MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 1493

October 24, 2017

Mr. Mark Rustad, Administrator
Valley Care and Rehab Llc
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

Subject: Valley Care and Rehab Lic - IDR
CCN# 245281
Project # H5281029 & S5281027

Dear Mr. Rustad:

This is in response to your letter of May 5, 2017, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F309 issued pursuant to the survey event NQV412, completed on April 6, 2017.

The information presented with your letter, the CMS 2567 dated 4/6/17, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F309 S/S-G § 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the* comprehensive assessment *of a resident, the facility must ensure that* residents receive *treatment and* care *in accordance with professional standards of practice, the* comprehensive *person-centered care plan, and the residents' choices, including but not limited to the following:

§483.25(k) Pain Management.

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Summary of the facility's reason for IDR of this tag: The facility staff assert they did not cause harm to R32 who had pre-existing chronic pain and skin breakdown along with numerous other comorbidities. They assert they had identified, assessed, monitored, developed and implemented interventions to aid in preventing development of moisture related skin breakdown, and had implemented measures to treat and prevent pain for R32.

Summary of facts:

R32's medical record indicated R32 had been admitted to the nursing home 11/18/16 with a history of skin breakdown in the peri-rectal area due to ongoing issues with incontinence of bowel and bladder. The record also indicated R32 had required hospitalization from 3/14/17 to 3/20/17 for diagnoses including: lack of water as cause of dehydration, cardiomyopathy and atrial fibrillation. In addition, a hospital note dated 3/14/17, indicated when R32 had presented to the hospital she was lethargic and had multiple open wounds and significant pain to the inner buttocks. The note further indicated R32 had required referral to a wound specialist and utilized intravenous pain medications while hospitalized to treat the pain in her rectal area, where the wounds were located.

During observations of care on 4/5/17, the skin around R32's rectal area was noted to be excoriated with four small open areas located near the rectum. At the time, R32 expressed discomfort when repositioned and when staff cleansed the peri-rectal area following an incontinent episode. The resident verbally expressed pain while her rectal area was cleansed, and made moaning type sounds of discomfort.

Neither before, nor following the resident's hospitalization, had the facility conducted a comprehensive evaluation of the resident's incontinence, pain or treatment and services necessary, to determine whether there were appropriate and effective interventions being implemented to ensure pain management, healing of the wounds, and to prevent further incidence of these concerns. The plan for treatment was identified after the resident was hospitalized.

Summary of findings: Following review of the CMS 2567, information submitted by the facility, a telephone conference with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined this is a valid deficiency at this tag and at the correct scope and severity of (G).

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 507-206-2731 Fax: 507-206-2711

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gail Anderson, Fergus Falls District Office Unit Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NQV4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00968

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245281**
2.STATE VENDOR OR MEDICAID NO.
(L2) **198148100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY CARE AND REHAB LLC**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2015**

6. DATE OF SURVEY **05/30/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (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
	35			
(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 :
Denise Erickson, HFE NEII 09/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/12/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1985
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/17/2017
(L33)

DETERMINATION APPROVAL

CCN: 24 5281

On May 30, 2017, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies and the complaint investigation number H5281029 substantiated at F157, F309 and F315 issued pursuant to a PCR, completed on April 6, 2017. We presumed, based on their plan of correction, that your facility had corrected these deficiencies as of May 8, 2017. Based on our visit, we have determined that the facility has corrected the deficiencies issued pursuant to our PCR, completed on April 6, 2017, effective May 8, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective May 8, 2017.

In addition, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letters of March 2, 2017 and April 25, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 10, 2017, be rescinded. (42 CFR 488.417 (b))

In addition, the Department recommended the following enforcement action to the Centers for Medicare and Medicaid Services (CMS) as it relates to the remedies outlined in our letters of March 2, 2017 and April 25, 2017:

• Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)

Furthermore, in our letters of March 2, 2017 and April 25, 2017, we advised the facility, 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), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 10, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 8, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Effective May 8, 2017, the facility is certified for 35 skilled nursing facility beds.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245281

September 12, 2017

Mr. Mark Rustad, Administrator
Valley Care and Rehabilitation, LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

Dear Mr. Rustad:

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

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

Effective May 8, 2017 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 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 letter.

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2017

Mr. Mark Rustad, Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

RE: Project Number S5281027 and H5281029

Dear Mr. Rustad:

On March 2, 2017 and April 25, 2017, as authorized by the CMS Region V Office (CMS), the Department informed you that the following enforcement remedies were being imposed:

- State Monitoring effective March 7, 2017. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017. (42 CFR 488.417 (b))

In Addition, on March 2, 2017, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

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

Further, On April 25, 2017, the Department recommended to the CMS Region V Office that the following additional enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

Furthermore, the Department notified you in our letters of March 2, 2017 and April 25, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 10, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on February 10, 2017, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on April 6, 2017, that included an investigation of complaint number H5281029, substantiated at F157, F309 and F315. 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 May 30, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies and the complaint investigation number H5281029 substantiated at F157, F309 and F315 issued pursuant to a PCR, completed on April 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 6, 2017, effective May 8, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective May 8, 2017.

In addition, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letters of March 2, 2017 and April 25, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 10, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 10, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 10, 2017, is to be rescinded.

Further, the Department recommended the following enforcement action to the Centers for Medicare and Medicaid Services (CMS) as it relates to the remedies outlined in our letters of March 2, 2017 and April 25, 2017:

- Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)

Furthermore, in our letters of March 2, 2017 and April 25, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 10, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 8, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronically Delivered
September 12, 2017

Mr. Mark Rustad, Administrator
Valley Care and Rehabilitation LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

RE: Project Number S5281027 and H5281029

Dear Mr. Rustad:

On April 25, 2017, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That notice, which was electronically delivered, imposed a daily fine in the amount of $700.00.

A reinspection was held on May 30, 2017 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $700.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $1,131.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $1,831.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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 letter.

Sincerely,

Mark Meath

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

cc: Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NQV4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00968

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245281**
2.STATE VENDOR OR MEDICAID NO.
(L2) **198148100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY CARE AND REHAB LLC**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2015**

6. DATE OF SURVEY **04/06/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (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
	35			
(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 :
Denise Erickson, HFE NEII 04/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1985
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/17/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5281

On April 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 10, 2017 and to investigate complaint number H5281029 which was found to be substantiated at F157, F309 and F315. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2017. Based on our visit, we have determined that the facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on February 10, 2017. The deficiencies not corrected are as follows:

F0157 -- S/S: D -- 483.10(g)(14) -- Notify Of Changes (injury/decline/room, Etc)
F0309 -- S/S: G -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being

In addition, at the time of this revisit, we identified the following deficiency:

F0315 -- S/S: D -- 483.25(e)(1)-(3) -- No Catheter, Prevent Uti, Restore Bladder

The most serious deficiencies in the facility was found to be isolated deficiencies that constituted
actual harm that was not immediate jeopardy (Level G), whereby corrections were required.As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related tothe remedies in our letter of March 2, 2017:

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

• Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017, remain in effect. (42 CFR 488.417 (b))

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

• Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

Post Certification Revisit (PCR) to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 25, 2017

Mr. Mark Rustad, Administrator
Valley Care And Rehabilitation LLC
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

RE: Project Numbers S5281027 and H5281029

Dear Mr. Rustad:

On March 2, 2017, as authorized by the Centers for Medicare and Medicaid (CMS) Region V Office, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective March 7, 2017. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017. (42 CFR 488.417 (b))

In addition, on March 2, 2017, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

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

Furthermore, as we notified you in our letter of March 2, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 10, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on February 10, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On April 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 10, 2017 and to investigate complaint number H5281029 which was found to be substantiated at F157, F309 and F315. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2017.

Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on February 10, 2017. The deficiencies not corrected are as follows:

F0157 -- S/S: D -- 483.10(g)(14) -- Notify Of Changes (injury/decline/room, Etc)
F0309 -- S/S: G -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being

In addition, at the time of this revisit, we identified the following deficiency:

F0315 -- S/S: D -- 483.25(e)(1)-(3) -- No Catheter, Prevent Uti, Restore Bladder

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies in our letter of March 2, 2017:

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

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017, remain in effect. (42 CFR 488.417 (b))

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

- Civil money penalty for the deficiency cited at F309. (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.

A copy of the Post Certification Revisit Form, (CMS-2567B) from this visit is being electronically delivered.

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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,

- Include electronic acknowledgement signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions 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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	R 04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	**600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514**

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{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 4/5/17, and 4/6/17. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition, complaint H5281029 was investigated and substantiated at F309, F157 and F315 during the on-site revisit.	{F 000}		
{F 157} SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	{F 157}		5/8/17

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

Electronically Signed | 05/04/2017

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

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{F 157}	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a primary physician was notified of a change of condition for 1 of 1	{F 157}	1. R32 has been seen by her primary physician with documentation of the visit. 2. All residents were reviewed for change	

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{F 157}	Continued From page 2 resident (R32) who utilized an indwelling urinary catheter to assist with wound healing. Findings includes: Review of R32's progress notes from 2/20/17, to 3/31/17, revealed the following: -On 2/20/17, R32 had complained of butt pain and knee pain. The note further revealed R32's buttocks was red and bleeding in areas and a cream was applied. The note indicated R32 had been encouraged to get off her buttocks more often. -On 2/22/17, a butterfly wound around the anus, red rash, bleeding in some areas was observed and A&D ointment was applied. The note indicated R32 had complained of pain, had difficulty with transfers and should be encouraged to off load more often. The note lacked the number of open areas and measurements of the wounds. The note did not indicate non pharmacological pain interventions for R32's peri-rectal wounds. -On 2/25/17, indicated R32 was incontinent of bowel and bladder, and her rectal area was red and irritated. The note revealed R32 had pain around her rectal area that was constant and had rated her pain at an 8 on a numeric scale. The note indicated R32 received Tylenol for the pain and it was effective. -On 2/26/17, a pain interview had been completed with R32, which revealed she had reported constant pain in her rectum and surrounding skin, rated the pain at an 8 and stated the Tylenol would help but it did not take	{F 157}	in status. All residents are reviewed at daily shift reports. Any resident who may have a status change or require interventions by required physician order; is reported to their primary physician for a determination of further assessment or treatment. 3. Policies & procedures were reviewed and updated as needed. All nursing staff have been re-educated on the need to report any changes noted in resident status. Licensed staff were further educated on the need to verify reported changes in resident status, receive appropriate verbal or written orders for necessary interventions/procedures, and follow facility protocols for provider notification. 4. The DON will monitor & review all daily shift reports and required follow-up with staff & providers as needed. These daily audits will be done daily for 90 days or until 100% compliance is achieved. The audit outcomes will be submitted to the QAA Committee for comment &/or review.	

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{F 157}	Continued From page 3	{F 157}		

the pain away. A later note revealed R32 had complained of pain in her buttock with sitting and moving, pain in chest, ribs and abdomen. The note revealed R32 had rated the pain at a 10, was constant and did not get relief from Tylenol. The note further indicated R32 and her family had requested something more for pain. A later note revealed the DON had contacted R32's primary physician and obtained an order for Tramadol 50 milligrams (mg) every 4 hours with a maximum of 6 per day. A later note revealed R32 had received the medication and had stated this was the first time she has had relief from the pain. The note revealed a new cushion had been placed in R32's wheelchair.

-On 2/27/17, R32 was incontinent of bowel and bladder. The note indicated R32's peri-rectal area had diffuse red streaking, was intact and had no bleeding. The note indicated staff were to encourage R32 not sit in wheelchair for prolonged periods, turn and reposition every 2 hours and use prn Tramadol and zinc-oxide. The notes further identified the physician would be notified on rounds the next morning.

-On 2/28/17, R32 was incontinent of bowel and bladder and had complained of rectal pain, her rectum was red and irritated and received a dose of prn Tramadol for complaints of overall pain. A further note indicated Diflucan had been started. Diflucan had been ordered every day for 4 days, then every other day thereafter.

-On 3/1/17, R32 was incontinent of bowel and bladder and the skin was red and irritated around her rectum. The note further revealed R32 complained of pain around her rectum and received Tramadol and Anusol (topical

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{F 157}	Continued From page 4 corticosteroid used to treat hemorrhoids) were used for buttocks pain. -On 3/2/17, R32 was incontinent of bowel and bladder and had an open wound on her buttock area, and had complained of pain in her back legs and buttocks. A further note indicated a pain interview had been completed with R32, which revealed R32 reported constant pain in her buttocks area, rated a 7 on a numeric scale. The note further revealed barrier cream, hydrocortisone cream were used at that time. -On 3/2/17, R32's buttocks area was noted to be red, raw and wet. The note did not identify any other characteristics of R32's peri-rectal area. A later note revealed R32 was incontinent of bowel and bladder and had complained of buttocks pain. -On 3/3/17, revealed R32 was incontinent of bowel and bladder and her peri-rectal area was red and irritated. -On 3/9/17, revealed R32 had open skin on the crease of her buttocks, was red, open and bleeding. The note indicated R32 complained of pain and barrier cream was applied. -On 3/11/17, R32 complained of pain in her buttocks and received barrier cream and Tramadol for pain. -On 3/12/17, R32's buttocks remained excoriated and barrier cream had been applied. -On 3/13/17, R32 received pain medication for all over pain.	{F 157}		

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{F 157}	Continued From page 5 Review of R32's clinical progress notes indicated R32's peri-rectal wounds continued to worsen, with worsening pain despite the use of as needed Tramadol and Tylenol and a scheduled dose of Diflucan. R32's record lacked documentation the physician had been notified of the worsening wounds, and worsening pain reports for R7. Further, R7's clinical record lacked documentation she had been admitted to the hospital on 3/15/17. Review of R32's hospital discharge orders dated 3/20/17, revealed an order to continue with Foley catheter to prevent further perineal ulcers. Review of R32's progress note dated 3/31/17, revealed R32 had complained of abdominal pain and had no relief from Tramadol (non-narcotic pain medication). The note revealed R32 had no urinary output from her urinary catheter. The note further revealed R32's catheter had been removed and not replaced. The note indicated R32 had voided following the catheter removal, and expressed relief from the abdominal pain. The note indicated R32's briefs would be monitored for wetness. The note did not identify whether R32's physician had ordered R32's catheter removal or if R32's physician had been notified of the removal. On 4/5/17, at 10:35 a.m. nursing assistant (NA)-B stated R32 needed assistance with all of her cares except for eating and drinking. NA-B stated R32 had an indwelling catheter when she returned from the hospital and stated R32's catheter had recently been removed. NA-B stated R32 was always incontinent of bowel and bladder and wore a brief daily.	{F 157}		

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{F 157}	Continued From page 6 On 4/5/17, at 1:14 p.m. during a phone interview, family member (FM)-B stated R32 had a urinary catheter placed during her hospitalization to help heal the peri-rectal sores. FM-B stated R32 had been discharged to the facility with the catheter and she came to visit one day and the catheter was gone. FM-B stated the facility nurse on duty at the time of the visit, was unsure of when or why the catheter had been removed. FM-B stated at that time, she had attempted to make contact with the director of nursing (DON) by email and in person, regarding her concerns, though had received no response. FM-B stated she continued to have concerns about R32's skin and indicated as recently as this past weekend, during a visit, R32 had sat in the same position for over 3 hours. On 4/6/17, at 11:56 a.m. R32's clinical record was reviewed with the DON. At that time she confirmed R32's Foley catheter had been removed on 3/31/17, by herself and another facility nurse. She confirmed R32's primary physician had not given an order to nor had he been notified of R32's Foley catheter removal until 4/4/17. The DON stated the facility's usual practice would be to notify and obtain physicians order for the catheter removal. On 4/14/17, during a telephone interview at 1:05 p.m., R32's primary physician stated he would expect the facility to notify him and have an order to remove the indwelling catheter. He confirmed R32 needed incontinence management to aid in healing the peri-rectal wounds and indicated he was considering a referral for possible suprapubic catheter placement for R32. Review of an undated facility policy titled,	{F 157}		

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{F 157}	Continued From page 7 Physician Notification of Resident Change of Condition Guidelines, directed the facility to notify a residents primary physician and responsible party of changes in condition.	{F 157}		
{F 309} SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	{F 309}		5/8/17

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{F 309}	Continued From page 8 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and monitor skin breakdown related to incontinence for 1 of 3 residents (R32) reviewed for skin conditions and incontinence. In addition, the facility failed to comprehensively reassess worsening pain for 1 of 3 residents (R32) reviewed for pain. These deficient practices resulted in actual harm for R32 who experienced worsening of skin breakdown and increasing pain with non-pressure skin breakdown. Findings include: R32 was incontinent of bowel and bladder and developed multiple peri-rectal sores which caused severe pain much of the time and with any incontinence care. The facility had not comprehensively assessed R32's skin when the peri-rectal sores developed in order to prevent further sores from developing and promote healing. R32 was not comprehensively reassessed for worsening pain to manage severity/frequency of pain for R32. Although the facility did provide pain analgesics that provided some relief, R32 had ongoing pain that she described often as severe. In addition, R32's indwelling urinary catheter was discontinued without MD notification, despite being ordered to treat the peri-rectal sores. R32's quarterly Minimum Data Set (MDS) dated 3/3/17, identified R32 had moderate cognitive impairment and had diagnoses which included	{F 309}	1. R32 has been assessed and care plan interventions for skin breakdown, worsening pain, and decline in bowel and bladder incorporated into the plan of care. Additionally, her existing non-pressure skin breakdown continues to be monitored for healing along with adequacy of pain coverage. 2. All residents at risk for worsening pain and/or decline in bowel and bladder secondary to diagnosis, accidents, or medication regimens have been reviewed and comprehensive assessments completed to identify actual or potential skin breakdown and baseline characteristics. All residents were reviewed for worsening pain and comprehensive assessments completed. Care plans were updated with directed modalities of pharmalogical and non-pharmalogical interventions for pain control. Hereafter, all residents with be monitored weekly for worsening, acute, or breakthrough pain and/or change in bowel habits to determine underlying cause and interventions. 3. The DON or designee will also review all daily pain progress notes and PRN administration notes for 90 days to monitor for non-pharmalogical approaches trialed and efficacy until 100% compliance is achieved & maintained. Pain will be monitored daily by review of daily progress notes and weekly pain	

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{F 309}	Continued From page 9 congestive heart failure, non-infective gastroenteritis and colitis. The MDS identified R32 required extensive assistance with activities of daily living (ADL's) including toileting and personal hygiene. The MDS identified R32 was frequently incontinent of urine, always incontinent of bowel (which was increase in frequency from previous MDS completed 12/1/16) and was not on a toileting program for urinary or bowel incontinence. The MDS identified R32 had frequent pain, rated a five (5) on a numerical scale of 0-10 (0 indicating no pain and 10 indicating the worst pain imaginable) had received as needed (PRN) medication and non-pharmacological interventions and had not received scheduled pain medications. The MDS further identified R32 had moisture associated skin damage (MASD) and received a topical ointment. The MDS revealed R32 had not had any physician prescribed order changes or physician visits within the last 14 days. Review of R32's care plan revised 3/28/17, revealed R32 required extensive assistance with toileting by one staff, was incontinent of bowel and required checking, changing and repositioning every 2 hours. The care plan directed staff to provide the bedpan as needed and to complete peri cares after each incontinent episode. R32's care plan identified R32 had a peri-rectal skin ulcer near the anus related to moisture and incontinence. (However, the care plan did not identify the multiple skin wounds R32 sustained). R32's care plan directed staff to monitor and document the wound characteristics, and complete weekly measurements. R32's care plan identified the treatment included use of Balsam Peru Castor oil three times a day, reposition every 2 hours, and the use of pressure	{F 309}	notes and Administered PRN Listing Report to monitor for increasing use of PRN analgesic. Bowel habits will be reviewed daily by reviewing Urinary Output and Bowel Management Look Back Reports looking specifically for change in resident ability and signs of constipation or ongoing loose stools. 4. All staff providing direct cares to residents has been educated on the monitoring protocols to assure any pain or change in bowel/bladder habits is immediately reported and recorded. Direct care staff educated on the importance of charting all bowel movements for accurate monitoring and, if needed any medication administration. Additionally, all nursing staff was educated on use and documentation criteria for pain, pharmalogical and non-pharmalogical interventions. Nursing staff also educated on indications for change in bowel and bladder habits and associated potential for non-pressure skin breakdown for at risk residents as well as updated policies and procedures for accurate, consistent monitoring of non-pressure skin conditions. 5. Implementation of coordinated approach to resident needs assessing hourly pain, position, potty, and placement. The DON or designee will review/audit rounding daily for 7 days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. Additionally, the DON or designee will do unannounced, observational audits on select residents daily to assure consistency in rounding for	

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{F 309}	Continued From page 10 relieving devices in wheelchair and in bed. Review of the untitled facility form identified as the current nursing aide care sheet, identified R32 required assistance of one staff, utilized a incontinent brief, was to be checked and changed every 2 hours, and had a foley catheter in place. The form identified R32 was frequently incontinent of stool, and to contact nurse for barrier cream to sore on bottom. During observation on 4/5/17, at 10:27 a.m. R32 was seated in a wheelchair, in the dining room. Nursing assistant (NA)-A offered R32 assistance with cares and proceeded to wheel R32 to her room. At that time NA-B entered R32's room with a full mechanical lift. As NA-B lifted R32 out of the wheelchair with the lift, R32 groaned. NA-A asked R32 if she was sore and R32 responded she was. NA-B and NA-A assisted R32 over to the bed with the mechanical lift. As NA-B and NA-A laid R32 down on the bed, R32 groaned again. R32 moaned as she was turned side to side while NA-B and NA-A removed the lift sling from underneath R32. NA-A and NA-B offered R32 reassurance they would be done soon. R32 was assisted to turn to her left side, facing the wall and groaned again. NA-B and NA-A proceeded to remove R32's slacks and incontinent brief. R32 was incontinent of a moderate amount of urine and a moderate amount of formed, soft, sticky bowel. At that time, NA-A stated R32 was always incontinent of bowel and bladder and the characteristics of the bowel were typical for R32. NA-A then proceeded to wipe the stool away from R32's peri-rectal area with a wet wipe. At that time, a deep guttural groan had emanated from R32. NA-B patted R32's shoulder and reassured her they would be done shortly. R32 groaned	{F 309}	7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 6. Policies & procedures for pain management were reviewed and updated to include non-pharmalogical approaches individualized to each resident as well as when indications for comprehensive review is warranted. 7. Policies and procedures for non-pressure skin integrity breakdown were developed and reviewed to include physician notification, comprehensive review to establish risks and root cause, weekly monitoring for new concerns, and audit for decline in ADL function or increased pain associated with new non-pressure concerns.	

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throughout the peri-rectal cleansing. NA-A stated R32's bowel were often sticky and hard to wipe off her skin.

R32's buttocks had four open areas on her peri-rectal area, two on the left side at the 8 o'clock position and two on the right side at the 2 and 3 o'clock position. NA-A stated before R32 went to the hospital in March, she had had more than 4 open areas which would bleed. NA-A stated she felt R32 had a lot of pain from the open areas. NA-A then applied an ointment in a plastic cup to all four of R32's open areas. R32 moaned during the application. NA-A stated she had obtained the ointment from the nurse and it was to help heal the open areas. NA-A and NA-B proceeded to apply a clean brief to R32, pulled up her slacks and assisted to her to a right side lying position. R32 expressed relief the cares were done and stated she wanted to sleep.

Review of R32's Skin Observation Tool form dated 2/21/17, revealed R32 had an irritation in the crease of her buttocks.

Review of R32's Skin Observation Tool form dated 3/10/17, revealed R32 had a red rectal area which measured 6 centimeters (cm) by 6 cm. However, a comprehensive assessment of R32's skin condition was not conducted despite worsening of the peri-rectal sores.

Review of R32's Skin Observation Tool form dated 3/20/17, revealed R32 had two stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister. definition) on the right buttock and two stage 2

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pressure ulcers on the left buttock. The right buttocks pressure ulcers measured .3 cm by .3 cm with .1 cm in depth and .5 cm by .5 cm with .1 cm in depth. The left buttocks pressure ulcers measured .5 cm by .5 cm and .1 cm in depth and 2 cm by 2 cm with .1 cm in depth. (However, due to the lack of a comprehensive skin assessment, the wounds were unable to be determined related to pressure or moisture).

Review of R32's Weekly Wound Observation tool form dated 3/23/17, identified R32 had a stage 2 pressure areas on her buttocks near the anus which had worsened and measured 22 millimeter (mm) by 22 mm by 1 mm. The form indicated the treatment included an application of Balsam Peru-Castrol Oil Ointment to R32's buttocks three times a day for moisture associated open areas, reposition every 2 hours, wheelchair cushion and a Foley urinary catheter.

Review of R32's quarterly Pain Assessment signed 2/21/17, identified R32 reported burning pain in the rectal area which limited day to day activities, which she rated a 6 on a numeric pain scale. R32 reported bowel movements exacerbated the pain. The assessment indicated R32 experienced intermittent rectal pain when incontinent of bowel movements. The assessment revealed various interventions were in place such as, Tylenol, rest, repositioning and barrier cream. The assessment indicated R32 had relief from the Tylenol and somewhat relief from repositioning.

No further comprehensive wound and pain assessments were found in R32's clinical record.

On 4/5/17, at 10:35 a.m. NA-B stated R32

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needed assistance with all of her cares except for eating and drinking. NA-B stated R32 had an indwelling urinary catheter when she returned from the hospital and stated R32's catheter had recently been removed. NA-B stated R32 was always incontinent of bowel and bladder and wore a brief daily. NA-B stated staff were to check and change R32 every two hours for incontinence. NA-B stated R32 no longer used the toilet since R32 required a full mechanical lift, since approximately December. NA-B stated in the past R32 had utilized a bedpan for bowel movements and stated she felt it was too painful for R32 to use the bedpan presently because of the sores. NA-B stated R32's sores around her peri-rectal area started at the end of February and at times had been bleeding. She indicated R32 had several more areas that had been open before she went to the hospital in mid-March. NA-B stated she felt the open sores on R32's peri-rectal area were very painful for her and she was aware R32 had often complained of pain with peri-cares. NA-B stated there have been no changes to R32's check and change program since the sores started, other than applying ointment or cream after incontinence.

On 4/5/17, at 1:02 p.m. with family member (FM)-A and R32, FM-A stated in the past the family had concerns with the facility providing adequate care to R32, though felt another family member had spoken with staff regarding their concerns. R32 stated she did not like to bother the staff too much by asking for things and liked to lay in bed. R32 stated her bottom was very painful for her and described the pain as a burning sensation which she rated an 8-10 (sever) on a numeric pain scale. R32 stated she had a difficult time explaining to staff where she

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was having pain, however, she felt staff was aware the sores on her bottom were painful for her. R32 stated she had ongoing pain elsewhere in her body such as her back, and joints and stated she received medication for the pain and it was effective some of the time. R32 stated she not been offered other types of pain interventions (non-pharmacological). R32 stated that although she still had significant pain from the sores, she felt it was better since her return from the hospital. R32 stated she was unaware of any changes in her care since her return from the hospital.

During a telephone interview on 4/5/17, at 1:14 p.m. FM-B indicated she was aware R32 had sores on her bottom in February and stated the nurse had explained to her at that time that sores were a common result of incontinence. FM-B stated she felt R32 continued to decline, developed a serious cough, and had become confused and disoriented. FM-B stated she again had voiced her concerns to facility staff and was told she would be updated with any changes.

On 4/6/17, at 9:08 a.m. NA- C stated R32 required extensive assistance all of her cares, except for eating. NA-C stated R32 was assisted with checking and changing her incontinent brief every two hours and was always incontinent of both bowel and bladder. NA-C stated R32 complained of pain with all peri-rectal cares and felt it was due to the sores on her peri-rectal area. NA-C stated R32 had the peri-rectal sores for approximately two months and the sores had been open and bleeding at times. NA-C stated R32 used to use the bedpan, however it had become too painful for her so they no longer used it. NA-C stated since R32 had returned from the

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{F 309}	Continued From page 15 hospital, there have been no changes in her care. On 4/6/17, at 10:39 a.m. NA-A stated R32 was always incontinent of bowel and bladder and required routine, every two hour check and change. NA-A stated R32 was compliant with allowing staff to complete checking and changing of her incontinent brief. NA-A stated R32 used to use the toilet approximately three to four months ago, however, felt since R32's health has declined, she required a full mechanical lift. NA-A stated prior to R32's hospitalization, she had constant stooling in her brief, and at present R32 had soft incontinent stools. NA-A stated R32 developed sores around her peri-rectal area mid-February and had been open and bleeding at times. NA-A stated R32 complained of pain with all peri-rectal hygiene, and felt it was due to the sores. NA-A stated felt the sores had improved since R32's return from the hospital, though felt R32 continued to have pain with cares. NA-A stated she was unaware of any changes in R32's plan of care since her hospital return. NA-A indicated a couple of the NAs had considered requesting R32 receive pain medication prior to morning cares would help R32 with her pain, but had not discussed this with the nurse at present. On 4/6/17, at 11:08 a.m. licensed practical nurse (LPN)-A stated R32's peri-rectal wounds had started out as red lesions that were treated with a barrier cream. LPN-A stated R32 had small pinpoint open areas in the peri-rectal region prior to her hospitalization in March, though was unsure of how many areas were open at that time. She felt R32's peri rectal sores have been improving since her return from the hospital. LPN-A stated in the weeks before R32 went to the hospital in March, R32 had experienced an	{F 309}		

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increase in bowel incontinence. LPN-A further stated R32 currently received scheduled Tramadol (non-opioid analgesic) twice daily for pain and every 4 hours as needed (PRN.) LPN-A stated the scheduled dosing for Tramadol was started on 3/21/17, following her hospitalization. She stated prior to being hospitalized on 3/14/17, R32 had only PRN Tramadol and Tylenol. LPN-A stated she felt R32 continued to have frequent pain from the peri-rectal sores, though felt the scheduled Tramadol gave R32 some relief.

On 4/6/17, at 11:25 a.m. registered nurse (RN)-A stated she was aware R32 had peri-rectal redness prior to her hospitalization on 3/14/17, however was not aware R32 had open sores in her peri-rectal areas. RN-A stated she had been aware the area was reddened and sore. RN-A stated she was responsible for the facility's weekly wound assessments and had not completed a comprehensive wound assessment for R32's peri-rectal wounds until her hospital return on 3/21/17, (30 days after R32's peri-rectal wounds were first noted). At that time RN-A stated R32 had 4 open areas in her peri-rectal region, 2 on the left side and 2 on the right side of her rectum. RN-A stated part of the facility's plan of correction from the recent survey was to improve the facility's wound assessments and monitoring. RN-A stated she had not had a chance to complete a comprehensive wound assessment for R32's peri -rectal wounds before she was hospitalized and indicated the most recent assessment she had completed for R32's peri-rectal wounds was on 3/23/17, after R32's hospital return. RN-A stated she felt the cause of R32's peri-rectal wounds was both urinary and bowel incontinence and stated there had not been any changes made to R32's checking and

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changing routine at that time. RN-A further stated R32 had been complaining of frequent buttocks pain and felt it was it was due to the peri-rectal sores. RN-A stated R32 now had oral pain medications scheduled and prn, which she felt were effective.

During observation on 4/6/17, at 1:42 p.m. the director of nursing (DON) and RN-A entered R32's room to complete wound care. R32 was quiet, lying in bed tilted on her left side, covered with a blanket. The DON removed the blanket from over R32 and assisted R32 to turn fully on her left side. R32 abruptly groaned when she was turned. RN-A proceeded to visualize the open areas around R32's rectum and stated R32 had 2 open areas on the left side of her rectum which measured approximately 1.7 cm by 1.2 cm by 0.3 cm and the second open area measured approximately 0.3 cm by 0.4 cm and had no depth. RN-A indicated the previous 2 open areas that were on the right side were now only red, she had indicated she felt those areas had healed. RN-A then proceeded to apply an ointment to all 4 peri- rectal areas. R32 continued to groan while RN-A provided peri cares and applied the ointment to the peri-rectal areas.

Review of R32's progress notes from 2/20/17, to 3/31/17, revealed the following:

-On 2/20/17, R32 had complained of buttocks pain and knee pain. The note further revealed R32's buttocks was red and bleeding in areas and a cream was applied. The note indicated R32 had been encouraged to get off her buttocks more often.

-On 2/22/17, a butterfly wound around the anus,

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red rash, bleeding in some areas was observed and A&D ointment was applied. The note indicated R32 had complained of pain, had difficulty with transfers and should be encouraged to off load more often. The note lacked the number of open areas and measurements of the wounds. The note did not indicate non pharmacological pain interventions for R32's peri-rectal wounds.

-On 2/25/17, indicated R32 was incontinent of bowel and bladder, and her rectal area was red and irritated. The note revealed R32 had pain around her rectal area that was constant and had rated her pain at an 8 on a numeric scale. The note indicated R32 received Tylenol for the pain and it was effective.

-On 2/26/17, a pain interview had been completed with R32, which revealed she had reported constant pain in her rectum and surrounding skin, rated the pain at an 8 and stated the Tylenol would help but it did not take the pain away. A later note revealed R32 had complained of pain in her buttock with sitting and moving, pain in chest, ribs and abdomen. The note revealed R32 had rated the pain at a 10, was constant and did not get relief from Tylenol. The note further indicated R32 and her family had requested something more for pain. A later note revealed the DON had contacted R32's primary physician and obtained an order for Tramadol 50 milligrams (mg) every 4 hours with a maximum of 6 per day. A later note revealed R32 had received the medication and had stated this was the first time she has had relief from the pain. The note revealed a new cushion had been placed in R32's wheelchair.

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{F 309}	Continued From page 19 -On 2/27/17, R32 was incontinent of bowel and bladder. The note indicated R32's peri-rectal area had diffuse red streaking, was intact and had no bleeding. The note indicated staff were to encourage R32 not sit in wheelchair for prolonged periods, turn and reposition every 2 hours and use prn Tramadol and zinc-oxide. The notes further identified the physician would be notified on rounds the next morning. -On 2/28/17, R32 was incontinent of bowel and bladder and had complained of rectal pain, her rectum was red and irritated and received a dose of prn Tramadol for complaints of overall pain. A further note indicated Diflucan had been started. Diflucan (anti-fungal) had been ordered every day for 4 days, then every other day thereafter. -On 3/1/17, R32 was incontinent of bowel and bladder and the skin was red and irritated around her rectum. The note further revealed R32 complained of pain around her rectum and received Tramadol and Anusol (topical corticosteroid used to treat hemorrhoids) were used for buttocks pain. -On 3/2/17, R32 was incontinent of bowel and bladder and had an open wound on her buttock area, and had complained of pain in her back legs and buttocks. A further note indicated a pain interview had been completed with R32, which revealed R32 reported constant pain in her buttocks area, rated a 7 on a numeric scale. The note further revealed barrier cream, hydrocortisone cream were used at that time. -On 3/2/17, R32's buttocks area was noted to be red, raw and wet. The note did not identify any other characteristics of R32's peri-rectal area. A	{F 309}		

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{F 309}	Continued From page 20 later note revealed R32 was incontinent of bowel and bladder and had complained of buttocks pain. -On 3/3/17, revealed R32 was incontinent of bowel and bladder and her peri-rectal area was red and irritated. -On 3/9/17, revealed R32 had open skin on the crease of her buttocks, was red, open and bleeding. The note indicated R32 complained of pain and barrier cream was applied. -On 3/11/17, R32 complained of pain in her buttocks and received barrier cream and Tramadol for pain. -On 3/12/17, R32's buttocks remained excoriated and barrier cream had been applied. -On 3/13/17, R32 received pain medication for all over pain. Review of R32's clinical progress notes indicated R32's peri-rectal wounds continued to worsen, with worsening pain despite the use of as needed Tramadol and Tylenol and a scheduled dose of Diflucan. R32's record lacked documentation the physician had been notified of the worsening wounds, and worsening pain reports for R7. Further, R7's clinical record lacked documentation she had been admitted to the hospital on 3/15/17. -R32's medical record lacked documentation of R32's transfer to the hospital. However, a note on 3/20/17 indicated R32 had returned from the hospital on a gurney and had been assisted to bed.	{F 309}		

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{F 309}	Continued From page 21 -On 3/23/17, a late entry for 3/21/17, indicated R32's primary physician had been updated on R32's recent hospitalization, and open areas to buttocks. -On 3/23/17, R32 had moisture associated open sore to buttocks, and Balsam Peru-Castor Oil Ointment was to be applied to buttocks topically three times a day for moisture associated open area. -On 3/24/17, R32 was seen by her primary provider regarding peri-rectal area, the note indicated R32's wounds were showing improvement. The note further revealed R32's urinary catheter was to remain in place as her wounds continued to heal. -On 3/27/17, R32 had wounds on her left and right buttocks with the following measurements and characteristics; right buttocks wound measured 1.0 cm by 0.5 cm by 0.5 cm and had red granular tissue, left buttocks measured 2.0 cm by 1.5 cm and had red granular tissue. The note did not identify any depth, drainage or pain associated with R32's peri-rectal wounds. -On 3/28/17, R32 was seen by her primary physician for a follow up of "skin ulcer" and nursing was to continue current therapy as ordered. -On 3/30/17, a pain interview had been completed with R32 and revealed R32 reported daily, almost constant pain of her buttocks, rated a 7 out of 10 on a numeric scale and indicated scheduled and PRN medications were effective.	{F 309}		

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{F 309}	Continued From page 22 -On 3/31/17, R32 had complained of abdominal pain and had no relief from Tramadol. The note revealed R32 had no urinary output from her urinary catheter. The note further revealed R32's catheter had been removed and not replaced. The note indicated R32 had voided following the catheter removal, and expressed relief from the abdominal pain. The note indicated R32's briefs would be monitored for wetness. The note did not identify whether R32's physician had ordered R32's catheter removal or if R32's physician had been notified of the removal. Review of R32's hospitalization records from 3/14/17, to 3/20/17, identified the following: -3/14/17, R32 was admitted to the hospital with diagnoses which included: lack of water as cause of dehydration, cardiomyopathy and atrial fibrillation. A hospital note dated 3/14/17, revealed R32 presented to the hospital lethargic, with multiple open wounds and significant pain to inner buttocks. The note further revealed R32 was referred to a wound specialist and was treated with intravenous Tramadol (non-opioid analgesic) for pain. - On 3/15/17, revealed the hospital wound nurse completed an assessment of R32's peri-rectal area which revealed the following: left peri-rectal area measured 1.5 cm by 1.5 cm by 0.7 cm and right side had multiple small scattered wounds, both areas had red wound bases, small amount of serosanguinous drainage. The note indicated R32's peri-rectal ulcers were caused by moisture from incontinence. The note revealed R32 had a Foley urinary catheter placed, Venelex (Balsam Peru and castrol oil topical, used to increase blood flow and prevent bacteria,) ointment and a	{F 309}		

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{F 309}	Continued From page 23	{F 309}		

Mepilex (dressing used to minimize pain and trauma to the wound and surrounding skin,) border foam dressing for prevention. A further note revealed R32 continued to have significant pain of her buttocks, and intravenous (IV) Fentanyl (opioid analgesic) was required to manage R32's pain.

-On 3/16/17, revealed palliative care was discussed with R32 and her family, and agreed upon due to R32's poor prognosis and quality of life. A further note revealed R32 reported improvement of pain with the added IV Fentanyl.

-On 3/17/17, revealed R32's discharge plans included Hospice services and R32 was to return to the facility with the Foley catheter to prevent further perineal ulcers and skin tear injury from incontinence.

-On 3/20/17, R32 was discharged from the hospital and returned to the facility with physician orders which included: continue with Foley catheter to prevent further perineal ulcers, Tramadol 50 milligrams (mg) twice daily (bid) and every 4 hours as needed for ongoing buttocks pain.

On 4/6/17, at 11:56 a.m. R32's medical record was reviewed with the DON. She confirmed R32's medical record had identified R32 had open areas near her rectum which were painful and bleeding on 2/20/17. The DON stated she was unsure of how many open areas R32 had in her peri-rectal area at that time, and stated she felt they were more like skin tears. The DON stated she felt the cause of R32's peri rectal wounds was moisture, as a result of incontinence of bowel and bladder. She confirmed a Skin Observation

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{F 309}	Continued From page 24 Tool was completed on 3/10/17, which had also identified R32's peri-rectal wounds. The DON confirmed the tool lacked measurements and any characteristics of the wounds. She stated she expected R32's peri-rectal wound to be monitored weekly and stated she had been working with her nursing staff on improving pain management and wound assessments, monitoring and treatment. The DON confirmed the facility had not considered any changes in R32's incontinence management plan since the peri-rectal wounds were first documented on 2/20/17. The DON stated she felt R32 had experienced pain related to the peri-rectal wounds and she felt the facility had managed R32's pain appropriately. Further, the DON stated R32's primary physician had been notified of an increase in R32's pain on 2/26/17, and Tramadol had been ordered to be administered as needed. The DON indicated she felt R32 was responsible to ask for pain medications when she felt she needed them. The DON stated the facility had not considered a scheduled pain regiment to aid in R32's pain management. The DON stated she would expect staff to offer non-pharmacological pain interventions in addition to pain medication to R32 and confirmed R32's medical record lacked documentation of non-pharmacological interventions attempted for R32's pain. The DON stated she was aware the pain medication that was given to R32 had not always been effective. Further, DON confirmed R32's Foley catheter had been removed on 3/31/17, by herself and another facility nurse. She confirmed R32's primary physician had not given an order to nor had he been notified of R32's Foley catheter removal until 4/4/17. The DON stated the facility's usual	{F 309}		

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practice would be to notify and obtain physicians order for the catheter removal.

On 4/6/17, at 12:19 p.m. a telephone message was left for R32's primary physician for interview. No return phone call had been received before exit.

On 4/14/17, at 1:02 p.m. during a telephone interview, R32's primary physician indicated he could not recall whether he had been notified of R32's peri-rectal wounds. R32's primary physician stated he would have expected the facilty to complete a comprehensive assessment to identify a potential cause, interventions and to continually monitor any changes in condition which included peri-rectal sores, pain and incontinence.

Review of R32's Medication Administration Record (MAR) from February 2017, to March 2017, revealed the following:

-Review of R32's February MAR revealed an order dated 11/18/16, for Tylenol 1000 mg by mouth every 4 hours as needed for pain, not to exceed 4000 mg in 24 hours. The MAR further revealed an order dated 2/26/17, for Tramadol 50 mg by mouth every 4 hours as needed for severe pain, with a max of 6 tablets in 24 hours. The MAR identified the medications were not always effective.

-Review of R32's March MAR revealed R32 had received Tylenol for pain rated from a 7 to a 9 (severe pain) on four times with varying results. The MAR revealed R32 had received Tramadol PRN for pain rated from 5-6 (moderate pain) until 3/10 then 8-10 (severe pain) PRN 23 times with

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{F 309}	Continued From page 26 varying effectiveness. Review of R32's Treatment Administration Records (TAR) from February 2017, to April 6th, 2017, revealed the following; -R32's February TAR revealed an order dated 2/27/17, for Barrier cream to peri-rectal area for moisture associated skin damage (MASD,) encourage resident to be off buttocks, turn and reposition every 2 hours. The TAR revealed an order dated 12/29/16, to complete skin/wound note and pain note every day shift Thursday for skin and pain. -R32's March TAR revealed an order dated 2/28/17, to ensure R32 was toileted every 2 hours while awake every day and evening related to dermatitis. The TAR revealed R32 continued to receive barrier cream to peri-rectal area for MASD, encourage resident to be off buttocks, turn and reposition every 2 hours. -R32's April TAR revealed an order dated 3/16/17, to complete skin and wound note every day shift for skin and pain. The TAR identified 3 of the 4 assessments were not completed. The TAR revealed an order to continue to turn and reposition R32 off of buttocks every 2 hours every shift for moisture associated open areas. Review of a physician progress note dated 2/21/17, revealed R32 was seen for a routine visit. The note revealed R32 had progressive weakness, weight gain and deconditioning. The note indicated R32 was to be seen again in 2 weeks or sooner. The note did not identify R32's primary physician had assessed R32's peri-rectal wound which was noted on 2/20/17.	{F 309}		

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{F 309}	Continued From page 27 Review of a facility policy and procedure revised 3/4/17, identified the facility's purpose was to properly identify and assess residents that were at risk for impaired skin integrity. The policy and procedure identified an ongoing wound assessment and monitoring would be completed with any new skin issues and the primary physician would be notified of the condition and kept appraised of any changes. A policy and procedure for pain management was requested on 4/6/17, and not provided.	{F 309}		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary	F 315		5/8/17

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F 315	Continued From page 28 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively re-assess bowel incontinence following onset of moisture associated skin breakdown (MASD) for 1 of 1 resident (R32) reviewed with a change in bowel incontinence. Findings include: Review of R32's quarterly Minimum Data Set (MDS) dated 12/1/16, identified R32 had moderate cognitive impairment and had a diagnosis which included non-infective gastroenteritis and colitis. The MDS identified R32 required extensive assistance with toileting and was frequently incontinent of bowel. Review of R32's quarterly MDS dated 3/3/17, identified R32 had moderate cognitive impairment and had a diagnosis of non-infective gastroenteritis and colitis. The MDS identified R32 continued to require extensive assistance with toileting, personal hygiene and R32 was now always incontinent of bowel.	F 315	1. R32 comprehensive bowel and bladder assessment completed. R32 care plan has been reviewed and care plan interventions for moisture related ulcer prevention incorporated into the plan of care. 2. All residents will have baseline comprehensive assessment completed upon admission. Thereafter, all residents will have comprehensive assessment completed annually and with change in condition to include, but not limited to change in bowel and bladder habits and the increased risk of skin integrity problems. 3. All residents have had Bowel and Bladder assessments, Bowel/Bladder Continence Evaluations, and and/or reviewed, and their plans of care updated as needed to assure resident-specific toileting times are offered, proper incontinence product is being used, and appropriate interventions to maintain skin integrity are being utilized. Staff will	

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F 315	Continued From page 29 Review of R32's care plan revised 3/28/17, revealed R32 required extensive assistance with transfers, toileting and was incontinent of bowel related to colitis and physical limitations. R32's care plan directed facility staff to check R32 every 2 hours and assist with toileting as needed, provide bed pan/commode and to provide peri care after each incontinent episode. Review of the untitled facility form identified as the current nursing aide care sheet, identified R32 required assistance of one staff, utilized a incontinent brief, was to be checked and changed every 2 hours, and had a Foley catheter in place. The form identified R32 was frequently incontinent of stool, and to contact nurse for barrier cream to sore on bottom. Review of R32's Bladder/Bowel Continence Evaluation dated 2/19/17, revealed R32 was incontinent of bowel and bladder. The assessment indicated R32 had an unknown onset of bowel incontinence which fluctuated over the past six months, and had been present for 2-5 years. The assessment lacked any frequency of R32's bowel movements. The note further revealed R32's perineum skin was intact. No further Bladder/Bowel Continence Evaluation forms were found in R32's clinical record, despite the change in frequency of bowel incontinence causing MASD. During observation on 4/5/17, at 10:27 a.m. R32 was seated in a wheelchair, in the dining room. Nursing assistant (NA)-A offered R32 assistance with cares and proceeded to wheel R32 to her room. At that time NA-B entered R32's room with	F 315	document toileting times, attempts, and refusals on each resident within the resident point of care system. Care plans were updated with directed modalities or interventions for bowel and bladder monitoring. Hereafter, all residents will have bowel and bladder habits monitored monthly through reports generated in point of care system. A comprehensive assessment will be completed for any change in condition. 4. DON or designee will review weekly bowel/bladder look back reports change in toileting habits. All staff providing direct cares to residents have been educated on the monitoring protocols to assure any change in bowel and bladder habits or skin breakdown other integument involvement is immediately reported & recorded. Additionally, all nursing staff was educated on use and documentation criteria for bowel and bladder training and the prevention for residents at risk for skin issues. 5. The DON or designee will review/audit all daily shift reports for 7 days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. The DON or designee will audit to ensure comprehensive assessments are completed for all residents at admission, annually, with significant change in bowel and bladder habits. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 6. Policies & procedures for incontinence assessment and management were reviewed and updated as needed. All	

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F 315	Continued From page 30 a full mechanical lift. As NA-B lifted R32 out of the wheelchair with the lift, R32 groaned. NA-A asked R32 if she was sore and R32 responded she was. NA-B and NA-A assisted R32 over to the bed with the mechanical lift. As NA-B and NA-A laid R32 down on the bed, R32 groaned again. NA-B and NA-A proceeded to remove R32's slacks and incontinent brief. R32 was incontinent of a moderate amount of urine and a moderate amount of formed, soft, sticky bowel. At that time, NA-A stated R32 was always incontinent of bowel and bladder and the characteristics of the bowel were typical for R32. NA-A then proceeded to wipe the stool away from R32's peri-rectal area with a wet wipe. At that time, a deep guttural groan had emanated from R32. NA-B patted R32's shoulder and reassured her they would be done shortly. R32 groaned throughout the peri-rectal cleansing. NA-A stated R32's bowel were often sticky and hard to wipe off her skin. R32's buttocks had four open areas on her peri-rectal area, two on the left side at the 8 o'clock position and two on the right side at the 2 and 3 o'clock position. NA-A stated before R32 went to the hospital in March, she had had more than 4 open areas which would bleed. NA-A stated she felt R32 had a lot of pain from the open areas. NA-A then applied an ointment from a plastic cup to all four of R32's open areas. R32 moaned during the application. NA-A stated she had obtained the ointment from the nurse and it was to help heal the open areas. NA-A and NA-B proceeded to apply a clean brief to R32, pulled up her slacks and assisted to her to a right side lying position. R32 expressed relief the cares were done and stated she wanted to sleep. On 4/5/17, at 10:35 a.m. NA-B stated R32	F 315	nursing staff have been re-educated on the need to report any changes noted in resident status. Licensed staff were further educated on the need to verify reported changes in resident status, and follow facility protocols for provider notification.	

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needed assistance with all of her cares except for eating and drinking. NA-B stated R32 had an indwelling urinary catheter when she returned from the hospital and stated R32's catheter had recently been removed. NA-B stated R32 was always incontinent of bowel and bladder and wore a brief daily. NA-B stated staff were to check and change R32 every two hours for incontinence. NA-B stated R32 used to use the bedpan for bowel movements before the sores on her peri-rectal area developed and stated she felt it was too painful for R32 to use the bedpan because of the sores. NA-B stated there have been no changes to R32's check and change program since the sores started, other than applying ointment or cream after incontinence.

On 4/6/17, at 10:39 a.m. NA-A stated felt that R32's health had been declining in the last few months. NA-A stated R32 was always incontinent of bowel and bladder and required routine, every two hour check and change. NA-A stated prior to R32's hospitalization, she had constant stooling in her brief, and at present R32 had soft incontinent stools. NA-A stated R32 was compliant with allowing staff to complete checking and changing of her incontinent brief. NA-A stated she was unaware of any changes in R32's plan of care since her hospital return.

On 4/6/17, at 11:25 a.m. registered nurse (RN)-A stated she felt the cause of R32's peri-rectal wounds was both urinary and bowel incontinence and stated there had not been any changes made to R32's checking and changing routine at that time. RN-A further stated R32 had been complaining of frequent buttocks pain and felt it was it was due to the peri-rectal sores.

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F 315	Continued From page 32 On 4/6/17, at 11:56 a.m. the director of nursing (DON) confirmed R32's most recent bowel assessment indicated an increased in bowel incontinence. The DON stated she felt the cause of R32's peri rectal wounds was MASD, as a result of incontinence of bowel and bladder. The DON confirmed the facility had not considered any changes in R32's incontinence management plan since the peri-rectal wounds were first documented on 2/20/17. A policy and procedure for incontinence assessment and management was requested, and not provided.	F 315		

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)
245281		4/6/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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. # 483.21(b)(3)(ii) LSC	Correction Completed 03/13/2017	ID Prefix F0314 Reg. # 483.25(b)(1) LSC	Correction Completed 03/13/2017	ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/13/2017
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 [x]	REVIEWED BY (INITIALS) GA/mm	DATE 04/25/2017	SIGNATURE OF SURVEYOR 31256	DATE 04/06/2017
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/10/2017	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered
April 25, 2017

Mr. Mark Rustad, Administrator
Valley Care and Rehabilitation, LLC
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

Re: Project # S5281027 and H5281029

Dear Mr. Rustad:

On April 6, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 10, 2017 with orders received by you electronically on April 25, 2017. In addition an investigation of complaint number H5281029 was conducted and found to be substantiated at MN Rule 4658.0085, MN Rule 4658.0520 and MN Rule 4658.0525.

State licensing orders issued pursuant to the last survey completed on February 10, 2017 and found corrected at the time of this April 6, 2017 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on February 10, 2017, found not corrected at the time of this April 6, 2017 revisit and subject to penalty assessment are as follows:

20265 -- MN Rule 4658.0085 - Notification Of Chg In Resident Health Status - $350.00
20830 -- MN Rule 4658.0520 Subp. 1 - Adequate and Proper Nursing Care; General - $350.00

The details of the violations noted at the time of this revisit completed on April 6, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $700.00 ***per day beginning on the day you view this notice***.

The fines shall accumulate daily until notification from the nursing home is electronically submitted to the Department stating that the orders have been corrected.

When the Department receives the electronically submitted notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until an electronically submitted notification stating that the orders have been corrected is received and verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

In addition, at the time of this reinspection completed on April 6, 2017 an additional violation was cited as follows:

20910 -- MN Rule 4658.0525 Subp. 5 A B - Rehab Incontinence

The violation is delineated on the electronically delivered Minnesota Department of Health State form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00968	A. BUILDING: _____ B. WING _____	R 04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 4/6/17. During this onsite visit it was determined that the following corrections orders 0265, 0830 were NOT corrected. These uncorrected orders will remain in effect and will be reviewed at the next onsite visit. Also uncorrected orders will be reviewed for possible penalty assessment/s.	{2 000}		

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{2 000}	Continued From page 1 An investigation of complaint H5281029 was completed. The complaint was substantiated. Correction orders were reissued at State Licensing 4658.0085, 4658.0520, and new state licensing order issued 4658.0525 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	{2 000}		
{2 265}	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement	{2 265}		5/8/17

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{2 265}	Continued From page 2 policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 2/10/17 will remain in effect. Penalty assessment issued. Based on interview and document review, the	{2 265}	corrected	

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{2 265}	Continued From page 3 facility failed to ensure a primary physician was notified of a change of condition for 1 of 1 resident (R32) who utilized an indwelling urinary catheter to assist with wound healing. Findings includes: Review of R32's progress notes from 2/20/17, to 3/31/17, revealed the following: -On 2/20/17, R32 had complained of butt pain and knee pain. The note further revealed R32's buttocks was red and bleeding in areas and a cream was applied. The note indicated R32 had been encouraged to get off her buttocks more often. -On 2/22/17, a butterfly wound around the anus, red rash, bleeding in some areas was observed and A&D ointment was applied. The note indicated R32 had complained of pain, had difficulty with transfers and should be encouraged to off load more often. The note lacked the number of open areas and measurements of the wounds. The note did not indicate non pharmacological pain interventions for R32's peri-rectal wounds. -On 2/25/17, indicated R32 was incontinent of bowel and bladder, and her rectal area was red and irritated. The note revealed R32 had pain around her rectal area that was constant and had rated her pain at an 8 on a numeric scale. The note indicated R32 received Tylenol for the pain and it was effective. -On 2/26/17, a pain interview had been completed with R32, which revealed she had reported constant pain in her rectum and surrounding skin, rated the pain at an 8 and	{2 265}		

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{2 265}	Continued From page 4	{2 265}		

stated the Tylenol would help but it did not take the pain away. A later note revealed R32 had complained of pain in her buttock with sitting and moving, pain in chest, ribs and abdomen. The note revealed R32 had rated the pain at a 10, was constant and did not get relief from Tylenol. The note further indicated R32 and her family had requested something more for pain. A later note revealed the DON had contacted R32's primary physician and obtained an order for Tramadol 50 milligrams (mg) every 4 hours with a maximum of 6 per day. A later note revealed R32 had received the medication and had stated this was the first time she has had relief from the pain. The note revealed a new cushion had been placed in R32's wheelchair.

-On 2/27/17, R32 was incontinent of bowel and bladder. The note indicated R32's peri-rectal area had diffuse red streaking, was intact and had no bleeding. The note indicated staff were to encourage R32 not sit in wheelchair for prolonged periods, turn and reposition every 2 hours and use prn Tramadol and zinc-oxide. The notes further identified the physician would be notified on rounds the next morning.

-On 2/28/17, R32 was incontinent of bowel and bladder and had complained of rectal pain, her rectum was red and irritated and received a dose of prn Tramadol for complaints of overall pain. A further note indicated Diflucan had been started. Diflucan had been ordered every day for 4 days, then every other day thereafter.

-On 3/1/17, R32 was incontinent of bowel and bladder and the skin was red and irritated around her rectum. The note further revealed R32 complained of pain around her rectum and received Tramadol and Anusol (topical

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{2 265}	Continued From page 5 corticosteroid used to treat hemorrhoids) were used for buttocks pain. -On 3/2/17, R32 was incontinent of bowel and bladder and had an open wound on her buttock area, and had complained of pain in her back legs and buttocks. A further note indicated a pain interview had been completed with R32, which revealed R32 reported constant pain in her buttocks area, rated a 7 on a numeric scale. The note further revealed barrier cream, hydrocortisone cream were used at that time. -On 3/2/17, R32's buttocks area was noted to be red, raw and wet. The note did not identify any other characteristics of R32's peri-rectal area. A later note revealed R32 was incontinent of bowel and bladder and had complained of buttocks pain. -On 3/3/17, revealed R32 was incontinent of bowel and bladder and her peri-rectal area was red and irritated. -On 3/9/17, revealed R32 had open skin on the crease of her buttocks, was red, open and bleeding. The note indicated R32 complained of pain and barrier cream was applied. -On 3/11/17, R32 complained of pain in her buttocks and received barrier cream and Tramadol for pain. -On 3/12/17, R32's buttocks remained excoriated and barrier cream had been applied. -On 3/13/17, R32 received pain medication for all over pain. Review of R32's clinical progress notes indicated	{2 265}		

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{2 265}	Continued From page 6 R32's peri-rectal wounds continued to worsen, with worsening pain despite the use of as needed Tramadol and Tylenol and a scheduled dose of Diflucan. R32's record lacked documentation the physician had been notified of the worsening wounds, and worsening pain reports for R7. Further, R7's clinical record lacked documentation she had been admitted to the hospital on 3/15/17. Review of R32's hospital discharge orders dated 3/20/17, revealed an order to continue with Foley catheter to prevent further perineal ulcers. Review of R32's progress note dated 3/31/17, revealed R32 had complained of abdominal pain and had no relief from Tramadol (non-narcotic pain medication). The note revealed R32 had no urinary output from her urinary catheter. The note further revealed R32's catheter had been removed and not replaced. The note indicated R32 had voided following the catheter removal, and expressed relief from the abdominal pain. The note indicated R32's briefs would be monitored for wetness. The note did not identify whether R32's physician had ordered R32's catheter removal or if R32's physician had been notified of the removal. On 4/5/17, at 10:35 a.m. nursing assistant (NA)-B stated R32 needed assistance with all of her cares except for eating and drinking. NA-B stated R32 had an indwelling catheter when she returned from the hospital and stated R32's catheter had recently been removed. NA-B stated R32 was always incontinent of bowel and bladder and wore a brief daily. On 4/5/17, at 1:14 p.m. during a phone interview, family member (FM)-B stated R32 had a urinary	{2 265}		

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{2 265}	Continued From page 7	{2 265}		

catheter placed during her hospitalization to help heal the peri-rectal sores. FM-B stated R32 had been discharged to the facility with the catheter and she came to visit one day and the catheter was gone. FM-B stated the facility nurse on duty at the time of the visit, was unsure of when or why the catheter had been removed. FM-B stated at that time, she had attempted to make contact with the director of nursing (DON) by email and in person, regarding her concerns, though had received no response. FM-B stated she continued to have concerns about R32's skin and indicated as recently as this past weekend, during a visit, R32 had sat in the same position for over 3 hours.

On 4/6/17, at 11:56 a.m. R32's clinical record was reviewed with the DON. At that time she confirmed R32's Foley catheter had been removed on 3/31/17, by herself and another facility nurse. She confirmed R32's primary physician had not given an order to nor had he been notified of R32's Foley catheter removal until 4/4/17. The DON stated the facility's usual practice would be to notify and obtain physicians order for the catheter removal.

On 4/14/17, during a telephone interview at 1:05 p.m., R32's primary physician stated he would expect the facility to notify him and have an order to remove the indwelling catheter. He confirmed R32 needed incontinence management to aid in healing the peri-rectal wounds and indicated he was considering a referral for possible suprapubic catheter placement for R32.

Review of an undated facility policy titled, Physician Notification of Resident Change of Condition Guidelines, directed the facility to notify a residents primary physician and responsible

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{2 265}	Continued From page 8 party of changes in condition.	{2 265}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 2/10/17 will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to comprehensively assess and monitor skin breakdown related to incontinence for 1 of 3 residents (R32) reviewed for skin conditions and incontinence. In addition, the facility failed to comprehensively reassess worsening pain for 1 of 3 residents (R32) reviewed for pain. These deficient practices resulted in actual harm for R32 who experienced worsening of skin breakdown and increasing pain with non-pressure skin breakdown. Findings include:	{2 830}	corrected	5/8/17

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{2 830}	Continued From page 9 R32 was incontinent of bowel and bladder and developed multiple peri-rectal sores which caused severe pain much of the time and with any incontinence care. The facility had not comprehensively assessed R32's skin when the peri-rectal sores developed in order to prevent further sores from developing and promote healing. R32 was not comprehensively reassessed for worsening pain to manage severity/frequency of pain for R32. Although the facility did provide pain analgesics that provided some relief, R32 had ongoing pain that she described often as severe. In addition, R32's indwelling urinary catheter was discontinued without MD notification, despite being ordered to treat the peri-rectal sores. R32's quarterly Minimum Data Set (MDS) dated 3/3/17, identified R32 had moderate cognitive impairment and had diagnoses which included congestive heart failure, non-infective gastroenteritis and colitis. The MDS identified R32 required extensive assistance with activities of daily living (ADL's) including toileting and personal hygiene. The MDS identified R32 was frequently incontinent of urine, always incontinent of bowel (which was increase in frequency from previous MDS completed 12/1/16) and was not on a toileting program for urinary or bowel incontinence. The MDS identified R32 had frequent pain, rated a five (5) on a numerical scale of 0-10 (0 indicating no pain and 10 indicating the worst pain imaginable) had received as needed (PRN) medication and non-pharmacological interventions and had not received scheduled pain medications. The MDS further identified R32 had moisture associated skin damage (MASD) and received a topical ointment. The MDS revealed R32 had not had	{2 830}		

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{2 830}	Continued From page 10 any physician prescribed order changes or physician visits within the last 14 days. Review of R32's care plan revised 3/28/17, revealed R32 required extensive assistance with toileting by one staff, was incontinent of bowel and required checking, changing and repositioning every 2 hours. The care plan directed staff to provide the bedpan as needed and to complete peri cares after each incontinent episode. R32's care plan identified R32 had a peri-rectal skin ulcer near the anus related to moisture and incontinence. (However, the care plan did not identify the multiple skin wounds R32 sustained). R32's care plan directed staff to monitor and document the wound characteristics, and complete weekly measurements. R32's care plan identified the treatment included use of Balsam Peru Castor oil three times a day, reposition every 2 hours, and the use of pressure relieving devices in wheelchair and in bed. Review of the untitled facility form identified as the current nursing aide care sheet, identified R32 required assistance of one staff, utilized a incontinent brief, was to be checked and changed every 2 hours, and had a foley catheter in place. The form identified R32 was frequently incontinent of stool, and to contact nurse for barrier cream to sore on bottom. During observation on 4/5/17, at 10:27 a.m. R32 was seated in a wheelchair, in the dining room. Nursing assistant (NA)-A offered R32 assistance with cares and proceeded to wheel R32 to her room. At that time NA-B entered R32's room with a full mechanical lift. As NA-B lifted R32 out of the wheelchair with the lift, R32 groaned. NA-A asked R32 if she was sore and R32 responded she was. NA-B and NA-A assisted R32 over to the bed with	{2 830}		

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{2 830}	Continued From page 11	{2 830}		

the mechanical lift. As NA-B and NA-A laid R32 down on the bed, R32 groaned again. R32 moaned as she was turned side to side while NA-B and NA-A removed the lift sling from underneath R32. NA-A and NA-B offered R32 reassurance they would be done soon. R32 was assisted to turn to her left side, facing the wall and groaned again. NA-B and NA-A proceeded to remove R32's slacks and incontinent brief. R32 was incontinent of a moderate amount of urine and a moderate amount of formed, soft, sticky bowel. At that time, NA-A stated R32 was always incontinent of bowel and bladder and the characteristics of the bowel were typical for R32. NA-A then proceeded to wipe the stool away from R32's peri-rectal area with a wet wipe. At that time, a deep guttural groan had emanated from R32. NA-B patted R32's shoulder and reassured her they would be done shortly. R32 groaned throughout the peri-rectal cleansing. NA-A stated R32's bowel were often sticky and hard to wipe off her skin.

R32's buttocks had four open areas on her peri-rectal area, two on the left side at the 8 o'clock position and two on the right side at the 2 and 3 o'clock position. NA-A stated before R32 went to the hospital in March, she had had more than 4 open areas which would bleed. NA-A stated she felt R32 had a lot of pain from the open areas. NA-A then applied an ointment in a plastic cup to all four of R32's open areas. R32 moaned during the application. NA-A stated she had obtained the ointment from the nurse and it was to help heal the open areas. NA-A and NA-B proceeded to apply a clean brief to R32, pulled up her slacks and assisted to her to a right side lying position. R32 expressed relief the cares were done and stated she wanted to sleep.

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{2 830}	Continued From page 12 Review of R32's Skin Observation Tool form dated 2/21/17, revealed R32 had an irritation in the crease of her buttocks. Review of R32's Skin Observation Tool form dated 3/10/17, revealed R32 had a red rectal area which measured 6 centimeters (cm) by 6 cm. However, a comprehensive assessment of R32's skin condition was not conducted despite worsening of the peri-rectal sores. Review of R32's Skin Observation Tool form dated 3/20/17, revealed R32 had two stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister. definition) on the right buttock and two stage 2 pressure ulcers on the left buttock. The right buttocks pressure ulcers measured .3 cm by .3 cm with .1 cm in depth and .5 cm by .5 cm with .1 cm in depth. The left buttocks pressure ulcers measured .5 cm by .5 cm and .1 cm in depth and 2 cm by 2 cm with .1 cm in depth. (However, due to the lack of a comprehensive skin assessment, the wounds were unable to be determined related to pressure or moisture). Review of R32's Weekly Wound Observation tool form dated 3/23/17, identified R32 had a stage 2 pressure areas on her buttocks near the anus which had worsened and measured 22 millimeter (mm) by 22 mm by 1 mm. The form indicated the treatment included an application of Balsam Peru-Castrol Oil Ointment to R32's buttocks three times a day for moisture associated open areas, reposition every 2 hours, wheelchair cushion and a Foley urinary catheter. Review of R32's quarterly Pain Assessment	{2 830}		

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{2 830}	Continued From page 13 signed 2/21/17, identified R32 reported burning pain in the rectal area which limited day to day activities, which she rated a 6 on a numeric pain scale. R32 reported bowel movements exacerbated the pain. The assessment indicated R32 experienced intermittent rectal pain when incontinent of bowel movements. The assessment revealed various interventions were in place such as, Tylenol, rest, repositioning and barrier cream. The assessment indicated R32 had relief from the Tylenol and somewhat relief from repositioning. No further comprehensive wound and pain assessments were found in R32's clinical record. On 4/5/17, at 10:35 a.m. NA-B stated R32 needed assistance with all of her cares except for eating and drinking. NA-B stated R32 had an indwelling urinary catheter when she returned from the hospital and stated R32's catheter had recently been removed. NA-B stated R32 was always incontinent of bowel and bladder and wore a brief daily. NA-B stated staff were to check and change R32 every two hours for incontinence. NA-B stated R32 no longer used the toilet since R32 required a full mechanical lift, since approximately December. NA-B stated in the past R32 had utilized a bedpan for bowel movements and stated she felt it was too painful for R32 to use the bedpan presently because of the sores. NA-B stated R32's sores around her peri-rectal area started at the end of February and at times had been bleeding. She indicated R32 had several more areas that had been open before she went to the hospital in mid-March. NA-B stated she felt the open sores on R32's peri-rectal area were very painful for her and she was aware R32 had often complained of pain with peri-cares. NA-B stated there have been no	{2 830}		

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{2 830}	Continued From page 14 changes to R32's check and change program since the sores started, other than applying ointment or cream after incontinence. On 4/5/17, at 1:02 p.m. with family member (FM)-A and R32, FM-A stated in the past the family had concerns with the facility providing adequate care to R32, though felt another family member had spoken with staff regarding their concerns. R32 stated she did not like to bother the staff too much by asking for things and liked to lay in bed. R32 stated her bottom was very painful for her and described the pain as a burning sensation which she rated an 8-10 (sever) on a numeric pain scale. R32 stated she had a difficult time explaining to staff where she was having pain, however, she felt staff was aware the sores on her bottom were painful for her. R32 stated she had ongoing pain elsewhere in her body such as her back, and joints and stated she received medication for the pain and it was effective some of the time. R32 stated she not been offered other types of pain interventions (non-pharmacological). R32 stated that although she still had significant pain from the sores, she felt it was better since her return from the hospital. R32 stated she was unaware of any changes in her care since her return from the hospital. During a telephone interview on 4/5/17, at 1:14 p.m. FM-B indicated she was aware R32 had sores on her bottom in February and stated the nurse had explained to her at that time that sores were a common result of incontinence. FM-B stated she felt R32 continued to decline, developed a serious cough, and had become confused and disoriented. FM-B stated she again had voiced her concerns to facility staff and was told she would be updated with any changes.	{2 830}		

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{2 830}	Continued From page 15 On 4/6/17, at 9:08 a.m. NA- C stated R32 required extensive assistance all of her cares, except for eating. NA-C stated R32 was assisted with checking and changing her incontinent brief every two hours and was always incontinent of both bowel and bladder. NA-C stated R32 complained of pain with all peri-rectal cares and felt it was due to the sores on her peri-rectal area. NA-C stated R32 had the peri-rectal sores for approximately two months and the sores had been open and bleeding at times. NA-C stated R32 used to use the bedpan, however it had become too painful for her so they no longer used it. NA-C stated since R32 had returned from the hospital, there have been no changes in her care. On 4/6/17, at 10:39 a.m. NA-A stated R32 was always incontinent of bowel and bladder and required routine, every two hour check and change. NA-A stated R32 was compliant with allowing staff to complete checking and changing of her incontinent brief. NA-A stated R32 used to use the toilet approximately three to four months ago, however, felt since R32's health has declined, she required a full mechanical lift. NA-A stated prior to R32's hospitalization, she had constant stooling in her brief, and at present R32 had soft incontinent stools. NA-A stated R32 developed sores around her peri-rectal area mid-February and had been open and bleeding at times. NA-A stated R32 complained of pain with all peri-rectal hygiene, and felt it was due to the sores. NA-A stated felt the sores had improved since R32's return from the hospital, though felt R32 continued to have pain with cares. NA-A stated she was unaware of any changes in R32's plan of care since her hospital return. NA-A indicated a couple of the NAs had considered requesting R32 receive pain medication prior to	{2 830}		

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{2 830}	Continued From page 16 morning cares would help R32 with her pain, but had not discussed this with the nurse at present. On 4/6/17, at 11:08 a.m. licensed practical nurse (LPN)-A stated R32's peri-rectal wounds had started out as red lesions that were treated with a barrier cream. LPN-A stated R32 had small pinpoint open areas in the peri-rectal region prior to her hospitalization in March, though was unsure of how many areas were open at that time. She felt R32's peri rectal sores have been improving since her return from the hospital. LPN-A stated in the weeks before R32 went to the hospital in March, R32 had experienced an increase in bowel incontinence. LPN-A further stated R32 currently received scheduled Tramadol (non-opioid analgesic) twice daily for pain and every 4 hours as needed (PRN.) LPN-A stated the scheduled dosing for Tramadol was started on 3/21/17, following her hospitalization. She stated prior to being hospitalized on 3/14/17, R32 had only PRN Tramadol and Tylenol. LPN-A stated she felt R32 continued to have frequent pain from the peri-rectal sores, though felt the scheduled Tramadol gave R32 some relief. On 4/6/17, at 11:25 a.m. registered nurse (RN)-A stated she was aware R32 had peri-rectal redness prior to her hospitalization on 3/14/17, however was not aware R32 had open sores in her peri-rectal areas. RN-A stated she had been aware the area was reddened and sore. RN-A stated she was responsible for the facility's weekly wound assessments and had not completed a comprehensive wound assessment for R32's peri-rectal wounds until her hospital return on 3/21/17, (30 days after R32's peri-rectal wounds were first noted). At that time RN-A stated R32 had 4 open areas in her peri-rectal region, 2 on the left side and 2 on the right side of	{2 830}		

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{2 830}	Continued From page 17	{2 830}		

her rectum. RN-A stated part of the facility's plan of correction from the recent survey was to improve the facility's wound assessments and monitoring. RN-A stated she had not had a chance to complete a comprehensive wound assessment for R32's peri -rectal wounds before she was hospitalized and indicated the most recent assessment she had completed for R32's peri-rectal wounds was on 3/23/17, after R32's hospital return. RN-A stated she felt the cause of R32's peri-rectal wounds was both urinary and bowel incontinence and stated there had not been any changes made to R32's checking and changing routine at that time. RN-A further stated R32 had been complaining of frequent buttocks pain and felt it was it was due to the peri-rectal sores. RN-A stated R32 now had oral pain medications scheduled and prn, which she felt were effective.

During observation on 4/6/17, at 1:42 p.m. the director of nursing (DON) and RN-A entered R32's room to complete wound care. R32 was quiet, lying in bed tilted on her left side, covered with a blanket. The DON removed the blanket from over R32 and assisted R32 to turn fully on her left side. R32 abruptly groaned when she was turned. RN-A proceeded to visualize the open areas around R32's rectum and stated R32 had 2 open areas on the left side of her rectum which measured approximately 1.7 cm by 1.2 cm by 0.3 cm and the second open area measured approximately 0.3 cm by 0.4 cm and had no depth. RN-A indicated the previous 2 open areas that were on the right side were now only red, she had indicated she felt those areas had healed. RN-A then proceeded to apply an ointment to all 4 peri- rectal areas. R32 continued to groan while RN-A provided peri cares and applied the ointment to the peri-rectal areas.

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{2 830}	Continued From page 18 Review of R32's progress notes from 2/20/17, to 3/31/17, revealed the following: -On 2/20/17, R32 had complained of buttocks pain and knee pain. The note further revealed R32's buttocks was red and bleeding in areas and a cream was applied. The note indicated R32 had been encouraged to get off her buttocks more often. -On 2/22/17, a butterfly wound around the anus, red rash, bleeding in some areas was observed and A&D ointment was applied. The note indicated R32 had complained of pain, had difficulty with transfers and should be encouraged to off load more often. The note lacked the number of open areas and measurements of the wounds. The note did not indicate non pharmacological pain interventions for R32's peri-rectal wounds. -On 2/25/17, indicated R32 was incontinent of bowel and bladder, and her rectal area was red and irritated. The note revealed R32 had pain around her rectal area that was constant and had rated her pain at an 8 on a numeric scale. The note indicated R32 received Tylenol for the pain and it was effective. -On 2/26/17, a pain interview had been completed with R32, which revealed she had reported constant pain in her rectum and surrounding skin, rated the pain at an 8 and stated the Tylenol would help but it did not take the pain away. A later note revealed R32 had complained of pain in her buttock with sitting and moving, pain in chest, ribs and abdomen. The note revealed R32 had rated the pain at a 10, was constant and did not get relief from Tylenol.	{2 830}		

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{2 830}	Continued From page 19 The note further indicated R32 and her family had requested something more for pain. A later note revealed the DON had contacted R32's primary physician and obtained an order for Tramadol 50 milligrams (mg) every 4 hours with a maximum of 6 per day. A later note revealed R32 had received the medication and had stated this was the first time she has had relief from the pain. The note revealed a new cushion had been placed in R32's wheelchair. -On 2/27/17, R32 was incontinent of bowel and bladder. The note indicated R32's peri-rectal area had diffuse red streaking, was intact and had no bleeding. The note indicated staff were to encourage R32 not sit in wheelchair for prolonged periods, turn and reposition every 2 hours and use prn Tramadol and zinc-oxide. The notes further identified the physician would be notified on rounds the next morning. -On 2/28/17, R32 was incontinent of bowel and bladder and had complained of rectal pain, her rectum was red and irritated and received a dose of prn Tramadol for complaints of overall pain. A further note indicated Diflucan had been started. Diflucan (anti-fungal) had been ordered every day for 4 days, then every other day thereafter. -On 3/1/17, R32 was incontinent of bowel and bladder and the skin was red and irritated around her rectum. The note further revealed R32 complained of pain around her rectum and received Tramadol and Anusol (topical corticosteroid used to treat hemorrhoids) were used for buttocks pain. -On 3/2/17, R32 was incontinent of bowel and bladder and had an open wound on her buttock area, and had complained of pain in her back	{2 830}		

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legs and buttocks. A further note indicated a pain interview had been completed with R32, which revealed R32 reported constant pain in her buttocks area, rated a 7 on a numeric scale. The note further revealed barrier cream, hydrocortisone cream were used at that time.

-On 3/2/17, R32's buttocks area was noted to be red, raw and wet. The note did not identify any other characteristics of R32's peri-rectal area. A later note revealed R32 was incontinent of bowel and bladder and had complained of buttocks pain.

-On 3/3/17, revealed R32 was incontinent of bowel and bladder and her peri-rectal area was red and irritated.

-On 3/9/17, revealed R32 had open skin on the crease of her buttocks, was red, open and bleeding. The note indicated R32 complained of pain and barrier cream was applied.

-On 3/11/17, R32 complained of pain in her buttocks and received barrier cream and Tramadol for pain.

-On 3/12/17, R32's buttocks remained excoriated and barrier cream had been applied.

-On 3/13/17, R32 received pain medication for all over pain.

Review of R32's clinical progress notes indicated R32's peri-rectal wounds continued to worsen, with worsening pain despite the use of as needed Tramadol and Tylenol and a scheduled dose of Diflucan. R32's record lacked documentation the physician had been notified of the worsening wounds, and worsening pain reports for R7.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 21 Further, R7's clinical record lacked documentation she had been admitted to the hospital on 3/15/17. -R32's medical record lacked documentation of R32's transfer to the hospital. However, a note on 3/20/17 indicated R32 had returned from the hospital on a gurney and had been assisted to bed. -On 3/23/17, a late entry for 3/21/17, indicated R32's primary physician had been updated on R32's recent hospitalization, and open areas to buttocks. -On 3/23/17, R32 had moisture associated open sore to buttocks, and Balsam Peru-Castor Oil Ointment was to be applied to buttocks topically three times a day for moisture associated open area. -On 3/24/17, R32 was seen by her primary provider regarding peri-rectal area, the note indicated R32's wounds were showing improvement. The note further revealed R32's urinary catheter was to remain in place as her wounds continued to heal. -On 3/27/17, R32 had wounds on her left and right buttocks with the following measurements and characteristics; right buttocks wound measured 1.0 cm by 0.5 cm by 0.5 cm and had red granular tissue, left buttocks measured 2.0 cm by 1.5 cm and had red granular tissue. The note did not identify any depth, drainage or pain associated with R32's peri-rectal wounds. -On 3/28/17, R32 was seen by her primary physician for a follow up of "skin ulcer" and nursing was to continue current therapy as	{2 830}		

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	00968	A. BUILDING: _____ B. WING _____	R 04/06/2017

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{2 830}	Continued From page 22 ordered. -On 3/30/17, a pain interview had been completed with R32 and revealed R32 reported daily, almost constant pain of her buttocks, rated a 7 out of 10 on a numeric scale and indicated scheduled and PRN medications were effective. -On 3/31/17, R32 had complained of abdominal pain and had no relief from Tramadol. The note revealed R32 had no urinary output from her urinary catheter. The note further revealed R32's catheter had been removed and not replaced. The note indicated R32 had voided following the catheter removal, and expressed relief from the abdominal pain. The note indicated R32's briefs would be monitored for wetness. The note did not identify whether R32's physician had ordered R32's catheter removal or if R32's physician had been notified of the removal. Review of R32's hospitalization records from 3/14/17, to 3/20/17, identified the following: -3/14/17, R32 was admitted to the hospital with diagnoses which included: lack of water as cause of dehydration, cardiomyopathy and atrial fibrillation. A hospital note dated 3/14/17, revealed R32 presented to the hospital lethargic, with multiple open wounds and significant pain to inner buttocks. The note further revealed R32 was referred to a wound specialist and was treated with intravenous Tramadol (non-opioid analgesic) for pain. - On 3/15/17, revealed the hospital wound nurse completed an assessment of R32's peri-rectal area which revealed the following: left peri-rectal area measured 1.5 cm by 1.5 cm by 0.7 cm and right side had multiple small scattered wounds,	{2 830}		

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{2 830}	Continued From page 23	{2 830}		

both areas had red wound bases, small amount of serosanguinous drainage. The note indicated R32's peri-rectal ulcers were caused by moisture from incontinence. The note revealed R32 had a Foley urinary catheter placed, Venelex (Balsam Peru and castrol oil topical, used to increase blood flow and prevent bacteria,) ointment and a Mepilex (dressing used to minimize pain and trauma to the wound and surrounding skin,) border foam dressing for prevention. A further note revealed R32 continued to have significant pain of her buttocks, and intravenous (IV) Fentanyl (opioid analgesic) was required to manage R32's pain.

-On 3/16/17, revealed palliative care was discussed with R32 and her family, and agreed upon due to R32's poor prognosis and quality of life. A further note revealed R32 reported improvement of pain with the added IV Fentanyl.

-On 3/17/17, revealed R32's discharge plans included Hospice services and R32 was to return to the facility with the Foley catheter to prevent further perineal ulcers and skin tear injury from incontinence.

-On 3/20/17, R32 was discharged from the hospital and returned to the facility with physician orders which included: continue with Foley catheter to prevent further perineal ulcers, Tramadol 50 milligrams (mg) twice daily (bid) and every 4 hours as needed for ongoing buttocks pain.

On 4/6/17, at 11:56 a.m. R32's medical record was reviewed with the DON. She confirmed R32's medical record had identified R32 had open areas near her rectum which were painful and bleeding on 2/20/17. The DON stated she was

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{2 830}	Continued From page 24 unsure of how many open areas R32 had in her peri-rectal area at that time, and stated she felt they were more like skin tears. The DON stated she felt the cause of R32's peri rectal wounds was moisture, as a result of incontinence of bowel and bladder. She confirmed a Skin Observation Tool was completed on 3/10/17, which had also identified R32's peri-rectal wounds. The DON confirmed the tool lacked measurements and any characteristics of the wounds. She stated she expected R32's peri-rectal wound to be monitored weekly and stated she had been working with her nursing staff on improving pain management and wound assessments, monitoring and treatment. The DON confirmed the facility had not considered any changes in R32's incontinence management plan since the peri-rectal wounds were first documented on 2/20/17. The DON stated she felt R32 had experienced pain related to the peri-rectal wounds and she felt the facility had managed R32's pain appropriately. Further, the DON stated R32's primary physician had been notified of an increase in R32's pain on 2/26/17, and Tramadol had been ordered to be administered as needed. The DON indicated she felt R32 was responsible to ask for pain medications when she felt she needed them. The DON stated the facility had not considered a scheduled pain regiment to aid in R32's pain management. The DON stated she would expect staff to offer non-pharmacological pain interventions in addition to pain medication to R32 and confirmed R32's medical record lacked documentation of non-pharmacological interventions attempted for R32's pain. The DON stated she was aware the pain medication that was given to R32 had not always been effective. Further, DON confirmed R32's Foley catheter had	{2 830}		

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{2 830}	Continued From page 25	{2 830}		

been removed on 3/31/17, by herself and another facility nurse. She confirmed R32's primary physician had not given an order to nor had he been notified of R32's Foley catheter removal until 4/4/17. The DON stated the facility's usual practice would be to notify and obtain physicians order for the catheter removal.

On 4/6/17, at 12:19 p.m. a telephone message was left for R32's primary physician for interview. No return phone call had been received before exit.

On 4/14/17, at 1:02 p.m. during a telephone interview, R32's primary physician indicated he could not recall whether he had been notified of R32's peri-rectal wounds. R32's primary physician stated he would have expected the facilty to complete a comprehensive assessment to identify a potential cause, interventions and to continually monitor any changes in condition which included peri-rectal sores, pain and incontinence.

Review of R32's Medication Administration Record (MAR) from February 2017, to March 2017, revealed the following:

-Review of R32's February MAR revealed an order dated 11/18/16, for Tylenol 1000 mg by mouth every 4 hours as needed for pain, not to exceed 4000 mg in 24 hours. The MAR further revealed an order dated 2/26/17, for Tramadol 50 mg by mouth every 4 hours as needed for severe pain, with a max of 6 tablets in 24 hours. The MAR identified the medications were not always effective.

-Review of R32's March MAR revealed R32 had received Tylenol for pain rated from a 7 to a 9

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{2 830}	Continued From page 26	{2 830}		

(severe pain) on four times with varying results. The MAR revealed R32 had received Tramadol PRN for pain rated from 5-6 (moderate pain) until 3/10 then 8-10 (severe pain) PRN 23 times with varying effectiveness.

Review of R32's Treatment Administration Records (TAR) from February 2017, to April 6th, 2017, revealed the following;

-R32's February TAR revealed an order dated 2/27/17, for Barrier cream to peri-rectal area for moisture associated skin damage (MASD,) encourage resident to be off buttocks, turn and reposition every 2 hours. The TAR revealed an order dated 12/29/16, to complete skin/wound note and pain note every day shift Thursday for skin and pain.

-R32's March TAR revealed an order dated 2/28/17, to ensure R32 was toileted every 2 hours while awake every day and evening related to dermatitis. The TAR revealed R32 continued to receive barrier cream to peri-rectal area for MASD, encourage resident to be off buttocks, turn and reposition every 2 hours.

-R32's April TAR revealed an order dated 3/16/17, to complete skin and wound note every day shift for skin and pain. The TAR identified 3 of the 4 assessments were not completed. The TAR revealed an order to continue to turn and reposition R32 off of buttocks every 2 hours every shift for moisture associated open areas.

Review of a physician progress note dated 2/21/17, revealed R32 was seen for a routine visit. The note revealed R32 had progressive weakness, weight gain and deconditioning. The note indicated R32 was to be seen again in 2

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{2 830}	Continued From page 27 weeks or sooner. The note did not identify R32's primary physician had assessed R32's peri-rectal wound which was noted on 2/20/17. Review of a facility policy and procedure revised 3/4/17, identified the facility's purpose was to properly identify and assess residents that were at risk for impaired skin integrity. The policy and procedure identified an ongoing wound assessment and monitoring would be completed with any new skin issues and the primary physician would be notified of the condition and kept appraised of any changes. A policy and procedure for pain management was requested on 4/6/17, and not provided.	{2 830}		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced	2 910		5/8/17

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2 910	Continued From page 28 by: Based on observation, interview and document review, the facility failed to comprehensively re-assess bowel incontinence following onset of moisture associated skin breakdown (MASD) for 1 of 1 resident (R32) reviewed with a change in bowel incontinence. Findings include: Review of R32's quarterly Minimum Data Set (MDS) dated 12/1/16, identified R32 had moderate cognitive impairment and had a diagnosis which included non-infective gastroenteritis and colitis. The MDS identified R32 required extensive assistance with toileting and was frequently incontinent of bowel. Review of R32's quarterly MDS dated 3/3/17, identified R32 had moderate cognitive impairment and had a diagnosis of non-infective gastroenteritis and colitis. The MDS identified R32 continued to require extensive assistance with toileting, personal hygiene and R32 was now always incontinent of bowel. Review of R32's care plan revised 3/28/17, revealed R32 required extensive assistance with transfers, toileting and was incontinent of bowel related to colitis and physical limitations. R32's care plan directed facility staff to check R32 every 2 hours and assist with toileting as needed, provide bed pan/commode and to provide peri care after each incontinent episode. Review of the untitled facility form identified as the current nursing aide care sheet, identified R32 required assistance of one staff, utilized a incontinent brief, was to be checked and changed every 2 hours, and had a Foley catheter in place.	2 910	corrected	

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2 910	Continued From page 29 The form identified R32 was frequently incontinent of stool, and to contact nurse for barrier cream to sore on bottom. Review of R32's Bladder/Bowel Continence Evaluation dated 2/19/17, revealed R32 was incontinent of bowel and bladder. The assessment indicated R32 had an unknown onset of bowel incontinence which fluctuated over the past six months, and had been present for 2-5 years. The assessment lacked any frequency of R32's bowel movements. The note further revealed R32's perineum skin was intact. No further Bladder/Bowel Continence Evaluation forms were found in R32's clinical record, despite the change in frequency of bowel incontinence causing MASD. During observation on 4/5/17, at 10:27 a.m. R32 was seated in a wheelchair, in the dining room. Nursing assistant (NA)-A offered R32 assistance with cares and proceeded to wheel R32 to her room. At that time NA-B entered R32's room with a full mechanical lift. As NA-B lifted R32 out of the wheelchair with the lift, R32 groaned. NA-A asked R32 if she was sore and R32 responded she was. NA-B and NA-A assisted R32 over to the bed with the mechanical lift. As NA-B and NA-A laid R32 down on the bed, R32 groaned again. NA-B and NA-A proceeded to remove R32's slacks and incontinent brief. R32 was incontinent of a moderate amount of urine and a moderate amount of formed, soft, sticky bowel. At that time, NA-A stated R32 was always incontinent of bowel and bladder and the characteristics of the bowel were typical for R32. NA-A then proceeded to wipe the stool away from R32's peri-rectal area with a wet wipe. At that time, a deep guttural groan had emanated from R32. NA-B patted	2 910		

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2 910	Continued From page 30 R32's shoulder and reassured her they would be done shortly. R32 groaned throughout the peri-rectal cleansing. NA-A stated R32's bowel were often sticky and hard to wipe off her skin. R32's buttocks had four open areas on her peri-rectal area, two on the left side at the 8 o'clock position and two on the right side at the 2 and 3 o'clock position. NA-A stated before R32 went to the hospital in March, she had had more than 4 open areas which would bleed. NA-A stated she felt R32 had a lot of pain from the open areas. NA-A then applied an ointment from a plastic cup to all four of R32's open areas. R32 moaned during the application. NA-A stated she had obtained the ointment from the nurse and it was to help heal the open areas. NA-A and NA-B proceeded to apply a clean brief to R32, pulled up her slacks and assisted to her to a right side lying position. R32 expressed relief the cares were done and stated she wanted to sleep. On 4/5/17, at 10:35 a.m. NA-B stated R32 needed assistance with all of her cares except for eating and drinking. NA-B stated R32 had an indwelling urinary catheter when she returned from the hospital and stated R32's catheter had recently been removed. NA-B stated R32 was always incontinent of bowel and bladder and wore a brief daily. NA-B stated staff were to check and change R32 every two hours for incontinence. NA-B stated R32 used to use the bedpan for bowel movements before the sores on her peri-rectal area developed and stated she felt it was too painful for R32 to use the bedpan because of the sores. NA-B stated there have been no changes to R32's check and change program since the sores started, other than applying ointment or cream after incontinence.	2 910		

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2 910	Continued From page 31 On 4/6/17, at 10:39 a.m. NA-A stated felt that R32's health had been declining in the last few months. NA-A stated R32 was always incontinent of bowel and bladder and required routine, every two hour check and change. NA-A stated prior to R32's hospitalization, she had constant stooling in her brief, and at present R32 had soft incontinent stools. NA-A stated R32 was compliant with allowing staff to complete checking and changing of her incontinent brief. NA-A stated she was unaware of any changes in R32's plan of care since her hospital return. On 4/6/17, at 11:25 a.m. registered nurse (RN)-A stated she felt the cause of R32's peri-rectal wounds was both urinary and bowel incontinence and stated there had not been any changes made to R32's checking and changing routine at that time. RN-A further stated R32 had been complaining of frequent buttocks pain and felt it was it was due to the peri-rectal sores. On 4/6/17, at 11:56 a.m. the director of nursing (DON) confirmed R32's most recent bowel assessment indicated an increased in bowel incontinence. The DON stated she felt the cause of R32's peri rectal wounds was MASD, as a result of incontinence of bowel and bladder. The DON confirmed the facility had not considered any changes in R32's incontinence management plan since the peri-rectal wounds were first documented on 2/20/17. A policy and procedure for incontinence assessment and management was requested, and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	2 910		

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2 910	Continued From page 32 inservice nursing staff regarding how to comprehesnively assess and develop interventions to reduce bowel incontinence, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00968 Y1	A. Building B. Wing Y2	4/6/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 20565	Correction	ID Prefix 20900	Correction	ID Prefix 21390	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	04/06/2017
ID Prefix 21426	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/06/2017	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	
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
☒	GA/mm	04/25/2017	31256	04/06/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/10/2017

☐ 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: NQV4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00968

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245281**

2.STATE VENDOR OR MEDICAID NO.
(L2) **198148100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY CARE AND REHAB LLC**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2015**

6. DATE OF SURVEY **02/10/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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
	35			
(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 :
Tammy Williams, HFE NEII 04/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/17/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1985
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2017

Mr. Mark Rustad, Administrator
Valley Care And Rehabilitation LLC
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

RE: Project Number S5281

Dear Mr. Rustad:

On February 10, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G. Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 7, 2017. (42 CFR 488.422)

This Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

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

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 May 10, 2017 (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 May 10, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 10, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Furthermore, 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, Valley Care and Rehabilitation LLC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 10, 2017. 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.

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

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 .

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 10, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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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

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
	245281	A. BUILDING _____ B. WING _____	02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 157		3/13/17

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

Electronically Signed | 03/13/2017

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F 157	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to notify the physician of a significant change of condition for 1 of 1 resident (R32) when a reoccurring unstageable pressure ulcer developed in the facility. Findings include: R32's admission Minimum Data Set (MDS) dated 12/1/16, identified R32 had intact cognition and required extensive assistance with all activities of daily living (ADLs). The MDS further identified R32 was at risk for developing pressure ulcers, had no current pressure ulcers and utilized a	F 157	1. R32 has been seen by her primary physician with documentation of the visit. 2. All residents were reviewed for change in status. All residents are reviewed at daily shift reports. Any resident who may have a status change; his/her condition is reported to their primary physician for a determination of further assessment or treatment. 3. Policies & procedures were reviewed and updated as needed. All nursing staff have been re-educated on the need to report any changes noted in resident status. Licensed staff were further	

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F 157	Continued From page 2 pressure reducing device in her chair. R32's admission orders dated 11/17/16, identified R32 had diagnoses which included osteoporosis and peripheral edema. R32's Care Area Assessment (CAA) dated 12/1/16, identified R32 was at risk for developing pressure ulcers and required assessment. The CAA identified R32 required a cushion for her chair for pressure relief. On 2/6/17, at 5:35 p.m. the director of nursing (DON) stated R32 had a current unstageable pressure ulcer on her left heel. On 2/8/17, at 7:12 a.m. R32 had her eyes closed, lying on her back in bed with bed linens covering her torso and lower extremities. At 7:54 a.m., R32 remained on her back in bed and nursing assistant (NA)-C entered the room to assist R32 with morning cares. NA-C removed the bed linens that covered R32, both R32's heels/feet rested directly on a pillow, covered in white cloth socks and a second pillow was observed under R32's calves. R32's left heel had an approximate 2.5 centimeter (cm) sized open area on the back of the heel, which had an approximate 1.5 cm sized dark brown/black irregular shaped scab in the center of the area with a yellow colored slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed) area which surrounded the entire scab. On 2/8/17, at 12:59 p.m. director of nursing (DON) stated R32 was at risk for development of	F 157	educated on the need to verify reported changes in resident status and follow facility protocols for provider notification. 4. The DON will monitor & review all daily shift reports and required follow-up with staff & providers as needed. These daily audits will be done daily for 90 days or until 100% compliance is achieved. The audit outcomes will be submitted to the QAA Committee for comment &/or review. 5. Date of Completion: March 13, 2017	

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F 157	Continued From page 3	F 157		

pressure ulcers. DON reviewed R32's clinical record at that time and stated the record indicated R32's previous pressure ulcer had resolved. She indicated the facility had felt the previous pressure ulcer had been caused by R32's brown tie up shoes. DON stated R32 did not have a current pressure ulcer. DON confirmed R32's record lacked documentation of weekly skin monitoring, and indicated this was an area the facility needed to improve on.

On 2/8/17, at 1:14 p.m. R32 was seated in her wheelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left foot. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color.

On 2/9/17, at 9:40 a.m. during a follow up interview, the DON stated she felt there was no way to accurately determine when R32's current pressure ulcer occurred. She confirmed R32's current pressure ulcer and indicated she felt the current pressure ulcer had reopened soon after 1/10/17 or 1/12/17. DON stated the usual facility practice was for the nurses to complete a weekly skin check for all residents, and to document the results of the skin check in the resident clinical record. She also indicated she expected all the nurses to complete weekly skin inspections, assess and report abnormalities to the physician for treatment. She indicated she was not aware R32 had a current pressure ulcer and the status of the pressure ulcer until 2/8/17, and had not notified the physician of the current pressure ulcer. DON did not offer any other information

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F 157	Continued From page 4	F 157		

regarding notifying the survey team on 2/6/17 that R32 had a current unstageable pressure ulcer.

On 2/9/17, at 12:00 p.m. during a telephone interview, R32's physician (MD)-A confirmed R32 had developed a pressure ulcer in December, had seen the pressure ulcer last on 1/3/17, and he felt the pressure ulcer was healing at that time. He indicated he had not been notified of R32's current pressure ulcer.

R32's progress notes which included all skin/wound documentation was reviewed from 1/18/17 to 2/09/17, and revealed:

-1/8/2017, identified unstageable pressure ulcer to left heel had closed.

-1/12/2017, listed small red dots on the front and side of both knees and has redness at skin fold of stomach. However, the note did not address status of left heel pressure ulcer.

-1/19/17, skin/wound note listed no areas of concern

-1/26/2017, skin/wound note listed had no areas of concern

-2/2/2017, skin/wound note listed no areas of concern

-2/9/17, skin/wound note listed no areas of concern

Review of the facility policy, Prevention and Treatment of Skin Breakdown, dated 11/1/15,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 5 revealed when a resident developed a new pressure ulcer the facility would initiate a TTT, a Braden Scale Assessment and complete an evaluation of skin risk factors and reevaluate based on risk factors. Review of the facility policy, Skin Assessment dated 11/1/15, revealed all residents identified at risk for pressure ulcers would be assessed weekly to identify any new alterations in skin integrity. The policy also identified on residents designated bath days the licensed nurse would compele a head to toe skin assessment and note any alterations in skin condition and document an evaluation of the wound, the status of surrounding tissues and treatments, any changes, signs infection and document findings in the electronic record.	F 157		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care plan interventions for routine repositioning for 1 of 1 resident (R20) who was identified at risk for development of pressure ulcers. In addition, the facility failed to implement skin monitoring related to bruises for 1 of 1 resident (R37) who currently	F 282	1. R20 & R37's care sheets & care plans have been reviewed and updated as needed. 2. All residents at risk for pressure ulcer development have been reviewed and their plans of care updated as needed to assure appropriate turning, positioning or	3/13/17

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	245281	A. BUILDING _____ B. WING _____	02/10/2017

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VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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F 282	Continued From page 6 received anticoagulant therapy. Findings include: R20's care plan dated 1/24/16, identified R20 was at risk for altered skin integrity and directed facility staff to assist R20 to reposition every two (2) hours. R20's undated, nursing assistant care guide, indicated R20 required turning and repositioning every two hours. During continuous observation on 2/8/17, from 7:10 a.m. to 10:12 a..m. revealed the following: - At 7:10 a.m. R20 was seated in a wheelchair with a seat cushion in her room, wore a hospital gown, with the TV on. - At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares. - At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At that time NA-E entered R20's room, draped a blanket over R20's lap and proceeded to wheel R20 to the dining room. NA-D and NA-E were not observed to offer R20 assistance with repositioning. - At 8:40 a.m. R20 remained seated in the wheelchair in the dining room and ate independently. R20 was not observed to make	F 282	offloading activities are outlined. Staff will document turning, repositioning & offloading activities on each resident with the individual resident care sheets. All residents with noted bruising and those residents that are at risk for bruising secondary to diagnosis, accidents or medication regimens have had an initial full body audit, identifying existing bruises and the bruises' characteristics. Care plans were updated with directed modalities or interventions for bruise monitoring. Hereafter, all residents will have full body audits on a scheduled bath day. Resident skin conditions will additionally be monitored as needed throughout the day during routine ADL cares. 3. DON or designee will review all weekly bath audits for compliance. The DON or designee will also review all daily progress notes for 90 days or until 100% compliance is achieved & maintained. All staff providing direct cares to residents have been educated on the monitoring protocols to assure any bruise or other integument involvement is immediately reported & recorded. Additionally, all nursing staff were educated on use and documentation criteria for turning, repositioning and off-loading for residents at risk for skin issues. 4. The DON or designee will review/audit all care sheet documentation daily for 7 days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. Additionally, the DON or designee will do unannounced, observational audits on select residents	

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F 282	Continued From page 7 any independent changes in position. - At 8:57 a.m. R20 remained seated in the wheelchair in the dining room. R20 was not observed to make any independent changes in position. - At 9:07 a.m. R20 remained seated in the wheelchair in the dining room. At that time registered nurse (RN)-A approached R20 and was observed to administer medications to R20 and immediately walked away. - At 9:20 a.m. R20 had remained seated in the wheelchair in the dining room and was wheeled to the resident lobby by an activity aid to listen to trivia. R20 had remained seated in the wheelchair at that time for a total of 2 hours and 10 minutes. - At 9:40 a.m. R20 had remained seated in the wheelchair in the resident lobby. R20 had made no independent changes in position. No staff were observed to offer R20 assistance with repositioning. - At 9:57 a.m. NA-C was notified R20 had been up in the wheelchair without repositioning since 7:10 a.m. At that time NA-C stated R20 needed assistance with repositioning every 2 hours and was unsure of when R20 had last been repositioned. R20 was then wheeled to her room by NA-C. - At 10:08 a.m. R20 remained seated in the wheelchair in her room while NA-C and NA-E placed clean bedding on R20's bed. - At 10:13 a.m. NA-C and NA-E assisted R20 to transfer with a full mechanical lift from the	F 282	daily to assure consistency in documentation for 7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 5. Date of correction: March 13, 2017	

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F 282	Continued From page 8	F 282		

wheelchair to her bed. NA-E removed the lift sling and assisted R20 to roll towards NA-C. NA-C removed R20's dry incontinent brief which revealed R20's skin on the buttocks and back of upper thighs were bright red in color, skin intact.

-R20 remained in an observed seated position from 7:10 a.m. to 10:13 a.m. a total of 3 hours and 3 minutes.

During interview on 2/8/17, at 9:57 a.m. NA-C stated R20 was to be repositioned and toileted every two hours. NA-C stated she was unsure of the last time R20 was repositioned and her usual practice to keep track of repositioning was to keep an eye on the clock. NA-C stated that was the method staff used to ensure residents received timely toileting and repositioning.

During interview on 2/8/17, at 10:01 a.m. NA-E stated R20 had not been repositioned or checked and changed for incontinence since 7:00 a.m. NA-E stated was not able to independently reposition.

During interview on 2/8/17, at 1:1 p.m. licensed practical nurse (LPN)-A confirmed R20 was at risk for developing pressure ulcers. LPN-A reported staff were expected to reposition R20 every two hours and as needed. LPN-A confirmed three hours was too long to sit in the wheelchair without repositioning.

During interview on 2/9/17, at 8:37 a.m. the director of nursing (DON) confirmed R20 was at risk for development of pressure ulcers due to bowel and bladder incontinence, and immobility. The DON reported she added the specific interventions on the nursing assistance care

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F 282	Continued From page 9 guides after the comprehensive assessments and considered the care guides as an extension of the resident's care plan. The DON stated she expected R20 would have been repositioned and incontinence care provided every two hours to reduce risk of future skin breakdown. The DON stated there was no formal system in place to ensure timely cares were completed. The DON stated she was unsure how the staff were ensuring residents received timely care. The DON confirmed timely resident cares were not being monitored. The DON stated the point of care system captured resident care documentation, but not in actual time.	F 282		

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R37's care plan dated 12/10/16, identified R37 was on anticoagulant therapy, directed staff to monitor/document/report adverse reactions to anticoagulant therapy which included bruising and directed staff to complete daily skin inspections and report abnormalities to nurse.

On 2/07/17, at 12:00 p.m. R37 was seated in her wheelchair in her room with a family member (FM)-A present. Irregular shaped yellow/light green bruises, approximately 1.5 inch in diameter, were observed on both lower cheeks and several purple colored bruises in various sizes were observed on the tops of both hands. FM-A stated R37 had fallen in the facility in the past, and obtained the bruises. She indicated R37 was forgetful and did not remember falling.

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F 282	Continued From page 11	F 282		

Review of R37's progress notes from 12/19/16 to 2/5/17 revealed:

-12/19/16, R37 had a fall from bed and hit her head on the side table and was bleeding from her left eye and nose and was sent to the emergency room for evaluation.

-12/19/16, R37 returned from emergency room and had a laceration to her left eyebrow area which was closed with glue. R37 had bruising to the back top of her left shoulder which measured 40 centimeter (cm) x 50 cm, a bruise to her left elbow area which measured 90 cm x 80 cm, and a bruise to her left upper thigh area which measured 230 cm x 150 cm.

-1/2/17, R37 had faded bruises to her left cheekbone, left shoulder and elbow from previously documented fall.

Review of the R37's monthly treatment administration records (TAR) for December 2016 and January 2017 revealed R37 had various treatments and monitoring in place which included to monitor for ear wax, elevate feet 20 minutes two times a day, and respiratory monitoring. However, the TARs lacked documentation of monitoring for bruising and other adverse reactions to anticoagulant therapy.

No further documentation of monitoring of R37's bruising was found in the clinical record.

On 2/10/17, at 12:19 p.m. director of nurses (DON) stated R37 fell on 12/19/16, was sent to the emergency room and returned with significant bruises. DON confirmed progress notes and lack

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F 282	Continued From page 12 of monitoring of R37's bruises and stated she felt the measurements of the bruises were likely an error. She stated the usual facility practice when a bruise was identified was for the nurse to set up clinical weekly monitoring in the resident TAR. She stated she expected the nurse should have set up the bruise monitoring in the TAR when R37 returned from the emergency room and document weekly and confirmed the monitoring had not been done. She stated she expected orders to be followed, weekly skin inspections to be completed by nurses and bruises monitored. Review of the facility policy, Skin Assessment dated 11/1/15, identified on residents designated bath days the licensed nurse would complete a head to toe skin assessment and note any alterations in skin condition and document an evaluation in the electronic record. The facility's Care Plan Policy dated 9/14/15, indicated the resident care plan would ensure the appropriate care required to maintain or attain the residents highest level of functioning possible.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care	F 309		3/13/17

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F 309	Continued From page 13 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor bruising for 1 of 3 residents (R37) reviewed for non-pressure related skin conditions. Findings include: R37's quarterly Minimum Data Set (MDS) dated 1/12/17, identified R37 had moderate cognitive impairment, and required extensive assistance with all activities of daily living (ADL). The MDS further identified R37 had no current skin	F 309	1.R37 has been assessed and care plan interventions for bruising incorporated into the plan of care. Additionally, her existing bruises are being monitored for healing. 2.All residents with noted bruising and those residents that are at risk for bruising secondary to diagnosis, accidents or medication regimens have had an initial full body audit, identifying existing bruises and the bruises' characteristics. Care plans were updated with directed modalities or interventions for bruise monitoring. Hereafter, all residents will have full body audits on a scheduled bath	

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F 309	Continued From page 14 conditions/bruises. R37's care plan dated 12/10/16, identified R37 was on anticoagulant therapy, directed staff to monitor/document/report adverse reactions to anticoagulant therapy which included bruising and directed staff to complete daily skin inspections and report abnormalities to nurse. Review of order summary report dated 1/6/17, revealed R37 received a routine daily dose of Coumadin (medication to thin blood) and was to have every shift monitoring for bruising related to anticoagulant therapy. On 2/07/17, at 12:00 p.m. R37 was seated in her wheelchair in her room with a family member (FM)-A present. Irregular shaped yellow/light green bruises, approximately 1.5 inch in diameter, were observed on both lower cheeks and several purple colored bruises in various sizes were observed on the tops of both hands. FM-A stated R37 had fallen in the facility in the past, and obtained the bruises. She indicated R37 was forgetful and did not remember falling. Review of R37's progress notes from 12/19/16 to 2/5/17, revealed: -12/19/16, R37 had a fall from bed and hit her head on the side table and was bleeding from her left eye and nose and was sent to the emergency room for evaluation. -12/19/16, R37 returned from emergency room and had a laceration to her left eyebrow area which was closed with glue. R37 had bruising to the back top of her left shoulder which measured 40 centimeter (cm) x 50 cm, a bruise to her left	F 309	day. Resident skin conditions will additionally be monitored as needed throughout the day during routine ADL cares. 3. DON or designee will review all weekly bath audits for compliance. The DON or designee will also review all daily progress notes for 90 days or until 100% compliance is achieved & maintained. All staff providing direct cares to residents have been educated on the monitoring protocols to assure any bruise or other integument involvement is immediately reported & recorded. Additionally, all nursing staff were educated on use and documentation criteria for turning, repositioning and off-loading for residents at risk for skin issues. 4. The DON or designee will review/audit all care sheet documentation daily for 7 days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. Additionally, the DON or designee will do unannounced, observational audits on select residents daily to assure consistency in documentation for 7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 5. Date of correction: March 13, 2017	

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F 309	Continued From page 15	F 309		

elbow area which measured 90 cm x 80 cm, and a bruise to her left upper thigh area which measured 230 cm x 150 cm.

-1/2/17, R37 had faded bruises to her left cheekbone, left shoulder and elbow from previously documented fall.

Review of the R37's monthly Treatment Administration Records (TAR) for December 2016 and January 2017, revealed R37 had various treatments and monitoring in place which included to monitor for ear wax, elevate feet 20 minutes two times a day, and respiratory monitoring. However, the TARs lacked documentation of monitoring for bruising and other adverse reactions to anticoagulant therapy.

No further documentation of monitoring of R37's bruising was found in the clinical record.

On 2/10/17, at 12:19 p.m. director of nurses (DON) stated R37 fell on 12/19/16, was sent to the emergency room and returned with significant bruises. DON confirmed progress notes and lack of monitoring of R37's bruises and stated she felt the measurements of the bruises were likely an error. She stated the usual facility practice when a bruise was identified was for the nurse to set up clinical weekly monitoring in the resident TAR. She stated she expected the nurse should have set up the bruise monitoring in the TAR when R37 returned from the emergency room and document weekly and confirmed the monitoring had not been done. She stated she expected orders to be followed, weekly skin inspections to be completed by nurses and bruises monitored.

Review of the facility policy, Skin Assessment

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F 309	Continued From page 16 dated 11/1/15, identified on residents designated bath days the licensed nurse would complete a head to toe skin assessment and note any alterations in skin condition and document an evaluation in the electronic record.	F 309		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, accurately monitor and implement interventions for 1 of 1 resident (R32) with a reoccurring unstageable pressure ulcer to the heel. In addition, the facility failed to implement interventions to prevent development of pressure ulcers for 1 of 1 resident (R20) who was at risk for development of pressure ulcers. This deficient practice resulted in actual harm for R32 with the development of a recurring pressure ulcer.	F 314	1.R32 comprehensive assessment completed. R32 and R20 care plans have been assessed and care plan interventions for pressure ulcer prevention incorporated into the plan of care. 2. All residents will have baseline comprehensive assessment completed upon admission. Thereafter, all residents will have comprehensive assessment completed annually and with change in condition to include, but not limited to	3/13/17

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F 314	Continued From page 17 Findings include: R32's admission Minimum Data Set (MDS) dated 12/1/16, identified R32 had intact cognition and required extensive assistance with all activities of daily living (ADLs). The MDS further identified R32 was at risk for developing pressure ulcers, had no current pressure ulcers and utilized a pressure reducing device in her chair. R32's admission orders dated 11/17/16, identified R32 had diagnoses which included osteoporosis and peripheral edema. R32's Care Area Assessment (CAA) dated 12/1/16, identified R32 was at risk for developing pressure ulcers and required assessment. The CAA identified R32 required a cushion for her chair for pressure relief. R32's care plan dated 12/18/16, identified R32 had limited physical mobility, related to osteomyelitis of vertebra, weakness, had a history of falls, was weight bearing and required assistance from staff for toileting, transfers, locomotion, and ambulation. R32's care plan directed staff to ensure R32 wore appropriate footwear (laced, no skid shoes) when ambulating or mobilizing in wheelchair, and use of a pressure relieving cushion in the wheelchair. The care plan indicated R32 had the potential/actual skin impairment related to contact dermatitis and fragile skin and utilized a pressure relieving cushion in wheelchair. The care plan further directed staff R32 required weekly skin inspections to identify redness and open areas and any changes in R32's skin were be reported to the nurse. However, R32's care plan did not	F 314	formation of new pressure ulcer as outline in the RAI Manual. 3. . All residents have had physical skin assessments completed, tissue tolerance and Braden assessments completed and/or reviewed, and their plans of care updated as needed to assure appropriate turning, positioning or offloading activities are outlined. Staff will document turning, repositioning & offloading activities on each resident with the individual resident care sheets. Care plans were updated with directed modalities or interventions for skin/wound monitoring. Hereafter, all residents will have full body audits on a scheduled bath day. Resident skin conditions will additionally be monitored as needed throughout the day during routine ADL cares. 4. DON or designee will review all weekly bath audits for compliance. The DON or designee will also review all daily progress notes for 90 days or until 100% compliance is achieved & maintained. All staff providing direct cares to residents have been educated on the monitoring protocols to assure any bruise or other integument involvement is immediately reported & recorded. Additionally, all nursing staff were educated on use and documentation criteria for turning, repositioning and off-loading for residents at risk for skin issues. MDS Coordinator was educated on requirements for completion of a comprehensive assessment based on RAI Manual. 6. The DON or designee will review/audit all care sheet documentation daily for 7	

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F 314	Continued From page 18 identify R32's current pressure ulcer, and lacked direction for the use of Prevalon boots or pillows to keep pressure off of R32's heel. Review of the untitled facility form provided by the facility, identified as the nursing assistant care guide, listed various directions for R32's cares which included assistance with toileting, transferring, dressing and directed the use of shoes at night. The care guide did not include direction for pressure relief for R32's heels or use of the Prevalon boots. R32's Tissue Tolerance Test (TTT) form (tool used to determine appropriate repositiong schedule) dated 11/21/16, identified R32 had no current skin integrity concerns, did not have a history of pressure ulcers and could tolerate a 2 hour repositioning program. No further TTT forms were found in R32's clinical record, despite development of pressure ulcers. R32's Braden Scale Assessment (risk assessment for pressure ulcers) forms dated 11/29/16, 12/2/16, and 12/6/16, identified R32 had very moist skin, had potential problem for friction and shear, walked occasionally, spent the majority of her time in her chair or bed and was at risk for development of pressure ulcers. Review of R32's Skin Observation Tool form dated 11/21/16, identified R32 had purpura (rash of purple spots on the skin caused by internal bleeding from small blood vessels) on upper extremities, and identified no other open areas. Review of the untitled form provided by the facility, dated 12/23/16, revealed the form listed various resident names and reason to be seen.	F 314	days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. The DON or designee will audit to ensure comprehensive assessments are completed for all residents at admission, annually, with significant change and/or the development of any new pressure ulcer. Additionally, the DON or designee will do unannounced, observational audits on select residents daily to assure consistency in documentation for 7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 7. Date of correction: March 13, 2017	

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The form listed R32 had 12/20/16, labs for review, had 3 centimeter (cm) blackened area in the middle of her sole of the left foot, edges were pulling away in a blister form, and center was soft.

On 2/6/17, at 5:35 p.m. the director of nursing (DON) stated R32 had a current unstageable pressure ulcer on her left heel.

On 2/8/17, at 7:12 a.m. R32 had her eyes closed, lying on her back in bed with bed linens covering her torso and lower extremities. At 7:54 a.m. R32 remained on her back in bed and nursing assistant (NA)-C entered the room to assist R32 with morning cares. NA-C pulled down R32' bed linens, and both R32's heels/feet rested directly on a pillow, covered in white cloth socks and a second pillow was observed under R32's calves. The heels/feet were not elevated off the pillow to relieve pressure. An approximately 2.5 centimeter (cm) sized open area on the back of the heel was observed, and an approximately 1.5 cm sized dark brown/black irregular shaped scab in the center of the area with a yellow colored slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed) area which surrounded the entire scab. NA-C assisted R32 to lift each foot/leg to remove the socks, apply compression hose to both lower extremities and reapply both socks to her feet. NA-C continued to place R32's heels/feet directly on to the pillow, alternating between assisting to dress R32's lower extremities. R32's heels rested directly on the pillow during morning cares. At 8:00 a.m.,

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NA-C assisted R32 to sit on the edge of the bed, transfer into the seat of a wheelchair and proceeded to assist R32 into the bathroom.

On 2/8/17, at 9:03 a.m. NA-C stated she had been unaware R32's heels were resting directly on the pillow and had been unaware she had rested R32's heel directly on the pillow during cares. She indicated she thought the facility had tried the boots (Prevalon) with R32 once, and understood R32 did not like them.

On 2/8/17, at 9:16 a.m. NA-A stated R32's heels should be off the bed and heels were to be hanging off the pillow, not directly resting on the bed or pillow.

On 2/8/17, 9:24 a.m. licensed practical nurse (LPN)-A stated R32 was at risk for development of pressure ulcers and stated she did not think R32 had a current pressure ulcer. She stated she expected staff to float R32's heels off the bed and pillow.

On 2/8/17, 9:27 a.m. registered nurse (RN)-A stated R32 had a pressure ulcer at her left heel in the past which had resolved, and stated she did not have a current pressure ulcer. She stated she felt R32 was not at risk for pressure ulcers at this time.

On 2/8/17, at 11:59 a.m. R32 was observed seated in a wheelchair in the dining room. R32 wore brown tie up shoes on both feet, which rested on the foot pedals of the wheelchair.
At 12:36 p.m., R32 was seated in her wheelchair in the dining room, with the same brown shoes on both feet.
At 3:08 p.m., R32 was seated in her wheelchair in

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F 314	Continued From page 21 the dining room, participating in an activity with several other residents. R32 continued to wear the same brown tie up shoes on both feet. On 2/8/17, at 12:59 p.m. DON stated R32 was at risk for development of pressure ulcers. DON reviewed R32's clinical record at that time and stated the record indicated R32's previous pressure ulcer had resolved/closed. She indicated the facility had felt the previous pressure ulcer had been caused by R32's brown tie up shoes. DON stated R32 did not have a current ulcer. She confirmed the most current comprehensive skin assessment for R32 had been completed on 12/6/17, prior to the development of R32's previous pressure ulcer. DON confirmed R32's record lacked documentation of weekly skin monitoring, and indicated this was an area the facility needed to improve on. She indicated the facility had become aware of the previous pressure ulcer when R32 told facility staff her foot was uncomfortable in the shoe and felt the pressure ulcer had been caused by friction from the shoe. DON stated the facility should have comprehensively assessed R32's pressure ulcer. On 2/8/17, at 1:14 p.m. R32 was seated in her wheelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left foot. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color. She stated she would expect staff to complete a comprehensive reassessment for R32 at the time the reoccurring pressure ulcer had developed.	F 314		

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F 314	Continued From page 22 On 2/9/17, at 9:03 a.m. NA-A stated R32 had not worn her brown shoes for about a month after she developed an open area on her foot. NA-A stated she understood since R32's open area had healed, she could wear the brown shoes and indicated she wore them routinely. On 2/9/17, at 9:05 a.m. R32 stated staff routinely place pillows under her heels at night. She stated she needed staff assistance to apply her shoes and she did not remember the last time she wore her shoes. On 2/9/17, at 9:15 a.m. NA-D confirmed R32 currently had an open area on her left heel and indicated she had notified the nurses and DON about the open area in the past. She indicated she felt R32 had not worn shoes since she had been admitted to the facility. On 2/9/17, at 9:40 a.m. during a follow up interview, the DON stated she felt there was no way to accurately determine when R32's current pressure ulcer occurred. She confirmed R32's current pressure ulcer and indicated she felt the current pressure ulcer had reopened soon after 1/10/17 or 1/12/17. On 2/9/17, at 9:40 a.m. DON added the usual facility practice was for the nurses to complete a weekly skin check for all residents, and to document the results of the skin check in the resident clinical record. The DON confirmed R32's care plan and current nursing assistant care guide and stated the facility did not have a designated wound nurse but she expected nursing assistants to report any changes to the nurses and nurses to assess the area. She also	F 314		

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indicated she expected all the nurses to complete weekly skin inspections, assess and report abnormalities to the physician for treatment. DON confirmed R32 had developed a pressure ulcer after admission, at that time she felt the shoes had caused the pressure ulcer. She indicated R32 had stopped wearing the shoes and staff had discussed alternative shoes for R32, however, the facility was concerned about causing a blister somewhere else on her foot. DON stated she felt once R32's shoes were worn again, it was like putting gas onto a fire. She stated R32 was a not reliable historian and DON confirmed R32 wore her brown shoes daily at present, and confirmed R32 required assistance with applying her shoes. DON stated R32 had not seen a podiatrist since the past June 2016, she stated she had not had time to assess R32's current pressure ulcer since she was aware of the pressure ulcer.

On 2/9/17, at 9:40 a.m. DON stated the facility had R32 remove the brown tie up shoes for 2 weeks after the previous pressure ulcer developed and after the 2 weeks, R32 had resumed wearing the shoes. Further, the DON stated she had not visualized R32's left heel pressure since 12/23/16, when the physician was in the facility. She indicated she was not aware R32 had a current pressure ulcer and the status of the pressure ulcer until 2/8/17, and had not notified the physician of the current pressure ulcer. DON did not offer any other information regarding notifying the survey team on 2/6/17 R32 had a current unstageable pressure ulcer.

On 2/9/17, at 12:00 p.m. during a telephone interview, R32's physician (MD)-A confirmed R32 had developed a pressure ulcer in December, the area had been denuded, and had a small amount

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of erythema. He stated he had been concerned about development of osteomyelitis and had started her on antibiotics at that time. MD-A indicated he was unsure of the cause of R32's pressure ulcer, had seen the pressure ulcer last on 1/3/17, and he felt the pressure ulcer was healing at that time and understood it continued to heal.

On 2/10/17, at 8:50 a.m. during a follow up interview in the facility, MD-A stated R32's previous pressure ulcer had been open and superficial. He indicated the area had been red and inflamed, and he had ordered a culture of the open area because R32 had a history of osteomyelitis and multiple infections. He stated on 1/3/ 17, he had felt R32's previous pressure ulcer was healing. MD-A stated during exam of R32's left heel, he felt R32's current pressure ulcer was healing, and indicated he felt at that time it was almost healed.

Review of R32's physician orders revealed the following:

-12//23/16, identified diagnosis of pressure ulcer left heel, culture of the ulcer to be obtained, antibiotic started, and directed staff to keep patient positioned and use boot/pillows to keep pressure off of left heel. Further, the orders indicated to follow up with physician in 1 week and sooner as needed.

-1/3/17, left heel looked better, and directed staff to continue treatment.

Review of R32's Treatment Administration Records (TAR) revealed for December 2016, staff documentation of skin/wound note weekly, every

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Thursday and Prevalon boots or pillows to keep pressure off of heel which was documented as done every evening and night shift 12/23/16 thru 12/31/16. However, R32's TAR lacked direction for use of Prevalon boots, pillows or pressure relief for left heel during the day.

Review of R32's January TAR staff documentation of skin/wound note weekly, every Thursday and Prevalon boots or pillows to keep pressure off of heel which was documented as done every evening and night shift 1/1/17 thru 1/31/17. However, R32's TAR lacked direction for use of Prevalon boots, pillows or pressure relief for left heel during the day.

R32's progress notes which included all skin/wound documentation was reviewed from 11/18/16 to 2/09/17 and revealed:

-12/16/2016, identified a nickel size black area on R32's left heel with the surrounding area raised like a scab. The note also indicated education was provided regarding offloading of heels, provider was updated and they would continue to monitor.

-12/23/2016, identified R32's provider was there and wrote new orders for left sole ulcer which included a wound culture, and medication changes. The note indicated provider would follow up next week for foot.

-12/23/2016, identified resident had an open area on her left heel measuring 5 millimeters (mm) in diameter, and a black area surrounding the open area which measured 2.5 cm in diameter. The note indicated R32's wound was cultured and sent to the lab.

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F 314	Continued From page 26 -12/28/2016, identified R32 had an open left heel ulcer which measured 1.5 cm X .5 cm, was dark in color, no drainage and was improved. -12/29/2016, identified area on heel was not draining, dressing was applied as ordered and did not indicate the status of the ulcer.. -1/2/2017, identified left heel treatment continued as ordered. -1/3/2017, identified left heel scab had sloughed off, leaving a clean smooth surface and area measured 0.5 cm X .25 cm. -1/5/2017, identified left heel was dry, scabbed over and measured 4 mm and was improving -1/8/2017, identified unstageable pressure ulcer to left heel had closed. -1/12/2017, listed small red dots on the front and side of both knees and had redness at skin fold of stomach. However, the note did not address status of left heel skin/ pressure ulcer. -1/19/17, listed no areas of concern. -1/26/2017, listed had no areas of concern. -2/2/2017, listed no areas of concern. -2/9/17, listed no areas of concern. Review of the facility policy, Prevention and Treatment of Skin Breakdown, dated 11/1/15, revealed when a resident developed a new	F 314		

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F 314	Continued From page 27 pressure ulcer the facility would initiate a TTT, a Braden Scale Assessment and complete an evaluation of skin risk factors and reevaluate based on risk factors. Review of the facility policy, Skin Assessment dated 11/1/15, revealed all residents identified at risk for pressure ulcers would be assessed weekly to identify any new alterations in skin integrity. The policy also identified on residents designated bath days the licensed nurse would compele a head to toe skin assessment and note any alterations in skin condition and document an evaluation of the wound, the status of surrounding tissues and treatments, any changes, signs infection and document findings in the electronic record. R20's quarterly MDS dated 12/8/16, indicated R20 had diagnoses which included dementia, hypertension (HTN) and chronic obstructive pulmonary disease (COPD). The MDS identified R20 was severely cognitively impaired, required extensive to total assistance for all activities of daily living (ADL). The MDS also indicated R20 was totally dependent on two staff assistance for bed mobility, transfers. Further, the MDS identified R20 was at risk for pressure ulcers, skin was intact, was on a turning and repositioning program and had a pressure reducing device in the wheelchair.	F 314		

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R20's CAA dated 6/20/16, indicated R20 was dependent on staff for activities of daily living, including repositioning. The CAA identified R20 was at risk for pressure ulcers related to weakness, limited mobility, and dementia. Further, the CAA identified R20 needed to be offered repositioning every two hours.

R20's care plan dated 1/24/16, identified R20 was at risk for altered skin integrity and directed facility staff to assist R20 to reposition every two (2) hours.

R20's undated, nursing assistant care guide, indicated R20 required turning and repositioning every two hours.

R20's Braden Scale/Skin Risk Assessment for Pressure ulcer dated 12/5/16, indicated R20 was at risk for pressure ulcer development.

During continuous observation on 2/8/17, from 7:10 a.m. to 10:12 a..m. revealed the following:

- At 7:10 a.m. R20 was seated in a wheelchair with a seat cushion in her room, wore a hospital gown, with the TV on.

- At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares.

- At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At

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that time NA-E entered R20's room, draped a blanket over R20's lap and proceeded to wheel R20 to the dining room. NA-D and NA-E were not observed to offer R20 assistance with repositioning.

- At 8:40 a.m. R20 remained seated in the wheelchair in the dining room and ate independently. R20 was not observed to make any independent changes in position.

- At 8:57 a.m. R20 remained seated in the wheelchair in the dining room. R20 was not observed to make any independent changes in position.

- At 9:07 a.m. R20 remained seated in the wheelchair in the dining room. At that time RN-A approached R20 and was observed to administer medications to R20 and immediately walked away.

- At 9:20 a.m. R20 had remained seated in the wheelchair in the dining room and was wheeled to the resident lobby by an activity aid to listen to trivia. R20 had remained seated in the wheelchair at that time for a total of 2 hours and 10 minutes.

- At 9:40 a.m. R20 had remained seated in the wheelchair in the resident lobby. R20 had made no independent changes in position. No staff were observed to offer R20 assistance with repositioning.

- At 9:57 a.m. NA-C was notified R20 had been up in the wheelchair without repositioning since 7:10 a.m. At that time NA-C stated R20 needed assistance with repositioning every 2 hours and was unsure of when R20 had last been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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 30	F 314		

repositioned. R20 was then wheeled to her room by NA-C.

- At 10:08 a.m. R20 remained seated in the wheelchair in her room while NA-C and NA-E placed clean bedding on R20's bed.

- At 10:13 a.m. NA-C and NA-E assisted R20 to transfer with a full mechanical lift from the wheelchair to her bed. NA-E removed the lift sling and assisted R20 to roll towards NA-C. NA-C removed R20's dry incontinent brief which revealed R20's skin on buttocks and back of upper thighs were bright red, but intact.

-R20 remained in an observed seated position from 7:10 a.m. to 10:13 a.m. a total of 3 hours and 3 minutes.

During interview on 2/8/17, at 9:57 a.m. NA-C stated R20 was to be repositioned and toileted every two hours. NA-C stated she was unsure of the last time R20 was repositioned and her usual practice to keep track of repositioning was to keep an eye on the clock. NA-C stated that was the method staff used to ensure residents received timely toileting and repositioning.

During interview on 2/8/17, at 10:01 a.m. NA-E stated R20 had not been repositioned or checked and changed for incontinence since 7:00 a.m. NA-E stated was not able to independently reposition.

During interview on 2/8/17, at 1:1 p.m. LPN-A confirmed R20 was at risk for developing pressure ulcers. LPN-A stated staff were expected to reposition R20 every two hours and as needed. LPN-A confirmed three hours was

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F 314	Continued From page 31 too long to sit in the wheelchair without repositioning. During interview on 2/9/17, at 8:37 a.m. the DON confirmed R20 was at risk for development of pressure ulcers due to bowel and bladder incontinence, and immobility. The DON reported she added the specific interventions on the nursing assistance care guides after the comprehensive assessments and considered the care guides as an extension of the resident's care plan. The DON stated she expected R20 would have been repositioned and incontinence care provided every two hours to reduce risk of future skin breakdown. The DON stated there was no formal system in place to ensure timely cares were completed. The DON stated she was unsure how the staff were ensuring residents received timely care. The DON confirmed timely resident cares were not being monitored. The DON stated the point of care system captured resident care documentation, but not in actual time. The facility's policy titled, Prevention and Treatment of Skin Breakdown dated 9/6/16, indicated staff would implement preventative measures such as effective turning and repositioning schedules to help reduce the risk of developing a pressure ulcer with residents identified to be at risk for impaired skin integrity.	F 314		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 441		3/13/17

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F 441	Continued From page 32 a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

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F 441	Continued From page 33 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program which included surveillance of all signs/symptoms of infections including those not treated with an antibiotic to prevent potential spread of infection in the facility. This deficient practice had the potential to affect all 34 resident. Findings include: During interview with the director of nursing (DON) on 2/9/17, at 10:59 a.m. a review of the infection control log for 12/31/15, through 12/16/16, was completed. The infection control log flow sheets identified the date, room, diagnosis, signs & symptoms, culture/lab order (if	F 441	1. Policies & procedures were reviewed and updated to establish and identify location of resident in facility with infection, symptoms, diagnosis and/or cultures performed, treatment modalities, and resolution of infection. 2. All residents have had a preliminary review to determine if there are any signs & symptoms of potential infections. 3. All residents who have objective or subjective symptoms of potential infections shall be tracked & trended utilizing current protocols. These protocols have been updated to include the additional potential infections. 4. The DON or designee will review all residents at daily shift reports and	

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F 441	Continued From page 34 ordered or not), medication ordered, medication end date, culture results (if obtained), and isolation required. However, the log lacked documentation of infections not treated with antibiotics in the facility. Review of the monthly infection control logs from 12/15 through 12/16 revealed the facility tracked various resident infections which included urinary tract infections, bronchitis, pneumonia, eye infections and all infections listed identified the specific antibiotic used to treat the infection. However, the logs lacked documentation of symptoms of infections or viral illness not treated with antibiotics in the facility. No further information was provided to demonstrate surveillance was being conducted for infections not treated with medications. On 2/09/2017, at 10:59 a.m. the DON identified the procedure for the infection control log to include: Any time an antibiotic was prescribed to a resident, the resident and the medication utilized were added to the list, and then the symptoms and when the symptoms began were added. She indicated the facility did not routinely monitor for viral illness or symptoms of infections which were not treated with antibiotics and confirmed the facility did not include infections that were not treated with medication on the monthly logs. The facility policy titled, Outcome Surveillance for Healthcare Acquired Infections revised 10/28/16, identified the purpose to provide guidelines and forms for the surveillance of healthcare acquired and cluster infections occurring within the facility, and an assessment of presenting symptoms will	F 441	review/audit all progress notes daily for new symptoms. All audit outcomes shall be reported to the QAA Committee for comment &/or review. 5. Management/charge personnel will attempt to have the ill employee indicate what symptoms are present to warrant an illness call-in and document same on an absence report for tracking. 6. The DON or designee shall track and trend resident infections and employee reported illnesses as they occur. This will be ongoing and be reviewed quarterly. 7. Quarterly the DON or designee shall track and trend, compile data, with an analysis to determine if there are commonalities to staff illnesses and/or resident symptoms of infection. All charge personnel who take absence calls shall be educated on the need to ascertain symptoms r/t illness or absences. 8. All staff will receive education on Infection Control policy and procedures upon hire, annually at staff in-service, and as needed for any new updates from CDC. 9. Date of Correction: March 13, 2017	

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F 441	Continued From page 35 be completed utilizing the criteria of the definitions of system infections.	F 441		

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	245281	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2017**

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VALLEY CARE AND REHAB LLC	**600 FIFTH STREET SOUTHEAST. BOX 129 BARNESVILLE, MN 56514**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Valley Care & Rehab LLC 01 Main Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code, (NFPA 99). Valley Care & Rehab is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1980, a Sun Room addition was added to the south of the Dining Room/Day Room that was determined to be of Type V(000) construction. In 1994 an addition to the main entrance, to the west was constructed and was determined to be of Type II(111) construction. The building is divided into 4 smoke zones by two 30-minute fire barriers, one two hour fire barrier and is fully sprinkled per NFPA 13. The facility has a capacity of 35 beds and a census of 34 at the time of the survey.. Because of the lack of 2-hr fire separation between the Sun Room addition and the original building, the entire building is downgraded to Type V(000) and was surveyed as 1 building. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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

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

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K 000	Continued From page 1 MET:	K 000		

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2017

Mr. Mark Rustad, Administrator
Valley Care And Rehabilitation LLC
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

Re: Enclosed State Nursing Home Licensing Orders - Project Number

Dear Mr. Rustad:

The above facility was surveyed on February 6, 2017 through February 10, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson at: (218) 332-5140 or email: gail.anderson@state.mn.us**.

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

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

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
	00968	A. BUILDING: _____ B. WING _____	02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 6th, 7th, 8th, 9th and 10th 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status	2 265		3/13/17

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2 265	Continued From page 2 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to notify the physician of a significant change of condition for 1 of 1 resident (R32) when a reoccurring unstageable	2 265	corrected	

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2 265	Continued From page 3 pressure ulcer developed in the facility. Findings include: R32's admission Minimum Data Set (MDS) dated 12/1/16, identified R32 had intact cognition and required extensive assistance with all activities of daily living (ADLs). The MDS further identified R32 was at risk for developing pressure ulcers, had no current pressure ulcers and utilized a pressure reducing device in her chair. R32's admission orders dated 11/17/16, identified R32 had diagnoses which included osteoporosis and peripheral edema. R32's Care Area Assessment (CAA) dated 12/1/16, identified R32 was at risk for developing pressure ulcers and required assessment. The CAA identified R32 required a cushion for her chair for pressure relief. On 2/6/17, at 5:35 p.m. the director of nursing (DON) stated R32 had a current unstageable pressure ulcer on her left heel. On 2/8/17, at 7:12 a.m. R32 had her eyes closed, lying on her back in bed with bed linens covering her torso and lower extremities. At 7:54 a.m., R32 remained on her back in bed and nursing assistant (NA)-C entered the room to assist R32 with morning cares. NA-C removed the bed linens that covered R32, both R32's heels/feet rested directly on a pillow, covered in white cloth socks and a second pillow was observed under R32's calves. R32's left heel had an approximate 2.5 centimeter (cm) sized open area on the back of the heel, which had an approximate 1.5 cm sized dark brown/black irregular shaped scab in the center of the area with a yellow colored slough	2 265		

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	00968	A. BUILDING: _____ B. WING _____	02/10/2017

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VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4 (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed) area which surrounded the entire scab. On 2/8/17, at 12:59 p.m. director of nursing (DON) stated R32 was at risk for development of pressure ulcers. DON reviewed R32's clinical record at that time and stated the record indicated R32's previous pressure ulcer had resolved. She indicated the facility had felt the previous pressure ulcer had been caused by R32's brown tie up shoes. DON stated R32 did not have a current pressure ulcer. DON confirmed R32's record lacked documentation of weekly skin monitoring, and indicated this was an area the facility needed to improve on. On 2/8/17, at 1:14 p.m. R32 was seated in her wheelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left foot. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color. On 2/9/17, at 9:40 a.m. during a follow up interview, the DON stated she felt there was no way to accurately determine when R32's current pressure ulcer occurred. She confirmed R32's current pressure ulcer and indicated she felt the current pressure ulcer had reopened soon after 1/10/17 or 1/12/17. DON stated the usual facility practice was for the nurses to complete a weekly skin check for all residents, and to document the results of the skin check in the resident clinical	2 265		

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2 265	Continued From page 5 record. She also indicated she expected all the nurses to complete weekly skin inspections, assess and report abnormalities to the physician for treatment. She indicated she was not aware R32 had a current pressure ulcer and the status of the pressure ulcer until 2/8/17, and had not notified the physician of the current pressure ulcer. DON did not offer any other information regarding notifying the survey team on 2/6/17 that R32 had a current unstageable pressure ulcer. On 2/9/17, at 12:00 p.m. during a telephone interview, R32's physician (MD)-A confirmed R32 had developed a pressure ulcer in December, had seen the pressure ulcer last on 1/3/17, and he felt the pressure ulcer was healing at that time. He indicated he had not been notified of R32's current pressure ulcer. R32's progress notes which included all skin/wound documentation was reviewed from 1/18/17 to 2/09/17, and revealed: -1/8/2017, identified unstageable pressure ulcer to left heel had closed. -1/12/2017, listed small red dots on the front and side of both knees and has redness at skin fold of stomach. However, the note did not address status of left heel pressure ulcer. -1/19/17, skin/wound note listed no areas of concern -1/26/2017, skin/wound note listed had no areas of concern -2/2/2017, skin/wound note listed no areas of concern	2 265		

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2 265	Continued From page 6 -2/9/17, skin/wound note listed no areas of concern Review of the facility policy, Prevention and Treatment of Skin Breakdown, dated 11/1/15, revealed when a resident developed a new pressure ulcer the facility would initiate a TTT, a Braden Scale Assessment and complete an evaluation of skin risk factors and reevaluate based on risk factors. Review of the facility policy, Skin Assessment dated 11/1/15, revealed all residents identified at risk for pressure ulcers would be assessed weekly to identify any new alterations in skin integrity. The policy also identified on residents designated bath days the licensed nurse would compele a head to toe skin assessment and note any alterations in skin condition and document an evaluation of the wound, the status of surrounding tissues and treatments, any changes, signs infection and document findings in the electronic record. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to notifying the physician with all resident change of conditions, including but not limited to: development of pressure ulcers. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 265		

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2 565	Continued From page 7	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care plan interventions for routine repositioning for 1 of 1 resident (R20) who was identified at risk for development of pressure ulcers. In addition, the facility failed to implement skin monitoring related to bruises for 1 of 1 resident (R37) who currently received anticoagulant therapy. Findings include: R20's care plan dated 1/24/16, identified R20 was at risk for altered skin integrity and directed facility staff to assist R20 to reposition every two (2) hours. R20's undated, nursing assistant care guide, indicated R20 required turning and repositioning every two hours. During continuous observation on 2/8/17, from 7:10 a.m. to 10:12 a..m. revealed the following: - At 7:10 a.m. R20 was seated in a wheelchair with a seat cushion in her room, wore a hospital gown, with the TV on.	2 565	corrected	3/13/17

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2 565	Continued From page 8 - At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares. - At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At that time NA-E entered R20's room, draped a blanket over R20's lap and proceeded to wheel R20 to the dining room. NA-D and NA-E were not observed to offer R20 assistance with repositioning. - At 8:40 a.m. R20 remained seated in the wheelchair in the dining room and ate independently. R20 was not observed to make any independent changes in position. - At 8:57 a.m. R20 remained seated in the wheelchair in the dining room. R20 was not observed to make any independent changes in position. - At 9:07 a.m. R20 remained seated in the wheelchair in the dining room. At that time registered nurse (RN)-A approached R20 and was observed to administer medications to R20 and immediately walked away. - At 9:20 a.m. R20 had remained seated in the wheelchair in the dining room and was wheeled to the resident lobby by an activity aid to listen to trivia. R20 had remained seated in the wheelchair at that time for a total of 2 hours and 10 minutes. - At 9:40 a.m. R20 had remained seated in the wheelchair in the resident lobby. R20 had made	2 565		

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2 565	Continued From page 9	2 565		

no independent changes in position. No staff were observed to offer R20 assistance with repositioning.

- At 9:57 a.m. NA-C was notified R20 had been up in the wheelchair without repositioning since 7:10 a.m. At that time NA-C stated R20 needed assistance with repositioning every 2 hours and was unsure of when R20 had last been repositioned. R20 was then wheeled to her room by NA-C.

- At 10:08 a.m. R20 remained seated in the wheelchair in her room while NA-C and NA-E placed clean bedding on R20's bed.

- At 10:13 a.m. NA-C and NA-E assisted R20 to transfer with a full mechanical lift from the wheelchair to her bed. NA-E removed the lift sling and assisted R20 to roll towards NA-C. NA-C removed R20's dry incontinent brief which revealed R20's skin on the buttocks and back of upper thighs were bright red in color, skin intact.

-R20 remained in an observed seated position from 7:10 a.m. to 10:13 a.m. a total of 3 hours and 3 minutes.

During interview on 2/8/17, at 9:57 a.m. NA-C stated R20 was to be repositioned and toileted every two hours. NA-C stated she was unsure of the last time R20 was repositioned and her usual practice to keep track of repositioning was to keep an eye on the clock. NA-C stated that was the method staff used to ensure residents received timely toileting and repositioning.

During interview on 2/8/17, at 10:01 a.m. NA-E stated R20 had not been repositioned or checked and changed for incontinence since 7:00 a.m.

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2 565	Continued From page 10 NA-E stated was not able to independently reposition. During interview on 2/8/17, at 1:1 p.m. licensed practical nurse (LPN)-A confirmed R20 was at risk for developing pressure ulcers. LPN-A reported staff were expected to reposition R20 every two hours and as needed. LPN-A confirmed three hours was too long to sit in the wheelchair without repositioning. During interview on 2/9/17, at 8:37 a.m. the director of nursing (DON) confirmed R20 was at risk for development of pressure ulcers due to bowel and bladder incontinence, and immobility. The DON reported she added the specific interventions on the nursing assistance care guides after the comprehensive assessments and considered the care guides as an extension of the resident's care plan. The DON stated she expected R20 would have been repositioned and incontinence care provided every two hours to reduce risk of future skin breakdown. The DON stated there was no formal system in place to ensure timely cares were completed. The DON stated she was unsure how the staff were ensuring residents received timely care. The DON confirmed timely resident cares were not being monitored. The DON stated the point of care system captured resident care documentation, but not in actual time. R37's care plan dated 12/10/16, identified R37 was on anticoagulant therapy, directed staff to monitor/document/report adverse reactions to anticoagulant therapy which included bruising and directed staff to complete daily skin inspections and report abnormalities to nurse. On 2/07/17, at 12:00 p.m. R37 was seated in her	2 565		

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2 565	Continued From page 11	2 565		

wheelchair in her room with a family member (FM)-A present. Irregular shaped yellow/light green bruises, approximately 1.5 inch in diameter, were observed on both lower cheeks and several purple colored bruises in various sizes were observed on the tops of both hands. FM-A stated R37 had fallen in the facility in the past, and obtained the bruises. She indicated R37 was forgetful and did not remember falling.

Review of R37's progress notes from 12/19/16 to 2/5/17 revealed:

-12/19/16, R37 had a fall from bed and hit her head on the side table and was bleeding from her left eye and nose and was sent to the emergency room for evaluation.

-12/19/16, R37 returned from emergency room and had a laceration to her left eyebrow area which was closed with glue. R37 had bruising to the back top of her left shoulder which measured 40 centimeter (cm) x 50 cm, a bruise to her left elbow area which measured 90 cm x 80 cm, and a bruise to her left upper thigh area which measured 230 cm x 150 cm.

-1/2/17, R37 had faded bruises to her left cheekbone, left shoulder and elbow from previously documented fall.

Review of the R37's monthly treatment administration records (TAR) for December 2016 and January 2017 revealed R37 had various treatments and monitoring in place which included to monitor for ear wax, elevate feet 20 minutes two times a day, and respiratory monitoring. However, the TARs lacked documentation of monitoring for bruising and other adverse reactions to anticoagulant therapy.

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2 565	Continued From page 12 No further documentation of monitoring of R37's bruising was found in the clinical record. On 2/10/17, at 12:19 p.m. director of nurses (DON) stated R37 fell on 12/19/16, was sent to the emergency room and returned with significant bruises. DON confirmed progress notes and lack of monitoring of R37's bruises and stated she felt the measurements of the bruises were likely an error. She stated the usual facility practice when a bruise was identified was for the nurse to set up clinical weekly monitoring in the resident TAR. She stated she expected the nurse should have set up the bruise monitoring in the TAR when R37 returned from the emergency room and document weekly and confirmed the monitoring had not been done. She stated she expected orders to be followed, weekly skin inspections to be completed by nurses and bruises monitored. Review of the facility policy, Skin Assessment dated 11/1/15, identified on residents designated bath days the licensed nurse would complete a head to toe skin assessment and note any alterations in skin condition and document an evaluation in the electronic record. The facility's Care Plan Policy dated 9/14/15, indicated the resident care plan would ensure the appropriate care required to maintain or attain the residents highest level of functioning possible. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff implement resident care plans. The quality assessment and assurance	2 565		

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2 565	Continued From page 13 committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor bruising for 1 of 3 residents (R37) reviewed for non-pressure related skin conditions. Findings include: R37's quarterly Minimum Data Set (MDS) dated 1/12/17, identified R37 had moderate cognitive impairment, and required extensive assistance with all activities of daily living (ADL). The MDS further identified R37 had no current skin	2 830	corrected	3/13/17

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2 830	Continued From page 14 conditions/bruises. R37's care plan dated 12/10/16, identified R37 was on anticoagulant therapy, directed staff to monitor/document/report adverse reactions to anticoagulant therapy which included bruising and directed staff to complete daily skin inspections and report abnormalities to nurse. Review of order summary report dated 1/6/17, revealed R37 received a routine daily dose of Coumadin (medication to thin blood) and was to have every shift monitoring for bruising related to anticoagulant therapy. On 2/07/17, at 12:00 p.m. R37 was seated in her wheelchair in her room with a family member (FM)-A present. Irregular shaped yellow/light green bruises, approximately 1.5 inch in diameter, were observed on both lower cheeks and several purple colored bruises in various sizes were observed on the tops of both hands. FM-A stated R37 had fallen in the facility in the past, and obtained the bruises. She indicated R37 was forgetful and did not remember falling. Review of R37's progress notes from 12/19/16 to 2/5/17, revealed: -12/19/16, R37 had a fall from bed and hit her head on the side table and was bleeding from her left eye and nose and was sent to the emergency room for evaluation. -12/19/16, R37 returned from emergency room and had a laceration to her left eyebrow area which was closed with glue. R37 had bruising to the back top of her left shoulder which measured 40 centimeter (cm) x 50 cm, a bruise to her left elbow area which measured 90 cm x 80 cm, and	2 830		

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2 830	Continued From page 15 a bruise to her left upper thigh area which measured 230 cm x 150 cm. -1/2/17, R37 had faded bruises to her left cheekbone, left shoulder and elbow from previously documented fall. Review of the R37's monthly Treatment Administration Records (TAR) for December 2016 and January 2017, revealed R37 had various treatments and monitoring in place which included to monitor for ear wax, elevate feet 20 minutes two times a day, and respiratory monitoring. However, the TARs lacked documentation of monitoring for bruising and other adverse reactions to anticoagulant therapy. No further documentation of monitoring of R37's bruising was found in the clinical record. On 2/10/17, at 12:19 p.m. director of nurses (DON) stated R37 fell on 12/19/16, was sent to the emergency room and returned with significant bruises. DON confirmed progress notes and lack of monitoring of R37's bruises and stated she felt the measurements of the bruises were likely an error. She stated the usual facility practice when a bruise was identified was for the nurse to set up clinical weekly monitoring in the resident TAR. She stated she expected the nurse should have set up the bruise monitoring in the TAR when R37 returned from the emergency room and document weekly and confirmed the monitoring had not been done. She stated she expected orders to be followed, weekly skin inspections to be completed by nurses and bruises monitored. Review of the facility policy, Skin Assessment dated 11/1/15, identified on residents designated bath days the licensed nurse would complete a	2 830		

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2 830	Continued From page 16 head to toe skin assessment and note any alterations in skin condition and document an evaluation in the electronic record. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff identify and monitor bruising and skin conditions, non-pressure related until resolved. In addition, the DON or designee could implement policies and procedures related to ensuring staff and the interdisciplinary team thoroughly reviews falls and accidents to identify root cause and appropriate interventions, and ensure staff implement identified interventions to reduce injury and further falls/accidents. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		3/13/17

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2 900	Continued From page 17 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, accurately monitor and implement interventions for 1 of 1 resident (R32) with a reoccurring unstageable pressure ulcer to the heel. In addition, the facility failed to implement interventions to prevent development of pressure ulcers for 1 of 1 resident (R20) who was at risk for development of pressure ulcers. This deficient practice resulted in actual harm for R32 with the development of a recurring pressure ulcer. Findings include: R32's admission Minimum Data Set (MDS) dated 12/1/16, identified R32 had intact cognition and required extensive assistance with all activities of daily living (ADLs). The MDS further identified R32 was at risk for developing pressure ulcers, had no current pressure ulcers and utilized a pressure reducing device in her chair. R32's admission orders dated 11/17/16, identified R32 had diagnoses which included osteoporosis and peripheral edema. R32's Care Area Assessment (CAA) dated 12/1/16, identified R32 was at risk for developing pressure ulcers and required assessment. The CAA identified R32 required a cushion for her chair for pressure relief.	2 900	corrected	

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2 900	Continued From page 18 R32's care plan dated 12/18/16, identified R32 had limited physical mobility, related to osteomyelitis of vertebra, weakness, had a history of falls, was weight bearing and required assistance from staff for toileting, transfers, locomotion, and ambulation. R32's care plan directed staff to ensure R32 wore appropriate footwear (laced, no skid shoes) when ambulating or mobilizing in wheelchair, and use of a pressure relieving cushion in the wheelchair. The care plan indicated R32 had the potential/actual skin impairment related to contact dermatitis and fragile skin and utilized a pressure relieving cushion in wheelchair. The care plan further directed staff R32 required weekly skin inspections to identify redness and open areas and any changes in R32's skin were be reported to the nurse. However, R32's care plan did not identify R32's current pressure ulcer, and lacked direction for the use of Prevalon boots or pillows to keep pressure off of R32's heel. Review of the untitled facility form provided by the facility, identified as the nursing assistant care guide, listed various directions for R32's cares which included assistance with toileting, transferring, dressing and directed the use of shoes at night. The care guide did not include direction for pressure relief for R32's heels or use of the Prevalon boots. R32's Tissue Tolerance Test (TTT) form (tool used to determine appropriate repositiong schedule) dated 11/21/16, identified R32 had no current skin integrity concerns, did not have a history of pressure ulcers and could tolerate a 2 hour repositioning program. No further TTT forms were found in R32's clinical record, despite development of pressure ulcers.	2 900		

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2 900	Continued From page 19 R32's Braden Scale Assessment (risk assessment for pressure ulcers) forms dated 11/29/16, 12/2/16, and 12/6/16, identified R32 had very moist skin, had potential problem for friction and shear, walked occasionally, spent the majority of her time in her chair or bed and was at risk for development of pressure ulcers. Review of R32's Skin Observation Tool form dated 11/21/16, identified R32 had purpura (rash of purple spots on the skin caused by internal bleeding from small blood vessels) on upper extremities, and identified no other open areas. Review of the untitled form provided by the facility, dated 12/23/16, revealed the form listed various resident names and reason to be seen. The form listed R32 had 12/20/16, labs for review, had 3 centimeter (cm) blackened area in the middle of her sole of the left foot, edges were pulling away in a blister form, and center was soft. On 2/6/17, at 5:35 p.m. the director of nursing (DON) stated R32 had a current unstageable pressure ulcer on her left heel. On 2/8/17, at 7:12 a.m. R32 had her eyes closed, lying on her back in bed with bed linens covering her torso and lower extremities. At 7:54 a.m. R32 remained on her back in bed and nursing assistant (NA)-C entered the room to assist R32 with morning cares. NA-C pulled down R32' bed linens, and both R32's heels/feet rested directly on a pillow, covered in white cloth socks and a second pillow was observed under R32's calves. The heels/feet were not elevated off the pillow to relieve pressure. An approximately 2.5 centimeter	2 900		

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2 900	Continued From page 20 (cm) sized open area on the back of the heel was observed, and an approximately 1.5 cm sized dark brown/black irregular shaped scab in the center of the area with a yellow colored slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed) area which surrounded the entire scab. NA-C assisted R32 to lift each foot/leg to remove the socks, apply compression hose to both lower extremities and reapply both socks to her feet. NA-C continued to place R32's heels/feet directly on to the pillow, alternating between assisting to dress R32's lower extremities. R32's heels rested directly on the pillow during morning cares. At 8:00 a.m., NA-C assisted R32 to sit on the edge of the bed, transfer into the seat of a wheelchair and proceeded to assist R32 into the bathroom. On 2/8/17, at 9:03 a.m. NA-C stated she had been unaware R32's heels were resting directly on the pillow and had been unaware she had rested R32's heel directly on the pillow during cares. She indicated she thought the facility had tried the boots (Prevalon) with R32 once, and understood R32 did not like them. On 2/8/17, at 9:16 a.m. NA-A stated R32's heels should be off the bed and heels were to be hanging off the pillow, not directly resting on the bed or pillow. On 2/8/17, 9:24 a.m. licensed practical nurse (LPN)-A stated R32 was at risk for development of pressure ulcers and stated she did not think R32 had a current pressure ulcer. She stated she expected staff to float R32's heels off the bed and pillow.	2 900		

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2 900	Continued From page 21 On 2/8/17, 9:27 a.m. registered nurse (RN)-A stated R32 had a pressure ulcer at her left heel in the past which had resolved, and stated she did not have a current pressure ulcer. She stated she felt R32 was not at risk for pressure ulcers at this time. On 2/8/17, at 11:59 a.m. R32 was observed seated in a wheelchair in the dining room. R32 wore brown tie up shoes on both feet, which rested on the foot pedals of the wheelchair. At 12:36 p.m., R32 was seated in her wheelchair in the dining room, with the same brown shoes on both feet. At 3:08 p.m., R32 was seated in her wheelchair in the dining room, participating in an activity with several other residents. R32 continued to wear the same brown tie up shoes on both feet. On 2/8/17, at 12:59 p.m. DON stated R32 was at risk for development of pressure ulcers. DON reviewed R32's clinical record at that time and stated the record indicated R32's previous pressure ulcer had resolved/closed. She indicated the facility had felt the previous pressure ulcer had been caused by R32's brown tie up shoes. DON stated R32 did not have a current ulcer. She confirmed the most current comprehensive skin assessment for R32 had been completed on 12/6/17, prior to the development of R32's previous pressure ulcer. DON confirmed R32's record lacked documentation of weekly skin monitoring, and indicated this was an area the facility needed to improve on. She indicated the facility had become aware of the previous pressure ulcer when R32 told facility staff her foot was uncomfortable in the shoe and felt the pressure ulcer had been caused by friction from the shoe. DON stated the facility	2 900		

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2 900	Continued From page 22 should have comprehensively assessed R32's pressure ulcer. On 2/8/17, at 1:14 p.m. R32 was seated in her wheelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left foot. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color. She stated she would expect staff to complete a comprehensive reassessment for R32 at the time the reoccurring pressure ulcer had developed. On 2/9/17, at 9:03 a.m. NA-A stated R32 had not worn her brown shoes for about a month after she developed an open area on her foot. NA-A stated she understood since R32's open area had healed, she could wear the brown shoes and indicated she wore them routinely. On 2/9/17, at 9:05 a.m. R32 stated staff routinely place pillows under her heels at night. She stated she needed staff assistance to apply her shoes and she did not remember the last time she wore her shoes. On 2/9/17, at 9:15 a.m. NA-D confirmed R32 currently had an open area on her left heel and indicated she had notified the nurses and DON about the open area in the past. She indicated she felt R32 had not worn shoes since she had been admitted to the facility. On 2/9/17, at 9:40 a.m. during a follow up interview, the DON stated she felt there was no way to accurately determine when R32's current pressure ulcer occurred. She confirmed R32's	2 900		

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2 900	Continued From page 23 current pressure ulcer and indicated she felt the current pressure ulcer had reopened soon after 1/10/17 or 1/12/17. On 2/9/17, at 9:40 a.m. DON added the usual facility practice was for the nurses to complete a weekly skin check for all residents, and to document the results of the skin check in the resident clinical record. The DON confirmed R32's care plan and current nursing assistant care guide and stated the facility did not have a designated wound nurse but she expected nursing assistants to report any changes to the nurses and nurses to assess the area. She also indicated she expected all the nurses to complete weekly skin inspections, assess and report abnormalities to the physician for treatment. DON confirmed R32 had developed a pressure ulcer after admission, at that time she felt the shoes had caused the pressure ulcer. She indicated R32 had stopped wearing the shoes and staff had discussed alternative shoes for R32, however, the facility was concerned about causing a blister somewhere else on her foot. DON stated she felt once R32's shoes were worn again, it was like putting gas onto a fire. She stated R32 was a not reliable historian and DON confirmed R32 wore her brown shoes daily at present, and confirmed R32 required assistance with applying her shoes. DON stated R32 had not seen a podiatrist since the past June 2016, she stated she had not had time to assess R32's current pressure ulcer since she was aware of the pressure ulcer. On 2/9/17, at 9:40 a.m. DON stated the facility had R32 remove the brown tie up shoes for 2 weeks after the previous pressure ulcer developed and after the 2 weeks, R32 had resumed wearing the shoes. Further, the DON stated she had not visualized R32's left heel	2 900		

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2 900	Continued From page 24	2 900		

pressure since 12/23/16, when the physician was in the facility. She indicated she was not aware R32 had a current pressure ulcer and the status of the pressure ulcer until 2/8/17, and had not notified the physician of the current pressure ulcer. DON did not offer any other information regarding notifying the survey team on 2/6/17 R32 had a current unstageable pressure ulcer.

On 2/9/17, at 12:00 p.m. during a telephone interview, R32's physician (MD)-A confirmed R32 had developed a pressure ulcer in December, the area had been denuded, and had a small amount of erythema. He stated he had been concerned about development of osteomyelitis and had started her on antibiotics at that time. MD-A indicated he was unsure of the cause of R32's pressure ulcer, had seen the pressure ulcer last on 1/3/17, and he felt the pressure ulcer was healing at that time and understood it continued to heal.

On 2/10/17, at 8:50 a.m. during a follow up interview in the facility, MD-A stated R32's previous pressure ulcer had been open and superficial. He indicated the area had been red and inflamed, and he had ordered a culture of the open area because R32 had a history of osteomyelitis and multiple infections. He stated on 1/3/ 17, he had felt R32's previous pressure ulcer was healing. MD-A stated during exam of R32's left heel, he felt R32's current pressure ulcer was healing, and indicated he felt at that time it was almost healed.

Review of R32's physician orders revealed the following:

-12//23/16, identified diagnosis of pressure ulcer left heel, culture of the ulcer to be obtained,

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2 900	Continued From page 25 antibiotic started, and directed staff to keep patient positioned and use boot/pillows to keep pressure off of left heel. Further, the orders indicated to follow up with physician in 1 week and sooner as needed. -1/3/17, left heel looked better, and directed staff to continue treatment. Review of R32's Treatment Administration Records (TAR) revealed for December 2016, staff documentation of skin/wound note weekly, every Thursday and Prevalon boots or pillows to keep pressure off of heel which was documented as done every evening and night shift 12/23/16 thru 12/31/16. However, R32's TAR lacked direction for use of Prevalon boots, pillows or pressure relief for left heel during the day. Review of R32's January TAR staff documentation of skin/wound note weekly, every Thursday and Prevalon boots or pillows to keep pressure off of heel which was documented as done every evening and night shift 1/1/17 thru 1/31/17. However, R32's TAR lacked direction for use of Prevalon boots, pillows or pressure relief for left heel during the day. R32's progress notes which included all skin/wound documentation was reviewed from 11/18/16 to 2/09/17 and revealed: -12/16/2016, identified a nickel size black area on R32's left heel with the surrounding area raised like a scab. The note also indicated education was provided regarding offloading of heels, provider was updated and they would continue to monitor. -12/23/2016, identified R32's provider was there	2 900		

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2 900	Continued From page 26 and wrote new orders for left sole ulcer which included a wound culture, and medication changes. The note indicated provider would follow up next week for foot. -12/23/2016, identified resident had an open area on her left heel measuring 5 millimeters (mm) in diameter, and a black area surrounding the open area which measured 2.5 cm in diameter. The note indicated R32's wound was cultured and sent to the lab. -12/28/2016, identified R32 had an open left heel ulcer which measured 1.5 cm X .5 cm, was dark in color, no drainage and was improved. -12/29/2016, identified area on heel was not draining, dressing was applied as ordered and did not indicate the status of the ulcer.. -1/2/2017, identified left heel treatment continued as ordered. -1/3/2017, identified left heel scab had sloughed off, leaving a clean smooth surface and area measured 0.5 cm X .25 cm. -1/5/2017, identified left heel was dry, scabbed over and measured 4 mm and was improving -1/8/2017, identified unstageable pressure ulcer to left heel had closed. -1/12/2017, listed small red dots on the front and side of both knees and had redness at skin fold of stomach. However, the note did not address status of left heel skin/ pressure ulcer. -1/19/17, listed no areas of concern.	2 900		

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2 900	Continued From page 27 -1/26/2017, listed had no areas of concern. -2/2/2017, listed no areas of concern. -2/9/17, listed no areas of concern. Review of the facility policy, Prevention and Treatment of Skin Breakdown, dated 11/1/15, revealed when a resident developed a new pressure ulcer the facility would initiate a TTT, a Braden Scale Assessment and complete an evaluation of skin risk factors and reevaluate based on risk factors. Review of the facility policy, Skin Assessment dated 11/1/15, revealed all residents identified at risk for pressure ulcers would be assessed weekly to identify any new alterations in skin integrity. The policy also identified on residents designated bath days the licensed nurse would compele a head to toe skin assessment and note any alterations in skin condition and document an evaluation of the wound, the status of surrounding tissues and treatments, any changes, signs infection and document findings in the electronic record. R20's quarterly MDS dated 12/8/16, indicated R20 had diagnoses which included dementia, hypertension (HTN) and chronic obstructive pulmonary disease (COPD). The MDS identified R20 was severely cognitively impaired, required extensive to total assistance for all activities of daily living (ADL). The MDS also indicated R20 was totally dependent on two staff assistance for bed mobility, transfers. Further, the MDS identified R20 was at risk for pressure ulcers, skin was intact, was on a turning and repositioning program and had a pressure	2 900		

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2 900	Continued From page 28 reducing device in the wheelchair. R20's CAA dated 6/20/16, indicated R20 was dependent on staff for activities of daily living, including repositioning. The CAA identified R20 was at risk for pressure ulcers related to weakness, limited mobility, and dementia. Further, the CAA identified R20 needed to be offered repositioning every two hours. R20's care plan dated 1/24/16, identified R20 was at risk for altered skin integrity and directed facility staff to assist R20 to reposition every two (2) hours. R20's undated, nursing assistant care guide, indicated R20 required turning and repositioning every two hours. R20's Braden Scale/Skin Risk Assessment for Pressure ulcer dated 12/5/16, indicated R20 was at risk for pressure ulcer development. During continuous observation on 2/8/17, from 7:10 a.m. to 10:12 a..m. revealed the following: - At 7:10 a.m. R20 was seated in a wheelchair with a seat cushion in her room, wore a hospital gown, with the TV on. - At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares. - At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At	2 900		

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2 900	Continued From page 29 that time NA-E entered R20's room, draped a blanket over R20's lap and proceeded to wheel R20 to the dining room. NA-D and NA-E were not observed to offer R20 assistance with repositioning. - At 8:40 a.m. R20 remained seated in the wheelchair in the dining room and ate independently. R20 was not observed to make any independent changes in position. - At 8:57 a.m. R20 remained seated in the wheelchair in the dining room. R20 was not observed to make any independent changes in position. - At 9:07 a.m. R20 remained seated in the wheelchair in the dining room. At that time RN-A approached R20 and was observed to administer medications to R20 and immediately walked away. - At 9:20 a.m. R20 had remained seated in the wheelchair in the dining room and was wheeled to the resident lobby by an activity aid to listen to trivia. R20 had remained seated in the wheelchair at that time for a total of 2 hours and 10 minutes. - At 9:40 a.m. R20 had remained seated in the wheelchair in the resident lobby. R20 had made no independent changes in position. No staff were observed to offer R20 assistance with repositioning. - At 9:57 a.m. NA-C was notified R20 had been up in the wheelchair without repositioning since 7:10 a.m. At that time NA-C stated R20 needed assistance with repositioning every 2 hours and was unsure of when R20 had last been repositioned. R20 was then wheeled to her room	2 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 30 by NA-C. - At 10:08 a.m. R20 remained seated in the wheelchair in her room while NA-C and NA-E placed clean bedding on R20's bed. - At 10:13 a.m. NA-C and NA-E assisted R20 to transfer with a full mechanical lift from the wheelchair to her bed. NA-E removed the lift sling and assisted R20 to roll towards NA-C. NA-C removed R20's dry incontinent brief which revealed R20's skin on buttocks and back of upper thighs were bright red, but intact. -R20 remained in an observed seated position from 7:10 a.m. to 10:13 a.m. a total of 3 hours and 3 minutes. During interview on 2/8/17, at 9:57 a.m. NA-C stated R20 was to be repositioned and toileted every two hours. NA-C stated she was unsure of the last time R20 was repositioned and her usual practice to keep track of repositioning was to keep an eye on the clock. NA-C stated that was the method staff used to ensure residents received timely toileting and repositioning. During interview on 2/8/17, at 10:01 a.m. NA-E stated R20 had not been repositioned or checked and changed for incontinence since 7:00 a.m. NA-E stated was not able to independently reposition. During interview on 2/8/17, at 1:1 p.m. LPN-A confirmed R20 was at risk for developing pressure ulcers. LPN-A stated staff were expected to reposition R20 every two hours and as needed. LPN-A confirmed three hours was too long to sit in the wheelchair without repositioning.	2 900		

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	00968	A. BUILDING: _____ B. WING _____	02/10/2017

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2 900	Continued From page 31 During interview on 2/9/17, at 8:37 a.m. the DON confirmed R20 was at risk for development of pressure ulcers due to bowel and bladder incontinence, and immobility. The DON reported she added the specific interventions on the nursing assistance care guides after the comprehensive assessments and considered the care guides as an extension of the resident's care plan. The DON stated she expected R20 would have been repositioned and incontinence care provided every two hours to reduce risk of future skin breakdown. The DON stated there was no formal system in place to ensure timely cares were completed. The DON stated she was unsure how the staff were ensuring residents received timely care. The DON confirmed timely resident cares were not being monitored. The DON stated the point of care system captured resident care documentation, but not in actual time. The facility's policy titled, Prevention and Treatment of Skin Breakdown dated 9/6/16, indicated staff would implement preventative measures such as effective turning and repositioning schedules to help reduce the risk of developing a pressure ulcer with residents identified to be at risk for impaired skin integrity. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff complete a comprehensive assessment on all pressure ulcers, identify causal factors and appropriate interventions, and routinely monitor all pressure ulcers for healing until resolved. The quality assessment and assurance	2 900		

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2 900	Continued From page 32 committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		3/13/17

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21390	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program which included surveillance of all signs/symptoms of infections including those not treated with an antibiotic to prevent potential spread of infection in the facility. This deficient practice had the potential to affect all 34 resident. Findings include: During interview with the director of nursing (DON) on 2/9/17, at 10:59 a.m. a review of the infection control log for 12/31/15, through 12/16/16, was completed. The infection control log flow sheets identified the date, room, diagnosis, signs & symptoms, culture/lab order (if ordered or not), medication ordered, medication end date, culture results (if obtained), and isolation required. However, the log lacked documentation of infections not treated with antibiotics in the facility. Review of the monthly infection control logs from 12/15 through 12/16 revealed the facility tracked various resident infections which included urinary tract infections, bronchitis, pneumonia, eye infections and all infections listed identified the specific antibiotic used to treat the infection. However, the logs lacked documentation of symptoms of infections or viral illness not treated with antibiotics in the facility. No further information was provided to demonstrate surveillance was being conducted for infections not treated with medications. On 2/09/2017, at 10:59 a.m. the DON identified	21390	corrected	

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21390	Continued From page 34 the procedure for the infection control log to include: Any time an antibiotic was prescribed to a resident, the resident and the medication utilized were added to the list, and then the symptoms and when the symptoms began were added. She indicated the facility did not routinely monitor for viral illness or symptoms of infections which were not treated with antibiotics and confirmed the facility did not include infections that were not treated with medication on the monthly logs. The facility policy titled, Outcome Surveillance for Healthcare Acquired Infections revised 10/28/16, identified the purpose to provide guidelines and forms for the surveillance of healthcare acquired and cluster infections occurring within the facility, and an assessment of presenting symptoms will be completed utilizing the criteria of the definitions of system infections. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control monitoring program. Facility staff could be educated on the components of surveillance of infections. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis	21426		3/10/17

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21426	Continued From page 35 infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) baseline screening was completed for 2 of 5 residents (R40, R32), tuberculin skin test (TST) were completed and documentation guidelines were followed for 2 of 5 residents (R40, R3) according to the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH) guidelines. Findings include: R40 was admitted to the facility on 2/3/17. R40's first step TST was administered 2/4/17, at 2:12 p.m. with results read on 2/5/17, at 7:15 p.m. (29 hours after the test was administered.) R40's symptom screening had been completed on	21426	corrected	

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21426	Continued From page 36 2/6/17. The TST test was not given the appropriate amount of time to reveal an accurate reaction of the skin test. In addition, R40's TST results were not documented as negative nor was the measurement of induration or lack of it documented. R40's electronic medication administration record (EMAR) had a check mark in the box with staff initials and the time of the reading. No further documentation of the results of the skin testing was found in the clinical record. R32 was admitted 11/18/16. Review of R32's electronic chart lacked a base line TB symptom screen. R3 was admitted on 8/22/16. Review of R3's electronic chart revealed R3's first TST had not been administered until 9/8/16, seventeen days after admission. R3's chart documentation also lacked the required exact number of induration and the interpretation of the reading for both the first and second step TST. On 2/10/17, at 11:25 a.m. the director of nursing (DON) verified R40 had not had a symptom screen prior to administering the TST and the TST had been read a day too early. The DON verified a TB symptom screen had not been completed for R32's admission date of 11/18/16. The DON identified the facility practice to read TST results was to identify in the EMAR only that the test was read. The DON indicated the staff chart by exception and would document in the progress notes if a negative reaction had occurred. The DON verified at a later time the TST results were placed in to the immunization area of the electronic record. The DON verified the EMAR did not link to the immunization record and the nurse that had read the TST would not necessarily be the nurse transferring the	21426		

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21426	Continued From page 37 information. The facility policy titled Tuberculosis Control Plan revised 10/26/16, directed #1. Upon admission, all residents shall be screened for tuberculosis with a TST. #3. All initial skin testing will utilize the two step process. #5. The results of all screenings and interventions shall be documented in the residents electronic medical record. SUGGESTED METHOD OF CORRECTION: The infection control coordinator/nurse or designee could review the TB policies and procedures to ensure required information is included. Appropriate staff could be educated regarding requirements. Audits could be could be conducted and the results reviewed at the quality committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		