided call	6/25/16

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

Electronically Signed | 06/13/2016

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F 246	Continued From page 1 R5's Diagnosis Report dated 5/13/16, identified R5 was admitted to the facility on 3/5/02, with a principal diagnosis of cerebral infarction (stroke), and had other diagnoses that included: chronic pain, left hand stiffness, multiple contractures, hallucinations, anxiety, idiopathic neuropathy, unspecified psychosis, type 2 diabetes. R5's quarterly Minimum Data Set (MDS) dated 3/22/16, indicated R5 had severe cognitive impairment and required extensive assist of two for bed mobility and transfer, was totally dependent on staff for locomotion on the unit, required extensive assist of one off the unit, and was non-ambulatory. On 5/11/16, at 7:24 a.m. R5 was observed seated in the dinning room. There were no staff in the dining room, and there was no way for the resident to summon assistance. From 7:24 a.m. to 7:32 a.m. R5 was observed waving her hand for the surveyor to come to her several times, and when approached R5 stated she needed to use the bathroom. The surveyor found NA-B who assisted R5 to her room to use the bathroom. -At 7:53 a.m. R5 was observed in her room, in bed, partially lying on a bedpan. R5 had been served her breakfast tray in which he was eating while positioned on the bedpan. -At 8:03 a.m. R5 was observed seated in her wheelchair eating breakfast. R5 did not have a call light available within reach. R5 was periodically observed several times asking for assistance stating she wanted to go back to bed. -At 8:48 a.m. the surveyor put the call light on for R5 and at 9:06 a.m. NA-D entered R5's room to assist R5 back to bed. NA-D was asked if R5	F 246	light access when noted not accessible. Audits will be completed daily during each shift to ensure that call lights [via Nurse Action Rounds] are within reach for all residents at all times. Education was provided immediately to staff during the survey visit, and additionally on 6/21/2016. Mandatory nursing department education will be conducted June 20th-24th with emphasis on call light accessibility. Director of Nursing or designee will be responsible to ensure monitoring is conducted using the Nurse Action Rounds form and audit form for monitoring review. Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance.	

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F 246	Continued From page 2 could use the call light if it had been available and NA-D stated "yes" and stated R5 should have had the call light. On 5/13/16, at 11:33 a.m. the DON confirmed R5 should have been provided the call light to summon assistance when staff were not in the residents room. A facility policy regarding call light use or accommodation of needs was requested but not available.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 3 of 3 residents (R13, R14, R5) reviewed for activities. Findings include: R13's quarterly Minimum Data Set (MDS) dated 3/1/16, indicated R13 was diagnosed with dementia, paraplegia, seizure disorder and altered mental status. The MDS also indicated R12 had severe cognitive impairment, required	F 248	F248 Activities Meet Interests/Needs of Each Resident It is the practice of JPECC to involve capable residents to participate in care planning, and for care plans to be revised and updated as residents care needs change. F248----Residents 5, 13, and 14 will have an individual customized recreational services tracking sheet to develop an activities plan that reflects the choices and interests of these residents. Each	6/25/16

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F 248	Continued From page 3 extensive assist of two persons for transfers, was non-ambulatory and was totally dependent on staff for locomotion on and off of the unit. R13's annual MDS dated 12/8/15, indicated the interview for activity preferences could not be completed by R13 or family/significant other. The staff assessment of activity preferences indicated R13 preferred reading books, newspapers or magazines, listening to music, keeping up with the news, and participating in favorite activities. R13's Activities Care Area Assessment (CAA) dated 12/8/15, indicated R13 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations and cognitive deficits. R13's Psychosocial Well being CAA dated 12/8/15, indicated R13 had a potential for psychosocial well-being problems related to dementia, limited mobility, inability to speak, and seizure disorder. The CAA indicated R13 preferred to stay in room and enjoyed watching television. The CAA also indicated R13 would shake head yes/no when asked if he wanted to participate in group activities or watch television in the activity room. The CAA further indicated R13 had 1 on 1 time with activity staff. R13's undated Care Plan indicated R13 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations and cognitive deficits. The Care Plan directed staff to invite R13 to scheduled activities. The Care Plan indicated R13 required assistance/escort to activity functions and required 1:1 bedside/in-room visits and activities 3x/weekly if unable to attend out of room events and when R13 chose not to	F 248	resident's activities plan shall relate to his/her comprehensive assessment and should reflect his/her individual needs. The administrator, social worker and activity coordinator will monitor the recreational services tracking sheet to see these residents are involves in programs according to their needs. The completed activity plan shall be updated at the time of resident MDS. The Activity department will provide activities that are in alignment with residents interests. The Social Worker will identify other current residents and within 14 days of admission any new resident having the potential to be affected by function level, cognition and medical conditions to help in planning their activity plan. Individual interests will be noted and activities created to meet the preference of the resident. Measures will be put in place or systemic changes: Group activities and 1:1s will be offered to assure that each resident has an activity that is individualized to meet their preferences/needs. The Administrator and or designee will audit the activity tracking sheets, and MDS for resident preference and complete resident interviews to assure compliance until resolved. Education was provided to Activities staff on 6/21/2016. Audit results will be reported to the QA	

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F 248	Continued From page 4 participate in organized activities, he preferred to watch television for social and sensory stimulation. The Care Plan further directed staff to engage R13 in simple, structured activities and R13 enjoyed watching sports, westerns and old TV shows. On 5/10/16, at 4:00 p.m. R13 was observed resting in bed with his eyes closed while a card activity was taking place in the activity area. On 5/11/16, the facility activity calendar indicated Ski ball was scheduled at 9 a.m. and 7-11 activity scheduled for 1:00 p.m. On 5/11/16, at 9:25 a.m. R13 was observed in bed with lights off. The television was not on and no music played. --At 11:02 a.m. R13 remained in bed with the lights on. No television or music played. --At 12:48 p.m. R13 remained in bed with the lights off. No television or music played. Nursing assistant (NA)-D stated R13 got out of bed once per shift and the time R13 got up depended on the day. She stated R13 had refused to get up at 10:45 a.m. but would be getting up later. --At 1:59 p.m. R13 remained resting in bed with lights off. No television or music played. A dice game was in progress in the activity room. On 5/12/16, the facility activity calendar had Red Lake casino scheduled at 10 a.m. No other activities were identified at this time. --At 10:40 a.m. R13 was observed resting in bed	F 248	Committee for review and action plans developed as needed to ensure compliance.	

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F 248	Continued From page 5	F 248		

with lights off and his eyes closed. A news program played on the television. R13 was positioned on his right side, facing the television.
--At 11:16 a.m. NA-D stated R13 spent much of his time in bed, however, got up for 2 hours on each shift. NA-D stated R13 liked to watch television, especially football, and also enjoyed watching the news. NA-D indicated R13 was able to indicate yes or no and able to point to indicate his television preferences.

Review of R13's Activity Participation Notes from 2/1/16, to 5/13/16, revealed R13 was provided the following activities:

--Month of February: one 1:1 activity and one out of room activity
--Month of March: two 1:1 activities and three out of room activities
--Month of April: two 1:1 activities and zero out of room activities
--Month of May: zero 1:1 activities and zero out of room activities

R14's Diagnosis Report dated 5/16/15, indicated R14 had diagnoses which included Alzheimer's disease, stage 3 pressure ulcer of sacral region, and a left femur fracture.

R14's significant change MDS dated 4/19/16, indicated R14 had severe cognitive impairment and required extensive assist of two persons for transfers and locomotion off the unit, limited assist of one person for locomotion on the unit and was non-ambulatory. The Interview for Activity Preferences indicated it was very important to R14 to go outside when weather was

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F 248	Continued From page 6 nice and participate in religious practices and somewhat important to R14 to listen to music, keep up with news, do things with groups of people, and do favorite activities. R14's Cognitive Loss/Dementia CAA dated 4/19/16, indicated R14 had impaired cognitive function/dementia related to Alzheimer's disease, was alert but not aware of place or time. The CAA indicated R14 had a decline in verbalization and could not speak or respond with a full sentence but could usually respond with a word or two. The CAA further indicated R14 lacked the ability to ask for assistance. R14's Care Plan dated 8/7/14, indicated R14 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to Alzheimer's disease and dementia. The Care Plan directed staff to: --ensure the activities R14 attended were: compatible with physical and mental capabilities, compatible with known interests and preferences, needs and abilities and age appropriate --invite R14 to scheduled activities. --modify daily schedule, treatment plan as needed to accommodate activity participation as requested by R14. --provide a program of activities that was of interest and empowered R14 by encouraging/allowing choice, self-expression and responsibility --provide R14 with materials for individual activities as desired. The Care Plan indicated R14 liked reading, required assistance/escort to activity functions and required activities which did not involve overly demanding cognitive tasks. The Care Plan further directed staff to engage R14 in simple, structured	F 248		

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F 248	Continued From page 7	F 248		

activities such as outdoor activities, cultural events, music, bingo, cooking/baking.

On 5/10/16, at 3:07 p.m. R14 was observed seated in a wheelchair, next to the nursing station. R14 had just returned from a medical appointment. R14 was wheeled into own room and transferred to bed.

On 5/11/16, from 7:18 a.m. until 10:37 a.m. R14 was observed to remain in bed. The facility activity calendar indicated a ski ball activity was scheduled at 9:00 a.m.

On 5/12/16, at 9:45 a.m. R14 was observed to have remained in bed. At this time, NA-B stated R14 stayed in bed due to open areas on the buttocks and would sit on the edge of bed to eat her meals. The facility activity calendar indicated Red Lake casino was scheduled at 10 a.m. No other activities were identified at this time.

On 5/12/16, at 2:16 p.m. R14 was again observed in bed. The facility activity calendar indicated 7 up game was scheduled at 1:30 p.m. and bean bag toss scheduled at 3:30 p.m. No other afternoon activities were identified or indication of activity would be provided to R14.

On 5/13/16, at 8:59 a.m. R14 was observed in bed, facing the wall with the privacy curtain pulled. The facility activity calendar indicated Walmart scheduled for 10:00 a.m. No other activities were identified at this time or indication R14 would be provided activities.

Review of R14's Activity Participation Notes from 2/1/16, to 5/12/16, revealed R14 was provided the

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F 248	Continued From page 8	F 248		

following activities:

--Month of February: two activities provided (baking, bingo)
--Month of March: three activities provided (balloon volley, ring toss, 1:1 visit)
--Month of April: zero activities provided
--Month of May: zero activities provided

R5's quarterly MDS dated 3/22/16, indicated R5 was diagnosed with anxiety disorder, psychotic disorder, depression, dementia, stroke and hemiplegia (paralysis of one side of the body). The MDS also indicated R5 had severe cognitive impairment and required extensive assist of two for transfer, required extensive assist of one for locomotion on and off the unit and was non-ambulatory. R5's annual MDS dated 7/21/15, indicated having books, newspapers and magazines to read, listening to music, keeping up with the news, doing things with groups of people, doing favorite activities, going outside, and participating in religious activities were very important and being around animals was somewhat important to R5.

R5's Activities CAA dated 7/21/16, indicated R5 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive and physical deficits. The CAA indicated R5 enjoyed going on outings with activities department, but if over stimulated her behaviors increased.

R5's Care Plan dated 7/29/15, indicated R5 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to

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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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cognitive and physical deficits. The Care Plan directed staff to:
--Modify daily schedule, treatment plan as needed to accommodate activity participation as requested by R5.
--Provide with activities calendar. Notify R5 of any changes to the calendar of activities.
--Engage in simple, structured activities such as socialization, casino, baking/cooking, spiritual services, music, cultural events, facility events and outings with activities.
--R5 was to receive 1:1 bedside/in-room visits and activities 3x weekly
--R5 needed assistance/escort to activity functions.

R5 was observed on 5/10/16, from 8:45 a.m. to 4:00 p.m. on 5/11/16, from 7:00 a.m. to 4:30 p.m. on 5/12/16, from 8:35 a.m. to 4:00 p.m. and 5/13/16, from 8:45 a.m. to 4:00 p.m. R5 was not provided activities during any of the aforementioned times.

Review of R5's Activity Participation Notes from 2/1/16, to 5/13/16, revealed R5 was provided the following activities:

--Month of February: zero 1:1 activities, zero group activities
--Month of March: six 1:1 activities, zero group activities
--Month of April: nine 1:1 activities, zero group activities
--Month of May: one 1:1 activity, zero group activities

On 5/13/16, at 3:36 p.m. the activity director (AD) indicated the activity staff relied on 1:1 visits for

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F 248	Continued From page 10 residents who had dementia and could not participate in regular activities. The AD stated 1:1 visits included such things as hand massage and visiting. The AD stated they completed a Life Story form with each resident to find their past history and interests and if a resident was unable to complete the form they would complete it with the family. The AD confirmed documentation regarding activity programs including 1:1 visits were lacking for R13, R14 and R5. On 5/16/16, at 9:20 a.m. the DON stated she would expect R13, R14 and R5 would have had activities provided based on their assessed need and according to the care plan. The DON confirmed documentation regarding activity programs for R13, R14 and R5 was lacking. An Activities policy was not provided.	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		6/25/16

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F 280	Continued From page 11 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include the appropriate timing of renal medication administration for 1 of 1 resident (R28) who received dialysis and was prescribed renal medication. Findings include: R28's care plan dated 3/1/16, indicated R28 was diagnosed with end-stage renal disease (ESRD) and received dialysis three times a week. The plan did not direct the staff as to how to administer medications specifically for the treatment of ESRD. R28's Physicians orders dated 2/19/16, included an order for calcium acetate (a medication used to bind phosphorous in dietary intake and normalize phosphorous levels in patients who have ESRD) 667 milligrams (mg) three times a day. On 5/13/16, at 11:15 a.m. R28 stated the Calcium Acetate was to be given with meals, however, the facilty staff administered the medication up to an hour after the meal.	F 280	F280 Right to Participate Planning Care-Revise CP It is the practice of JPECC to involve capable residents to participate in care planning, and for care plans to be revised and updated as residents care needs change. Resident 28 care plan and MAR was reviewed and revised to include the administration of calcium acetate with meals. Staff were immediately educated on how to administer ESRD medication during the survey week. Any resident receiving dialysis will be reviewed to ensure medications are administrated as ordered in relationship to dialysis, with food, or the specific physician order. The dialysis checklist was updated to include updating the MD on all medications that are recommended to be given with meals. The dialysis check list will be utilized on all residents receiving dialysis to ensure medications are administered as ordered or recommended. All licensed nurses are responsible to update resident care plans as medication	

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F 280	Continued From page 12 R28's Medication Administration Record (EMAR) for May 2015, directed staff to administer R28's Calcium Acetate at 9:00 a.m., 2:00 p.m. and 9:00 p.m. On 5/13/16, at 11:45 p.m. registered nurse (RN)-B stated the medication was to be given with meals. On 5/13/16, at 11:45 a.m. the director of nursing verified the medication was to be given with meals and R28's care plan was in need of revision to include this. A policy related to care plan revisions was requested but none was provided.	F 280	orders are initiated or change. Action Rounds audit form will be conducted every shift additionally and routed to the Director of Nursing for review and monitoring. All licensed nurses will receive mandatory education with emphasis on care plan updating the week of June 20th □ June 24th, 2016. Auditing will be conducted using the dialysis checklist. All dialysis residents will have an initial audit conducted, then weekly x 4, then monthly x 4, and quarterly x3. Results of audits will be presented to the QA committee for review and further action plans as needed to ensure compliance.	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions for smoking were followed for 1 of 3 residents (R20) observed to smoke without supervision and smoking materials unsecured as directed by the care plan. In addition, the facility failed to ensure restorative nursing services were provided as directed by the care plan for 2 of 3 residents (R5, R3) who required range of motion	F 282	F282 Services by Qualified Person/Per Care Plan JPECC provides safety with smoking for all residents that smoke. JPECC ensures that restorative programs are individualized and delivered to all residents requiring restorative nursing. JPECC recognizes and manages preventative pain management for all	6/25/16

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F 282	Continued From page 13 services; failed to implement pain interventions as directed by the care plan for 1 of 2 (R5) residents reviewed for pain; and failed to provide activities according to the care plan for 2 of 3 residents (R13, R5) reviewed for activities. Findings include: R20 was not provided supervision while smoking nor were R20's smoking supplies secured in accordance with R20's care plan. R20's care plan revision date 3/26/15, directed staff to assist R20 off the unit due to R20's periods of forgetfulness, macular degeneration, and impaired mobility. In addition, R20 was identified as a smoker and on 4/18/16, the care plan was revised and directed staff to: -Instruct R20 about the facility policy on smoking: locations, times and safety concerns -R20's clothing and skin should be observed for signs of cigarette burns -R20 required supervision and cues while smoking -R20's smoking supplies should be stored in the south medication cart in the narcotic drawer and the number of cigarettes R20 had would be tracked in the narcotic log book On 5/9/16, at 6:49 p.m. R20 was observed seated in a wheelchair outside in the gazebo area smoking a cigarette. No staff were in proximity nor supervised R20 while R20 smoked. On 5/10/16, at 3:13 p.m. R20 was observed seated in a wheelchair in the activity area. R20 wheeled herself up to the exit door to the gazebo area, pushed the automatic door button and	F 282	residents that experience pain. Resident 20 care plan specifically to smoking will be reviewed and modified if needed. The corrective action will be accomplished by reviewing and updating all of the care plans as it relates to smoking, restorative nursing, pain meds and resident preferences as it relates to activities. Additionally, the facility has updated the smoking policy to reflect actual practice and to more fully incorporate resident rights. The facility will identify other residents at risk by: A) Admission smoking assessment reveals if the resident smokes. B) Residents are identified and reviewed weekly by meeting with the therapy department and reviewing the restorative nursing programming. C) Residents experiencing pain are identified by the multidisciplinary team and interventions are reviewed with the primary provider. Medicating prior to therapy is identified by therapy and restorative nursing staff. Nursing will report pain with movement and update the MD. D) Residents activities and their preferences are identified via the MDS assessment. Measures will be put in place/system changes made are: A) Completing a smoking assessment and following the facility policy as it relates to smoking. B) The restorative program has been	

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F 282	Continued From page 14 proceeded to wheel self outside. The surveyor followed R20 as she entered the gazebo area, pulled a pack of cigarettes out of her purse which was on R20's lap, removed a cigarette and lit the cigarette and proceeded to smoke it. During this time R20 remained unsupervised by staff. -At 3:30 p.m. activity aide (AA)-A entered the gazebo area and sat down on the bench. AA-A stated R20 wasn't supposed to be outside smoking without supervision. On 5/11/16, at 9:08 a.m. R20 was observed seated in a wheelchair in her room. R20 proceeded to wheel herself out of her room and down the hall into the activity room and positioned herself directly in front of the exit door by the gazebo. R20 searched her purse, pulled out a cigarette and lighter, lit the cigarette while stationed in the activity room. R20 pushed the automatic door opener and made her way out into the gazebo area. No staff were in close proximity of R20, nor was R20 supervised while R20 smoked. -At 9:15 a.m. R20 pushed the automatic door from the gazebo area and entered the facility. Once inside, R20 took the lighter and placed it back into her purse and then took the remaining portion of the cigarette R20 had just smoked and placed it into a pack of cigarettes. R20 placed the cigarette pack back into her purse. On 5/11/16, at 2:20 p.m. R20 was seated in her wheelchair outside in the gazebo area smoking a cigarette. No staff were in close proximity nor was R20 supervised when she smoked. On 5/11/16, at 11:03 a.m. LPN-A confirmed R20's cigarettes and smoking supplies were supposed to be locked up in the medication cart	F 282	updated to include specific guidelines for restorative nursing to follow. C) The EMR pain assessment is completed per the MDS schedule and as needed. Residents who are in therapy will be reviewed for pain at the weekly therapy meeting. Nursing will review residents for pain at shift report. Nursing Assistants will review residents for pain and update the nurses when there is pain with movement. The MD will be updated with the need for a change in the pain management program. D) Activities department will utilize the MDS assessment for activities to determine resident preference and resident interview to assure that the preferences are followed through. Audits of the care plan and resident interview will assure that systemic changes have occurred. The facility plan to monitor its performance and assure solutions are sustained by : Education occurred on June 21th, 2016. DON or designee will be responsible to oversee that auditing is performed per audit schedule. Audits will be performed to ensure staff is following the plan of care. Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3. Audit results will be reported to the QA Committee for review and action plans developed as needed to ensure compliance.	

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and R20 was supposed to have supervision when smoking, as directed by the care plan.

On 5/11/16, at 11:28 a.m. registered nurse (RN)-B confirmed R20's cigarettes were supposed to be locked in the south medication cart and was to be supervised when smoking as directed by the care plan.

On 5/11/16, at 11:57 a.m. nursing assistant (NA)-A confirmed R20 was supposed to be supervised when she smoked.

On 5/11/15, at 12:41 p.m. the director of nursing (DON) confirmed R20 was to have supervision when smoking and her cigarettes and smoking supplies should have been locked up in the medication cart as directed by the care plan.

Smoking Policy-Residents dated 12/2011, indicated safe resident smoking practices would be established and maintained. Any smoking -related privileges, restrictions, and concerns would be noted on the resident's care plan, and all staff would be alerted to these issues.

R5's restorative nursing care plan was not implemented as directed.

R5's care plan revised 7/28/15, indicated R5 had an activities of daily living self-care performance deficit related to a stroke with hemiparesis and pain and directed staff to provide therapeutic exercises as ordered.

R5's functional maintenance program (FMP) dated 2/15/16, indicated R5 was to maintain

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range of motion (ROM) of bilateral lower extremities three times a week and directed staff to provide the following:
-gentle passive ROM to left lower extremity
-active ROM to right lower extremity and to place pillow or wedge to achieve neutral position and max extension of knee on left. Place heel boot if patient allows.
-under the precautions and comments section of the FMP directed staff to really focus on left hip adduction and extension and knee extension with prolonged holds. Patient can be distracted with conversation, it is helpful. Ask " Does this feel good?" to give her that idea. Stop if she becomes increasingly angry.

R5 also had a FMP developed by occupational therapy dated 8/3/15, for R2 to maintain ROM for upper extremities and lower extremities and directed staff to provide:
-gentle passive ROM to left upper extremity and hand.
-two sets of 10 repetitions each to left shoulder, bicep, wrist and finger flexion and extension.
-active ROM to right upper extremity.

On 5/11/16, at 9:06 a.m. R5 was observed while in bed and there was no pillow or wedge placed on the lateral side of the left knee as directed by the FMP.

On 5/12/16, at 8:43 a.m. NA-F stated she had been trained to provide nursing rehabilitation services to the residents including R5. When R5 was observed laying on her back in bed it was noted that R5's left leg was significantly externally rotated and the left knee was bent and unable to reach neutral position of zero degree's extension. There was no pillow placed on the lateral side of

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the left knee to achieve neutral position and max extension of knee on left as the FMP had indicated. NA-F provided passive ROM to R5's left lower extremity never attempting to reach or stretch the end point of resistance to the joint movement at any point. NA-F then went to the right lower extremity and started doing passive ROM to the right lower extremity (although the FMP identified R5 was supposed to complete active ROM). No attempt was made on right knee, dorsi, and plantar flexion and extension. NA-F removed the splint on R5's left hand/arm and attempted passive ROM on the wrist and fingers, but had not completed exercises on the shoulder and elbow. When NA-F finished with the ROM exercises a pillow was not placed on the lateral side of the left leg according to the FMP to minimize external rotation of the left lower extremity, and a pillow was not placed under the calf to increase left lower extremity knee extension.

On 5/13/16, 11:33 a.m. the DON stated she expected R5's ROM be provided according to the care plan which directed the restorative aide to provide therapeutic exercises according to the FMP.

R5's pain management interventions had not been implemented as directed by the care plan.

R5's care plan revised on 7/28/15, indicated R5 had chronic pain related to stroke with hemiparesis and complaints of left shoulder, arm, leg and coccyx pain. The plan directed staff to administer pain medications as ordered, anticipate R5's need for pain relief and respond immediately to any complaint of pain, Attempt

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non-pharmacological interventions such as music, massage/relaxation techniques and other diversional activities or quiet room and to evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Monitor/ record/report to nurse any signs and symptoms of non-verbal pain: changes in breathing, vocalizations, mood & behavior changes, monitor eye and face movements for non-verbal signs of pain (sad worried, pained, clenches teeth, crying, grimacing). Monitor/ record/report to nurses resident complaints of pain or requests for pain treatment. Notify physician for significant changes in pain characteristics from previous experiences.

On 5/12/16, at 8:43 a.m. NA-F identified she had been trained to provide nursing rehabilitation services to the residents including R5. NA-F started to provide passive ROM to R5's left lower extremity and during the first stretch R5 said ouch ouch ouch. NA-F attempted to provide stretches to the left lower extremity two more times never attempting to reach or stretch the end point of resistance to the joint movement at any point. R5 complained of pain during each attempt at passive ROM saying ouch and don't do that. R5 was asked by the surveyor if she was having pain and R5 stated "yes." NA-F then went to the right lower extremity and started doing passive ROM (although the FMP identified R5 was supposed to complete active ROM). R5 again complained of pain saying ouch when R5 attempted hip flexion and extension and NA-F completed 2-3 stretches before stopping. NA-F removed the splint on R5's

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left hand/arm and attempted passive ROM on the wrist and fingers, but had not completed exercises on the shoulder and elbow. R5 continued to complain of pain during the exercises saying ouch and R5 stated she was going to kick NA-F. NA-F finished the exercises and placed the splint back on R5's hand . NA-F was interviewed at this time and stated that R5 always complained of pain when NA-F attempted ROM. NA-F was asked what her role was in providing interventions for pain for R5 for example does NA-F request pain medications from the nurse for R5 prior to therapy so there was pain medication on board prior to starting. NA-F stated no that it was too hectic in the morning to coordinate with the nurses the time for pain medication in relation to the time ROM was provided. NA-F was asked if she was expected to report R5's symptoms of pain to the nurse and NA-F stated, "no."

On 5/12/16, at 9:11 a.m. licensed practical nurse (LPN)-A was interviewed and verified R5 was not provided with pain medication prior to having ROM and pain medication had not been requested by NA-F prior to initiating ROM.

LPN-A was again interviewed on 5/12/16, at 9:45 a.m. and stated that NA-F had not reported to him R5 had pain during ROM.

On 5/13/16, 11:33 a.m. the director of nursing (DON) stated she would expect NA-F to report to the nurse responsible for R5's care that R5 was experiencing pain during ROM exercises and would expect the care planned pain management plan to be implemented.

R3 was not provided ROM services as directed

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F 282	Continued From page 20 by the care plan R3's care plan dated 9/9/15, indicated R3 had an ADL self-care performance deficit related to quadriplegia from anoxic brain damage and contractures to upper and lower extremities. The plan directed staff to provide therapeutic exercises as ordered. R3's Order Summary Report included the following physician order dated 3/10/16: COMPLETE 2-3x WEEKLY: Complete lower extremity passive range of motion (1 set of 15-20 repetitions) --hip flexion and extension --hip abduction and adduction --knee flexion and extension --ankle dorsiflexion and plantar flexion --ankle inversion and eversion --ankle supination and pronation The order indicate little motion in ankles was normal. R3's Order Summary Report included the following physician order dated 2/17/16: COMPLETE 2-3x WEEKLY: Passive range of motion (PROM): 1) Elbow extension 3 minutes, wrist and digit extension 5 minutes 2) ROM - reaching for the ball overhead (10 repetitions) --reach for the ball forward (10 repetitions) --ball rolling on table left (L) and right (R) arm (R to L and L to R 10 repetitions each) --rings over arc - complete each arm with R	F 282		

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getting help from L
--full arm extension next to chair - yellow theraband 5 repetitions x 2 sets
--full arm flexion with 1 pound dowel 5 repetitions x 2 sets

On 5/11/16, at 11:10 a.m. NA-F stated she was the restorative aid and worked with R3. NA-F stated she applied a hand splint to his right hand every morning and completed ROM exercises to R3's upper extremities every other day. NA-F indicated she did not provide ROM exercises for R3's lower extremities and indicated lower extremity ROM was provided by the physical therapy aide (PTA).

On 5/12/16 from 9:15 a.m. until 9:50 p.m.. NA-F was observed to provide ROM exercises to R3's upper extremities but did not provide ROM exercises to R3's lower extremities.

Review of restorative nursing task documentation from 4/17/16 to 5/12/16 revealed the following:

The Task Schedules dated April 2016, and May 2016, indicated lower extremity tasks were documented by NA-F on the following dates: 4/19, 4/21, 4/26, 4/29, 5/3, 5/10 and 5/12. There was no other documentation of lower extremity ROM completed.

On 5/13/16, at 9:29 a.m. lower extremity ROM task documentation in the electronic record was reviewed with NA-F. NA-F confirmed she had not performed any lower extremity ROM for R3 since December as she had understood this was done by the PTA. NA-F stated she had spoken with PTA on today and she would now start doing it.

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F 282	Continued From page 22 On 5/13/16, at 11:01 a.m. the DON confirmed lower extremity ROM had not been provided and indicated there had been miscommunication between therapy and restorative nursing. The DON stated she would have expected the ROM to be done as directed by the care plan. R13 was not provided activities according to the care plan. R13's undated care plan indicated R13 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations and cognitive deficits. The plan directed staff to invite R13 to scheduled activities. The plan indicated R13 required assistance/escort to activity functions, required 1:1 bedside/in-room visits and activities 3x/weekly if unable to attend out of room events and when R13 chose not to participate in organized activities, he preferred to watch television for social and sensory stimulation. The plan further directed staff to engage R13 in simple, structured activities and R13 enjoyed watching sports, westerns and old TV shows. On 5/10/16, at 4:00 p.m. R13 was observed resting in bed with his eyes closed while a card activity was taking place in the activity area. On 5/11/16, the facility activity calendar had Ski ball scheduled at 9 a.m. At 9:25 a.m. R13 was observed resting in bed with lights off. The television was not on and no music played. --At 11:02 a.m. R13 remained in bed with the lights on. No television or music played. --At 12:48 p.m. R13 remained in bed with the	F 282		

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lights off. No television or music played. NA-D stated R13 got up once per shift. NA-D also stated the time R13 got up depended on the day. She indicated R13 had refused to get up at 10:45 a.m. but would be getting up later. The facility activity calendar had 7-11 activity scheduled at 1 p.m.
--At 1:59 p.m. R13 remained resting in bed with lights off. No television or music played. A dice game was in progress in the activity room

On 5/12/16, the facility activity calendar had Red Lake casino scheduled at 10 a.m. No other activities were identified at this time.
--At 10:40 a.m. R13 was observed resting in bed with lights off and his eyes closed. A news program played on the television. R13 was positioned on his right side, facing the television. TV on a news channel.
--At 11:16 a.m. NA-D stated R13 spent much of his time in bed, however, got up for 2 hours on each shift. NA-D stated R13 liked to watch television, especially football, and also enjoyed watching the news. NA-D indicated R13 was able to indicate yes or no and able to point to indicate his television preferences.

Review of R13's Activity Participation Notes from 2/1/16, to 5/13/16 revealed R13 participated in the following:

--Month of February: one 1:1 activity and one out of room activity
--Month of March: two 1:1 activities and three out of room activities
--Month of April: two 1:1 activities and zero out of room activities
--Month of May: zero 1:1 activities and zero out of room activities

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R5 was not provided activities according to assessed need.

R5's care plan dated 7/29/15, indicated R5 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive and physical deficits and directed staff to:
--Modify daily schedule, treatment plan as needed to accommodate activity participation as requested by R5.
--Provide with activities calendar. Notify R5 of any changes to the calendar of activities.
--Engage in simple, structured activities such as socialization, casino, baking/cooking, spiritual services, music, cultural events, facility events and outings with activities.
--R5 was to receive 1:1 bedside/in-room visits and activities 3x weekly
--R5 needed assistance/escort to activity functions.

R5 was observed on 5/10/16, from 8:45 a.m. to 4:00 p.m. on 5/11/16, from 7:00 a.m. to 4:30 p.m. on 5/12/16, from 8:35 a.m. to 4:00 p.m. and 5/13/16, from 8:45 a.m. to 4:00 p.m. R5 was not provided activities during any of the aforementioned times.

Review of R13's Activity Participation Notes from 2/1/16, to 5/13/16, revealed R13 participate in the following:

--Month of February 2016: zero 1:1 activities
--Month of March 2016: six 1:1 activities
--Month of April 2016: nine 1:1 activities
--Month of May 2016: one 1:1 activity

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F 282	Continued From page 25 On 5/13/16, at 3:36 p.m. the activity director (AD) indicated the activity staff relied on 1:1 visits for residents' who had dementia and could not participate in regular activities. The AD stated 1:1 visits included such things as hand massage and visiting. The AD confirmed documentation regarding activity programs/participation including 1:1 visits were lacking for R13, R14 and R5. On 5/16/16, at 9:20 a.m. the DON indicated she would expect R13, R14 and R5 be provided activities as directed by the care plan. The DON confirmed documentation regarding activity programs/participation for R13, R14 and R5 was lacking.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a timely pain assessment and implement interventions to minimize pain for 1 of 1 (R14) resident who had ineffective pain control following the development of stage three pressure ulcers and a pelvic fracture. This failure resulted in actual harm to R14 due to increased pain without adequate pain	F 309	F309 Provide Care/Services for Highest Well Being Resident 14 will be reassessed for pain using the facility pain assessment tool. Resident 5 will be reassessed for pain using the facility pain assessment tool, and restorative nursing exercises will be	6/25/16

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F 309	Continued From page 26 management. In addition, the facility failed to provide pain medication prior to ROM exercises for 1 of 1 (R5) resident observed to have pain during the provision of ROM exercises as directed. The facilty failed to ensure renal medications were appropriately adminsitered to 1 of 1 resident (R28) who required phosphorus binding renal medication to be administered with meals. Lastly, the facility failed to ensure adequate foot supports were provided for 1 of 1 resident (R1) observed to with unsupported feet/legs while seated in the wheelchair. Findings include: R14 had sustained a pelvic fracture and acquired two stage three pressure ulcers without effective pain management which resulted in harm to R14. R14's Diagnosis report dated 5/16/16, indicated R14 was diagnosed with Alzheimer's disease, history of left femur fracture, current fractured pelvis, muscle weakness, pain in left hip, anemia, stage three (full thickness tissue loss) sacral pressure ulcer, cutaneous abscess of buttock, osteoarthritis, and diabetes. R14's change of status Minimum Data Set (MDS) dated 4/18/16, indicated R14 was severely cognitively impaired, required extensive assistance of two staff for bed mobility and transfers, did not walk and had pain. The MDS indicated R14 could not verbalize pain but did display non-verbal signs of pain such as crying or moaning, vocal complaints of pain (ouch), facial	F 309	reviewed/revised to limit pain producing movements. Resident 28 referred to in F280 for corrective measures. Resident 1 will be reassessed for wheelchair positioning. The facility will identify other residents at risk in addition to the scheduled pain assessments as per the MDS requirements the following will occur: Residents will be identified and reviewed weekly by restorative nursing and therapy for pain with movement. This information is then communicated to the licensed nurse, designee or DON. Residents experiencing pain are identified by the multidisciplinary team and interventions are reviewed with the primary provider. Medicating prior to therapy is identified by therapy and restorative nursing staff. Nursing will report pain with movement and update the MD. Residents are reviewed at each shift change via report specifically for pain. All wheelchair dependent residents will be reviewed for proper wheelchair positioning and referred to therapy if needed for formal wheelchair position evaluation and treatment. Measures will be put in place/system changes made are:	

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F 309	Continued From page 27 expressions and protective body movements. The MDS also indicated R14 received pain medication but did not receive any PRN (as needed) pain medication. -R14's Cognitive Loss/Dementia Care Area Assessment (CAA) for dated 4/21/16, indicated R14 had impaired cognitive function, a gradual decline in verbalization, was usually very quiet and lacked ability to ask for assistance. The assessment indicated R14 was not able to complete an interview in order to determine mental or pain status. -R14's Pain CAA dated 4/26/16, indicated R14 had chronic and acute pain related to coccyx ulcers, disorder of bone and cartilage, history of closed fracture of femur and recent pelvic fracture from a fall on 3/13/16. The CAA noted R14 exhibited non-verbal signs and symptoms of pain and severe cognitive impairment prevented resident's ability to ask for PRN medications when needed. Staff needed to monitor for signs of pain every shift and to give pain medications prior to completing treatments to coccyx and buttock ulcers. The CAA noted R14 had fallen on 3/13/16, hydrocodone 5mg/325 was increased and then changed to 7.5mg/325mg/15ml liquid as resident had difficulty swallowing the tablet form. However, the CAA indicated R14 would spit out the liquid and state that it was "too much", therefore not receiving complete/effective pain relief. Hydrocodone was then changed to MS concentrate 20mg/ml on 4/12/16, 5mg three times a day (TID) and 2.5mg every 4hrs PRN. The CAA also noted R14 appeared to have effective pain relief but showed some non-verbal signs when being transferred into or out of wheelchair and per wound clinic orders resident was to limit time in wheelchair to keep pressure	F 309	The facility will continue to follow MDS schedule for pain assessments as indicated by regulation. Therapy and Restorative nursing will update a licensed nurse when a resident is experiencing pain with movement. Nursing will update the primary provider and obtain pain meds as indicated. Nursing will evaluate residents for pain relief and concerns by specifically noting pain on the shift report sheet every 8 hours. Auditing will be conducted daily x 2 weeks; weekly x 3 months; and monthly x 3 quarters to ensure that pain assessments are conducted per policy and procedure. Therapy and ROM is performed with prior pre-medication. Skin/wound care is performed with pre-medication for pain. Director of Nursing or designee will be responsible to oversee that auditing is performed per audit schedule. Results of audits will be presented to the QA committee for review and further action plans as needed to ensure compliance. The facility plans to monitor its performance and assure solutions are sustained by 6/25/2016. Education occurred on June 21th, 2016	

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F 309	Continued From page 28 off coccyx. -R14's Pressure Ulcer CAA dated 4/26/16, indicated R14 had two stage three pressure ulcers to coccyx and right buttock, had a history of ulcers, had limited mobility and severe dementia with a history of refusing to reposition. R14's Pain Assessment form dated 2/1/16, indicated R14 had pain in the right hip and bilateral knees. Due to R14's inability to verbalize pain level, a facial diagram was used which scored pain per a six level pain format which ranged from a no hurt level to hurts worst level. R14's pain was identified as "hurts even more." Elevating legs and taking time with cares made the pain better. The form indicated R14's pain at it's least was coded as "hurts a little bit." Legs in a dependent position for too long, quick sudden movements and increased wandering made the pain worse. The form indicated when pain was at it's worst, R14's pain was coded highest severity of "hurts worst." Pain affected R14's social activities, physical activity, mobility and emotions. The effects of pain on R14's sleep and rest, appetite and intimacy was undetermined. The comment section indicated R14 had non verbal signs/symptoms of pain such as crying, moaning, grimacing, wincing, wrinkled forehead, guarding and rubbing body part. Medications/Treatments/Modalities section indicated Vicodin twice a day was used for pain relief. An incident report dated 3/13/16, at 1:31 p.m. indicated R14 rolled out of bed, complained of abdominal pain and was sent to the emergency room (ER) via ambulance for evaluation. R14's ER report dated 3/13/16, indicated R14 was diagnosed with a fracture of the pelvis. The report	F 309		

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indicated this type of fracture was very painful and treated with pain medication and by applying ice to the area. (There was no indication in the medical record of any non-pharmalogical interventions attempted or implemented.)

R14's progress note (PN) dated 3/13/16, at 9:40 p.m. indicated R14 returned to facility via ambulance. Assist of four staff to transfer R14 from the gurney to the bed. R14 denied pain upon return, however, called out during the transfer and during subsequent cares. R14 appears comfortable as long as no movement was required. Ambulance personnel noted physician at ER wanted staff to be aware R14 had open wounds. Wounds assessed to be inflamed, edematous, and tender to the touch. R14's primary care physician (PCP) to assess resident ulcerations for further treatment options.

Further review of R14's March 2016, PN's revealed several entries related to R14's verbal and non-verbal signs/symptoms of pain without effective pain management.

R14's PN dated 4/1/16, at 2:54 p.m. indicated non verbal signs of pain noted before scheduled pain med administered. R14 moaning, rubbing hips, cried out when coccyx dressings were changed. -3:55 p.m. PN indicated during dressing change, R14 displayed non verbal signs/symptoms of pain during treatment by crying and moaning out. R14 was pretreated with scheduled pain med which appeared to provide "some" comfort.

R14's PN dated 4/3/16, at 3:08 a.m. indicated R14 complained of pain rated 7 on a 0-10 pain scale but did not specify where the pain was. Non verbal signs noted such as R14 clenching fists

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and facial grimacing. R14 refused attempts to administer pain med three times. However, the note does not identify any non pharmacological interventions attempted.
-at 8:08 p.m. indicated dressings on coccyx changed. Non-verbal signs and symptoms of pain noted during treatment. Patient crying and moaning. Patient was pre-treated with scheduled Vicodin prior to treatment which appeared to provide "some" pain control.

R14's PN dated 4/4/16, [time unreadable] indicated pain med given for complaints of pelvic pain, facial grimacing and clenching of fist. R14 in bed, sleeping.
-10:30 a.m. indicated pain med ineffective.

A Palliative Care Follow-Up note from the consulting pharmacist dated 4/12/16, indicated the MDS nurse had called requesting different formulation of pain medication. The note indicated R14 was having difficulty with the high volume of Vicodin elixir. The recommendation was to use a more concentrated pain medication with low volume for ease in administration. The plan/order indicated to discontinue the Vicodin elixir and start morphine 20mg/ml and give 0.25ml schedule three times a day and then 0.125ml every four hours as needed for breakthrough pain.

R14's PN dated 4/12/16, at 2:11 p.m. indicated treatments completed per order, wound bed was bright red with moderate drainage. R14 was pretreated with pain medication prior to the treatments and had vocalized "some" pain when wounds were being cleansed.
-2:30 p.m. PN note indicated decision made by interdisciplinary team that a significant change

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F 309	Continued From page 31 MDS would be completed instead of a quarterly due to R14 sustaining a fall that resulted in pelvic fracture, had two small superficial open areas to buttocks/coccyx which worsened into stage three ulcers which became infected, and R14's increased pain. MDS Assessment reference date would be 4/19/16. -7:20 pm. PN indicated R14 having difficulty with intake of high volume of hydrocodone elixir. New order received to discontinue elixir and start morphine concentrate 20mg/ml, scheduled doses and PRN for breakthrough pain. R14's PN dated 4/19/16, indicated wound treatments completed per order. Wounds bright red, purulent drainage with strong odor noted. R14 was previously treated with morphine prior to dressing change and R14 only had one negative vocalization of coccyx wound hurting while new dressing was changed. Otherwise, R14 was very calm and relaxed during the treatment. The morphine was more effective in managing R14's pain. R14's Pain Assessment dated 4/18/16, (completed 31 days following the fractured pelvis) indicated R14's pain site was left iliac crest (pelvis) due to fracture and coccyx due to pressure ulcers. Because R14 was unable to verbalize pain, a facial diagram was used which scored pain per a six level pain format which ranged from a no hurt level to hurts worst level. R14's pain level was "hurts a little more." Pain medication appeared to be effective with R14 able to turn and reposition without yelling out. When R14's pain was at it's least, it was coded as "hurts a little more." Too much movement and	F 309		

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dressing changes made the pain worse with R14 crying out during dressing changes. Pain at it's worst was coded as "hurts worst." The assessment indicated pain had not effected R14's sleep/rest, social activities, appetite or intimacy but had an effect on R14's physical activity, mobility and emotions. The comment section indicated R14 was unable to answer the effect of pain questions due to severe cognitive impairment so the above noted effects were noted to have occurred by staff. The Methods/Treatments/Modalities section indicated scheduled MS (Morphine Sulfate) 5mg orally three times a day with PRN MS 2.5mg every 4 hrs for breakthrough pain and R14 was to be turned and repositioned hourly.

R14's PN dated 4/20/16, at 1:57 p.m. indicated care plan meeting held. Note identified fall with fracture and pressure ulcers as well as pain control. Original Vicodin order was increased and changed several times after fracture but appeared to be ineffective. Scheduled morphine was then ordered with better results in pain control. R14 appears to be more comfortable with less signs/symptoms of non verbal pain and resistance to cares.

R14's PN dated 4/26/16, 4/29/16, and 4/30/16, revealed improved pain control with the use of the morphine. Schedule morphine appears to be effective."

R14's PN dated 5/9/16, at 12:52 p.m. indicated morphine given for left hip pain.
-At 1:40 p.m. PN indicated R14 appeared very distressed, crying out when staff attempted to reposition her. Pain med ineffective. Note lacked any non pharmacological interventions attempted.

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R14's PN dated 5/11/16, indicated wound treatments completed. R14 adminsitered morphine prior to with only a few negative vocalizations of the coccyx wound hurting while a new dressing was changed. Otherwise, R14 was very calm and relaxed during the treatment, and having a nursing assistant assisting with R14 helped to reassure R14 during the treatments.

R14's Medication Administration Record (MAR) for March 2016, indicated R14 had received routine Vicodin 5-325mg table twice a day since 8/23/15, for pain in joint/lower leg. R14's pain medication regimen had not been increased after the development of the pressure ulcers and not immediately assessed after the pelvic fracture on 3/13/16.
-On 3/15/16, R14 was ordered to receive Vicodin 7.5-325mg/15ml every six hours PRN pain. The MAR indicated R14 received 23 doses of the PRN medication in which three doses were ineffective and two doses effectiveness was unknown. This dose was discontinued on 3/24/16.
-On 3/24/16, order was changed for R14 to receive 7.5-325mg liquid Vicodin three times a day for pain. No PRN doses of pain medication were administered through the rest of the month, since this order was received.

R14's MAR for April 2016, revealed R14 received Vicodin 7.5-325mg/15ml three times a day through 4/12/16.
-On 4/13/16, morphine 20mg/ml was started (0.25 ml to be administered) three times a day.
-On 4/12/16, morphine 20mg/ml to give 0.125mg every four hours PRN breakthrough pain was started. However, MAR indicated the first PRN

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dose was adminsitered 4/25/16. R14 received 4 PRN doses from 4/25/16 through 4/30/16. Of the four doses administered, the medicated was effective once, ineffective once and effectiveness undetermined one time.

R14's MAR for May 2016, revealed R14 received morphine 0.25 ml three times a day for pain through 5/12/16, and morphine 0.125mg PRN five times through 5/10/16.

On 5/10/16 at 3:07 p.m. R14 was observed seated in a wheelchair, next to the nurse's station. A ROHO cushion (a specialty cushion that redistributes pressure on the buttocks) was in place. R14 had just returned from a wound clinic appointment. R14's MAR for 5/10/16, revealed the following:
-R14 was administered Morphine at 1:00 a.m., 9:00 a.m. and 5:00 p.m. as scheduled.
-At 1:00 a.m. R14's pain level was coded as "7" on a 0-10 pain
-At 9:00 a.m. R14's pain level was coded as "7."
-At 12:15 p.m. R14's pain level was coded as "4" at which time PRN Morphine was administered.
--At 6:44 pm. R14's pain was coded as "7" at which time Morphine PRN was administered.

On 5/11/16, at 7:18 a.m. R14 was observed in bed laying on her right side. No signs/symptoms of pain noted.
-At 7:56 a.m. nursing assistant (NA)-A and NA-D were observed to reposition R14 who shouted out in pain when they rolled her over. R14 continued to say "ow, ow, ow." NA-D stated R14's pain was in her leg as she had a previous hip fracture and then fractured it again a few months ago when she fell. R14 was repositioned to lay on her left side. R14's MAR revealed R14 was last

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administered Morphine at 1:00 a.m.
-At 8:27 a.m. licensed practical nurse (LPN)-A was asked if R14 had received pain medication yet this morning. The LPN stated "no" because another nurse was going to complete the dressing change and they were going to wait to give the medication closer to the time dressing change was to be completed.
-At 9:16 a.m. LPN-A administered R14's morphine oral pain medication. At the time of the administration, R14's MAR revealed pain level of "0" no pain.
-At 10:37 a.m. registered nurse (RN)-A and NA-F were observed to reposition R14 and change the dressings to the two pressure ulcers. RN-A stated they were going to move her slowly because it hurts. During the movement, R14 continued to say "no, no." RN-A stated R14 had picked the old dressing off so there were no dressing on the coccyx wound, the wound was measured and RN-A stated it looked really good, but was deeper. The pressure ulcers were treated per physician orders. When RN-A applied the gauze sponge soaked in 25% Dakins (solution containing sodium Hypochlorite (bleach) which kills most forms of bacteria and viruses), R14 flinched and stated "ow, ow." R14's wound was covered with dressing and then she was covered with a blanket and left on her right side. R14's May 2016, revealed no PRN doses of Morphine was administered on 5/11/16.

On 5/11/16, at 11:16 a.m. RN-A stated R14 had a series of falls and fracture her pelvis on 3/15/16, and had also developed open areas on the buttocks. RN-A stated everything seemed to happen all at once.

On the morning of 5/12/16, R14 was observed to

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be repositioned from side to side every hour. At 9:45 a.m. NA-B and NA-C stated R14 was supposed to be repositioned every hour. NA-B stated R14 refused to be washed up this morning and stated she yelled "ow, ow," every time staff moved her which made NA-B not want to move R14. NA-C stated R14 had been like that since she fell and broke her hip.
-At 10:12 a.m. NA-B stated it was time to reposition R14 who was laying in bed on her side. NA-B explained to R14 what was going to happen and asked if she could help roll over. R14 was observed to move herself to her back and when NA-B physically rolled her to the right side R14 said, "Ow, Ow, Ow," grimaced, closed her eyes, and brought her knees up in the fetal position. NA-B stated that was the best R14 had ever done for her, normally she yelled very loud.

On 05/12/16 at 1:50 p.m. LPN-A stated R14's dressing change had been completed for the day and R14 only complained of pain when the Dankins was applied to the wound because that "stings."

On 05/12/16, at 2:16 p.m. a loud scream was heard coming from R14's room. NA-G was observed standing between the bed and the wall and another NA was standing next to the other side of the bed. The NAs were tuning R14 from her right side to her left side and both confirmed R14 had screamed with the movement. NA-G stated R14 had pain but was not sure if it was due to the open areas on the bottom or the fracture.
-R14's MAR for 5/12/16, revealed R14 was administered Morphine at 1:00 a.m. at which time R14's pain level was coded as "2" and again at 9:00 a.m with a pain level of "0" no pain. No PRN

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F 309	Continued From page 37 pain medication was administered 5/12/16. On 5/13/16, at 8:59 a.m. NA-B stated R14 complained of pain when they rolled her over and was not sure if it was due to the open areas on the bottom or the fractured pelvis. On 5/13/16, at 9:36 a.m. the director of nursing (DON) and RN-B was interviewed. The DON verified R14's skin issues began in February, she had a series of falls and fractured her pelvis on 3/13/16. The DON verified a change of status MDS was not started over a month after the fall and the diagnosis of two stage three pressure ulcers which was when a comprehensive pain assessment was completed. The DON stated she thought the interventions were in place but maybe it did not look like it on paper. The DON verified R14's medical record did not identify any non pharmacological interventions to be attempted to decrease pain. The DON also stated the physician was notified of the pain but was hesitant of changing the medication for fear of over-medicating R14. The DON also stated R14 was not a morning person, liked to sleep in, but could be seen wheeling around the facility in the wheelchair most evenings and if approached correctly, would be less resistive. RN-B stated the pharmacist had recommended palliative-care. On 5/13/16, at 11:19 a.m. the consulting pharmacist was interviewed and R14's pain medication was reviewed. The pharmacist verified R14's medication regime was reviewed on 3/24/16, and 4/12/16, due to R14's pain and refusing the large amounts of liquid medication. The pharmacist stated there were no hospice services available at the nursing home. The	F 309		

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pharmacist stated R14's case was complicated due to the pain felt when being repositioned and requiring frequent repositioning due to the pressure ulcers and then sitting in the wheelchair for so long when going to the wound clinic. Following review of R14's MAR and progress notes to determine effectiveness of pain medication and when asked if R14's pain was being effectively treated, the pharmacist stated, "I would say not." The pharmacist stated R14 was "not getting any break through doses" of pain medication for the breakthrough pain and confirmed R14's PRN doses of pain medication was not utilized.

On 5/13/16, at 12:02 p.m. the DON was asked to review R14's nursing notes which described R14's pain with cares and treatments and was asked if R14 had an effective pain management regimen, the DON stated, "No, it was not."

The facility's Pain-Clinical Protocol revised June 2013, indicated the physician and staff would identify individuals at risk for having pain which included a review of each person's known diagnosis and conditions that commonly caused or predisposed a person to pain and review for any treatments the resident was currently receiving for pain including non-pharmacological treatments.
R5's pain management interventions were not implemented prior to range of motion exercises.

R5's Diagnosis Report dated 5/13/16, indicated R5 was diagnosed with a cerebral infarction (stroke), chronic pain, left hand stiffness, multiple contractures, hallucinations, anxiety, idiopathic neuropathy, psychosis and type 2 diabetes.

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R5's quarterly MDS dated 3/22/16, indicated R5 had severe cognitive impairment and required extensive assist of two staff for bed mobility and transfer, total dependence on staff for locomotion on the unit, required extensive assist of one off the unit, and was non-ambulatory. The MDS also indicated R5 had moderate pain occasionally and had functional limitation in range of motion (ROM) of the upper and lower extremities with impairment on one side.

Review of the pain assessment interview completed on 3/22/16, indicated R5 had moderate pain almost constantly in the last 5 days. The indicators of pain had not been assessed and frequency of pain had not been assessed. The pain management plan included the following: Scheduled gabapentin 100mg po BID and 300mg at bedtime. Schedule Tramadol 100mg every Tues, Fri and Sunday prior to bath. Non-medication interventions were identified as the following: "Splint applied to left hand, repositioning." Under the section for comments the following was identified: "Resident has severe dementia, complains of pain to left side of body during transfers, cares and repositioning."

Another PAIN Assessment dated 3/22/16, identified R5's pain description as: "Left arm and leg r/t [related to] Hemiplegia from CVA [stroke], unable to describe type of pain but states that it hurts often." Current level of pain was not identified. What makes pain better was identified as "taking the pain medications." What makes pain worse: "transferring, repositioning." The assessment identified pain had no effect on ADL's including physical activity and mobility. The medications and treatment modalities section described all methods of alleviating pain and their

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effectiveness included: Gabapentin 100 mg twice a day, gabapentin 300 mg at bedtime, Tramadol 100 mg on Tues, Fri, and Sun, and as needed Tramadol 50 mg. Splint to left hand, pillow placement under left leg, Biofreeze and massages. Other comments were: Resident has dementia and answers regarding pain will vary greatly.

R5's ADL [activities of daily living] Functional/Rehabilitation Potential CAA dated 7/28/15, indicated R5 had an ADL self-care performance deficit related to stroke with hemiparesis, chronic left arm, shoulder, and leg pain. The CAA also indicated possible underlying problems that may affect function included, pain, communication, mood and behavioral symptoms, and recent hospitalizations.

R5's care plan revised on 7/28/15, indicated R5 had chronic pain related to stroke with hemiparesis and complaints of left shoulder, arm, leg and coccyx pain. The plan directed staff to administer pain medications as ordered, anticipate R5's need for pain relief and respond immediately to any complaint of pain. Attempt non-pharmacological interventions such as music, massage/relaxation techniques, other diversional activities or quiet room. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Monitor/ record/report to nurse any signs and symptoms of non-verbal pain such as changes in breathing, vocalizations, mood & behavior changes, monitor eye and face

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movements for non-verbal signs of pain (sad worried, pained, clenches teeth, crying, grimacing). Monitor/ record/report to nurses resident complaints of pain or requests for pain treatment. Notify physician for significant changes in pain characteristics from previous experiences.

Review of the PT- Therapist Progress & Discharge Summary indicated R5 started physical therapy on 12/2/15, and the ROM goal included: The patient will tolerate gentle ROM, stretching to maximize joint movement and aide in pain management/improve stiffness with ROM increase five degrees on each plane without increase in pain. The assessment indicated R5 had poor tolerance of ROM due to pain.

Review of R5's functional maintenance program (FMP) dated 2/15/16, identified a goal that included: Maintain ROM of bilateral lower extremities three times a week. The approaches included: Really focus on left hip adduction and extension and knee extension with prolonged holds. Patient can be distracted with conversation, it is helpful. Ask " Does this feel good?" to give her that idea. Stop if she becomes increasingly angry.

On 5/12/16, at 8:43 a.m. NA-F stated she had been trained to provide nursing rehabilitation services to the residents including R5. NA-F was observed to start to provide passive ROM to R5's left lower extremity. During the first stretch, R5 said, "ouch, ouch, ouch." NA-F attempted to provide stretches to the left lower extremity two more times never attempting to reach or stretch the end point of resistance to the joint movement at any point. R5 complained of pain during each attempt at passive ROM saying "ouch" and "don't

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do that." R5 was asked by the surveyor if she was having pain and R5 stated, "yes". NA-F proceeded to the right lower extremity and started passive ROM exercises (although the FMP identified R5 was supposed to complete active ROM). R5 again complained of pain saying "ouch" when R5 attempted hip flexion and extension. NA-F completed 2-3 stretches before stopping. No attempt was made on knee, dorsi, and plantar flexion and extension. R5 completed active ROM on the right upper extremity according to the FMP. NA-F removed the splint on R5's left hand/arm and attempted passive ROM on the wrist and fingers, but had not completed exercises on the shoulder and elbow. R5 continued to complain of pain during the exercises saying "ouch" and R5 stated she was going to kick NA-F. NA-F finished the exercises and placed the splint back on R5's hand. NA-F was interviewed at this time and stated R5 always complained of pain when NA-F attempted ROM. NA-F was asked what her role was in providing interventions for pain for R5, for example does NA-F request pain medications from the nurse for R5 prior to therapy so there is pain medication on board prior to starting. NA-F stated "no" that it was too hectic in the morning to coordinate with the nurses the time for pain medication in relation to the time ROM was provided. NA-F was asked if she was expected to report R5's symptoms of pain to the nurse and NA-F stated "no." When NA-F finished with the ROM exercises a pillow was not placed on the lateral side of the left leg according to the FMP to minimize external rotation of the left lower extremity, and a pillow was not placed under the calf to increase left lower extremity knee extension.

On 5/12/16, at 9:11 a.m. LPN-A was interviewed

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and verified R5 was not provided with pain medication prior to having ROM and stated pain medication had not been requested by NA-F prior to initiating ROM exercises.
-At 9:45 a.m. LPN-A stated NA-F had not reported to him R5 had pain during ROM.

Physical therapy assistant (PTA)-A was interviewed on 5/12/16, at 3:40 p.m. and stated R5 would sometimes complain of pain during ROM at which time PTA-A would stop the exercises and request a pain medication and return to complete the ROM when the medication was working. PTA-A stated that distraction worked well too when attempting to complete ROM for R5 and included that in the directions for the FMP.

On 5/13/16, 11:33 a.m. the DON and RN-B were interviewed together. RN-B stated R5 was on a scheduled pain medication regimen three times a day receiving Tramadol because R5 had pain with movement and the scheduled pain medication was provided so R5 would have pain management interventions on board during ROM exercises. However, when RN-B checked the physician orders and medication administration record she stated she had been mistaken. RN-B stated R5 should have been on a scheduled pain medication regimen to be covered for pain during ROM exercises. The DON stated she would expect NA-F to report to the nurse responsible for R5's care that R5 was experiencing pain during ROM exercises and would expect the care planned pain management plan to be implemented.

R28 was not administered renal medication at the

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appropriate time to ensure maximum efficacy.

R28's physicians orders dated 2/19/16, included an order for calcium acetate (a medication used to bind phosphorous in dietary intake and normalize phosphorous levels in patients who have ESRD) 667 milligrams (mg) three times a day.

R28's admission MDS dated 2/25/16, indicated R28 was alert and orientated and had diagnoses of diabetes mellitus and end stage renal disease (ESRD) and was receiving dialysis three times a week.

R28's Nutritional Status CAA, dated 3/1/16, indicated R28 required dialysis three times a week and was aware of dietary restrictions such as limiting foods high in potassium, sodium and phosphorus.

R28's care plan dated 3/1/16, indicated R28 received dialysis three times a week and directed staff to ensure R28 was monitored for a 1500 cubic centimeter fluid restriction per day. The plan also directed staff how to care for the dialysis resident, but it did not direct staff as to how to administer medications specifically for the treatment of ESRD.

R28's MAR for May 2016, directed staff to administer the calcium acetate at 9:00 a.m., 2:00 p.m. and 9:00 p.m..

On 5/13/16, at 11:15 a.m. R28 was observed eating lunch in her room. R28 stated when she was at home, she took the calcium acetate medication with her meals, however, while at the facility, staff gave her the medication up to an

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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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hour after her meals. She stated she had informed the staff she was to take the medication with meals, but they continued to give the medication after she had eaten.

On 5/13/16, at 11:30 a.m. LPN-C stated the only medication R28 received with her meals was insulin. She stated the calcium acetate was to be given at 9 a.m., 2:00 p.m. and 9:00 p.m. LPN-C stated she felt the medication would be more effective if given with food, but she did not have the authority to change the time of administration.

On 5/13/16, at 11:45 p.m. RN-B stated the medication was to be given according to the times identified on R5's MAR. Upon further review, RN-B stated the medication was to be given with meals. She stated the MAR would need to be adjusted to ensure the medication was given with meals.

On 5/13/16, at 11:45 a.m. the DON verified the medication was to be given with meals to ensure the medication was effective. She stated the medication times were to be changed to 8:00 a.m., 11:00 a.m. and 5:00 p.m. to correlate with the facility meal times.

The End-State Renal Disease policy dated 9/2010, directed staff to be trained in the care and services required for individuals with ESRD. Included in the educational needs was the specific training regarding the timing and administration of medications, particularly those before and after dialysis.

R1 was not provided adequate foot support to prevent feet from hanging while seated in the

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wheelchair.
R1's current care plan dated 10/2015, indicated R1 was diagnosed with chronic obstructive pulmonary disorder, congestive heart failure, schizophrenia, impaired mobility and organic brain damage.
R1's quarterly MDS dated 3/15/16, indicated R1 had mild cognitive impairment, required extensive assistance of staff for transferring, bed mobility and locomotion on and off the unit. The MDS indicated R1 did not ambulate.
R1's care plan dated 3/26/16, indicated R1 utilized a custom wheelchair and directed staff to wheel R1 long distances and encourage R1 to wheel self short distances.
On 5/9/16 at 1:00 p.m. R1 was observed in her room, seated in a wheelchair. There were no footrests on the wheelchair. R1's feet were dangling not touching the floor.
On 5/9/16, at 5:26 p.m. R1 was observed being wheeled from the commons area to her bedroom in the wheelchair. Both both feet dangling approximately six inches off the floor. The wheelchair did not have foot rests.
On 5/10/16, at 9:28 a.m. R1 was observed at the dining room table with her feet resting on the pedestals of the round dining room table.
On 5/10/16 at 3:14 p.m. R1 was observed to be wheeled by the administrator to the nurses station and the medication nurse stated she had just returned from the eye doctor. R1's feet were dangling, not touching the floor. There were no foot rests on the wheelchair. R1 was then wheeled into her room. R1 was observed to have her toes bent so they were touching the floor.
On 5/11/16, at 7:19 a.m. R1 was observed seated in a wheelchair with no foot rests at the dining room table. Both feet were resting on the pedestal of the dining room table.

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On 5/11/16, at 8:33 a.m. NA-A wheeled R1 to her room. R1's feet dangled during transport. NA-A assisted R1 to transfer to the toilet. NA-A stated R1 worked with choice therapy because she wanted to walk and stated she could wheel self short distances.

On 5/11/16, at 9:12 a.m. the physical therapy assistant (PTA) stated she was not sure if R1 had foot rests but she could get some for her. The PTA stated she just picked her up for ambulation services and she was not sure if a wheelchair assessment had been completed. The PTA confirmed R1's feet could not touch the floor and stated they should not be dangling because they liked to encourage the residents' to wheel themselves if they could. R1 was observed to wheel herself a short distance using her arms for pushing the chair, not her feet.

On 5/11/16, at 11:27 a.m. PTA stated she did some digging and found some foot rests and as soon as R1 saw them, R1 stated, no I don't want those. LPN-B stated R1 had a history of refusing to use foot rests and if there was any documentation, it would have been six years ago. The PTA stated the facility could get an order for occupational therapy (OT) to evaluate R1 for wheelchair positioning.

On 5/11/16, an order for an OT evaluation for wheelchair positioning was obtained.

On 5/12/2016 at 2:40 p.m. the DON verified R1's feet were not touching the floor in the wheel chair she was sitting in and should be re-evaluated.

The facility policy Repositioning revised 5/2013,

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F 309	Continued From page 48 indicated the purpose is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning and to promote comfort for all bed or chair bound residents. The policy addressed repositioning the resident in the chair and indicated resident-specific positioning needs included special equipment.	F 309		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eyeglasses were in good repair for 1 of 1 resident (R23) who required corrective eyeglasses. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/8/16, indicated R23 had moderate cognitive impairment and diagnoses which included diabetes, neuropathy (disorder of the nerves causing numbness or weakness), stroke and	F 313	F313 Treatment/Devices to maintain hearing/vision JPECC ensures that residents receive proper treatment and assistive devices to maintain vision and hearing abilities. Resident 23 eye glasses were repaired the week of May 9th, 2016 All residents assessed to require eyeglasses will be audited to ensure eye glasses are in good working condition and available for use. Director of Nursing or designee will be responsible to ensure audits are completed.	6/25/16

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F 313	Continued From page 49 epiphora (excessive tearing of the eyes). The MDS also indicated R23 required extensive assistance of one person for dressing and personal hygiene. The MDS further indicated R23 had adequate vision with the use of corrective lenses. R23's Care Plan dated 7/20/15, directed staff to remind R23 to wear glasses when up, to ensure the glasses were clean, free from scratches and in good repair and to report any damage to nurse/family. On 5/9/16, at 12:20 p.m. R23 was observed in his room, seated in a wheelchair. R23 stated he could not find his glasses and asked if the surveyor knew where they were. R23 stated he would really like his eyeglasses. No glasses were observed in R23's room. On 5/10/16, at 3:18 p.m. R23 stated he was missing his eyeglasses. On 5/11/16, at 7:04 a.m. R23 was observed seated in a wheelchair in the activity area. R23 was not wearing eyeglasses. On 5/11/16, at 12:41 p.m. nursing assistant (NA)-D stated R23 frequently broke his glasses and she believed they were out being repaired. On 5/12/16, at 10:42 a.m. NA-B stated she didn't know what R23 had done with his glasses and she had been looking for them. NA-B further stated she wasn't sure how long they had been missing and indicated it had been "maybe a month."	F 313	Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance.	

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F 313	Continued From page 50 On 5/12/16, at 2:14 p.m. licensed practical nurse (LPN)-A stated R23 did wear glasses and there was a pair belonging to R23 on the medication cart. LPN-A stated he was not sure if they were R23's current glasses. LPN-A entered R23's room and asked if he was missing glasses. R23 confirmed his glasses were missing and LPN-A looked under the bed, in R23's wheelchair and in the bedside table for R23's glasses without finding the glasses. On 5/12/16, at 2:20 p.m. the ward clerk (WC) stated she would be the person to coordinate eyeglass repair or ordering new glasses, if missing. The WC stated she was unaware of any issues with R23's glasses or missing shoes. -At 2:30 p.m. the WC stated R23's current eyeglasses had been stored in the medication cart and were in need of adjustment. The WC stated she had been unaware they were stored there otherwise she would have had them sent in for repair. The WC stated she did not know how long the glasses had been in the medication cart. On 5/13/16, at 11:07 a.m. the director of nursing (DON) confirmed R23's glasses should have been repaired promptly and stated today his glasses had been adjusted. No policy regarding accommodation of resident needs was provided.	F 313		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		6/25/16

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F 314	Continued From page 51 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a timely wound assessment, ensure a ROHO pressure redistribution cushion functioned properly and provide every one hour turning and repositioning assistance in order to promote the healing and/or prevent the development and subsequent decline of facility acquired pressure ulcers for 1 of 1 resident (R14) who had acquired pressure ulcers which worsened to stage three ulcers and also became infected. This failure resulted in actual harm for R14. Findings include: R14's Diagnosis report dated 5/16/16, indicated R14 was diagnosed with Alzheimer's disease, history of left femur fracture, current fractured pelvis, muscle weakness, pain in left hip, anemia, stage three sacral pressure ulcer, cutaneous abscess of buttock and diabetes. R14's annual Minimum Data Set (MDS) dated 2/2/16, indicated R14 had impaired cognition, required extensive assistance of one staff for bed mobility and transfers, and did not walk. The MDS also indicated R14 was at risk for developing a pressure ulcer but did not have a pressure ulcer at the time of the MDS.	F 314	F314 Treatment/SVCS to prevent/heal pressure sores JPECC ensures based on comprehensive assessment of each resident, that a resident that enters the facility without pressure sores does not develop any clinically avoidable pressure sores. TTT was conducted for resident # 14 during the week of May 9th, 2016 CP reviewed/revised with new cushion placed the week of May 9th, 2016 Director of Nursing or designee will be responsible to ensure audits are completed. Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance. Corrective action was accomplished for R14 when a new roho cushion was placed. The facility will be utilizing a gel/foam cushion in the future so that proper inflation is not an issue. R14 has an nurses order to medicate the resident prior to dressing changes.	

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F 314	Continued From page 52 R14's change of status MDS dated 4/18/16, indicated R14 had severely impaired cognition, required extensive assistance of two staff for bed mobility and transfers, did not walk, and had pain. The MDS indicated R14 had two stage three (full thickness tissue loss) pressure ulcers and could not verbalize pain but did display non-verbal signs of pain such as crying or moaning, vocal complaints of pain (ouch), facial expressions, and protective body movements. The MDS also indicated R14 did receive pain medication but did not receive any PRN (give as needed) pain medication. R14's Pressure Ulcer Care Area Assessment (CAA) dated 4/26/16, indicated R14 had stage three pressure ulcers to coccyx and right buttock with a history of ulcers, limited mobility, and severe dementia with a history of refusing to reposition. The assessment noted R14 had an air mattress and ROHO (air floatation pressure redistribution cushion) in wheelchair and turning and repositioning done hourly, if resident allowed. The assessment also indicated R14 was being transported to a wound clinic for treatment and was given Arginaid (Protein supplement) twice a day for healing. R14's Tissue Tolerance Observation (assessment to determine the skin's ability to withstand pressure without change) form dated 1/28/16, indicated under the lying observation section, R14 had no skin concerns, did not utilize a pressure redistribution mattress, no redness to skin after lying in same position for two hours. The Sitting Observation section completed 1/21/16, indicated R14 had no skin concerns, utilized a foam, pressure reduction device in the wheelchair and	F 314	R14 is resistive to turning and repositioning and has an air bed. R14s tissue tolerance has been updated. The facility has identified other residents who were admitted with pressure ulcers and they are being medicated prior to dressing changes. Turning schedules have been updated to coincide with the tissue tolerance assessment. The Repositioning policy has bee updated to align with turning as per the tissue tolerance policy. The facility has updated the Wound Assessment Progress Reporting tool to include pressure relieving device assessment, review of tissue tolerance/turning schedule, as well as review of pain management. This tool will assure that solutions are monitored and sustained as it is completed weekly. The Wound Assessment Progress Reporting tool will be routed weekly to the DON for review. Education provided on 6/21/16	

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had no skin redness after being seated for two hours. The results section of the form indicated R14 had no skin integrity concerns therefore no turning and repositioning schedule was indicated.

-R14's care plan dated 3/24/16, indicated R14 had stage three pressure ulcers on the coccyx and right buttock related to history of ulcers, limited mobility, and severe dementia (refusing to reposition). The plan directed staff administer meds and treatments as ordered, appointments for wound care as ordered, follow facility policy/protocols for the prevention/treatment of skin breakdown, inform family/resident/caregivers of any new skin breakdown, assist to turn and reposition at least every hour or more often as needed or requested, treat pain per orders, weekly treatment documentation, and to utilize a ROHO in wheelchair and air bed.

On 5/10/16 at 3:07 p.m. R14 was observed seated in the wheelchair, next to the nursing station. A ROHO cushion was in place. R14 had just returned from a wound clinic appointment.

On 5/11/16, at 7:18 a.m. R14 was observed in bed laying on her right side.
-At 7:56 a.m. nursing assistant (NA)-A and NA-D were observed to reposition R14 to her left side facing the door. An air mattress was in place on the bed. NA-D stated R14 was on an every two hour repositioning schedule.
-At 9:16 a.m. LPN-A administered R14's oral pain medication (Morphine Sulfate 20 mg/ml 0.25 ml). R14 continued to lay on her left side, facing the door.
-At 10:37 a.m. (2 hours and 41 minutes since last repositioned)registered nurse (RN)-A and NA-F were observed to reposition R14 and change the

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wound dressings. RN-A stated R14 had picked the old dressing off so there was no dressing on the coccyx wound. The wound was measured and RN-A stated it was 1.9 cm x 1.1 cm. and 1.8 cm deep. RN-A stated it looked really good, but was deeper. The dressing was removed off the right buttock pressure ulcer which measured 1.0 cm x 0.8 cm. and appeared to be superficial. There was a small amount of drainage noted. The pressure ulcers were treated per physician orders. R14 was then covered and left laying on her right side.

During the morning hours on 5/12/16, R14 was observed to be repositioned from side to side every hour. At 9:45 a.m. NA-B and NA-C both stated R14 was supposed to be repositioned every hour.

Review of R14's Progress Notes (PN) revealed the following:

-On 1/11/16, , 1/18/16, and 1/25/16, indicated R14's skin was intact.

-On 2/1/16, at 4:16 p.m. indicated area on coccyx was slightly opened closer to the right gluteal cheek. A&D ointment applied. No other skin breakdown over bony prominences. A reassessment related to the new opened skin area was not completed.

-On 2/9/16, wound bed was bright red with some drainage present. Area measures 2.2 centimeters (cm) x 1.0 cm. wound superficial with uneven borders. Area feels slightly firm to touch. Will continue to monitor area and change dressing per orders and as needed to prevent skin breakdown.
-On 2/15/16, indicated open area on coccyx

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measured 1.7 cm x 1.9 cm. Treatment completed as ordered, no other concerns noted at this time.

-On 2/17/16, care plan meeting note indicated R14 was at risk for impaired skin integrity, has a pressure reducing cushion in wheelchair and an airbed as R14 refuses to offload when in wheelchair and has history of open areas to buttocks/coccyx. Will continue current plan of care.

-On 2/28/16, indicated R14 had three open areas on or near buttocks region. Areas were described as follows:
-right buttock, two superficial regions which measured: 1. lower part measured 0.5 cm and 2. middle measured 0.3 cm. Neither had drainage. no pain, A&D applied.
-Larger area on coccyx measured 2.3 cm x 1.7 cm with area reddened with white surrounding tissue. Area is tender. R14 has a history of recurrent open area in region and has current order for foam dressing application. Primary care physician updated regarding most recent open areas. No signs/symptoms of infections. Scant clear drainage from coccyx found on old dressing. No active bleeding noted. A reassessment of the additional open areas was not completed in order to determine if current interventions were effective or additional interventions were needed.

-On 3/1/16, at 11:03 a.m. indicated large open area on coccyx measured 2.2 cm x 1.5 cm. Area is red and tender with white tissue surrounding open area. Moderate amount purulent drainage present with slight odor detected. Edges of wound are not well defined and broken. Area cleansed and bacterial swab was completed. Will

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F 314	Continued From page 56 continue to monitor area for any further signs/symptoms of breakdown or infection. -On 3/3/16, a physician order form revealed a written request from the occupational therapist to start using a ROHO cushion in the wheelchair due to current skin breakdown. Would discontinue use when breakdown was resolved. -On 3/6/16, at 3:05 p.m. coccyx area 2.0 cm x 2.0 cm. Area is red with white tissue surround open area. Large amount of purulent drainage and strong "musky" odor noted. Second open area measured 1.7 cm x 1.7 cm with large amount purulent drainage with strong musky odor noted. Both areas felt hard when palpated. -On 3/8/16, indicated results from coccyx open area culture positive for MRSA (methicillin resistant staph aureus) infection. Orders received to start antibiotic. Continue current wound care and update if no improvement. -On 3/16/16, indicated coccyx wound was a stage three pressure ulcer and possible abscess to right gluteal wound. R14 seen by wound physician. Yellow, stringy tissue was removed from lower right buttock wound and assessed tissue beneath. Wound bed drained fresh blood. No pus or signs/symptoms of infection. Wound not measured, however, large open area with potential tunneling noted underneath. Physician indicated coccyx wound would eventually open up as well and that an open hole will exist. Referral to wound clinic with expectation that wound packing would be involved in the future. At this point the physician would like Duoderm used on each wound and changed every three days and requested R14 remained off of wound bed as	F 314		

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much as possible and having R14 up in wheelchair would only exacerbate wound and deny promotion of healing. Physician aware R14 currently utilized an air mattress and was in agreement with continued use. Duoderm applied while at the clinic.

R14's physician progress note dated 3/16/16, indicated R14 had developed pressure related ulcers, utilized an air mattress and a ROHO cushion. However, the facility staff did not know how old the cushion was and unsure of where it came from. Facility staff have to pump up the ROHO cushion with air every day to get it back to baseline effective inflation level. The physician indicated he suspected the ROHO cushion was a used one therefore not providing R14 with sufficient pressure abatement. The note further described R14's wounds had necrotic (dead) tissue, wounds debrided and felt the wound to be deep tissue injury. The plan indicated R14 was to stay out of her wheelchair as her ROHO cushion failed to provide adequate pressure relief therefore R14 needed to stay out of the wheelchair as much as possible.

On 3/22/16, indicated coccyx wound measured 3.2 cm x 2.0 cm with 85% slough and remaining areas bright red/pink tissue. Tissue surrounding wound was red with distinct, non-intact edges. Moderate amount serosanguineous drainage present on old dressing and drainage had moderately strong foul smell. Wound appears to have declined. Right lower buttock wound measured 2.8 cm x 1.7 cm with possible depth and undermining but unable to determine as R14 uncooperative with assessment. Wound bed has 30% slough and remaining area open with some bright red tissue. Tissue surrounding wound was

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red and edges were distinct and non-intact. Moderate amount serosanguineous drainage on old dressing and moderately strong foul odor noted. Wound has declined. During dressing change, R14 was agitated and had complained of pain with wound cares but had received pain medication prior to wound cares. Will continue to monitor wounds and apply treatment and dressings as ordered.

R14's Clinic Referral form dated 3/23/16, indicated both right coccyx and right buttocks were stage three pressure related ulcers. The wound clinic summary of discharge instructions directed staff to ensure the ROHO cushion was functioning properly, please have cushion checked as age of the cushion was unknown, it is essential R14 rested in bed, off these areas several times a day and off areas while sleeping and to continue the low air loss mattress. Order received to ensure ROHO cushion was functioning properly, to ensure (essential for) R14 to rest in bed off wounds several times a day and is off the wound areas while sleeping and continue the use of low air loss mattress were received.

-On 4/5/16, at 11:04 a.m. indicated coccyx wound measured 3.4 cm x 3.5 cm with no tunneling present, 90% slough which yellow/white in color with a slightly darker area in center of wound. Remaining portion of wound bright pink/red. Moderate amount drainage with a strong odor. Wound edges well defined and intact, but very red and inflamed looking. Lower right buttock wound measured 1.3 cm x 1.7 cm with 0.5 cm depth. No tunneling present. 5% yellow slough with remaining portion very red and inflamed looking. Scant amount serious drainage. Wound

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edges well defined and intact.

-On 4/7/16, indicated R14 was seen at wound clinic. Silver nitrate (debridment) used on wounds, expect some dark/black drainage and wound base. New orders to both wounds. Orders to offload pressure to buttocks at all times.

-On 4/12/16, at 2:29 p.m. indicated interdisciplinary team met to discuss significant change MDS completion due to fractured pelvis and two small superficial open areas to buttocks and coccyx. Open areas worsened, culture done which was positive for infection. Wound clinic debrided wounds and classified as stage three pressure ulcers.

R14's wound Clinic Referral form dated 4/14/16, indicated R14's ROHO cushion was "flat" and directed staff to "please inflate and have evaluated."

R14's Tissue Tolerance Observation form indicated under the lying observation section dated 4/14/16, R14 had skin concerns related to open areas on the right ischial and coccyx, utilized an air pressure redistribution mattress on bed and tissue tolerance ability was not conducted due to current skin condition. The sitting observation section dated 4/14/16, indicated R14 had skin concerns related to the above noted open areas, utilized a ROHO pressure redistribution cushion in the wheelchair and skins toleration to sitting pressure was not assessed due to current skin concerns. The results section of this form indicated R14 would be turned and repositioned per physician order/directive. This assessment was signed by the licensed practical nurse (LPN) on 4/19/16.

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F 314	Continued From page 60 (five days after the assessment was conducted) -On 4/20/16, care plan meeting note indicated R14 had two superficial open areas on buttocks/coccyx which quickly worsened and infected with subsequent treatment with antibiotics. Wounds debrided at wound clinic and determined to be stage three pressure ulcers. Follow up wound clinic appointments, continued wound care treatments as ordered, turning and repositioning done hourly, ROHO cushion in wheelchair at all times and air mattress to bed. R14 would scratch open areas and pull off dressings often. Medication for pain management. -On 4/26/16, indicated both wounds were stage three which were acquired at the facility. Coccyx wound measured 2.5 cm x 1.2 cm x 1.1 depth with 60% slough and remaining wound bright red/pink tissue, drainage same, no odor but very red and inflamed. Lower right buttock wound measured 1.5 cm x 1.0 cm x 0.3 cm depth. Wound bed bright red with scant drainage, no odor, red and inflamed. -On 5/11/16, at 3:02 p.m. indicated ulcers were acquired at the facility. Coccyx wound measured 1.9 cm x 1.1 cm x 1.9 cm depth with 30% loose slough. R14 had removed the dressing. No signs of inflammation. This wound has remained stable in size but appears to look better from last week. The hard white raised lesions were not present. -lower right stage three buttock wound measured 1.0 cm x 0.8 cm with superficial depth. wound improved. R14 also had more red areas on left buttock and some superficial scratches that were also red, these areas washed and ointment applied.	F 314		

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R14's Medication / Treatment Adminstation form for March 2016, April 2016, and May 2016, revealed the following:

-3/4/16, a directive to ensure R14 had a ROHO cushion in wheelchair at all times.
-3/7/16, a directive to ensure the air mattress on the bed was working properly every shift.
-3/10/16, a "N.O" air mattress directive directed staff to ensure mattress was working properly.
-3/16/16, a directive to ensure R14 remained off wound as much as possible and to limit use of wheelchair.
-3/24/16, a directive to ensure ROHO cushion was functioning properly.

On 5/11/16, at 11:16 a.m. RN-A stated R14 had a series of falls, developed open areas on the buttock and fractured her pelvis on 3/15, and everything seemed to happen all at once.

On 5/13/16, at 9:36 a.m. the director of nursing (DON) and RN-B were interviewed. RN-B stated they had thought the pressure ulcer started as a cyst. The DON confirmed they had problems with the ROHO cushion and had monitored the cushion's inflation and had to keep pumping it up to the appropriate pressure redistribution inflation. The DON stated the facility was finally able to purchase a new ROHO cushion (purchase order dated 3/31/16) but the delivery date was unknown. The DON verified R14's skin issues were identified in February and a reassessment was not conducted timely.

A ROHO purchase order revealed the redistribution device was ordered on 3/28/16, and Direct Supply receipt initialed by a staff member

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F 314	Continued From page 62 as received on 4/21/16. The policy for Pressure Ulcers/Skin Breakdown-Clinical Protocol revised 2014, indicated the nursing staff and attending physician would assess and document an individual's significant risk factors for developing pressure ulcers. In addition, under the Interventions section of the policy indicated a turning and repositioning program was defined as a specific approach that was organized, planned, documented, monitored and evaluated. The frequency of repositioning a bed or chair bound resident should be determined by type of support surface used, condition of skin, overall condition of resident, response to current repositioning schedule and overall treatment objectives. Residents who were in bed should be on at least every two hours repositioning scheduled and for residents with a stage one or above pressure ulcers an every two hour repositioning scheduled was inadequate. If ineffective, the turning and repositioning frequency would be increased.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 318	F318 Increase/Prevent Decrease in ROM	6/25/16

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F 318	Continued From page 63 review, the facility failed to ensure range of motion exercises had been provided according to the resident's restorative nursing program for 2 of 3 residents (R3, R5) who were observed not to have received restorative nursing services as directed. Findings include: R3's Admission Record dated 8/27/13, indicated R3 had diagnoses of anoxic brain damage (injury to the brain due to lack of oxygen), quadriplegia, and contracture (fixed high resistance to passive stretch of a muscle). R3's quarterly Minimum Data Set (MDS) dated 4/5/16, indicated R3 had severe cognitive impairment and required extensive assist of two for bed mobility and transfer, extensive assist of one for locomotion on and off the unit and was non-ambulatory. The MDS also indicated R3 had functional limitation in range of motion (ROM) of the upper and lower extremities with impairment on both sides. R3's ADL (activities of daily living) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 8/4/15, indicated R3 had an ADL self-care performance deficit related to quadriplegia from anoxic brain damage, and contractures to upper and lower extremities. The CAA also indicated R3 was mainly totally dependent on staff for all ADL's. R3's care plan dated 9/9/15, indicated R3 had an ADL self-care performance deficit related to quadriplegia from anoxic brain damage and contractures to upper and lower extremities. The plan directed staff to provide therapeutic	F 318	JPECC ensures that all residents with limited range of motion, based on individualized comprehensive assessment, receive appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. Resident 3: Restorative program reviewed by therapy and restorative nurse Resident 5: Restorative program reviewed by therapy and restorative nurse DON or designee is responsible to ensure monitoring is conducted and weekly audit performed Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance. Corrective action will be accomplished: Each restorative program will be reviewed weekly with therapy, facility registered nurse, and restorative aide in order to assure that care is delivered as per program requirement. Measures will be put in place or systemic changes: Kiosk charting will be brought to restorative nursing meeting and cross referenced with restorative plan. Facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits will be completed by the RN to assure compliance. Education: Occurred immediately during survey and again on June 21, 2016.	

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F 318	Continued From page 64 exercises as ordered. R3's Order Summary Report included the following physician order dated 3/10/16: complete 2-3x WEEKLY: Lower extremity passive ROM (1 set of 15-20 repetitions) --hip flexion and extension --hip abduction and adduction --knee flexion and extension --ankle dorsiflexion and plantar flexion --ankle inversion and eversion --ankle supination and pronation The order indicate little motion in ankles was normal. R3's Order Summary Report included the following physician order dated 2/17/16: Complete 2-3x WEEKLY: Passive range of motion (PROM): -Elbow extension three minutes, wrist and digit extension five minutes -ROM - reaching for the ball overhead (10 repetitions) --reach for the ball forward (10 repetitions) --ball rolling on table left (L) and right (R) arm (R to L and L to R 10 repetitions each) --rings over arc - complete each arm with R getting help from L --full arm extension next to chair - yellow theraband five repetitions x two sets --full arm flexion with 1 pound dowel five repetitions x two sets On 5/11/16, at 11:10 a.m. nursing assistant	F 318		

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(NA)-F stated she was the restorative aide and worked with R3. NA-F stated she applied a hand splint to his right hand every morning and completed ROM exercises to R3's upper extremities every other day. NA-F stated she did not provide ROM exercises for R3's lower extremities as lower extremity ROM was provided by the physical therapy aide (PTA).

On 5/12/16, from 9:15 a.m. until 9:50 p.m. NA-F was observed to provide ROM exercises to R3's upper extremities but did not provide ROM exercises to R3's lower extremities.

On 5/13/16 at 9:13 a.m. the physical therapy assistant (PTA) stated she no longer saw R3 for ROM exercises and had last seen him on 8/31/15. PTA stated she thought they still had a few kinks to work out in the communication between physical therapy and restorative nursing. PTA stated she had developed R3's restorative care program which was to be provided by nursing staff and provided a copy. PTA also indicated she had performed a recent updated ROM screening of R3 and provided a copy of that screening.

R3's Restorative Care Program dated 8/31/15, indicated the goals for R3's restorative program included maintain ROM and flexibility. The approach/recommendations for implementation of the goals included the following:
1) Complete lower extremity PROM 1 x 15-20 each: hip flexion/extension, hip abduction/adduction, knee flexion/extension, ankle dorsiflexion/plantar flexion, ankle inversion/eversion, ankle supination/pronation. Precautions or comments to the program included: could be done in wheelchair or bed and

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little motion in ankles was normal. The Restorative Care Program indicated a separate upper extremity protocol was provided.

R3's Rehabilitation Screen dated 3/9/16, indicated the reason for the screen was "update." The findings included:
--Right upper extremity ROM: within normal limits (WNL) passive - long stretch to neutral
--Left upper extremity ROM: WNL Passive - long stretch
--Right lower extremity ROM: WNL - lack full hip/knee extension. Abnormal - ankle into plantar flexion/inversion
--Left lower extremity ROM: Abnormal - ankle into plantar flexion/inversion
The Rehabilitation Screen comments included R3 was dependent for transfers and ROM. Current FMP [functional maintenance program] made at last discharge from physical therapy 8/31/16, currently on OT [occupational therapy]. The Rehabilitation Screen indicated an evaluation was not indicated.

Review of R3's restorative nursing task documentation from 4/17/16, to 5/12/16, revealed the following:

The Task Schedules dated April 2016 and May 2016, indicated lower extremity tasks were documented by NA-F on the following dates: 4/19, 4/21, 4/26, 4/29, 5/3, 5/10 and 5/12. There was no other documentation of lower extremity ROM completed.

On 5/13/16, at 9:29 a.m. lower extremity ROM task documentation in the R3's medical record was reviewed with NA-F. NA-F confirmed she had not performed any lower extremity ROM for

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R3 since December as she had understood this was done by the PTA. NA-F stated she had spoken with PTA today and she would now start doing it.

On 5/13/16, at 11:01 a.m. the director of nursing (DON) confirmed lower extremity ROM had not been provided and indicated there had been miscommunication between therapy and restorative nursing. The DON stated she would have expected the ROM to be done as directed by R3's care plan.

R5 was not provided ROM restorative nursing services as directed by the care plan.

R5's Diagnosis Report dated 5/13/16, indicated R5's diagnoses included cerebral infarction (stroke), left hand stiffness, multiple contractures, chronic pain, hallucinations, anxiety, idiopathic neuropathy, unspecified psychosis and diabetes.

R5's quarterly MDS dated 3/22/16, indicated R5 had severe cognitive impairment and required extensive assist of two staff for bed mobility and transfer, was totally dependent on staff for locomotion on the unit, required extensive assist of one off the unit, and was non-ambulatory. The MDS also indicated R5 had functional limitation in range of motion (ROM) of the upper and lower extremities with impairment on one side.

R5's ADL Functional/Rehabilitation Potential CAA dated 7/28/15, indicated R5 had an ADL self-care performance deficit related to dementia, type II diabetes, pacemaker, stroke with hemiparesis, chronic left arm, shoulder, and leg pain. The CAA also indicated possible underlying problems that may affect R5's function included, pain,

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communication, mood and behavioral symptoms, and recent hospitalizations.

R5's care plan revised on 7/28/15, indicated R5 had an ADL self-care performance deficit related to a stroke with hemiparesis and pain. The plan directed staff to provide therapeutic exercises as ordered.

Review of the PT- Therapist Progress & Discharge Summary indicated R5 started physical therapy on 12/2/15, through 2/15/16. Upon discharge, The physical therapist discharge plan revealed a functional maintenance plan (FMP) was to be provided by facility staff which involved left lower extremity passive range of motion and right lower extremity active range of motion and active assisted range of motion.

Review of R5's FMP dated 2/15/16, indicated R5 would maintain ROM of bilateral lower extremities three times a week and directed staff to provide the following:
-gentle passive ROM to left lower extremity
-active ROM to right lower extremity, hip adduction and to place a pillow or wedge to achieve neutral position and max extension of knee on left.
-place heel boot if patient allowed.
-the precautions and comments section of the FMP directed staff to really focus on left hip adduction and extension and knee extension with prolonged holds. Patient can be distracted with conversation, it is helpful. Ask " Does this feel good?" to give her that idea. Stop if she becomes increasingly angry.

R5 also had a FMP developed by occupational therapy dated 8/3/15, which indicated R5 would

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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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maintain ROM for upper and lower extremities. the FMP directed staff to provide the following:
-gentle passive ROM to left upper extremity and hand.
-active ROM to right upper extremity.

On 5/11/16, at 9:06 a.m. R5 was observed in bed. There was no pillow or wedge placed on the lateral side of the left knee to achieve neutral position and max extension of knee on left as the FMP had directed.

On 5/12/16, at 8:43 a.m. NA-F stated she had been trained to provide nursing rehabilitation services to the residents including R5. When R5 was observed laying on her back in bed it was noted that R5's left leg was significantly externally rotated and the left knee was bent and unable to reach neutral position of zero degrees extension. NA-F started to provide passive ROM to R5's left lower extremity and during the first stretch R5 said, "ouch ouch ouch." NA-F attempted to provide stretches to the left lower extremity two more times never attempting to fully stretch the extremity. NA-F proceeded to the right lower extremity and started doing passive ROM however, the FMP directed R5 to complete active ROM. No attempt was made on knee, dorsi, and plantar flexion and extension as directed. R5 completed active ROM on the right upper extremity according to the FMP. NA-F removed R5's left hand/arm splint and attempted passive ROM on the wrist and fingers, but had not completed exercises on the shoulder and elbow. NA-F finished the exercises and placed the splint back on R5's hand. When NA-F finished with ROM exercises, a pillow was not placed in the R5's lateral side of left leg as directed by the FMP in order to minimize external rotation of the

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F 318	Continued From page 70 extremity and a pillow was not placed under the calf to increase left lower extremity extension. On 5/12/16, at 3:40 p.m. physical therapy assistant (PTA)-A stated she had developed R5's FMP program when R5 was discharged from physical therapy and at that time had reviewed the FMP with NA-F verbally and NA-F verbalized understanding of the ROM exercises to be provided. PTA-A stated distraction worked well when attempting to complete ROM for R5. PTA-A stated R5's FMP should have been provided as directed in order for R5 to maintain maximum function. On 5/13/16, 11:33 a.m. the DON stated she would have expected R5's ROM to have been completed according to the FMP. The DON confirmed the facility did not have a licensed nurse in charge of the restorative nursing program who periodically reviewed each residents' FMP for appropriateness and implementation. The Rehabilitative Nursing Care policy dated July 2013, indicated the rehabilitative nursing care program was designed to assist each resident to achieve and maintain an optimal level of self-care and independence. The policy indicated the program included but was not limited to assisting resident to carry out prescribed therapy exercises between visits of the therapists and assisting residents with their routine range of motion exercises.	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a	F 322		6/25/16

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F 322	Continued From page 71 resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication was administered as directed by facility policy for 1 of 1 resident (R13) observed to receive a cocktail of medications via a gastrostomy tube without water flushes in between each medication. Findings include: R13's current physician orders dated 5/13/16, identified diagnoses which included dysphagia, altered mental status, and dementia. A physician order dated 10/22/15, directed staff to flush gastrostomy tube (tube inserted into the stomach for feeding) with 50 milliliters (ml) of water before,	F 322	F322 NG Treatment/Services-Restore eating skills JPECC, based on individualized comprehensive assessment, ensures that gastric feeding tube dependent residents receive medications as ordered. Immediately at time of survey the nurse in question was educated on importance of following instruction on MAR as it relates to giving medications through a gastrostomy tube. Immediate staff education occurred and addition staff education will occurred on June 21th, 2016.	

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F 322	Continued From page 72 between, and after medication administrations. R13's quarterly Minimum Data Set (MDS) dated 3/1/16, identified R13 as being totally dependent on staff for all activities of daily living. R13's care plan dated 11/27/12, indicated R13 was dependent on staff for all physical needs related to physical and cognitive deficits. The plan indicated R13 required tube feeding related to seizure disorder and dysphagia and directed staff to administer medications as ordered. The facility's policy for Administering Medication Through An Enteral (into the small intestine) Tube revised March 2015, directed staff not to mix medications together prior to administering through an enteral tube. On 5/10/16 at 10:00 a.m. licensed practical nurse (LPN)-A was observed to set up medication for R13. LPN-A set up one Hydrochlorothiazide tablet 25 mg. one Metoprolol Tartrate Tablet 50 mg. and one Thiamine HCl Tablet 100 mg. and proceeded to crush the three tablets together and dissolve them in 15 ml of water. At 10:12 a.m. LPN-A administered all three tablets at one time via the gastrostomy tube and then flushed with 50 ml of water. On 5/11/16 at 9:06 a.m. LPN-A verified all three medications were given at the same time and stated that was how it was always done when LPN-A administered R13's medications. LPN-A was not sure how other nurses completed the administration of medication through the feeding tube. On 5/12/16 at 2:20 p.m. the director of nursing	F 322	Systemic change: orders clarified by MD stated it was not necessary to give medications separately. All future admissions with a feeding tube will have medication administration clarified with MD. Director of Nursing or designee is responsible to ensure licensed nurses are administering medications per g-tube per P&P Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance. Monitoring: Weekly audit of the medication administration of FT feeding will be competed by DON/Designee. Audit results will be reported to the QA Committee for review and action plans developed as needed to ensure compliance.	

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F 322	Continued From page 73 (DON) verified LPN-A did not follow the policy or R13's physician orders. The DON stated the medication administration record clearly directed staff to give water after each medication and they should not have been given together.	F 322		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement current interventions related to supervision while outside and/or assess and develop new interventions following a fall with a head injury in order to minimize the risk of falls/injury for 1 of 4 residents (20) reviewed who had fallen outside without supervision as directed This resulted in actual harm for R20. In addition, the facility failed to ensure safe smoking practices were followed for 1 of 3 residents (R20) in the sample observed to independently smoke. Findings include: R20's Diagnosis Report dated 5/12/16, indicated R20's diagnoses included peripheral vascular disease, atherosclerotic heart disease, nicotine	F 323	F323 Accidents JPECC ensures that the environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents. Resident 20 was reassessed for smoking safety the week of May 9th. Smoking assessment results revealed that the resident was safe smoking unsupervised. Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3 when a resident requires supervision of smoking. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance. Corrective action occurred when the	6/25/16

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F 323	Continued From page 74 dependence, iron deficiency anemia, below the knee amputation, diabetes, macular degeneration (poor vision), and hypertension. R20's quarterly Minimum Data Set (MDS) dated 3/1/16, indicated R20 had severe cognitive impairment, visual impairment, was independent with bed mobility and transferring, however, required supervision off the unit, had functional limitations with range of motion due to a below the knee amputation on one lower extremity, and R20 was not steady but able to stabilize herself without human assistance when moving from a sit to stand position. In addition, the current tobacco use section had not been completed. R20's Fall Care Area Assessment (CAA) dated 12/15/15, indicated R20 was a fall risk due to R20's below the knee amputation, impaired mobility and eye sight, was cognitively impaired and had difficulty with maintaining balance while seated and during transitions. The CAA indicated R20 was independent with transfers and toileting, utilized a prosthesis however had refused to wear and an order to for a physical/occupational therapy consult was obtained. R20's Fall Risk Assessment dated 2/25/16, indicated R20 had no falls in past 90 days, had moderately impaired vision, was independent with toileting, was non-ambulatory, had unsteady balance while standing, sitting and during transitions which required physical assistance to stabilize and was at risk for falls. R20's care plan dated 9/22/15, indicated R20 had a potential risk for falls related to right below the knee amputation, impaired mobility and impaired eye sight. The plan directed staff to anticipate	F 323	facility reassessed the resident for safe smoking while survey was still present. The resident has had non burns. The assessment revealed that the resident was safe to smoke without supervision outside. This resident did experience one fall while outside smoking due to reaching from the wheel chair. An anti-rollback was added to the wheelchair. A reacher/grabber was given to the resident. Since survey exit there continues to be no falls and no cigarette burns. The residents wishes are to smoke outside independently and continues to safely do so. Each resident who smokes has had a smoking assessment. Residents are checked for cigarette burns during cares. Admission assessment checklist updated to require that residents who smoke be checked for burns during cares. Quarterly the MDS nurse will update the smoking assessments to assure that solutions are sustained. Incident reports contain fall interventions. The DON will review incident reports for compliance with interventions and root cause analysis as they occur in an ongoing manner. Education was provided on 6/21/16. Audit results will be reported to the QA Committee for review and action plans developed as needed to ensure compliance.	

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and meet R20's needs, assure R20's call light was within reach and encourage R20 to use it for assistance, R20 needs prompt response to all requests for assistance, ensure R20 wore appropriate footwear, follow facility fall protocol, physical therapy to evaluate and treat as ordered or when needed, R20 to utilize a high low bed and ensure bed was positioned at knee level while R20 was in bed. R20's care plan revised on 3/26/15, directed staff to assist R20 off the unit as R20 had periods of forgetfulness, macular degeneration, and impaired mobility. In addition, R20 was identified as a smoker and on 4/18/16, the care plan was revised and directed staff to provide supervision and cues while smoking outside and to remind R20 she required supervision when outside smoking.

R20's Progress Notes (PN) dated 5/5/16, indicated R20 had sustained an unwitnessed fall on 5/5/16, at 6:00 p.m. The summary of the incident revealed while R20 was outside in the gazebo area, R20 bent down to pick something up from the ground and proceeded to fall out of the wheelchair. R20 was assessed for injury and assisted back into the wheelchair. Injury noted was a scratch above R20's right eye which was cleansed and an antibiotic was applied, At this time, R20 refused to be seen at the emergency room. Vital signs were obtained and R20 denied pain. The "If suspected head injury- follow neuro sheet and If Skin Tear or Bruise - Intervention Put Into Place" sections were both left blank. (R20 was outside smoking unsupervised at the time of the fall).

R20's PN dated 5/5/16, at 6:20 p.m. indicated while R20 was seated in the dining room, R20 became lethargic and unresponsive and was

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taken to the Red Lake emergency room (ER).

R20's emergency room encounter note dated 5/5/16, at 7:00 p.m., indicated R20 had been seated outside and fell out of the wheelchair hitting the right side of her head on the ground. The facility staff reported R20 had been unresponsive. Upon arrival to the Red Lake emergency room R20 was alert and oriented. R20's review of systems included complaints of discomfort at the site of R20's lesion, neuro exam was stable, R20 had about a 2.0 centimeter (cm) by 3.0 cm hematoma on the right eyebrow area with some abrasions. R20's concluded assessment with this emergency room visit was that R20 had sustained a contusion of her forehead, right eyebrow area due to a fall. R20 was discharged back to the facility with instructions for ice packs to be applied and head injury instructions were given.

R20's PN dated 5/6/16, at 12:55 p.m. indicated Red Lake ER discharge orders included: apply ice pack as needed to hematoma, monitor R20 for headache, vomiting, difficultly awakening, blurred/double vision, or dizziness.

R20's neurological assessments had been completed and revealed the following:

-5/6/16, at 10:03 a.m. - R20 complained of a mild headache and mild facial pain, in addition R20's blood pressure was 184/62 (elevated)
-5/6/16, at 10:08 p.m. - above R20's right eye was swollen and had an abrasion. All around right eye was black, blue and purple area.
-5/8/16, at 2:01 p.m. R20 showed non-verbal signs of pain, grimaced and withdrawals.

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On 5/9/16, at 6:49 p.m. R20 was observed seated in a wheelchair outside in the gazebo area, smoking a cigarette. No staff were in proximity nor supervised R20 while R20 smoked.

On 5/10/16, at 2:04 p.m. R20 was observed seated in a wheelchair in the activity area participating in bingo. R20 had a large black, blue and purple bruise noted on the right side of R20's face. The bruise extended from above R20's right eyebrow to the level of the corner of R20's mouth. R20 had a shoe on her left foot. -At 3:13 p.m. R20 wheeled herself outside in the gazebo area to smoke. R20 was unsupervised while outside smoking.

On 5/11/16, at 9:08 a.m. R20 was observed seated in her wheelchair, propelled herself out of her room, down the hall and into the activity area. R20 wheeled herself out the activity door and into the gazebo to smoke. R20 was unsupervised while outside smoking.

On 5/11/16, at 11:03 a.m. LPN-A stated R20 was supposed to have supervision when outside smoking, which meant someone should be outside with R20.

On 5/11/16, at 11:28 a.m. registered nurse (RN)-B confirmed R20' needed to be supervised when outside smoking. RN-B verified supervision meant a staff member needed to be outside with R20 when R20 smoked.

On 5/11/16, at 11:33 a.m. LPN-B stated since R20 had such bad dementia and was forgetful R20 was to be supervised when R20 was outside smoking. LPN-B defined supervised as a staff member being outside with R20 while R20

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smoked.

On 5/11/16, at 11:57 a.m. nursing assistant (NA)-A confirmed R20 was supposed to be supervised when R20 smoked.

On 5/11/16, at 2:20 p.m. R20 was observed seated in her wheelchair outside in the gazebo smoking a cigarette. R20 was unsupervised while outside.

On 5/12/16, at 2:18 p.m. R20 was seated in her wheelchair in the activity area participating in bingo. R20's bruise was still evident covering the right side of R20's face. The bruise had started to turn a tinge of yellow and purple in color.

On 5/12/16, at 10:52 a.m. licensed practical nurse (LPN)-B confirmed R20 was at risk for falls. LPN-B stated the facility's process following a fall was to first take care of the resident, notify the administrator, director of nursing (DON), physician and family, complete an incident report and then interventions to prevent further falls would be developed. LPN-B reviewed R20's 5/5/16, fall incident, LPN-B confirmed R20 had sustained an injury and been taken to the Red Lake ER for assessment and treatment. LPN-B verified no new or additional fall prevention interventions had been developed and/or implemented following the fall and stated there should have been.

On 5/12/16, at 11:22 a.m. the director of nursing (DON) confirmed R20 was identified as at risk for falls and it was her expectation that when a fall occurred, fall interventions would be implemented and put into place to prevent future falls. The DON verified following R20's fall on 5/5/16, no

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new or additional fall interventions had been developed and/or implemented to prevent further falls and stated there should have been.

R20 was identified as an unsafe smoker and was observed to be smoking unsupervised.

R20's care plan note dated 3/2/16, indicated R20 had macular degeneration and was cognitively impaired. In addition, R20 was a smoker and was to wear a smoking apron due to R20's poor eyesight and noted cigarette burns in clothing. Due to refusals to wear a smoking apron, R20 must now be supervised when R20 smoked and R20's cigarettes stored in the medication cart.

R20's Smoking - Safety screen dated 4/18/16, indicated R20 needed to have the facility store lighter and cigarettes, smoked 5-10 cigarettes a day, had cognitive loss, had dexterity problems, was deemed be safe to smoke with supervision. In addition, the screen indicated R20 refused to wear a smoking apron and burns had been noted in R20's clothing. R20 was unable to see the burns and had cognitive impairments. The rational/conditions identified on R20's smoking screen indicated R20 was to have staff supervision when smoking to ensure R20's safety and to prevent further burns to R20's clothing. In addition, the facility would store R20's lighter and cigarettes as R20 would forget that supervision when smoking was needed.

R20's care plan dated 3/26/15, directed staff to assist R20 off the unit as R20 had periods of forgetfulness, macular degeneration, and impaired mobility. In addition, R20 was identified

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as a smoker and on 4/18/16, the care plan was revised and directed staff to:

-Instruct R20 about the facility policy on smoking: locations, times and safety concerns
-R20's clothing and skin should be observed for signs of cigarette burns
-R20 required supervision and cues while smoking
-R20's smoking supplies should be stored in the south medication cart in the narcotic drawer and the number of cigarettes R20 had would be tracked in the narcotic log book

R20's care plan dated 4/18/16, identified R20's goals to promote safe smoking as R20 would not smoke without supervision and would not suffer from any unsafe smoking practices.

R20's nursing progress note dated 5/6/16, at 10:00 p.m. indicated for staff to ensure R20 be supervised while smoking and that R20's cigarettes were to be kept in the medication cart. Document any noncompliance every shift for safety - R20 refused to give up cigarettes and continued to go out and smoke without staff.

R20's nursing progress note dated 5/6/16, at 3:14 p.m. indicated R20 refused to have her cigarettes locked up in the medication cart.

On 5/9/16, at 6:49 p.m. R20 was observed seated in a wheelchair outside in the gazebo area, smoking a cigarette. No staff were in proximity nor supervised R20 while R20 smoked.

On 5/10/16, at 3:13 p.m. R20 was observed seated in a wheelchair in the activity area. R20 wheeled herself up to the exit door to the gazebo

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area. R20 pushed the automatic button and the door to the gazebo area opened. This surveyor followed R20 as R20 wheeled herself outside and proceeded to pull a pack of cigarettes out of her purse which was on R20's lap. R20 removed a cigarette from the pack and placed the pack of cigarettes back into her purse. R20 removed a lighter from her purse and attempted to ignite the lighter. R20 was unable to ignite the lighter, placed this lighter back into her purse and started searching for another one. R20 stated I have four lighters in here, you would think I could find one that worked. R20 pulled another lighter out of her purse and attempted to ignite the lighter. On the third attempt R20 was able to light her cigarette. During this time R20 remained unsupervised by staff.

-At 3:30 p.m. activity aide (AA)-A entered the gazebo area and sat down on the bench. AA-A stated R20 wasn't supposed to be outside smoking without supervision. R20 continued to smoke a cigarette and at 3:35 p.m. snubbed the cigarette out into the cigarette receptacle. R20's blue, button up the front sweater, which R20 had on, had several burn holes with dark melted fibers around the holes on front panels and sleeves.

On 5/11/16, at 9:08 a.m. R20 was observed seated in a wheelchair in her room. R20 proceeded to wheel herself out of her room and down the hall into the activity room and positioned herself directly in front of the exit door by the gazebo. R20 searched in R20's purse, pulled out a cigarette and lighter, ignited the lighter and lit the cigarette up while stationed in the activity room. Smoke permeated into the activity area. R20 placed the lighter in a Styrofoam cup which was attached to the side armrest of R20's wheelchair. R20 pushed the automatic door

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	245535	A. BUILDING _____ B. WING _____	05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(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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opener and made her way out into the gazebo area. No staff were in close proximity of R20, nor was R20 supervised while R20 smoked. R20 took three long drags on her cigarette, leaving about an inch long ash. R20 snubbed out her cigarette into the ash tray and without looking at the end of her cigarette, immediately placed the remainder of the smoked cigarette into a Styrofoam cup which held R20's lighter. -At 9:15 a.m. R20 pushed the automatic door from the gazebo area and entered the facility. Once inside, R20 took the lighter and placed it back into her purse and then took the remaining portion of the cigarette R20 had just smoked and placed it into a pack of cigarettes. R20 placed the cigarette pack back into her purse.

On 5/11/16, at 11:03 a.m. LPN-A stated R20 had quit smoking for a while, but had started up again. LPN-A confirmed R20's cigarettes and smoking supplies were supposed to be locked up in the medication cart in the narcotic drawer. LPN-A checked the medication cart and confirmed R20 had no cigarettes or smoking supplies locked up in the medication cart. LPN-A stated R20 was supposed to have supervision when R20 went out to smoke, which meant someone should be outside with R20 in case R20 should burn herself. LPN-A stated R20 sometimes hid cigarettes from the staff. LPN-A verified R20 had a sweater which LPN-A had observed to have burn holes in it. LPN-A stated the facility had a smoking apron, however, R20 refused to wear one.

On 5/11/16, at 11:28 a.m. RN-B confirmed R20's cigarettes were supposed to be locked in the south medication cart. RN-B was unsure if R20's lighter needed to be locked up. RN-B stated she

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was aware R20 had some burn holes in R20's sweater. RN-B stated that was why the decision had been made that R20 needed to be supervised when R20 smoked. RN-B verified supervision meant a staff member needed to be outside with R20 when R20 smoked.

On 5/11/16, at 11:33 a.m. LPN-B confirmed R20's cigarettes and smoking supplies were to be kept in the locked medication cart. LPN-B stated there had been times when R20 had acquired cigarettes and since R20 had such bad dementia and was forgetful R20 was to be supervised when R20 smoked. LPN-B defined supervised as a staff member being outside with R20 while R20 smoked. LPN-B stated R20 had tried a smoking apron, however with R20's cognitive status R20 would forget she was supposed to wear one, so that was when R20 was changed to needing supervision when R20 smoked. LPN-B confirmed she had seen burn holes in R20's clothing and that too was why R20 needed to be supervised when R20 smoked. LPN-B was not aware of any burns on R20, just R20's clothing.

On 5/11/16, at 11:57 a.m. NA-A confirmed R20 was supposed to be supervised when R20 smoked.

On 5/11/16, at 12:38 p.m. R20 was observed seated in a wheelchair in the activity area participating in a dice game. R20 had on the blue, button up the front sweater. The sweater had several burn holes noted on the front panels and also the sleeves. One hole on the one side panel was an inch in diameter. All holes had melted black fibers on the perimeter of the holes.

On 5/11/15, at 12:41 p.m. the DON confirmed

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R20's last smoking assessment completed on 4/18/16, deemed R20 safe to smoke with supervision. In addition, R20's cigarettes and smoking supplies should be locked up in the medication cart. The DON stated a smoking apron had been tried with R20, however, R20 would forget to wear the apron, and when R20 would be reminded to put the apron on, R20 refused to wear it. The DON confirmed a lot of R20's clothing had burn holes in them, however, they were unable to determine if they were new burn holes or old.

On 5/11/16, at 2:20 p.m. R20 was observed seated in her wheelchair outside in the gazebo area smoking a cigarette. No staff were in close proximity and/or was R20 supervised when R20 smoked.

On 5/11/16, at 3:35 p.m. LPN-A verified the last time R20's cigarettes had been tracked in the narcotic log book was 3/16/16.

R20's narcotic log for cigarettes from 3/1/16 - 3/15/16, indicated R20's cigarettes had been counted during this time frame, however, no further documentation of R20's cigarettes were found in the narcotic log book since 3/15/16.

Smoking Policy-Residents dated 12/2011, indicated safe resident smoking practices would be established and maintained. Any smoking -related privileges, restrictions, and concerns would be noted on the resident's care plan, and all staff would be alerted to these issues. In addition, the facility would impose restrictions on residents at any time, if it was determined the resident could not smoke safely. Any resident with restricted smoking privileges which required

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F 323	Continued From page 85 monitoring would have direct supervision. Smoking articles for those residents without independent smoking privileges could not have or keep any types of smoking articles including cigarettes except when the resident was directly supervised.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the	F 329	F329 Drug Regimen is free from	6/25/16

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F 329	Continued From page 86 facility failed to ensure insomnia symptoms had been comprehensively assessed prior to the use of hypnotic medications for 1 of 1 residents (R29) in the sample who received hypnotic medications. Findings include: R29's Admission Record dated 5/13/16, indicated R29's diagnoses included, cerebral infarction (stroke), insomnia, and restless leg syndrome. R29's admission Minimum Data Set (MDS) dated 4/6/16, indicated R29 had no cognitive impairment, had symptoms of insomnia, had trouble with falling asleep or staying asleep or sleeping and had pain which made it difficult for R29 to sleep at night. R29 was interviewed on 5/12/16, at 10:04 a.m. and stated she had trouble falling asleep at night and staying asleep because her roommate woke her several times during the night asking for assistance to get out of bed and get to the bathroom. Review of R29's physician orders revealed R29 received hypnotic (medication that induces sleep) medication trazodone 50 milligrams (mg) every night for insomnia since admission in March 2016. R29's medical record was reviewed and lacked an assessment of insomnia symptom's that determined which symptoms could be minimized or removed to justify the ongoing use of the hypnotic medication trazodone. Review R9's medication administration record (MAR) revealed the facility had monitored 29's	F 329	unnecessary drugs JPECC ensures that each residents drug regimen is free from unnecessary drugs. Individual comprehensive assessment is conducted as defined by the F329 regulation. Resident 29 initial sleep study was conducted within 7 days of admission. Resident 29 has been transferred to a single room. Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance. Corrective action will be accomplished by chart review for residents receiving hypnotics. Residents receiving hypnotic without a sleep study in place will be given a sleep study. Facility will identify other residents by utilizing the new admission checklist which includes guidance regarding hypnotics and the need for sleep studies. DON or designee will be responsible to ensure psychotropic policy and procedure is being followed. Education immediately occurred during time of survey and again on 6/21/16.	

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F 329	Continued From page 87 sleep/awake pattern daily however, factors that contributed to R29's insomnia had not been assessed including but not limited to: environment, such as excessive heat, cold, noise, lighting, inadequate physical activity, facility routines that may not accommodate R29's individual needs, provision of care in a manner that disrupted sleep, caffeine or medications known to disrupt sleep, pain and discomfort nor R29's underlying condition's. R29's pharmacy review for April 2016, had not identified the lack of an assessment related to insomnia symptoms and factors that could be minimized or removed addressed, and there were no recommendations related to the use of trazodone for sleep induction. However, R29 was admitted within the previous month. On 5/13/16, at 11:27 a.m. the director of nursing confirmed an assessment of R29's insomnia symptom's had not been assessed. The Jourdain Perpich Extended Care Center Psychotropic Medication Policy and Procedure dated as last revised on 3/29/16, was reviewed and it did not address assessment of hypnotic medications.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		6/25/16

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F 441	Continued From page 88 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an ongoing, comprehensive infection control program which included investigation, prevention, control, surveillance and reporting of disease and infection. This had the potential to affect all 25 residents who resided in the facility.	F 441	F441 Infection Control JPECC has an established Infection Control program and maintains a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. Corrective action will be accomplished by	

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F 441	Continued From page 89 Findings include: Review of the facility's infection control program revealed a system which lacked a surveillance program with ongoing analysis and interpretation of infections and infection risks. The Infection Control Log for December 2015, January 2016, February 2016, March 2016, April 2016 and May 2016, revealed only infections with prescribed antibiotics were tracked. The facility's tracking system lacked tracking and trending of infections without antibiotics. On 5/13/16, at 2:14 p.m. the facility infection control program was reviewed with registered nurse (RN)-B who was responsible for infection control. RN-B indicated information regarding residents who were prescribed antibiotics was communicated to her via weekday huddles, shift reports, direct report from nursing staff, or she would learn about it first hand if working the floor. RN-B indicated she entered this information onto a monthly Infection Control Log. RN-B provided the Infection Control Log for the months of December 2015, and January, February, March, April and May 2016. Each month had a separate log which included columns for information regarding resident name, room number, dates of treatment, date of onset, date of admission, admit/acquired, type/site of infection and symptoms, culture, X-ray, result of X-ray or culture and antibiotic. Each monthly log also had a floor plan of the facility attached with the location of each infection highlighted. RN-B stated at the end of the month she compiled a report of infection totals broken down by type.	F 441	adding to the facilities infection control program the tracking and trending of infections without antibiotics. The facility will identify residents with infections without antibiotics via examination of the new orders, daily huddle and the 24 hour report process. The format of the facility surveillance program will be changed to included the trending of infections without antibiotics. Designated Infection Control nurse, with oversight of the Director of Nursing, will audit the tracking and trending forms. Audits will be conducted daily x 2 weeks, weekly x4 weeks, and monthly x3. Audit results will be presented to the QA committee for review and further action plans as needed to ensure compliance. Education was provided to the infection control nurse at the time of survey and again on 6/21/16.	

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F 441	Continued From page 90 RN-B stated this report was reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting where contributing factors were discussed. RN-B stated she mainly clued in on antibiotic use and confirmed she didn't always have the cultures on the logs. RN-B also confirmed date of onset fields were frequently left blank and indicated this occurred due to infections carrying over from one month to the next. RN-B confirmed she did not log viral or other infection symptoms not requiring an antibiotic. RN-B confirmed she had not included a recent discovery of a bed bug in a resident bed in the infection control logs indicating it had not occurred to her to do so. On 5/16/16, at 9:24 a.m. the director of nursing (DON) confirmed all infections should be tracked and trended, not just those infections requiring antibiotics. The DON confirmed the infection control program was lacking and not carried out according to facility policy. The Infection Control Policy and Procedure dated 6/11/14, indicated through ongoing monitoring the facility would take appropriate action to investigate, prevent, control and report disease and infection. The policy directed the tracking and trending of infections by calculating infection rates by period and comparing rates over time to identify patterns, clusters, trends and opportunities for improvement.	F 441		

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	245535	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/10/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey The Jourdain/ Perpich Extended Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us 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. The Jourdain/ Perpich Extended Care Center is a 1-story building without a basement. The building was constructed in 1989 and is of Type II(000) construction. An assisted living apartment building, constructed in 2006 is separated from the building with a 2-hour fire barrier to the west and a hospital building, built prior to the extended care building is separated with a 2-hour fire barrier is to the east. The building is divided into 3 smoke compartments with 1-hour fire rated barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with corridor smoke detection, smoke detection in all common areas and automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and has automatic fire detection in all areas required by the Minnesota State Fire Code 2007 edition.	K 000		

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K 000	Continued From page 2 The facility was surveyed as one building. The facility has a capacity of 47 beds. At the time of the survey the census was 25 residents. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify a non required exit door leading to the exterior that does not lead to the public way due to a locked gate in accordance with NFPA 101 (00) sections 7.10.1.7 and 7.10.8.1. This deficient practice could negatively affect all residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On the facility tour between 8:45 am to 11:30 am on 05/10/2016 observations and staff interview revealed the door to the exterior from the activity room was not posted as a "No Exit" due to the locked gate in the courtyard. This deficient practice was verified by the Houskeeping Supervisor.	K 022	K22---A NO EXIT SIGN has been posted on the door and above the door leading from the activity room to the courtyard.	6/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 19.3.7.1, 19.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect 26 of the 47 residents as well as an undetermined number of staff and visitors. Findings include: On the facility tour between 8:45 am to 11:30 am on 05/10/2016 observations and staff interview revealed the smoke barriers in the North and West wings have penetrations above the cross corridor doors. This deficient condition was verified by the Housekeeping Supervisor	K 025	K25---The penetrations in the smoke barriers above the cross corridor doors in the north and west wings have been caulked with Red Intumscent Fire Barrier Sealant. Any future penetrations to smoke barriers will be monitored by the Administrator and/or Maintenance Supervisor to see they are properly sealed.	6/10/16
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 050		6/13/16

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K 050	Continued From page 4 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 47 residents and undetermined amount of staff and visitors Findings include: On the facility tour between 8:45 am to 11:30 am on 05/10/2016 record review and staff interview revealed in the last 12 months, the following fire drills were missed. 1. The first quarter, the day and night shift. 2. The second quarter, the day shift. 3. The third quarter, the evening and night shift. 4 The fourth quarter, the night shift. This deficient condition was verified by the Interim Facility Administrator	K 050	K50---The six (6) fire drills that were missed on the different shifts have been made up and copies are on file in the Administrator Office. The Tribal Sanitarian who is responsible for conducting the fire drills at the care center has put in place a schedule for all fire drills to be completed in each quarter. This will also be monitored by the Administrator and/or Maintenance Supervisor.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with	K 052		6/10/16

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	245535	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/10/2016**

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K 052	Continued From page 5 applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all 47 residents, staff, and visitors of the facility. Findings include: On the facility tour between 8:45 am to 11:30 am on 05/10/2016 record review and staff interview revealed the DACT system was not tested monthly. This deficient condition was verified by the Interim Facility Administrator	K 052	K52---The fire system for the care center is connected and part of the Hospital fire system, so even with the fire drills that were missed at the care center the hospital had conducted all their monthly drills during the last year which are documented and shows that the DACT system had been tested monthly and that is was working. On all future fire drill documentation for the care center it will show that the DACT was tested.	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under	K 066		7/11/16

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K 066	Continued From page 6 direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations by MDH the facility has failed to follow the smoking policy and meet requirements for the use of the designated resident exterior smoking area in accordance with NFPA LSC (00) Edition Section 19.7.4. This deficient practice could affect all residents, staff and visitors with the inhalation of unwanted smoke and the possibility of fire with the improper use of extinguishing containers. Findings include: It was observed by MDH surveyors on two occasions that residents lit their cigarettes prior to leaving the building to enter the designated smoking area. The first on 05/10/2016 at 1:55 pm and the second on 05/11/2016 at 9:08 am. On both occasions smoke from the cigarettes was blown into the adjacent activity room and on 05/10 the incident was witnessed by a staff member without intervention. The use of improper extinguishing containers was also witnessed on 05/11 with the resident storing a recently smoked cigarette in a Styrofoam cup. This deficient practice was verified by the Interim Facility Administrator.	K 066	K66--- The Social Worker will document in the Elders record and meet with each of the Elders who smoke to remind them that they cannot lite their cigarettes in the activity area prior to leaving the building for the designated smoke area. The Elders will also be instructed that they need to use the proper extinguishing containers when they have finished a cigarette. Staff were educated immediately and again on 6-29-2016 on not letting Elders lite up before going out to the designated smoking area. We have six (6) proper extinguishing containers in the smoke area.	