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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NKFZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00114

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245164**

2.STATE VENDOR OR MEDICAID NO.
(L2) **296842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **HEALTH AND REHABILITATION OF NEW**
(L4) **825 FIRST AVENUE NORTHWEST**
(L5) **NEW BRIGHTON, MN** (L6) **55112**

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 **07/25/2013** (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 **100** (L18)

13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(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 :
Mary Heim, HPR-Social Work Specialist 09/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/09/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00452
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5164

At the time of the July 25, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. In addition, an investigation of complaint number H5164102 was conducted and determined to be unsubstantiated. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5216

August 13, 2013

Ms. Sandra Larson, Administrator
Health And Rehabilitation Of New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

RE: Project Number S5164022, H5164102

Dear Ms. Larson:

On July 25, 2013, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 25, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5164102 that was found to be unsubstantiated.

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:

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

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

<u>Remedies</u> - 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:

Susanne Reuss
Minnesota Department of Health
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 September 3, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

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 October 25, 2013 (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 January 25, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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:

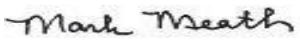
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5164s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH AND REHABILITATION OF NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(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. 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 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. An investigation was completed during the standard survey related to complaint, H5164102. The complaint was unsubstantiated.	F 000	This Plan of Correction is not a submission of guilt on behalf of the provider. This Plan of Correction is being submitted because it is required by law.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain up to date family emergency contact information on face sheet for 1 of 1 resident reviewed, R68, whose family, (F) -A, expressed a concern. Findings include: During a standardized initial interview on 7/22/13 at 5:56 p.m., a family member of R68 (F)-A, expressed concerns that she did not find out R68	F 166	F166: Resident's face sheet has been updated to designate the primary contact's phone number as a cell number. All residents face sheets will be reviewed with the OBRA –MDS care conference schedule for appropriate primary contact phone numbers. Admission staff, nursing staff, and social service were re-educated regarding updating face sheets with designated primary contact phone numbers. Staff receiving primary contact information changes will provide medical records with the new information and primary contact numbers to update the face sheet. NHA/Designee will audit 5 face sheets per week for one month to ensure accuracy. Audit results will be reviewed in QPI. Completion date: 9/3/13 9/3/13 SER	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra Larson — TITLE: Administrator — (X6) DATE: 8/23/13

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

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

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F 166	Continued From page 1 was hospitalized until the hospital called to tell her R68 was returning to the nursing home. F-A explained she was not at home over the weekend and staff had called only her home phone to leave a message. She reported she spoke with nursing staff about the concern and was told staff had not called her cellular phone, a preferred method of contact. Due to it being labeled as a "work" phone number on the face sheet, the facility had not called it. F-A stated she had not been employed for several years. F-A explained she understood how the incident happened, but would expect the current contact information to be up to date and accurate since she spoke with them about her concern. F-A was not sure of the resolution to her concern. F-A explained she was concerned about R68 due to her physical health issues and cognitive impairment. She carried her cellular phone with her so staff could contact her at any time if there was a change of condition for R68. On 7/23/13 at 7:23 a.m., R68's face sheet, dated 7/19/13 was reviewed. A "Work" number was listed as a secondary number with the "Home" number marked with a star as the primary number. During interview on 7/24/13 at 12:51 p.m., the nurse manager for R68's unit, (RN)-B, reported F-A had spoken to her about concerns related to accurate emergency contact information. RN-B confirmed R68's Face Sheet was not up to date related to R68's contact information. RN-B did not elaborate when asked how a nurse would know which number to call to get in contact with F-A in the event of a change in condition. On 7/29/13, the facility provided a facsimile	F 166		

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F 166	Continued From page 2	F 166		

message from the administrator that read "Review of R68 family contact information, 7/5/13-Resident went to hospital, call to [F-A] left message [see attached nursing note); 7/8/13: Resident returned from hospital; 7/9/13-Staff spoke with [F-A] regarding resident's condition (see attached nursing note) Summary: We continued to have the same home number and the same secondary number (labeled on the 7/19/13 face sheet as office, but was correct on 5/23/13 and 7/24/13 face sheets as cell.(see attached face sheets) Valid contact numbers were in place and called per nursing notes." A nursing note, dated 7/5/13, read "Call to [F-A}. Left message." The note did not indicate which number a message was left on. The next nursing note, dated 7/9/13, did indicate staff spoke with F-A after R68 returned from hospital. A Face Sheet, dated 5/23/13. had "Work" crossed out and "Cell #" written in by hand as a secondary number and "Home" listed as the primary number. No date indicated when the change was made. A 7/24/13 Face Sheet, corrected after surveyor intervention, did have the "Cellular" listed as primary number with "Home" listed as a secondary number.

The Concerns-Resident/Family Procedure, last revised 10/2009, directed staff: "The procedure is such that each and every resident and/or family has the right to express their grievance or concerns to the center's administration either verbally or in writing. Assure the resident and/or family that they can voice their concern without fear of discrimination or reprimand. All staff are responsible for documenting resident/family concerns. The Social Worker will keep the Resident Concern Log. The Social Worker will bring the log to the Daily Stand -Up Meeting and

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F 166	Continued From page 3 inform the team of pending unresolved concerns."	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F225 Resident 14 & 142's allegations have been reported and investigated. All allegations of abuse/neglect are being reported and investigated. IDT team was re-educated regarding reporting and investigating allegations. NHA/Designee will audit up to 2 reports per week for 1 month to ensure timely reporting and investigating. Results of audits will be reviewed in QPI. Completion date:	9/3/13

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F 225	Continued From page 4	F 225		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to thoroughly investigate and immediately report to the state agency (SA), allegations of abuse, neglect or mistreatment, for 2 of 2 residents (R14 and R142) reviewed for abuse.
Findings include:
On 7/17/13, R14 reported an allegation of neglect to the facility. The allegation was not thoroughly investigated and was not reported immediately to the SA.
R14 diagnoses included cardiovascular accident (stroke). The quarterly Minimum Data Set (MDS) dated 7/8/13, indicated R14 was cognitively intact and had the ability to be understood and understand others.
During interview on 7/23/13, at 10:10 a.m. R14 reported allegations of rude treatment and neglect by a facility employee. He stated that the employee was heard making comments he perceived as rude as male nursing assistant (NA) left his room. R14 added that the same employee had at times left him with unmet needs during the overnight hours. R14 declined to provide writer with a specific employee's name, but did report the employee was male and had worked with him the night prior.

Review of a Resident Concern Report dated 7/17/13, completed by registered nurse (RN)-B, indicated an allegation of neglect was reported to the administrator and director of nursing (DON) on 7/17/13. The alleged perpetrator was identified as nursing assistant (NA)-A, with the

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F 225	Continued From page 5	F 225		

alleged victim being R14. Although the administrator was notified of the incident on the same day, the incident was not immediately reported to the SA and was not further investigated.
R142 reported an allegation of mistreatment to a facility nurse. The allegation was not thoroughly investigated and was not reported immediately to the SA.
R142 diagnoses included anxiety. The admission MDS dated 6/20/13 revealed R142 was cognitively intact and had the ability to be understood and understand others.

During interview on 7/22/13, at 7:05 p.m. R142 reported rude treatment by NA-A. R142 reported the employee worked at night and had a rude manner in the way he provided assistance. R142 indicated that he reported the rude treatment to a nurse the following morning, but was unable to recall the name of the nurse. R142 was unable to recall how long ago the alleged rude treatment had occurred but was recent.

During interview on 7/24/13, at 2:15 p.m. DON reported that she had spoken with R142 regarding the alleged rude treatment by NA-A. She indicated that R142 reported, " 'What do you want?' are the words he [NA-A] used." R142 confirmed he had informed a facility nurse of his allegation, but was unable to identify the nurse to the DON. The DON revealed her investigation of R14's allegation of neglect was not complete, to conclude neglect or rule out possible neglect for R14. The DON verified it was her expectation for employees to follow the facility's abuse prohibition policies and conduct a thorough investigation of abuse allegations.
During interview on 7/25/13, at 9:00 a.m. RN-B

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(nurse manager) indicated she had spoken with R14 after submission of the Resident Concern Report on 7/17/13. Per RN-B, R14 denied feeling rushed by NA-A. RN-B further stated the Resident Concern Report did not explain thoroughly what had occurred. She confirmed that she was responsible to report abuse allegations to the facility administrator and DON. RN-B stated that she did notify the administrator adding, "I took this form to [administrator], and it was signed by the administrator I think maybe between 1:00 p.m. and 4:00 p.m. [on 7/17/13]." RN-B stated she felt a full investigation was not necessary; therefore, the incident did not require a report to the SA. RN-B stated, "It was not done because we did not think it was reportable." RN-B commented that she should have documented exactly what had happened, rather than assume what had happened.

During interview on 7/25/13, at 9:10 a.m. the DON stated R14's allegation of neglect was not reported to the SA because she did not believe it met the definition of neglect.

During interview on 7/25/13, at 9:40 a.m. the administrator reported that she had worked with NA-A at a different facility in the past and she did not recall concerns with NA-A performance in that setting. The administrator reiterated that R14's allegation of neglect was not reported to the SA because she did not believe it met the definition of neglect. At 11:00 a.m., the administrator verified a thorough investigation into R14's allegation of neglect by NA-A had not been completed.

The facility's Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries, of Unknown Source, and Misappropriation of resident Property policy revised dated 4/13, noted, "Report the incident immediately to the

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F 225	Continued From page 7 Administrator and DON/designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries, of unknown source, and misappropriation of resident property to applicable state and other agencies." The policy further noted, "Report the results to other officials in accordance with state law (including to the State survey and certification agency) within 5 [five] working days of the incidents, and if the alleged violation is verified, appropriate corrective action must be taken."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse prohibition policies, related to thorough investigations and immediate reporting to the state agency (SA), for 2 of 2 residents (R14 and R142) reviewed for abuse. Findings include: The facility's Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries, of Unknown Source, and Misappropriation of resident Property policy dated 4/13, noted, "Report the incident immediately to the Administrator and DON/designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries,	F 226	F226 The policy for Abuse / Neglect was implemented for resident 14 & 142. All allegations of abuse/neglect are being reported per policy. The IDT team was re-educated regarding the policy on abuse and neglect. NHA/Designee will audit up to 2 reports per week for one month to ensure that the Abuse/Neglect policy is being adhered to. Audit results will be reviewed in QPI. Completion date:	9/3/13

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of unknown source, and misappropriation of resident property to applicable state and other agencies." The policy further noted, "Report the results to other officials in accordance with state law (including to the State survey and certification agency) within 5 [five] working days of the incidents, and if the alleged violation is verified, appropriate corrective action must be taken."
R14 diagnoses included cardiovascular accident (stroke). The quarterly Minimum Data Set (MDS) dated 7/8/13, indicated R14 was cognitively intact and had the ability to be understood and understand others.
During interview on 7/23/13, at 10:10 a.m. R14 reported allegations of rude treatment and neglect by a facility employee. He stated that the employee was heard making comments he perceived as rude as they left his room. R14 added that the same employee had at times left him with unmet needs during the overnight hours. R14 declined to provide writer with a specific employee's name, but did report the employee was male and had worked with him the night prior.

Review of a Resident Concern Report dated 7/17/13, completed by registered nurse (RN)-B, indicated an allegation of neglect was reported to the administrator and director of nursing (DON) on 7/17/13. The alleged perpetrator was identified as nursing assistant (NA)-A, with the alleged victim being R14. Although the administrator was notified of the incident on the same day, the incident was not immediately reported to the SA and was not further investigated.
R142 diagnoses included anxiety. The admission MDS dated 6/20/13 revealed R142 was cognitively intact and had the ability to be

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F 226	Continued From page 9 understood and understand others. During interview on 7/22/13, at 7:05 p.m. R142 reported rude treatment by NA-A. R142 reported the employee worked at night and had a rude manner in the way he provided assistance. R142 indicated that he reported the rude treatment to a nurse the following morning, but was unable to recall the name of the nurse. R142 was unable to recall how long ago the alleged rude treatment had occurred but was recent. During interview on 7/24/13, at 2:15 p.m. DON reported that she had spoken with R142 regarding the alleged rude treatment by NA-A. She indicated that R142 reported, "' What do you want?' are the words he [NA-A] used." R142 confirmed he had informed a facility nurse of his allegation, but was unable to identify the nurse to the DON. The DON revealed investigation of R14's allegation of neglect was not complete, to conclude neglect or rule out possible neglect for R14. The DON verified it was the expectation for employees to follow the facility's abuse prohibition policies and conduct a thorough investigation of abuse allegations. During interview on 7/25/13, at 9:00 a.m. RN-B (nurse manager) indicated she had spoken with R14 after submission of the Resident Concern Report on 7/17/13. Per RN-B, R14 denied feeling rushed by NA-A. RN-B further stated the Resident Concern Report did not explain thoroughly what had occurred. She confirmed that she was responsible to report abuse allegations to the facility administrator and DON. RN-B stated that she did notify the administrator adding, "I took this form to [administrator], who signed it ...I think maybe between 1:00 p.m. and 4:00 p.m. [on 7/17/13]." RN-B stated a full	F 226		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	Continued From page 10 investigation was not necessary; therefore, the incident did not require a report to the SA. RN-B stated, "It was not done because we did not think it was reportable." RN-B commented she should have documented exactly what had happened, rather than assume what had happened. During interview on 7/25/13, at 9:10 a.m. the DON stated R14's allegation of neglect was not reported to the SA because she did not believe it met the definition of neglect. During interview on 7/25/13, at 9:40 a.m. the administrator reported that she had worked with NA-A at a different facility in the past and she did not recall concerns with his performance in that setting. The administrator reiterated that R14's allegation of neglect was not reported to the SA because she did not believe it met the definition of neglect. At 11:00 a.m., the administrator verified a thorough investigation into R14's allegation of neglect by NA-A had not been completed.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F279 Resident #101 Care Plan has been developed and implemented. All residents on dialysis have had care plans developed and implemented. Licensed nurses have been re-educated regarding dialysis care planning. DON/Designee will audit up to 2 dialysis care plans per week for one month to ensure appropriate development and implementation of care plan. Audit result will be reviewed at QPI. Completion date:	9/3/13

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F 279	Continued From page 11 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive peritoneal dialysis plan of care for 1 of 1 resident (R101) reviewed for dialysis. Findings include: Review of the facility's Dialysis Management (Peritoneal) policy revised 7/08, indicated all residents who received peritoneal dialysis were affiliated with a dialysis unit whether or not the procedure was performed there. The procedure indicated the following were to be ensured: detailed instructions to be provided by the dialysis center; 24-hour, seven-day per week laboratory coverage; and development of a peritoneal dialysis plan of care. R101's diagnoses included end stage renal disease. R101 had been living at home with family administering peritoneal dialysis. Following a fall with subsequent fractures and admission to another nursing home, R101 was admitted to the facility for further rehabilitation and peritoneal dialysis. The nursing staff administered the peritoneal dialysis treatment to R101 four times daily. R101's care plan dated 6/24/13, directed staff to	F 279		

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F 279	Continued From page 12 coordinate care with the dialysis center, (which was not identified in the medical record), monitor for nausea, vomiting, infection, abnormal laboratory results, note drainage characteristics amount, color, character and observe for fluid retention, dehydration and electrolyte imbalance. No parameters for R101's weights were identified in the care plan/ medical record and weights were recorded inconsistently. Although these were all identified as possible problems, no comprehensive approaches to resolve the problems were identified. During interview on 7/24/13, at 9:45 a.m. registered nurse (RN)-C reported she was unsure which dialysis center was responsible for R101's dialysis related care. She agreed R101's care plan had not been comprehensively developed and there was no coordination of services with the dialysis unit. When asked, she was unsure about procedures for site care and the protocol for a dislodged catheter. RN-C was also unsure of the amount of solution that was to be extracted during R101's runs and parameters for weights. During interview on 7/24/13, at 11:30 a.m. RN-E reported she was unsure of whether R101's catheter was sutured in. RN-E was also unsure of the protocol for what to do if the catheter had become dislodged. In addition, RN-E was unsure how much fluid was to be returned after the solution was inserted and was unaware of which dialysis unit oversaw R101's dialysis related care.	F 279	F 309 continued on page 14	
F 309 SS=D	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	F 309		

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F 309	Continued From page 13 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 document review, interview, and observation, the facility failed to ensure dialysis services were coordinated with the dialysis unit for 1 of 1 resident (R101) observed, who received peritoneal dialysis within the facility and failed to monitor the sodium level as ordered by the physician. Findings include: During review of the medical record R101's diagnoses included end stage renal disease. R101 had been living at home with family administering peritoneal dialysis. Following a fall with subsequent fractures and admission to another nursing home, R101 was admitted to the facility for further rehabilitation and peritoneal dialysis. The nursing staff administered the peritoneal dialysis treatment to R101 four times daily. R101's care plan dated 6/24/13, directed staff to coordinate care with the dialysis center, (which was not identified in the medical record), monitor for nausea, vomiting, infection, abnormal laboratory results, note drainage characteristics amount, color, character and observe for fluid retention, dehydration and electrolyte imbalance. No parameters for R101's weights were identified in the care plan/ medical record and the weights	F 309	F309 Resident #101 care is being coordinated with the dialysis center and labs have been drawn. All dialysis residents are having their care coordinated with the dialysis center and ordered labs are being drawn. Licensed nurses have been re-educated regarding coordination of care and lab draws. DON/Designee will audit up to 2 dialysis resident charts per week for one month to ensure coordination of care and lab draws. Results of audit will be reviewed in QPI. Completion date: 9/3/13	

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F 309	Continued From page 14 recorded on the weight record were not completed on a inconsistent basis. Although these were all identified as possible problems, no comprehensive approaches to resolve the problems were identified. During interview on 7/24/13, at 9:45 a.m. registered nurse (RN)-C reported she was unsure which dialysis center was responsible for R101's dialysis related care. She agreed R101's care plan had not been comprehensively developed and there was no coordination of services with the dialysis unit. When asked, she was unsure about procedures for site care and the protocol for a dislodged catheter. RN-C was also unsure of the amount of solution that was to be extracted during R101's runs and parameters for weights. Observation of the dialysis run was completed on 7/24/13, at 11:30 a.m. with RN-E. The catheter site was observed in the lower, left abdomen. The dressing was removed, cares were completed and another dressing was placed over the catheter insertion site. When asked if the catheter was sutured in, RN-E did not know. RN-E was also unsure of the protocol for what to do if the catheter had become dislodged. In addition, RN-E was unsure how much fluid was to be returned after the solution was inserted and was unaware of which dialysis unit oversaw R101's dialysis related care. Review of the facility's Dialysis Management (Peritoneal) policy revised 7/08, indicated all residents who received peritoneal dialysis were affiliated with a dialysis unit whether or not the procedure was performed there. The procedure indicated the following were to be ensured: detailed instructions to be provided by the dialysis	F 309		

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F 309	Continued From page 15 center; 24-hour, seven-day per week laboratory coverage; and development of a peritoneal dialysis plan of care. R101's oral intake was being monitored by the physician. In response to the residents low sodium (Na) problem the most recent being 127 on 07/19/2013, the physician ordered 1200 cc fluid restriction on 7/23/13 and a repeat Na on 7/24/13. During review of the medical record on 7/24/13 the Na level was requested and it was discovered that it had been missed and had not been drawn. An immediate Na was requested and the lab draw was completed on 7/25/13 and results were returned at 127 (low value). When interviewed on 7/24/13 at 9:45 a.m. RN-C was unsure why the Na level had not been completed. She indicated when labs are ordered the nurse writes the order on the treatment record and in the lab book. RN-C was unsure how it was missed because the order appeared on the treatment record and in the lab book. Interview with the MD on 7/25/13 at 1:10 p.m. revealed the MD was concerned about the missed Na level. He could not recall this happening before however he indicated his orders were not followed as requested and stated the residents condition was very fragile.	F 309		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	F425 Resident #104 does have Coumadin 11mg medication available. All residents have medication available. Licensed nurses / TMA's have been re-educated about utilization of e-kit when needed. DON/Designee will audit 5 MARs per week for one month to ensure medications are available. Audit results will be reviewed in QPI. Completion date: 9/3/13	

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F 425	Continued From page 16 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to obtain and dispense medications in an accurate and safe manner for 1 of 10 residents (R104), whose medication regimans were reviewed Findings include: R104 required a change in medication dose, based on lab values. R104 was admitted 7/11/13 after surgery for osteomyelitis with angioplasty and stent placement along with amputation of the 5th metatarsal. In addition R104 had end stage renal disease, dialysis, and diabetes. R104 was placed on Coumadin 10 mg after the surgery and INRs (lab value done to adjust the Coumadin dose) ordered. During medication review in the medical record on 7/24/13, it was discovered when reviewing the lab reports, that the INR had not been completed as ordered on 7/12/13 and no subsequent INR's had been ordered or completed. RN-C notified the MD on 7/24/13 at 10:25 a.m. and the MD	F 425		

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F 425	Continued From page 17 ordered a stat (immediate) INR lab draw. On 7/24/13 at 1:40 p.m. R104 was observed and interviewed. Other than being tired, due to having a dialysis treatment, R104 stated she was fine. No noticeable bruising was noted on the resident's exposed skin. On 7/25/13 at 8:35 a.m. RN-C reported the INR was 1.44 on 7/24/13. The physician was called and ordered Coumadin 11 mg to be given the evening of 7/24/13, and recheck the INR on Monday 7/29/13. On 7/25/13 at 3:30 p.m. a review of the medication administration record (MAR) was completed. There was no record that Coumadin 11 mg had been given on 7/24/13, as ordered by the physician, in response to the low INR. On 7/25/13 at approximately 4:15 p.m. with licensed practical nurse (LPN)-B revealed she gave the Coumadin last night but was unable to find it documented on the MAR. LPN-B said she had borrowed from another resident on 7/24/13 and stated she should not have done that. The director of nursing and consultant nurse said that it appeared the medication had not been given, due to lack of documentation, and stated it was against the facilitiy policy and procedure, to borrow a medication from another resident. Review of the policy and procedure entitled, Medication Administration, dated 11/2012 revealed, "the practice of borrowing medications from other resident's supplies is not consistent with professional standards and contributes to medication errors."	F 425		

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F 441	Continued From page 18	F 441	F441	
F 441 SS=D	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 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.	F 441	Resident #68 is receiving treatments using appropriate technique. All residents with treatments are receiving treatments using appropriate technique. Licensed staff have been re-educated regarding appropriate dressing change technique. DON/Designee to observe 3 dressing changes per week for one month to ensure appropriate technique. Audit results will be reviewed in QPI. Completion date:	9/3/13

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	245164	A. BUILDING _____ B. WING _____	07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 19	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure proper hand washing and glove changing were completed during wound cleaning and dressing for one of two residents (R68) reviewed for wound care.

R68's Care Area Assessment, dated 2/6/13, stated "Resident had a chronic stage 4 pressure ulcer on her sacral area." A stage four pressure ulcer has full thickness tissue loss with exposed bone, tendon or muscle.

The July 2013 treatment administration record directed staff "Clean sacral wound with sterile water, cover w/ [with] Silverstat, Loose moist Light dressing [and] cover with Allevyn" (Silverstat is a brand of antibacterial wound dressing gel. Allevyn is a brand of wound dressing.)

During observation on 7/24/13 at 9:35 a.m. the floor nurse, (LPN)-A, draped the area surrounding R68's sacral area. LPN-A was observed to clean R68's pressure ulcer on her sacrum with sterile water and gauze, gently pushing the moistened gauze into the wound. After cleansing the wound, the soiled gauze was disposed of into a garbage bag. The soiled gauze had brown and red matter dotted on it. LPN-A then wiped the surrounding skin area with moistened wipe and disposed of it. Without removing gloves, washing hands and donning new gloves, LPN-A was observed to touch the box of moistened wipes with gloved hands that had been used to clean the wound, open a dressing package, cut the dressing with a scissors and squeeze the tube of antibacterial

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F 441	Continued From page 20 wound dressing gel on the dressing. LPN-A then secured the dressing with gel over the wound and placed her equipment, including box of moistened wipes into a storage container. LPN-A was interviewed, immediately following the procedure, and reported she did not think it was necessary to wash her hands after cleaning the pressure ulcer and before placing a clean dressing on it. On 7/24/13 at 11:03 a.m. the nurse manager, (RN)-B reported she had not been trained to wash hands and change gloves between cleaning a wound and placing a clean dressing on the wound. When interviewed on 7/24/13 at 2:25 p.m. the director of nursing [DON] reported there was no policy on wound care. The DON explained LPN-A should have washed her hands and changed gloves if they were contaminated, but did not think most nurses would think to do so between cleaning a wound and putting a clean dressing on. The Hand Hygiene-Plain Soap and Water Handwash, last revised November 2011, directed staff "A plain soap and water handwash will be used: If hands are visibly soiled" "A plain soap and water handwash or an alcohol hand rub may also be used: "After contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings if the hands are not visibly soiled"	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465	F 465 continued on page 22	

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F 465	Continued From page 21 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to identify and rectify maintenance needs within the facility for 4 of 35 residents (R66, R108, R35 and R202) whose rooms were observed and for 12 of 12 sampled residents who resided on the transitional care unit. Findings include: During the environmental tour on 7/24/13, at 1:30 p.m. with director of maintenance, administrator and two contracted housekeeping staff, the following concerns were noted: The faucet in R66's room was observed to continually drip water into the sink. R108's room had multiple sections of wall paper peeling around the call light area on the wall. R35's room had two large holes in the metal heat register plate affixed to the base of the wall. R202's room had multiple scratches on the wall and peeling wall paper. The transitional care nursing station floor had three large areas of missing linoleum on the floor. During interview on 7/24/13, 1:30 p.m. the director of maintenance documented each concern and verified all of the areas identified needed to be fixed. The director of maintenance did not recall whether the staff had completed a work order for any of the identified areas. He stated each nursing station had an area where blank maintenance order forms were kept for staff to complete and deposit maintenance concerns/ requests, the maintenance staff then collected the order forms on a frequent basis to fix areas/items noted on these forms. He indicated the facility had no logging system in	F 465	F465 Areas noted on the 2567 for R 66, R 108, R 35, R202, and TCU nurse station floor have been repaired or replaced as needed. All staff have been re-educated on use of the Building Service Work Order Request forms for reporting areas that require maintenance. Care Partner Round Checklist includes an observation of room maintenance needs and reported via the work order. Maintenance Director/Designee to complete a weekly environmental tour to observe for unreported maintenance needs. Bi-weekly random room audits completed for one month to ensure room repair and maintenance . Audit results will be reviewed in QPI. Completion date:	9/3/13

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F 465	Continued From page 22 place to keep track of what had been fixed; however, he did store a copy of each completed work order in his file for up to six months. During interview on 7/25/13, at 9:25 a.m., with the administrator, it was verified no previous work order had been completed for R66's drippy faucet. The administrator reported that a work order slip had been completed for R108's peeling wallpaper; however, the staff did not put the room number on this order so it could not be completed. The administrator indicated there were no other work order slips for areas observed/discussed during the environmental tour. No other documentation was provided related to the areas of concern noted during the environmental tour.	F 465		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to monitor lab values, per physician orders, for an anticoagulant drug for 1 of 10 residents (R104) reviewed. Findings include: R104 was admitted 7/11/13 after surgery for osteomyelitis with angioplasty and stent placement along with amputation of the 5th metatarsal. In addition R104 had end stage renal disease, dialysis, and diabetes. R104 was placed on Coumadin 10 mg after the surgery and INRs (lab value done to adjust the Coumadin dose)	F 504	F504 Resident #104 has had the lab draw for monitoring of medication completed. All residents on Coumadin where checked during survey and are having lab draws completed per MD order. Licensed nurses have been re-educated regarding lab draws. DON/Designee to audit 5 Coumadin residents per week for one month to ensure that lab draws are completed. Audit results will be reviewed in QPI. Completion date:	9/3/13

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F 504	Continued From page 23 ordered. During medication review in the medical record on 7/24/13, it was discovered when reviewing the lab reports, that the INR had not been completed as ordered on 7/12/13 and no subsequent INR's had been ordered or completed. A nurse on the unit, (RN)-C, confirmed that no lab reports were in the medical record and contacted the lab. RN-C was told it had been done, however, after checking more closely RN-C was informed it had not been completed. RN-C notified the MD on 7/24/13 at 10:25 a.m. and the MD ordered a stat (immediate) INR lab draw. Review of the procedure, Laboratory/Diagnostic Test Values Monitoring, dated 4/2013, directed the staff when transcribing to add the lab/test to the tracking sheet and place the order on the medication administration record. The staff were expected, after putting the order on the medication administration record, to "square" off the box. RN-C stated that the procedure had not been followed and that was the reason why the lab was missed. When interviewed on 7/25/13 at 1:10 p.m., the physician, who also was the medical director at the facility, expressed concern about the lab being missed. However, he indicated the resident was basically stable with her INR. He went on to say there was no excuse for the labs being missed and indicated not being aware of this happening before.	F 504		

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

F5164022

PRINTED: 08/13/2013
FORM APPROVED
OMB NO. 0938-0391

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	245164	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/24/2013

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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, Health & Rehabilitation of New Brighton 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 TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	RECEIVED AUG 26 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok FS 8-28-13	

DOC: 09.03.2013

EXIT: 07.25.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy Carson (Sandra) , TITLE: Administrator , (X6) DATE: 8/23/13

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 Barbara.Lundberg@state.mn.us and Marian.Whitney@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. This 1 story building, built in 1963, was determined to be of Type II(222) construction. It has a partial basement, and is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 110 beds and had a census of 97 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K 052 Smoke detector with in 3 feet of the corridor air duct on the 1st floor by room 170 was moved to be in compliance with required 3 foot NFPA 70(99) and NFPA 72(99) edition 9.6.1.4 code. Completion date:	8/6/13

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 70(99) and NFPA 72(99) edition. 9.6.1.4.This deficient practice could affect the residents, staff and visitors within the smoke compartment. Findings include: On facility tour between 09:00 AM and 01:00 PM on 07/24/2013, it was observed that the corridor smoke detector was within 3 feet of an air duct in the corridor on the 1st floor by room 170. This deficiency was verified by (JM) Director of Environmental Services at the time of this inspection.	K 052		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 - 2000	K 062	K 062 Sprinkler head in Housekeeping Clean Room on the lower level was moved so the sprinkler head is not obstructed by the door to the corridor when the door is open by the magnetic hold open device. Ahern Fire Protection contractor used to move the sprinkler head. The date of service was 8-6-13. Completion date: 8/6/13	

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K 062	Continued From page 3 edition, Sections 19.3.5 and 9.7; NFPA 13 - 1999 edition, Section 6.1.1.5 and NFPA 25 - 1998 edition, Sections 2.2.1.1, 2-3.2 and 2-4.1.4. This deficient practice could affect the residents, staff and visitors within the smoke compartments. Findings include: On facility tour between 09:00 AM and 01:00 PM on 07/24/2013, it was observed that the fire sprinkler head in the Housekeeping /Clean Room on the lower level, was obstructed by the door to the corridor when held open by a mag hold open device. This deficiency was verified by (JM) Director of Environmental Services at the time of this inspection.	K 062		