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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NQWH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245222**

2. STATE VENDOR OR MEDICAID NO. (L 2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT CHATEAU LLC**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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) **04/01/2006**

6. DATE OF SURVEY **03/16/2017** (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 **69** (L18)

13.Total Certified Beds **69** (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)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	69			
(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 : 05/19/2017
Lisa Hakanson, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/02/2017 (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 **10/01/1978** (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. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **03/27/2017** (L33)

DETERMINATION APPROVAL

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

CCN: 24 5222

Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on March 16, 2017. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request has been approved.

Please Note: during the recertification survey the facilty was also in the proces of a change of ownership, including the facility name change to, "The Estates at Chateau, LLC.". Previously the facilty's name was Golden LivingCenter - Chateau.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245222

May 19, 2017

Mr. Timothy Johnson, Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

Dear Mr. Johnson:

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 March 8, 2017 the above facility is certified for:

69 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 69 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

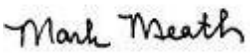
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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, 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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 19, 2017

Mr. Timothy Johnson, Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

RE: Project Number S5222027

Dear Mr. Johnson:

On February 15, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 27, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

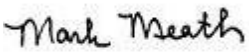
On March 16, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 8, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 27, 2017, effective March 8, 2017 and therefore remedies outlined in our letter to you dated February 15, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the January 27, 2017 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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, 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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245222 Y1	A. Building B. Wing Y2	3/16/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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	F0155	Correction	ID Prefix	F0241	Correction	ID Prefix	F0244	Correction
Reg. #	483.10(c)(6)(8)(g)(12), 483.24(a)(3)	Completed	Reg. #	483.10(a)(1)	Completed	Reg. #	483.10(f)(5)(iv)(A)(B)	Completed
LSC		03/08/2017	LSC		03/08/2017	LSC		03/08/2017
ID Prefix	F0246	Correction	ID Prefix	F0252	Correction	ID Prefix	F0280	Correction
Reg. #	483.10(e)(3)	Completed	Reg. #	483.10(e)(2)(i)(1)(i)(ii)	Completed	Reg. #	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed
LSC		03/08/2017	LSC		03/08/2017	LSC		03/08/2017
ID Prefix	F0282	Correction	ID Prefix	F0309	Correction	ID Prefix	F0313	Correction
Reg. #	483.21(b)(3)(ii)	Completed	Reg. #	483.24, 483.25(k)(l)	Completed	Reg. #	483.25(a)(1)(2)	Completed
LSC		03/08/2017	LSC		03/08/2017	LSC		03/08/2017
ID Prefix	F0329	Correction	ID Prefix	F0334	Correction	ID Prefix	F0353	Correction
Reg. #	483.45(d)(e)(1)-(2)	Completed	Reg. #	483.80(d)(1)(2)	Completed	Reg. #	483.35(a)(1)-(4)	Completed
LSC		03/08/2017	LSC		03/08/2017	LSC		03/08/2017
ID Prefix	F0371	Correction	ID Prefix	F0428	Correction	ID Prefix	F0431	Correction
Reg. #	483.60(i)(1)-(3)	Completed	Reg. #	483.45(c)(1)(3)-(5)	Completed	Reg. #	483.45(b)(2)(3)(g)(h)	Completed
LSC		03/08/2017	LSC		03/08/2017	LSC		03/08/2017

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GL/mm	05/19/2017	28230	03/16/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/27/2017

[ ] 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: NQWH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**
2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT CHATEAU LLC**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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) **04/01/2006**

6. DATE OF SURVEY **01/27/2017** (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 **69** (L18)
13.Total Certified Beds **69** (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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	69			
(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 :
Sandra Tatro, HFE NEII 02/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/27/2017 (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
10/01/1978
(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.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5222

On January 27, 2017, a standard survey was completed at this 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 the facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy
(Level F).

In addition, at the time of the January 27, 2017 standard survey an investigation of complaint number H5222069 was conducted and found to be unsubstantiated.

Further, the facility's request for an annual waiver of life safety code deficiency cited at K521 has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Approval of the waiver request has been recommended.

Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction and K84 Justification Page related to the life safety code waiver request. Post Certification Revisit to follow.

Please Note: during the recertification survey the facilty was also in the proces of a change of ownership, including the facility name change to, "The Estates at Chateau, LLC.". Previously the facilty's name was Golden LivingCenter - Chateau.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 15, 2017

Mr. Timothy Johnson, Administrator
Golden LivingCenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5222027 and H5222069

Dear Mr. Johnson:

On January 27, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 27, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5222069 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 8, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 8, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 27, 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 July 27, 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 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.

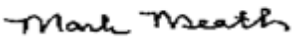
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

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

Sincerely,



Mark Meath, 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
	245222	A. BUILDING _____ B. WING _____	C 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	**2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation H52220679 was also completed at the time of the standard survey and was unsubstantiated.	F 000		
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 155		3/8/17

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

Electronically Signed | 02/24/2017

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F 155	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by:	F 155		

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F 155	Continued From page 2 Based on interview and document review, the facility failed to ensure the risk and benefit of care and treatment was provided to 1 of 1 resident (R104) who alleged she was not afforded a choice to refuse medication. Findings include: R104 reported in an interview on 1/25/17, at 11:20 a.m. a nurse attempted to force her to take medication. "They were trying to force me to take oxycontin [narcotic pain medication] and I have had severe reactions to oxy's [oxycontin/Oxycodone]. One of the nurses was trying to force me to take the oxy and I said 'absolutely not.' R104 described a nurse had placed a plastic cup containing oxycontin at her lips and was trying to force her to open her mouth. R104 stated the DON who was also present pushed the medication toward her, but did not push it to her mouth. R104 also stated, "I told them 'I will report this,' but was thinking at the time I don't know how to go about reporting it. Who is the best source to go to for help?" A Progress Note dated 1/11/17, indicated, "This writer spoke to resident at length about a few concerns mostly receiving oxycodone fixated on wanting to blame someone for ordering that explained would try to fix getting dilaudid not finding who ordered it, was ordered when arriving yesterday as new admit...note to [nurse practioner] and possibly change to dilaudid did tell her on call md's [physicians] will not change them. gave flexeril [muscle relaxant] and evening meds [medications] refused oxycodone for pain." The following day a Progress Note indicated "She complains of being in pain but refuses the prescribed oxycodone but want [sic] dilaudid	F 155	a. R 104 was provided a copy of Residents Rights, and reeducated on right to refuse medication and associated risks and benefits. A RN has reviewed resident 104 prescribed medication orders with resident, and resident was provided a copy of current medication orders. b. Residents are provided a copy of and review Residents Rights upon admission, and there is a posting on Residents rights in the facility. Residents rights are reviewed at Resident Council meeting monthly. Staff will be educated on resident□s rights upon hire and annually. c. Education is being completed for staff on resident□s rights. Licensed Nurses Staff are being educated on resident right to refuse medications, acceptable interventions to encourage compliance, and documenting education on the risks and benefits of taking prescribed medication. d. Nursing designee will audit 5 residents weekly that they are receiving medications per orders, and education of risk versus benefits is documented for refusals. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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F 155	Continued From page 3 ordered." The notes did not reflect the risk/benefit of refusing pain medication had been reviewed with the resident, nor was risk/benefit of taking pain medication addressed in thee resident's current care plan with a print date of 1/26/17. Diagnoses according to the Order Summary Report printed 1/26/17, included multiple fractures following a motor vehicle accident. Admission orders included oxycontin for pain, however, current orders were for Dilaudid 2 milligrams every hour hours as needed for pain (order date 1/19/17). The director of nursing (DON) was interviewed on 1/25/17, at 2:15 p.m. regarding R104's report. The DON stated, "She actually told me about that...the nurse denied it." In addition the DON denied being present, but said the nurse had said R104 was in pain and felt she needed to take the medication. Regarding staff training in resident rights the DON stated, "I probably need to hold another inservice on that stuff...Right now I know some of staff have not had the annual training and are overdue." The DON explained that usually staff who had not completed required training were removed from the schedule. Required annual Resident Rights training via Relias Learning was reviewed on 1/26/17. Four staff had completed the training, 20 staff were registered but were not overdue and 58 staff were "Registered/Past Due."	F 155		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		3/8/17

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F 241	Continued From page 4 (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure respectful treatment for 4 of 4 residents (R26, R9, R104, R60, R28) who reported they were not treated with dignity. In addition, staff did not knock and call residents by preferred names for 5 residents (R73, R89, R110, R60, R38) observed during random observation. Findings include: R26 was asked whether he felt staff treated him respect and dignity on 1/23/17, at 2:05 p.m. He stated, "Sometimes the musing staff are just not friendly. I understand they have people who don't show up and others have to fill in. We hear the nursing staff yelling at each other that if we did that we'd be thrown out. We come up to get our meds [medications] and we are told 'I'm here by myself' and 'you'll have to come back.' If they said it with kindness it would be nice instead of snapping back at us. They yell at each other and they say to us 'she's down on two [another floor] so you'll just have to wait.' They're the paid staff." R26 also said recently the meal was late, however, "No one comes to the tables and says 'We're so sorry we're running late'...We wouldn't know what to do with that statement, as we're are not talked to like that. A lot of people here are not in a good place and I see they are not treated with kindness and they don't have a way to show	F 241	a. R9, R104, R60 and R28 will be interviewed to ensure being treated with respectful and dignified treatment by staff. R26 no longer resides at facility. Facility will document follow up with residents based on observation that staff are knocking on doors prior to entering rooms and calling resident by preferred names and appropriate staff to staff communication. b. Facility policy for Dignity will be followed. Staff will be educated on resident□s rights upon hire and annually. c. Education is being provided to staff on respectful and dignified treatment of residents and residents rights, including knocking on doors and calling residents by their preferred names. Staff will be educated on appropriate and acceptable staff to staff communication in resident care areas. d. Administration designee will audit 5 residents weekly including observation and interview that staff is treating residents with respect and dignity, observed knocking on doors and using preferred names. Random 1 time weekly observation audits for appropriate and acceptable staff to staff communication in resident care areas. Audit results will be reviewed at monthly QAPI and the	

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F 241	Continued From page 5 staff kindness, but it's no excuse for the staff." R26's 1/12/17, admission Minimum Data Set (MDS) indicated the resident was cognitively intact. A follow up interview was conducted with R26 on 1/25/17, at 8:08 a.m. R26 explained that when the nurse was late "We get antsy for our meds. It makes a big difference when they are polite about it and tell us they will get them as soon as possible and not be rude." R26 also stated residents had been told by a nurse, "I'm here alone. Go back to your rooms and don't bother me right now." On the other hand, another time a nurse was polite and it "made all the difference." R9 was interviewed on 1/24/17, at 9:43 a.m. When asked if staff treated her with dignity and respect she replied, "No! I have some real problems with them." The resident stated the facility had been her fifth stay in a nursing home and she stated, "I have never run into a nursing home where the staff has an attitude of disrespect where they think they can just walk into resident's rooms without asking. So much of the staff here does not [knock] and if I say you're supposed to knock they get snotty with me." R9 explained people could easily see right into her room based on its location and stated, "I've complained and complained about it. It's not that hard. It's a very bad attitude. A couple people come in and then say 'knock knock' like 'haha.'" R9's 1/11/17, admission MDS indicated the resident was cognitively intact. R104 was interviewed on 1/24/17 at 11:04 a.m. and frequently cried throughout the interview. She reported she did not feel staff treated her with respect and dignity. "The nurses holler at me and	F 241	frequency of audits will be adjusted based on results.	

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F 241	Continued From page 6	F 241		

sometimes I'm on the phone and they can see I'm on the phone and my friends or sister have heard it." R104 described she at times felt "raked over the coals." In addition, R104 stated staff on the unit could be heard yelling and swearing at each other using vulgar language, including "using the 'F-word' and going on and on." R104 did not feel she should have been subjected to this.

R104 approached the nursing desk on 1/27/16, at 11:00 a.m. and informed registered nurse (RN)-E she had been waiting for her medications for one and one half hours. In a sharp tone the nurse responded to R104 stating, "I know, but I've been very busy with other residents." R104 had a distressed look on her face and asked RN-E if she would have to wait for "two hours?" RN-E responded, "I will get it as soon as can," to which R104 responded "Thank you," and returned to her room. R104's 1/17/17, admission MDS indicated the resident was cognitively intact, presented no behavioral issues, rejected care 1-3 times during the assessment period, and had mood indicators of feeling somewhat down and tired.

R28 was interviewed regarding resident council on 1/25/17, at 10:00 a.m. R28 expressed concern about the amount of staff arguing in front of residents which made her feel "very uncomfortable." R28 said she had reported the staffs' arguing.

The 1/12/17, New Business section indicated concerns about staff walking into resident rooms and bathrooms without knocking, noise at nurses station at night, hearing arguing by staff about whose turn it was to open the smoking room, as well as arguing about residents they did not want

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F 241	Continued From page 7 to care for. Morning observations were conducted on 1/25/17, beginning at 6:35 a.m. Registered nurse (RN)-B instructed R73, "Sweet Pea, I need you to go to your room and I'll meet you there." RN-B then entered R89 and R110's room, knocking after she was inside the room and then slamming the door. RN-B then left to obtain a pair of gloves, slamming the door as she left and then returned to the room. R110 stated sarcastically, "Slam the damn door!" to which RN-B replied, "sorry." RN-B then walked into R60's room without knocking at 7:45 a.m. and again at 7:50 a.m. NA-C then entered R73 and R110's room by pushing the lift through the doorway. and NA-C entered R89 and R110's room without knocking at 8:00 a.m. At 8:11 a.m. RN-B prepared R60's medicine at the desk and then entered the resident's room without knocking. NA-C then walked into R89 and R110's carrying a bag of linens without knocking. RN-B then entered R38's room at 8:20 giving one knock on the door as she was already in the room. R38 was not in her room, but upon returning unit at 8:41 and RN-B stated, "There you are Miss America." NA-C explained in an interview on 1/25/17, at 12:30 p.m. she did not knock on R60's door when entering, as the resident did not like it when staff knocked on his door. When asked how she learned of R60's preference she replied, "He told me--you can sometimes understand him." Regarding other residents NA- stated, "Other residents? You have to knock." When informed she did not consistently knock during observations NA- replied, "You have to," and confirmed that is how she had been trained. R60's care plan on 1/27/17, did not reflect a	F 241		

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F 241	Continued From page 8	F 241		

preference for staff to walk in without knocking.

RN-B stated on 1/25/17, at 1:20 p.m. regarding knocking, "Generally of course, it's pretty well known you're supposed to knock...I know I'm even guilty of knocking and walking in." When told observations revealed she also repeatedly walked in without any knocking on R60's door RN-B stated, "Because his door was open and he saw me coming. I can only speak for myself. He doesn't like the door shut ever."

On 1/25/17, at 11:00 a.m. the activity director (AD) was interviewed. She verified she was responsible for facilitating resident council meetings, completing the documentation, and notifying appropriate departments with resident concerns. The AD verified she did not always complete a written record for providing appropriate departments with resident concerns, but verbally informed the proper department. She stated she was still getting used to the new form and procedure for documenting and following up on concerns.

The social services director (SSD) was interviewed regarding resident rights training on 1/25/17, at 1:23 p.m. She stated resident council meetings were held every month and the therapeutic recreation director spoke about resident rights "in general terms" and allowed residents to bring up their own topics. She tried to attend the meetings. Regarding staff training, the SSD explained, "Resident rights is a part of On-boarding." This meant that certain topics were covered when staff was hired. Her focus was more on managing resident behavioral issues such as personality disorders, conflict management, de-escalation, and how to be

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F 241	Continued From page 9	F 241		

successful in working with residents. If she heard a staff person being disrespectful to a resident, she immediately corrected it and made suggestions as to how the interaction could have been improved. The SSD reported, "The residents are perceptive and they hear things." The SSD said that although she would like to speak to the situation further, she was not responsible for supervising the nursing staff.

On 1/25/17, at 2:15 p.m. the director of nursing (DON) was informed of resident reports of concerns staff were swearing and arguing among themselves and being generally disrespectful toward residents in tone and by not knocking. The DON said the business office manager was also working as the admissions coordinator and provided newly admitted residents with the Bill of Rights. Regarding staff training the DON stated, "I probably need to hold another inservice on that stuff." Newly hired staff went to a sister facility for orientation, "and then when they come here we go through how our facility runs. Right now I know some of staff have not had the annual training and are overdue." The DON explained that usually staff who had not completed required training were removed from the schedule. Staff had the ability to independently complete the computer based training. The DON said it was a courtesy to knock before entering a resident's room, and they covered this not just annually, but at meetings.

Required annual Resident Rights training via Relias Learning was reviewed on 1/26/17. Four staff had completed the training, 20 staff were registered but were not overdue and 58 staff were "Registered/Past Due."

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F 241	Continued From page 10 The facility's 2/26/15, Dignity policy directed staff, "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality...Speaking to the residents in a friendly and patient manner...Focusing on the resident as an individual when speaking to them...speaking respectfully, listening carefully, and addressing residents by preferred name...Respecting resident's private space...."	F 241		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up on resident council concerns, having the potential to affect most of the 63 residents residing at the facility. Findings include:	F 244	a. Resident council meeting will be held with residents, monthly and minutes documented according to policy, to include carryover of new business to old business, documenting facility and department responses and resolutions on appropriate forms, and taking a count of	3/8/17

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F 244	Continued From page 11 On 1/25/17, at 10:00 a.m. R28 was interviewed about the resident council meetings as she regularly attended the meetings. R28 expressed concerns about the time it took to resolve concerns and said some things keep coming up. She said some issues came up 3-4 times per year including the use of a dirty garbage can in the dining room which had been brought up five times. R28 was concerned about the amount of staff arguing in front of residents which made her feel "very uncomfortable." R28 said she had reported the staff arguing. During the interview a room deodorizer was sprayed in the hallway and created a heavy smell in R28's room. R28 said the room spray and floor spray was "awful" and had been a concern raised at the resident council. R28 said the council was told the spraying was up to the housekeeping staff, and therefore could not be addressed. The facility held resident council meetings monthly. A form was used for recording the minutes and contained specific standing agenda items. Old Business was a standing item to cover at each meeting. The instructions on the form directed staff to list each issue brought up as New Business at the last meeting. The facilitator was to read the department response that was submitted to show the resolution of the issue. A show of hands was to be requested by meeting attendees to see if they felt the issue had been resolved to their satisfaction. If the residents felt the issue was not resolved, the issue was to be re-submitted to the appropriate department head or the the Quality Assurance committee. The instructions for New Business directed staff to write in all new concerns raised, and for each	F 244	residents who agree that concerns were resolved or need to be carryover for further resolution and brought to the next meeting. b. The facility holds a monthly Resident Council meeting and residents are able express grievances and recommendations. c. Staff conducting meetings, and documenting and reviewing Resident Council Minutes are educated to document minutes and resolutions according to policy. Education is provided to staff on acceptable communication in resident care areas. d. Administration designee will review resident council minutes monthly for grievances, documented resolutions provided, and follow up to ensure residents agreement with resolutions is confirmed, or carried over for further resolution and brought to next monthly meeting. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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concern get a show of hands for all who agreed. The directions did not mention completing a response form to submit to the appropriate department.

Meeting minutes were reviewed and showed the following:

1) 9/6/16, Old Business about opening the smoking room on time and residents spitting outside. The minutes did not indicate if a department response had been provided or it residents felt the issues had been resolved. The New Business section indicated concerns with not feeding birds and animals outside, residents being told to wait for cares from 2:00 until 2:30 p.m. when the next shift would be working.

2) 10/4/16, Old Business did not contain information about the previous months new business and whether or not it had been addressed and/or resolved. The New Business section included concerns with taking hot beverages out of the dining room and that covered cups were to be used. A statement was documented that nursing staff over night were much quieter, but a show of hands on who agreed was not documented.

3) 11/8/16, Old Business as reviewed the smoking policy and remind to wear aprons while smoking. The Old Business did address the hot beverage cups and that night shift staff continued to be quieter. The New Business section indicated a discussion about Christmas gifts.

4) No meeting was held in December.

5) 1/12/17, meeting minutes lacked any

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F 244	Continued From page 13 documentation for Old Business. The New Business section indicated concerns about staff not knocking on doors, walking into the bathroom without knocking, questions about the policy regarding room searches, noise at nurses station at night, hearing arguing by staff, the smoking room not opening on time and staff arguing about whose turn it was to open the room. On 1/25/17, at 11:00 a.m. the activity director (AD) was interviewed. She verified she was responsible for facilitating resident council meetings, completing the documentation, and notifying appropriate departments with resident concerns. The AD verified she did not always complete a written record for providing appropriate departments with resident concerns, but verbally informed the proper department. She stated she was still getting used to the new form and procedure for documenting and following up on concerns. She verified she did not always take a vote as described in the procedure and it was difficult to determine resolutions from the meeting minutes.	F 244		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate personal preferences for 1 of 3 residents (R104) reviewed for choices.	F 246	a. R104 interviewed for personal preference for care and services. R104 plan of care will reflect resident preferences.	3/8/17

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F 246	Continued From page 14 Findings include: R104 was interviewed on 1/24/17, at 11:06 a.m. and stated she was not afforded a choice of when to get up in the morning. R104 explained she had awoken at 6:30 a.m. and was contemplating whether to ask for a pain pill when "someone I've never seen starts in with a battery of questions. She said it was a pain assessment and she keeps going on and on with all these questions. And I hadn't slept well--that's how I've started my morning here and that's typical here. They do knock on the door but it's constant." R104's 1/24/17, pain assessment indicated a completion time of 7:04 a.m. R104 also cited the therapist told her at 7:30 it was time for therapy "and I said no I can't--I haven't slept and I was deemed a problem because I didn't come when she wanted me to...No fair warning and I asked if I could have it at a later time." Therapy notes dated 1/13/17, revealed "Patient was tied and did not sleep well last night and stated she would like to work with therapy a little later." were consistent with the resident refusing therapy at 7:30 a.m. because she had not slept, and requested a change in the schedule. R104 felt she did not have a choice of when to go to bed, as "They don't let me sleep. They wake me up for whatever they want and I'm not allowed the courtesy of sleeping." In addition, R104 said she did not choose how many times a week she wanted a bath or shower. The resident's hair was long and greasy. She was dressed in a hospital gown. She reported it was her "eighth day since I've had a shower and they have never said when my bath day was and I've been through MAJOR MAJOR issues to get the first shower I requested." R104 stated regarding whether she participated in activities at the	F 246	b. Residents are interviewed upon admission, and quarterly care conferences regarding choices and preferences of care and services. c. Staff education is provided on process to learn about and make changes to the plan of care for reasonable accommodation of resident preferences and choices. Staff is educated on appropriate interventions to encourage compliance, and documenting education on risk and benefit of resident refusals of care. d. Administration designee will audit 5 residents weekly including interview of resident for accommodation of preferences and choices for care and services. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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facility, "Not as much as I'd like to thought because I'd like to be up on my hygiene."

R104's 1/17/17, admission MDS indicated the resident was cognitively intact, she had rejected care 1-3 times during the assessment period, but presented no behavioral issues. She did express mood indicators of feeling somewhat down and tired. R104 required staffs' assistance to dress, transfer, and bathe. She identified it was very important to her to choose her clothing and whether she had a bath or shower. The resident's physician orders printed 1/26/17, revealed the resident had sustained multiple fractures following a motor vehicle accident, in addition to scoliosis (curvature of the spine), anxiety disorder, and homelessness.

R104's care plan with a print date of 1/26/17, included interventions of allowing a "calm unhurried environment... consistent staff to work with patient...listen carefully...validate...provide for quiet setting."

On 1/26/17, at 1:19 p.m. nursing assistant (NA)-C stated she had offered to dress R104 in street clothes, and sometimes she dressed and sometimes was in a lot of pain and wanted to rest. NA-C said the occupational therapist had given R104 her first bath, and she was not scheduled for a bath on her shift, but the evening shift.

The director of nursing (DON) was interviewed on 1/26/17, at 2:15 p.m. regarding bathing schedules. The DON explained each room had a designated bath day and shift. At the time of a residents admission if they needed a bath, one was given. They then informed the resident of

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their scheduled bath day based on the schedule if that was acceptable to the resident. The DON said therapy staff wanted to complete an assessment of R104's first bath, which the resident agreed to only with the presence of the DON. R104's room/bed bath day was designated as Thursday p.m.

Following the interview with the DON R104 was interviewed. She cried throughout the conversation and said she felt she "got off on the wrong foot" at the time of her admission, and had been feeling incredibly sleep deprived. The surveyor informed her of her of her scheduled bath for that evening. The resident reported she had never been informed of her bath day, and said in fact when she had asked on Tuesday she had been told her bath day was Monday and she "missed it." R104 reported she was looking forward to receiving a shower. A Progress Note dated 1/17/17, indicated the resident had her first bath since her admission on 1/11/17. An activities of daily living summary from 1/19/17 to 1/25/17, revealed the resident had not had a bath during that time frame. R104 also reported someone asked to take her photo "yesterday" but she had declined since she had not had a shower. A Progress Note dated 1/24/17, indicated the resident "refused picture." The resident's hair appeared greasier than an observation two days prior. She was again dressed in a hospital gown and explained although she had been getting dressed, four clothing items had been lost in the laundry and she was not willing to risk losing more clothing. "If I was upright like you are it would be different." R104 went on to explain that with much difficulty due to physical limitations, she had recovered three of the four items.

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F 246	Continued From page 17 On 1/2/17, at approximately 3:15 p.m. RN-F was asked about R104's scheduled bath that evening. RN-F explained that R104's history and physical from the hospital indicated the resident displayed a lot of behaviors and manipulated how things were done. For example, she was upset she was not given a shower or as needed medication. For example she would not request the medication, but then later stated she had requested it but it had not been provided. RN-F was informed R104 stated she was looking forward to receiving a shower and having her linens changed. RN-F stated, "You have to validate her and then she's grateful. The RN reportedly had never observed R104 crying. Later that evening at approximately 4:30 p.m. NA-D reported she did not usually work on the unit, but was assigned that evening. She had given R104 a shower and changed her bed linens. She explained she approached the resident very warmly and called her by her name, and she very willingly took her shower. Following the shower NA-D said R104 was very grateful and was smiling.	F 246		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252		3/8/17

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F 252	Continued From page 18 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a home-like environment for 1 of 2 residents (R54) reviewed for personal property. Findings include: R54's room was observed void of any personal belongings on 1/23/17, at 5:44 p.m. When asked whether she had been encouraged to bring personal belongings to the facility R54 reported, "No. I have soap and deodorant." On 1/25/17, at 2:37 p.m. R54 was observed lying on her bed. A three drawer bedside stand next to the bed had nothing on it, and privacy curtains close to each side of R54's bed were both pulled. A bulletin board at the end of R54's bed contained a yellow plastic flower. On R54's bed were two hand bags and a tied up large plastic bag. R54's face sheet indicated the resident was admitted to the facility in 11/2014. R54's annual Minimum Data Set (MDS) dated 10/26/16, indicated R54 was cognitively intact, and it was very important to her to take care of her personal belongings.	F 252	a. R54 was interviewed and reassessed regarding opportunities for staff to assist her to personalize her environment, and her plan of care is updated to reflect her choices regarding her personal possessions and room environment. b. The facility policy encouraging residents and family or responsible parties to bring in personal items will be followed. c. Staff is educated on encouraging residents and family or responsible parties to bring in personal items upon admission and quarterly. Staff is educated to offer assistance to help personalize resident environment. d. Administration designee will audit 5 residents weekly for homelike environment and personal items. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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On 1/26/17, at 9:01 a.m. the director of activities (DA) was observed had asked permission of R54 to hang a calendar on the bulletin board. R54 replied, "That would be lovely," and then asked DA what day it was. R54 proceeded to tack a large, scenic calendar on R54's bulletin board.

Following the observation, at 9:03 a.m. on 1/26/17, R54 stated she was waiting for her sister, and did not know whether she would be staying at the facility, although it was "pretty much her home now." R54 stated she liked having a calendar and said she spent time in her room either napping or waiting for her medications.

During an interview with the social services director (SSD) on 1/25/17, at 11:56 a.m. SSD stated she had talked to R54 about her clothing, but not about her room. The SSD acknowledged the room was bare, and said R54 liked to bag up her belongings as she was waiting to go home. The SSD stated she knew R54 had a brother and court appointed guardian, and R54's cognition was not good and she had short term memory loss. R54 had been admitted prior to SSD's employment, but the resident's brother had left money in a trust for R54. The SSD stated she had seen R54's brother visit and her guardian attended care conferences and visited the resident in her room. The SSD stated the only thing R54 had been asking for was writing materials, which were provided. The SSD explained that no one had mentioned R54's room was void of personal belongings, and it was not a part of her social services role to help provide a home-like room for the residents, rather the DA was the person who decorated the facility.

On 1/26/17, at 8:20 a.m. registered nurse (RN)-A

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stated she had not noticed R54's room was bare of belongings nor had she seen R54's family visit.

At 8:41 a.m. on 1/26/17, the DA stated R54 had dementia and packed up her bags thinking her family would be picking her up and taking her home. The DA stated her brother visited and her sister picked R54 up monthly and took her to her home for visits. The DA reported she had given R54 some things that she put in her bags, but stated she could provide a picture for her room. At R54's last care conference in 11/16, the lack of personalized items in R54's room had not been brought up. The DA said she could provide a calendar if R54 would like one hung.

On 1/26/17, at 10:34 a.m. the SSD stated she had seen R54's family by her office and the family had not mentioned anything about R54's personal belongings or room nor had she asked.

R54's Care Area Assessment (CAA), dated 11/2/16, indicated R54 was visually impaired and had a history of bilateral cataracts. R54's CAA dated 11/2/16, also indicated R54 was cognitively impaired with altered mental status and poor memory (inconsistent with MDS).

R54's careplan dated 11/25/14, indicated "At present resident is active in room with tv ..." No television was observed nor was there space for a television in R54's room. R54's careplan dated Revision on 2/25/15, indicated "Calendar of events posted room... Provide with Audio tapes in room, cd player and head phones..." No calendar of events nor cd player, head phones and audio tapes were observed in R54's room time of survey 1/23-1/27/17.

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F 252	Continued From page 21 R54's careplan dated 5/1/15, indicated she had adjusted to placement and was comfortable. Interventions included on the careplan including asking the family to bring in pictures and other familiar items from home to have near for comfort and a sense of belonging. On 1/27/17, at 8:05 a.m. the director of nursing (DON) stated expectations were staff would assist to hang decorations for the residents and that a resident or their representative would bring in and set out knick knacks or whatever they wanted to bring. The DON said R54 had some knick knacks, but instead had her things bagged up while waiting for her family to come to pick her up. The facility's 12/14/16, Room Searches for Safety Violations policy indicated, "Golden Living recognizes the resident right to privacy with their personal belongings and the right to a safe, clean, homelike environment."	F 252		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type,	F 280		3/8/17

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F 280	Continued From page 22 amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 280		

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F 280	Continued From page 23 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident participation in care plan development for 6 of 6 cognitively intact residents (R26, R33, R9, R103, R104, R38) who reported they had not been involved in decisions regarding their care. Findings include: R26 was interviewed on 1/23/17, at 2:24 p.m. and reported, "They cut my pain medication down without consulting me. I understand they didn't want me to take it, but the nurse was the person	F 280	a. R33, R9, R103, R104, and R38 will be interviewed for involvement in decisions regarding their care. Plan of care will be communicated and updated for identified residents. R26 no longer resides at facility. b. Residents will be provided opportunity to be involved in decisions regarding their care when there is changes, and care conferences upon admission and quarterly. c. Nursing staff is educated on including residents on decisions of care, and	

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F 280	Continued From page 24 who had to break it to me." R26's 1/12/17, admission MDS revealed the resident was cognitively intact. R33 reported in an interview on 1/23/17, at 3:25 p.m. he did not feel he was involved in decisions about his care stating they "change medication without telling me." R33's 12/5/16, MDS revealed the resident was cognitively intact. R9 was asked in an interview on 1/24/16, at 9:52 a.m. whether staff included her in decisions about her medicine, therapy, or other treatments. R9 responded, "No and that, I am not very happy about. Just a couple days ago a woman showed up to draw blood and I said why? Nobody told me and I refused it." R9 stated she felt staff was "very poor about informing people about their appointments and everything...and I hear the staff talking about the lack of communication around here." R9's 1/11/17, admission MDS indicated the resident was cognitively intact. R103 reported she did not feel she had been involved in decisions about her care in an interview on 1/24/17, at 10:48 a.m. R103 stated, "No, I have told them I would like to be back on Neurontin [anticonvulsant commonly used to treat pain] because it helps with shooting pains." A 12/15/16, MDS indicated R103 was cognitively intact. R104 was asked whether she was included on decisions about her medicine, therapy, or other treatments on 1/24/17, at 11:19 a.m. R104 answered emphatically, "Absolutely NOT to the meds [medications] and the therapy, and that has been one of my many grievances and I have asked that they include me in the discussion and	F 280	documenting communication with residents when there is change to their plan of care, including orders, appts., and labs. d. Nursing designee will audit 5 residents weekly, including resident interview, for communication with changes of resident□s plan of care, and their involvement with decisions about their care. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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they have included me in nothing." R104's 1/17/17, admission MDS indicated the resident was cognitively intact.

R38 was asked about her involvement in decisions about her care on 1/24/17, at 12:12 p.m. and stated, "No, they just make changes on their own." R38's 1/16/17, MDS revealed the resident was cognitively intact.

Registered nurse (RN)-B stated on 1/25/17, at 2:07 p.m. "Usually it's the nurse at the station who informs the resident of changes...Med changes? Usually the doctor will inform them." RN-B said nurses were responsible for reviewing and informing a resident of order changes following hospitalization, as well as upcoming appointments, laboratory work, etc.

The director of nursing (DON) explained on 1/25/17, at 2:15 p.m. "The nurses are supposed to inform the residents if they have lab [laboratory] work, appointments, changes in their meds." As far as the nurse practioners and physicians the DON stated, "I think they are pretty good. They also should be talking to the residents."

R26 was further interviewed on 1/26/17, at 11:11 a.m. about his experience with a medication change. R26 explained he was admitted to the facility from the hospital after having back surgery. In the hospital he received a pain medication every three hours. When he arrived at the facility he discovered the pain medication was scheduled every 4 hours, which was acceptable to him. After a while the pain medication changed to every 6 hours and R26 felt nothing was explained to him about the time

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changes. Two weeks ago he was told by the nurse the pain medication was only available as 1 pill every 8 hours. R26 said one pill every eight hours was inadequate, as the effect wore off after 4-5 hours leaving him in "horrible" pain. R26 said he was told it was the doctor's order, however, he had not seen the doctor. He expressed his dissatisfaction that he had not been informed of the change and had to be informed by the nurse when he requested a pain pill.

On 1/26/17, at 11:09 a.m. RN-E was interviewed. She explained that the doctor discussed changes with residents. Also nurses told residents about medication changes and would generally make a notation the resident was informed. RN-E was reportedly unaware R26 had concerns with his medication schedule.

On 1/26/17, at 11:44 a.m. the medical director was interviewed. He verified it was a standard of practice to discuss a resident's plan of care with the resident, and to not make changes without the resident's agreement.

On 1/27/17, at 8:51 a.m. the assistant director of nursing (ADON) was interviewed and verified there had never been an order for R26's pain medication every 8 hours. The problem was a transcription error which was then corrected. The ADON verified medication changes were to be discussed with the resident and a notation was to be made in the medical record. R26's medical record, however, lacked an indication he had been informed of the change or of the mistaken entry which led to his confusion. The ADON stated she reminded the providers to ensure changes were reviewed with residents, as she had other residents who had reported they had

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F 280	Continued From page 27 not been informed of changes in their medication regimes as well.	F 280		
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 follow careplan for monitoring of psychotropic side effects for 2 of 5 residents (R1, R33) reviewed for unnecessary medications. In addition, the facility failed to follow careplan to provide a home-like environment for 1 of 2 residents (R54) reviewed for personal property. Findings include: R1 was admitted to the facility on 11/24/09. R1's care plan dated 12/3/16, indicated potential for drug related complications associated with daily use of psychotropic medications for diagnoses of paranoid schizophrenia and anxiety. R1's goal was to have minimal antipsychotic drug related complication. Staff interventions indicated to monitor for adverse side effects, report behavior changes to physician, evaluate for effectiveness of medications complete an AIMS every six months.	F 282	a. R1 and R33 psychotropic medication has been reviewed to include side effect monitoring, and completion of AIMS. R104 interviewed for personal preference and choices for care and services. R54 was reassessed and interviewed regarding her personal environment and possessions, and plan of care updated. b. The facility Antipsychotic Medication Review will be followed. The facility policy to encouraging residents and family or responsible parties to bring in personal items upon admission and quarterly will be followed. c. Licensed nursing staff are educated on monitoring of psychotropic medication side effects to include orthostatic blood pressure and completion of AIMS every 6 months. Staff is educated on encouraging residents and family or responsible parties to bring in personal items upon admission and quarterly will be followed. Staff is educated to offer assistance to help	3/8/17

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F 282	Continued From page 28 R1's physician orders dated 1/3/17, indicated R1 had received the following psychotropic medications. Benztropine mesylate 0.5 milligram (mg) daily at bedtime, clonazepam 0.5 mg two times a day, haloperidol 5 mg two times a day as needed for schizophrenia and olanzapine 15 mg daily at bedtime. R1 was seen on 1/12/17, by an in-house psychologist who stated R1 exhibited some paranoia with another resident controlling his thoughts. R1's facility AIMS sheet revealed only one assessment had been completed on 1/28/15, with a total score of zero. During an interview on 1/26/17, at 3:09 p.m. the assistant director of nursing (ADON) stated residents' AIMS assessment get done quarterly. The ADON verified the only AIMS assessment that was provided for R1 was completed on 1/28/15, she was unsure why his quarterly assessments were missed. R33's careplan dated 9/30/16, indicated "Potential for drug related complication associated with use of psychotropic medications related to: Anti-Depressant medication, Anti-psychotic medication" The goal was "Will be free of psychotropic drug related complications." Interventions included monitoring of side effects related to antipsychotic and antidepressant medication use, and side effect monitoring for muscle tremors and postural hypotension. R33's physician orders dated 12/21/16, indicated R33 was taking medication Risperidone (antipsychotic) 1 mg (milligram)/ml (milliliter) Give 2 mg two times a day related to schizophrenia (mental illness). R33's orders also indicated R33	F 282	personalize resident environment. e. Nursing designee will audit 5 residents weekly for side effect monitoring for psychotropic medications for ortho bp and AIMS completion. Administration designee will audit 5 residents weekly for homelike environment and personal items. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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was taking medication Trazodone HCL (antidepressant) Give 100 mg every 24 hours as needed for insomnia. Orders dated 1/10/17, indicated R33 had a history of unspecified major neurocognitive disorder after neuropsych testing and unspecified delusional disorder in remission, and Risperdal had recently been increased from 1 to 2 mg twice daily due to increasing behavioral issues.

R33 had experienced a fall in the last 30 days according to the assistant director of nursing (ADON) on 1/23/17, at 5:24 p.m. The resident slipped and fell in his room, bumping his head and resulting in a hospital emergency room visit.

On 1/27/17, at 10:38 a.m. RN-B stated when residents were admitted to the facility their medications were reviewed. If the admitting resident was prescribed antipsychotic medication, an Abnormal Involvement Movement Scale (AIMS) was completed initially and then quarterly and when a resident was newly prescribed antipsychotic medication.

Review of R33's vitals in record indicated no orthostatic blood pressure (OBP--drop in blood pressure upon rising) had been completed for R33 since admission. R33's assessments in record indicated no monitoring of side effects including muscle tremors had been completed.

On 1/27/17, at 8:50 a.m. the director of nursing (DON) explained an AIMS should have been completed at time of admission when antipsychotic medication was ordered or when an antipsychotic was newly prescribed, and then every six months thereafter. The DON also stated OBPS were to be completed monthly with

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residents who ambulated and were prescribed antipsychotic medication. The DON stated the consulting pharmacist (CP) came to the facility monthly for residents' medication review and to attend the facility's quality improvement meetings. The CP had previously mailed recommendations to the ADON for follow up, but more recently had instead been sending them to the DON. The DON verified there had been no AIMS assessment completed for R33's admission.

At 10:47 a.m. on 1/27/17, the DON stated AIMS were to be completed upon admission or readmission and then quarterly. The DON stated there was not a policy on OBPs, that staff was aware of procedures for residents on psychotropic medications. The DON stated if a resident complained of dizziness upon rising the nurse would let the physician know and the physician would decide if a resident should be monitored with an OBP.

On 1/27/17, at 3:30 p.m. the consulting pharmacist (CP) stated an AIMS should have been completed upon initial start of antipsychotic medication, with change in dose, and every six months thereafter. CP stated he needed to review the residents' records for AIMS and would periodically check for them. CP stated residents on antipsychotic medications should have OBP taken every 90 days. CP stated R33 who independently ambulated should have an OBP completed quarterly.

The facility's 1/26/17, Antipsychotic Medication Review...Additional Assessments directed staff to "Review to ensure that either the AIMS or DISCUS (also for purposes of identifying/monitoring tardive Dyskinesia

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symptoms) Assessment is completed every 6 months."

R54's current careplan dated 11/25/14, indicated "At present resident is active in room with tv ..." No television was observed nor was there space for a television in R54's room. R54's careplan revised 2/25/15, indicated "Calendar of events posted room... Provide with Audio tapes in room, cd player and head phones..." No calendar of events nor cd player, head phones and audio tapes were observed in R54's room during the survey. On 5/1/15, the care plan indicated she had adjusted to placement and was comfortable. Interventions included on the careplan including asking the family to bring in pictures and other familiar items from home to have near for comfort and a sense of belonging.

R54's room was observed void of any personal belongings on 1/23/17, at 5:44 p.m. When asked whether she had been encouraged to bring personal belongings to the facility R54 reported, "No. I have soap and deodorant."

On 1/25/17, at 2:37 p.m. R54 was observed lying on her bed. A three drawer bedside stand next to the bed had nothing on it, and privacy curtains close to each side of R54's bed were both pulled. A bulletin board at the end of R54's bed contained a yellow plastic flower. On R54's bed were two hand bags and a tied up large plastic bag.

R54's face sheet indicated the resident was admitted to the facility in 11/2014. R54's annual Minimum Data Set (MDS) dated 10/26/16, indicated R54 was cognitively intact, and it was very important to her to take care of her personal belongings.

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F 282	Continued From page 32 During an interview with the social services director (SSD) on 1/25/17, at 11:56 a.m. SSD stated she had talked to R54 about her clothing, but not about her room. The SSD acknowledged the room was bare, and said R54 liked to bag up her belongings as she was waiting to go home. The SSD explained that no one had mentioned R54's room was void of personal belongings, and it was not a part of her social services role to help provide a home-like room for the residents, rather the DA was the person who decorated the facility. On 1/26/17, at 8:41 a.m. the director of activities (DA) stated R54 had dementia and packed up her bags thinking her family would be picking her up and taking her home. The DA reported she had given R54 some things that she put in her bags, but stated she could provide a picture for her room. At R54's last care conference in 11/16, the lack of personalized items in R54's room had not been brought up. The DA said she could provide a calendar if R54 would like one hung. At 9:01 a.m. the DA was asked permission of R54 to hang a calendar on the bulletin board. R54 replied, "That would be lovely," and then asked DA what day it was. R54 proceeded to tack a large, scenic calendar on R54's bulletin board. On 1/27/17, at 8:05 a.m. the director of nursing (DON) stated expectations were staff would assist to hang decorations for the residents and that a resident or their representative would bring in and set out knick knacks or whatever they wanted to bring. The DON said R54 had some knick knacks, but instead had her things bagged up while waiting for her family to come to pick her up.	F 282		

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F 282	Continued From page 33 The facility's 12/14/16, Room Searches for Safety Violations policy indicated, "Golden Living recognizes the resident right to privacy with their personal belongings and the right to a safe, clean, homelike environment."	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 (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 provide timely nebulizer treatment for 1 of 1 resident (R68) observed in respiratory distress, and to provide	F 309	a. R68 is assessed and provided with respiratory treatment in a timely manner according to prescribed orders. R20 no longer resides at facility.	3/8/17

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F 309	Continued From page 34 an ear treatment for 1 of 1 resident (R20) who reported treatment was not completed as ordered by the physician. Findings include: R68 was interviewed on 1/25/17, at 2:33 p.m. after his friend (R70) informed the surveyor he wanted to talk about some health care concerns. Within seconds after the interview began, however, R68 became extremely short of breath (SOB), was only able to say 2-3 inaudible words before becoming agitated by grabbing at his oxygen mask and waving his hand for the surveyor and R70 leave the room. R70 asked R68 if it was okay for her to inform the surveyor of his concerns and R68 nodded his head up and down. R70 explained R68 just returned to the facility having been hospitalized and on a ventilator (artificial breathing machine). R70 explained R68's concern was that he required inhalers for his SOB, but when he put on his call lights, it can take "hours for them to get to his room--by that time he is ready to pass out. This is what happened on the evening shift right before he was sent into the hospital four weeks ago." Following R68's report, R70 verified his concern and stated, "Yes. Come up here tomorrow to see me." R68's physician orders dated 1/17, directed staff to administer oxygen 2-6 liters (L)/nasal cannula or 8-10 L per mask for severe SOB, Acetylcysteine solution (to aid in clearing mucous from the lungs) 4 milliliters (ml) three times daily, Duoneb solution 0.5-2.5 milligrams (mg)/3 ml inhaled orally every four hours while awake and every four hours as needed for SOB, Morphine sulfate solution 20 mg/ml every four hour for	F 309	b. The medication administration guideline and ear drops installation policy will be followed for timely administration. c. Licensed staff is educated on providing residents medications and treatments according to orders, and accurate transcription, and reconciliation of orders for reentry. The staff will be educated on ways to get additional assistance when needed. d. Nursing designee will complete 5 audits weekly of respiratory treatments orders, and medication transcription and reconciliation for reentry, and interview 5 staff on understanding of how to get additional assistance when needed. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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breakthrough pain/SOB. R68's diagnoses included chronic obstructive pulmonary disease (COPD), chronic kidney disease, chronic respiratory failure and asthma with exacerbation.

Continuous observation of R68 was conducted on 1/26/17, at 8:15 to 9:20 a.m. R68's room was not visible from the nursing station, however, was in view of the surveyor at all times from approximately 15-20 feet away. R68's door was open about 6-8 inches; he was wearing an oxygen mask and his eyes were closed. At 8:33 a.m. LPN-A explained R68 was sleeping and she did not want to wake him. LPN-A explained R68 was on hospice, received up 10 liters of oxygen for SOB, and his friend R70 visited the resident often. At 8:43 a.m. R68 activated his call light, and within seconds trained medication assistant (TMA)-A answered the light and emerged, leaving the light activated. TMA-A then walked to the nursing station and spoke to registered nurse (RN)-B. RN-B entered R68 room and could be heard asking R68 "Do you need a breathing treatment?" The call light was shut off and RN-B exited the room and left the floor via the stairway. TMA-A was then entering information into a wall computer and was talking with the ADON, although R68's need for a breathing treatment was not mentioned. R68 call light remained off and no one entered the room until the surveyor knocked at 8:56 a.m. R68 was sitting straight up in bed, and frantically put his hands straight in the air, was grabbing at his oxygen mask, taking rapid breaths, was unable to speak, appeared distraught and panicked. The surveyor intervened to summon a nurse. At 8:57 a.m. the ADON was informed of R68's situation. TMA-A then explained when he went into R68's room he could not understand what he wanted, but" maybe

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something to do with breathing" so he let RN-B know and she went and took care of it. The ADON called to the other floor and asked LPN-A to return to the floor, however, did not also check on R68. Three to four minutes later LPN-A returned to the floor explaining she needed to get some supplies. The ADON informed LPN-A that R68 needed a breathing treatment. At 9:02 a.m. RN-A returned to the floor and explained R68 motioned he needed a breathing treatment and said, "I went to the desk and no one was around so I left a note on the nurses cart." When asked if R68 appeared in respiratory distress RN-A replied, "I do not have keys to get into the medication cart anyway to help." Twenty-one minutes later at 9:04 a.m. R68 measured R68's oxygen saturation rate at 79 before providing Mucomyst solution via a mask. LPN-A stated the resident's oxygen saturation rate normally ran around 90 to 91. When asked if the resident appeared in distress LPN-A replied, "When [R68] is in distress he is very agitated." At 9:20 a.m. R68's breathing treatment was completed and LPN-A reported his oxygen saturation was at 93 and she had administered Morphine (used to reduce symptoms of air hunger). R68 reported his breathing had improved and reached for the surveyor's hand stating, "Thank you."

R68's 1/17, medication administration record (MAR) was reviewed and indicated on 1/26/17, at 8:00 a.m. LPN-A signed off as giving R68 the following medication Acetylcysteine solution (Mucomyst), and Morphine sulfate, however LPN-A had actually had not administered the medications at 9:04 a.m.

The facility's 5/12, Medication Administration--General Guidelines policy

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directed staff to follow the Five Rights (right time, drug, dose, route and resident). "Medications are to be administered within 60 minutes of scheduled times."

R20 was asked in an interview on 1/23/17, at 1:56 p.m. whether staff included him in decisions about his medication. R20 replied "No. I saw my doctor on January 6th, and ear drops had been ordered for me. I asked the nurse on January 20th, 'How come I haven't received them?' No reply from her. To this day I have not gotten one drop of ear medication." In addition, R20 reported no staff had looked in or cleaned his ears.

R20's 12/27/16, Minimum Data Set (MDS) indicated the resident was cognitively intact and did not display any behavioral issues or psychosis. R20 required staffs' assistance for cares. R20's care plan dated 12/21/16, indicated the resident's focus was to discharge to an apartment. Interventions included educating R20 on his medications and side effects and how/when medications should be taken. Staff were to administer medications as ordered by the physician and evaluate for effectiveness.

The 1/17, medication administration record (MAR) revealed R20 was prescribed Debrox ear solution (for softening, loosening, and removal of excessive earwax) of five drops into both ears twice daily for five days or a total of 10 treatments starting on 1/6/17, on evening shift. R20's MAR indicated staff had initialed giving R20 half of his scheduled ear treatments. On days 1/7, 1/8 and 1/9 staff indicated medications had not been given due to the resident being on leave of absence (LOA) from the facility.

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Progress Notes for R20 were as follows:
1) 1/7/17, at 2:11 p.m. R20 left with family at noon with plans to return at 5:00 p.m. however, a note at 10:36 p.m. revealed R20 had not returned to the facility.
2) 1/8/17, at 1:05 p.m. R20 still had not returned to the facility.
3) 1/9/17, at 1:00 p.m. R20 returned from LOA. No further documentation was available indicating R20's ear drops would be resumed for the missed days.

During an interview on 1/25/17, at 10:54 a.m. licensed practical nurse (LPN)-A stated she routinely cared for R20. LPN-A stated she was aware R20 had scheduled ear drops and explained she had administered the drops on 1/7/17, in the morning and then he left with his family at noon and did not return. LPN-A showed the surveyor where she had electronically signed that she had administered the medication that day. LPN-A explained if a medication was not given staff indicated using a number code as to the reason why. LPN-A said pointing to R20's MAR on 1/7, 1/8, and 1/9/17, "Here...5 on it with the staff initials indicated [R20] was on a LOA." LPN-A verified R20's ear drop medication was not reordered or resumed, although should have been, or he should have had his ears examined and/or cleaned.

On 1/25/17, at 11:25 a.m. R20 approached the surveyor and stated, "No staff here has ever given me ear drops, but [LPN-A] just came into my room and informed me, 'We are going to do the drops again for five days then flush your ears.'"

During an interview on 1/25/17, at 11:53 a.m. the

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F 309	Continued From page 39 assistant director of nursing (ADON) explained if a resident did not received all scheduled medication, then the medication should have been restarted. The ADON verified R20's had not received Debrox as ordered by the physician, and should have then been restarted when the resident returned from the LOA. The ADON explained Debrox was ordered, staff also should have scheduled an ear cleaning following the treatment. The ADON confirmed R20's MAR did not show an ear flush was scheduled nor completed. The director of nursing (DON) verified she expected staff to follow physician orders and if a medication was not given for the correct amount of days then to extend the days. The facility's 4/29/16, Ear Drops, Instillation policy directed staff to administer medication as ordered and document date, time, medication and amount instilled.	F 309		
F 313 SS=D	483.25(a)(1)(2) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 313		3/8/17

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F 313	Continued From page 40 Based on observation, interview and document review, the facility failed to ensure vision services were provided for 1 of 2 residents (R31) who reported visual problems. Findings include: R31 was interviewed on 1/23/17, at 2:20 p.m. and when asked if he had concerns that had not been addressed he replied, "Yes--with my eyes. I want to see the on-site eye doctor and I have not seen one since I have been here." R31 was admitted to the facility in 8/16. A quarterly Minimum Data Set (MDS) dated 10/26/16, revealed the vision section B1000 asking if the resident had the ability to see in adequate lighting with or with other visual appliances was all left blank. R31's progress notes were reviewed, but lacked any documentation R31 had been offered or had been provided vision services. During an interview on 1/25/17, at 3:39 p.m. the medical records staff (MRS) responsible for ensuring appointments were made explained that R31's Medical Assistance (MA) had expired/was inactive and the on-site vision services the facility utilized would not accept to see him without this. The MRS explained she was working with R31's family to ensure the correct paper work was filed, but it had not been received. The MRS verified R31 had not received any vision services while residing at the facility. Later that day the MRS reported she had been able to schedule an eye exam for R31 on 3/7/17. The administrator verified all resident should have been offered vision services annually.	F 313	a. R31 is scheduled for a vision appointment. b. Residents are assessed upon admission and quarterly for vision and hearing. c. Licensed Nurses and IDT staff has been educated on process for communicating and arranging for vision and hearing needs for identified residents. d. Administration designee will audit 5 residents weekly for vision and hearing needs and scheduled appointments. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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F 313	Continued From page 41 A policy and procedure for vision services was requested, but was not provided.	F 313		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor for potential side effects for 2 of 5 residents (R1, R33) reviewed for unnecessary medications. Findings include: R1 was observed on 1/25/17, at 12:13 p.m. quietly sitting near the nursing desk. A couple of minute later loud yelling was heard coming from	F 329	a. R1 and R31 psychotropic medications have been assessed and reviewed for side effect monitoring including orthostatic BP and completion of AIMS. b. The facility Antipsychotic Medication review will be followed. c. Licensed Nurses and IDT are educated on completion of antipsychotic review for side effect monitoring including ortho BP and AIMS for psychotropic	3/8/17

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F 329	Continued From page 42 the nursing station. R1 pointed to a chair and repeated in a raised voice, "I just want to sit there!" On 1/26/17, at 8:37 a.m. R1 was seated near the nursing desk talking to himself. Later at 2:37 p.m. R1 was interviewed in his room where he was looking through a magazine. R1 was very pleasant and spoke calmly. He stated he was not sure what medication he was prescribed, but felt his mood was controlled and he was not currently feeling depressed. R1 was admitted to the facility in 2009. R1's care plan dated 12/3/16, indicated potential for drug related complications associated with daily use of psychotropic medications for diagnoses of paranoid schizophrenia and anxiety. The goal was for R1 to experience minimal antipsychotic drug related complications. Interventions included monitoring for adverse side effects including performing an Abnormal Involvement Movement Scale (AIMS) assessment every six months, report behavior changes to physician, and evaluate for effectiveness of medications. R1's physician orders dated 1/3/17, included medications for paranoid schizophrenia; benztropine mesylate 0.5 milligram (mg) daily at bedtime, clonazepam 0.5 mg two times a day, haloperidol 5 mg two times a day as needed and olanzapine 15 mg daily at bedtime. R1 was seen on 1/12/17, by an in-house psychologist who stated R1 exhibited some paranoia with another resident controlling his thoughts. A review of R1's facility AIMS sheet indicated R1 has only had one AIMS assessment completed on 1/28/15, with a total score of zero. During an interview on 1/26/17, at 3:09 p.m. the	F 329	medication, and follow up on pharmacist consultant reviews for side effect monitoring. d. Nursing designee will audit 5 residents weekly on psychotropic for side effect monitoring including orthostatic BP, AIMS and pharmacy consultant reviews for side effect monitoring. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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(ADON) stated residents AIMS assessment were to be performed quarterly. The ADON verified the only AIMS assessment provided for R1 had been competed on 1/28/15, and was not sure why the assessments had been missed.

R33's physician orders dated 12/21/16, indicated R33 was taking medication Risperidone (antipsychotic) 1 mg (milligram)/ml (milliliter) Give 2 mg two times a day related to schizophrenia (mental illness). R33's orders also indicated R33 was taking medication Trazodone HCL (antidepressant) Give 100 mg every 24 hours as needed for insomnia. Orders dated 1/10/17, indicated R33 had a history of unspecified major neurocognitive disorder after neuropsych testing and unspecified delusional disorder in remission, and Risperdal had recently been increased from 1 to 2 mg twice daily due to increasing behavioral issues.

A review of R33's vitals in record indicated no orthostatic blood pressure (OBP-- drop in blood pressure upon rising) had been completed for R33 since admission. R33's assessments in record indicated no monitoring of side effects including muscle tremors had been completed.

R33 had experienced a fall in the last 30 days according to the assistant director of nursing (ADON) on 1/23/17, at 5:24 p.m. The resident slipped and fell in his room, bumping his head and resulting in a hospital emergency room visit.

On 1/25/17, at 8:49 a.m. was in bed with the door closed. After lunch at 2:34 p.m. the floor in R33's room was observed uncluttered and clear. Following the observation R33 was observed in an activity with his wheeled walker nearby. On

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F 329	Continued From page 44 1/27/17, at 9:06 a.m. R33 was observed lying in bed. The resident was wearing grippy socks and a brace on the right lower leg. A wheeled walker was near the bed. At 10:07 a.m. R33 was walking in the hallway with his walker. The resident appeared steady on his feet. When asked about his medications, R33 answered he refused them because he did not think they were necessary, and did "not believe in them." R33 reported he had slipped and fallen recently on the newly waxed floor. He reported he had not slept well because of right leg pain from a broken leg, wore a brace on his leg and took pain medication. He denied dizziness upon rising from a lying or sitting position. R33's Care Area Assessment (CAA) dated 9/28/16, indicated R33 was taking an antipsychotic and an antidepressant and sedation manifested by short term memory loss, decline in cognitive abilities, slurred speech, drowsiness, little/no activity involvement with disturbances of balance, gait, positioning ability. The CAA dated 9/28/16, also indicated R33 was at risk for adverse effects of antipsychotic and antidepressant medications and the plan was to proceed to careplan with a goal to minimize risks. R33's careplan dated 9/30/16, indicated "Potential for drug related complication associated with use of psychotropic medications related to: Anti-Depressant medication, Anti-psychotic medication" The goal was "Will be free of psychotropic drug related complications." Interventions included monitoring of side effects related to antipsychotic and antidepressant medication use, and side effect monitoring for muscle tremors and postural hypotension.	F 329		

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R33's quarterly Minimum Data Set (MDS) dated 12/5/16, indicated R33 had a diagnosis of schizophrenia and prescribed antipsychotic and antidepressant medication. R33's MDS dated 12/5/16, indicated intact cognition, displayed verbal behaviors and rejected care. It was also noted the resident was unsteady but able to stabilize self from seated to standing and walking and turning. An Admission Record face sheet indicated R33 was admitted to the facility in 9/16.

Registered nurse (RN)-D on 1/26/17, at 8:09 a.m. stated R33 was generally pleasant but could sometimes get agitated especially if he was awakened early. RN-D stated R33 was capable of getting out of been and walking with his walker independently.

The following morning on 1/27/17, at 10:08 a.m. NA-B stated R33 was independent with walking, was steady on his feet and had not ever reported feeling dizzy. NA-B stated R33 liked to sleep in.

On 1/27/17, at 10:38 a.m. RN-B stated when residents were admitted to the facility their medications were reviewed. If the admitting resident was prescribed antipsychotic medication, an AIMS was completed initially and then quarterly and when a resident was newly prescribed antipsychotic medication.

On 1/27/17, at 8:50 a.m. the director of nursing (DON) explained an AIMS should have been completed at time of admission when antipsychotic medication was ordered or when an antipsychotic was newly prescribed, and then every six months thereafter. The DON also stated OBPS were to be completed monthly with residents who ambulated and were prescribed

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antipsychotic medication. The DON stated the consulting pharmacist (CP) came to the facility monthly for residents' medication review and to attend the facility's quality improvement meetings. The CP had previously mailed recommendations to the ADON for follow up, but more recently had instead been sending them to the DON. The DON verified there had been no AIMS assessment completed for R33's admission.

At 10:47 a.m. on 1/27/17, the DON stated AIMS were to be completed upon admission or readmission and then quarterly. The DON stated there was not a policy on OBPs, that staff was aware of procedures for residents on psychotropic medications. The DON stated if a resident complained of dizziness upon rising the nurse would let the physician know and the physician would decide if a resident should be monitored with an OBP.

On 1/27/17, at 3:30 p.m. the consulting pharmacist (CP) stated an AIMS should be completed upon initial start of antipsychotic medication, with change in dose, and every six months thereafter. CP stated he needed to review the residents' records for AIMS and would periodically check for them. CP stated residents on antipsychotic medications should have OBP taken every 90 days. CP stated R33 who independently ambulated should have an OBP completed quarterly. CP stated he tried to keep checking for OBPs and had talked to the facility about they should be doing them. CP stated they could not catch everyone.

The facility's 1/26/17, Antipsychotic Medication Review...Additional Assessments directed staff to "Review to ensure that either the AIMS or

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F 329	Continued From page 47 DISCUS (also for purposes of identifying/monitoring tardive Dyskinesia symptoms) Assessment is completed every 6 months."	F 329		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 334		3/8/17

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F 334	Continued From page 48 refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement the current standards of immunizations for pneumonia for 2 of 5 residents (R77, R90) and to implement the Center for Disease Control and Prevention (CDC)	F 334	a. R90 will be administered the immunization for pneumonia according to current standards. R31, R33, and R90 will be administered the pneumococcal conjugate vaccine according to CDC	

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F 334	Continued From page 49 guidelines related to pneumococcal conjugate vaccine [PCV13] for 5 of 5 residents (R31, R33, R77, R87, R90) whose vaccination status was reviewed. Findings include: The Center for Disease Control and Prevention (CDC) recommendations included, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." Additional recommendations included the need to assess persons younger than 65 for risk factors that would indicate a need for immunization protection. R71, was 68 years old and admitted to the facility in 7/16. R71's medical record lacked evidence R71 had received or been offered PPSV23 or the PCV13 vaccination. R90, was 50 years old and was admitted to the facility in in 10/16. R90's medical record lacked evidence he had received or been offered the PPSV23 or the PCV13. R90's diagnostic list included anemia and abnormal immunological findings, as well as tobacco use. R31 was 69 years old and was admitted to the facility in 8/16. R31's medical record revealed the resident had received the PPSV23 on 8/20/09, however he had not been offered nor received PCV13. R31 had diagnoses including acute respiratory failure, diabetes and heart disease.	F 334	guidelines. R77 and R87 have discharged from facility. b. The current standards of immunizations for pneumonia, and CDC guidelines related to pneumococcal conjugate vaccine will be followed. c. Facility will review and revise system for tracking administration of pneumonia and pnemoccocal conjugate vaccine according to guidelines. Licensed Nruse staff will be educated on the CDC guidelines for administration of vaccines. Licensed Nruse staff will be educated on documenting education of risk and benefits for resident□s acceptance or refusal of immunization. d. Nursing designee will audit new admission for immunization status, and need for immunizations to be administered. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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F 334	Continued From page 50 R33 was 78 years old and was admitted to the facility in 9/16. R33's medical record indicated he had received PPSV23 on 12/23/09, however he had not received the PCV13. R90's diagnoses included chronic obstructive pulmonary disease and diabetes. R87 was 44 years old and was admitted to the facility in 9/16. R87's medical records revealed he had received PPSV23 on 1/1/08, however had not received the PCV13. R87's diagnoses included vitamin D deficiency and tobacco use. During an interview on 1/25/17, at 8:39 a.m. the assistant director of nursing (ADON) explained the facility's system for addressing PPSV23 and PCV13 for all residents. When the primary care doctor came to see a resident, the physician looked for up-to-date immunization on that resident in the computer system. If the physician felt the resident was in need of PPSV23 or PCV13, they worte an order directing the nurse to follow up and aadminister the vaccination. they will write an order in the resident chart for the nurse to follow up on and administer. In a follow up interview on 1/26/17, at 10:48 a.m. the ADON verified R77 and R90 did not received the PPSV23 immunization and the ADON verified all five resident R31, R33, R77, R87 and R90 did not received the PCV13. The ADON verified she could not find any documentation any of the five residents had been evaluated by their primary care physicians to determine if PCV13 should have been would have been recommended. The same day at 11:29 a.m. during an interview the medical director stated he feels all the	F 334		

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F 334	Continued From page 51 residents should be address for the need to received PCV13. He also felt its the responsibility of each physician to evaluated the resident for the need to receive PCV13. The facility "Influenza/Pneumococcal Immunization Guideline" revised date 5/2/16. indicated all residents are encouraged to receive the Pneumococcal immunization PPSV23 and/or PCV13. The policy did address the PCV13 and PPSV23 and the time lines of when the vaccinations would be given. The policy indicated annual influenza vaccinations would be given for all residents for the current year based on the CDC recommendations and resident admitted through March 31 should be obtained upon admission	F 334		
F 353 SS=C	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff.	F 353		3/8/17

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F 353	Continued From page 52 (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to designate a charge nurse for each shift. This had the potential to affect all 63 residents residing in the facility. Findings include: The nursing schedule from 1/23/17 through 1/27/17, revealed a charge nurse had not been designated. The space on the schedule where	F 353	a. The facility process for designation of charge nurse each shift will be reviewed and implemented. b. The facility will review and implement a process for designation of a nurse charge each shift. c. Licensed staff and staffing will be educated on the designation of a charge nurse each shift. d. Nursing designee will audit 7 daily	

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F 353	Continued From page 53 the charge nurse was to be written was left blank for 12 of 15 shifts. The assistant director of nursing (ADON) was interviewed on 1/27/17, at 8:34 a.m. The ADON reported she was unsure if there was a nurse designated as charge for the day, and said charge had not been designated lately. The daily posted schedule at the nursing station was then reviewed and did not indicate a charge designation. The ADON explained the system for assigning a charge nurse was for the registered nurse (RN) to be the charge, if there was an RN on duty. If there were no RN's scheduled for the shift, then the most senior licensed practical nurse would be the charge nurse. At 12:19 p.m. the director of nursing (DON) verified the system as explained by the ADON. The DON verified the staff who wrote the schedule could have designated an individual for charge nurse based on the system, and that way the staff would not be left determining at the start of the shift who would be in charge.	F 353	schedules weekly for designation of a nurse charge. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 371		3/8/17

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F 371	Continued From page 54 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner, potentially affecting the 60 residents who were served food from the kitchen. Findings include: An initial tour of the kitchen was conducted on 1/23/17, at approximately 11:45 a.m. with the director of dietary and registered dietitian. The following was noted: The handles and area surrounding the handles of the stainless steel refrigerators and freezers were soiled and heavily fingerprinted. The stove top and grill had a build up of grease on the tops, back splash, and sides of the stove. The grill had a large amount of liquid on the surface. The director explained it had not been cleaned after morning pancakes had been made. The vents directly above the stove had a heavy build up of grease with black dust on the grease. A fly swatter hung on the wall behind the mixer in the	F 371	a. The handles and area surrounding the handles of the refrigerators and freezers were cleaned. The stove top and grill were cleaned to remove grease on tops, back splash and sides of the stove and surface. The vents above the stove above the stove are scheduled for professional hood cleaners to remove build up of grease and black dust. The fly swatter has been removed. b. The facility will store, prepare and distribute food in accordance with standards. c. Dietary staff have been educated on facility policy and procedure and cleaning schedules for refrigerators, freezers, grill, stove top and vents. The staff has been educated on fly swatter and proper storage. Professional hood cleaners are contracted for hood cleaning. d. The Dietary Services manager will audit cleaning procedures and schedules weekly. Audit results will be reviewed at monthly QAPI and frequency of audits	

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F 371	Continued From page 55 clean preparation area. The director explained they utilized a routine cleaning schedule. In addition, the hoods above the stove were cleaned bi-annually, and were due for cleaning next month. On 1/24/17, at 3:00 p.m. the director explained the liquid observed on the grill from on the previous day was vinegar that one of the cooks poured on the grill to later clean it. The facility's previous Hood Cleaning Report dated 7/27/16, indicated "Overall Grease Condition Heavy." The facility's 2/12/15, Cleaning Schedules policy indicated "An effective cleaning schedule must be developed and posted for each piece of equipment and all areas that required routine cleaning in the Dining Services department...the director of dining should monitor compliance." The AM aide daily cleaning list included: "Clean/Sanitize inside & Outside all freezers and refrigerators/sides of doors every Sunday. Clean handles every day...Clean/Sanitize milk cooler (Inside and outside doors) every Thursday. Clean handles every day." The PM cook daily cleaning list included: "Clean/Sanitize Stove Top/Grill Top."	F 371	adjusted based on results.	
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not	F 428		3/8/17

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F 428	Continued From page 56 limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action	F 428		

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F 428	Continued From page 57 to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consulting pharmacist (CP) identified need for monitoring for side effects for 2 of 5 residents (R33, R1) on anti-psychotic medications. In addition, the facility failed to follow up on CP's recommendations in a timely manner for 2 of 5 residents (R33, R64) reviewed for unnecessary medications. Finding include: R33 had recommendations by the CP that were not followed up in a timely manner. Reports were as follows: 1) On 9/29/16, indicated, "Recommendations made, review Clinical Pharmacy Report [CPR]", "psych meds side effect monitoring needed" 2) On 10/18/16, "Recommendations made, review [CPR]", "Add rinse after use to Symbicort directions, trazodone prn d/c [discontinue] No use >30 days" 3) On 11/23/16, "This patient reviewed with no recommendations or irregularities noted at this time." 4) On 12/30/16, indicated, "Recommendations made, review [CPR] "trazodone prn d/c [discontinue]. No use >30 days, Symbicort: add rinse after use to directions." R33's physician orders dated 12/21/16, indicated R33 was taking medication Risperidone (antipsychotic) 1 mg (milligram)/ml (milliliter) Give	F 428	a. R1 and R31 psychotropic medications have been assessed and reviewed for side effect monitoring including orthostatic BP and completion of AIMS. R64 was reviewed for antipsychotic anti anxiety use. b. The facility Antipsychotic Medication review will be followed. The drug regimen review policy will be followed. c. Licensed Nurses and IDT are educated on completion of antipsychotic review for side effect monitoring including ortho BP and AIMS for psychotropic medication, and documentation on necessary follow up on pharmacist consultant recommendations d. Nursing designee will audit 5 residents weekly for documentation on necessary follow up on pharmacy consultant recommendations. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based on results.	

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F 428	Continued From page 58 2 mg two times a day related to Schizophrenia (mental illness). R33's orders also indicated R33 was taking medication Trazodone HCL (antidepressant) Give 100 mg every 24 hours as needed for insomnia. A Care Area Assessment for R33 dated 9/28/16, indicated antipsychotic and an antidepressant use and sedation manifested by short term memory loss, decline in cognitive abilities, slurred speech, drowsiness, little/no activity involvement with disturbances of balance, gait, positioning ability. The CAA also indicated R33 was at risk for adverse effects of antipsychotic and antidepressant medications and would proceed to careplan with goal to minimize risks. R33's careplan dated 9/30/16, indicated "Potential for drug related complication associated with use of psychotropic medications related to: Anti-Depressant medication, Anti-psychotic medication" Goal of "Will be free of psychotropic drug related complications" and indicated Interventions for monitoring of side effects related to Antipsychotic and Antidepressant medications R33 was receiving. R33's careplan dated 9/30/16, also indicated side effect monitoring included muscle tremors, and postural hypotension. R33's physician progress noted dated 1/10/17, indicated R33 had a history of unspecified major neurocognitive disorder after neuropsych testing and unspecified delusional disorder in remission. Nurse's concern in note indicated R33 with increasing behavioral issues. Progress note indicated R33's Risperdal had recently been increased from 1 mg twice a day to 2 mg twice a day.	F 428		

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F 428	Continued From page 59	F 428		

Review of R33's vitals in record indicated no orthostatic blood pressure (OBP) (used to identify drop in blood pressure upon arising) had been completed for R33 since admission. Review of R33's assessments in record indicated no monitoring of side effects including muscle tremors had been completed.

On 1/23/17, at 5:24 p.m. the ADON stated R33 had fallen once in the last thirty days, had slipped and fallen in his room, bumped his head and went to the emergency room.

On 1/27/17, at 8:50 a.m. the director of nursing (DON) stated an Abnormal Involvement Movement Scale (AIMS) assessment should have been be completed at time of admission when a resident was prescribed an antipsychotic and then every six months following and also completed when a resident started an antipsychotic. The DON also stated OBPS are to be completed monthly with residents who are on antipsychotic medication and ambulate. The CP came to the facility monthly for residents' medication review and attended quality meetings. The DON stated the CP had been emailing his recommendations to the assistant director of nursing (ADON) for follow up but now had been changed to sending CP's recommendations to the DON. The DON verified an AIMS had not been completed for R33 since coming to the facility.

On 1/27/17, at 10:38 a.m. RN-B stated when residents were admitted to the facility their medications were reviewed and if the admitting resident was on an antipsychotic medication an AIMS was completed and then quarterly and also completed when a resident started on an

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 60 antipsychotic medication. On 1/27/17, at 10:47 a.m. the stated AIMS were completed upon admission or readmission and then quarterly. The DON stated there was not a policy on OBPs, that staff was aware of procedures for residents on psychotropic medications. If a resident complained of dizziness upon rising the nurse would let the physician know and the physician would decide if a resident should be monitored with an OBP. The CP was interviewed on 1/27/17, at 3:30 p.m. the CP stated if a recommendation he made to the facility was not followed up in 30 days he would talk to the DON and see why the recommendation had not been addressed and then would recommend again. If not followed up in 60 days the CP would talk to the medical director, and that was usually the process and the CP would reissue the recommendation again. The CP stated recommendations from the CP to the facility should be followed up within 30 days. The CP stated an AIMS should be completed upon initial start of antipsychotic medication, with change in dose, and every six months thereafter. The CP stated he needed to review the residents' records for AIMS and would periodically check for them. Residents on antipsychotic medications should have had OBP taken every 90 days. The CP stated R33 who independently ambulated should have had an OBP completed quarterly. The CP stated he tried to keep checking for OBPs and had talked to the facility about they should be doing them. R1 was admitted to the facility on 11/24/09. R1's care plan dated 12/3/16, indicated potential for drug related complications associated with daily	F 428		

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	245222	A. BUILDING _____ B. WING _____	C 01/27/2017

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F 428	Continued From page 61	F 428		

use of psychotropic medications for diagnoses of paranoid schizophrenia and anxiety. R1's goal was to have minimal antipsychotic drug related complication. Staff interventions indicated to monitor for adverse side effects, report behavior changes to physician, evaluate for effectiveness of medications complete an AIMS every six months.

R1's physician orders dated 1/3/17, indicated R1 had received the following psychotropic medications. Benztropine mesylate 0.5 milligram (mg) daily at bedtime, clonazepam 0.5 mg two times a day, haloperidol 5 mg two times a day as needed for schizophrenia and olanzapine 15 mg daily at bedtime.

R1 was seen on 1/12/17, by an in-house psychologist who stated R1 exhibited some paranoia with another resident controlling his thoughts. R1's facility AIMS sheet revealed only one assessment had been completed on 1/28/15, with a total score of zero.

During an interview on 1/26/17, at 3:09 p.m. the ADON stated residents' AIMS assessment were completed quarterly. The ADON verified the only AIMS assessment that was provided for R1 was completed on 1/28/15, she was unsure why his quarterly assessments were missed.

R64 was prescribed the antipsychotic Haldol as well as the anti-anxiety medication Ativan, both as needed (PRN), neither of which was being administered. On 7/28/16 and 9/29/16, the pharmacist recommended discontinuation of Haldol. On 7/28/16, 10/28/16 and again on 12/30/16, the pharmacist recommended discontinuation of Ativan due to no use for 30

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F 428	Continued From page 62 days. On 1/26/17, at 2:32 p.m. the DON produced the two recommendations to discontinue Haldol that were signed by the physician in 9/17 and 10/17, and R64's medication administration record revealed Haldol had been discontinued on 10/6/16. The Ativan, however, remained a current order for order and the record lacked information the physician addressed the recommendations. On 1/27/17, at 3:30 p.m. the consulting pharmacist explained if a pharmacy recommendation was not followed up in 30 days he brought it to the attention of the DON, and then re-issued the recommendation. The pharmacist continued to re-issue recommendations until they were addressed by the physician. Follow up to the recommendations was expected within 30 days, and if no response was received by the physician issues were sometimes brought to the medical director's attention. The facility's 5/12, Documentation and Communication of Consultant Pharmacist Recommendations policy indicated a record of the consultant pharmacist's observations and recommendations were to be made available in an easily retrievable form to nurses, physicians, and the care planning team. Also, recommendations regarding medication therapy were to be communicated in a timely fashion to enable a response prior to the next medication review. The facility's Antipsychotic Medication Review...Additional Assessments provided 1/26/17, directed staff to "Review to ensure that	F 428		

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F 428	Continued From page 63 either the AIMS or DISCUS [alternative for tardive dyskinesia monitoring] Assessment is completed every 6 months."	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		3/8/17

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F 431	Continued From page 64 applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to establish a system to minimize the risk of loss and/or diversion of narcotic medications for 2 of 4 residents (R26, R104) reviewed for pain. Findings include: R26's Progress Notes dated 1/16/17, indicated the resident experienced a change in his level of consciousness with complaints of pain. However, no pain medication had been administered to R26 that date, according to the Medication Administration Record (MAR). Registered nurse (RN)-E was interviewed on 1/27/17, at 11:06 a.m. regarding the lack of administration of pain medication when R26 reported complaints of pain. RN-E explained she	F 431	a. R104 pain medication regimen is reviewed and documented to ensure she is receiving pain medication per orders. R26 no longer resides in facility. b. Facility will review and revise system to minimize the risk of loss and/or diversion of controlled medication. c. The process for controlled medication process is revised and implemented. The Licensed Staff and TMAs are educated on the removal and documentation of administered controlled medication d. Nursing designee will complete random weekly audits of 3 medication carts weekly for controlled medication documentation logs and eMar documentation. Audit results will be reviewed at monthly QAPI and the frequency of audits will be adjusted based	

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F 431	Continued From page 65 had given R26 pain medication earlier, and produced the Individual Narcotic Record (NR) to show the mediation had been given. RN-E stated she must have forgotten to complete corresponding documentation on the MAR. R26's MAR was further compared to the NR, which revealed several inaccuracies. For example, R26 was prescribed the narcotic Oxycodone 10 milligrams (mg) pain medication to be given as a dose of 2-5 mg tablets. The documentation for 1/17 showed the following: 1) On 1/7/17, the NR indicated 2 tablets were removed from the locked medication cart at 8:15 a.m. and again at 2:15 p.m. The MAR lacked documentation that the medication had been administered to R26. 2) On 1/8/17, the NR indicated 4 tablets had been removed from the cart, 2 tablets at 8:00 a.m. and 2 tablets at 6:30 p.m. The MAR for 1/8/17, indicated R6 received a dose of 2 tablets at 6:25 p.m. 3) On 1/12/17, the NR indicated 2 tablets had been removed at 8:30 a.m. The MAR for 1/12/17 was blank, and did not indicate R26 received the medication. 4) On 1/13/17, NR indicated 2 tablets had been removed at 7:45 p.m. although the MAR for 1/13/17, was also blank. 5) On 1/16/17, the NR indicated tablets had been removed at 5:00 a.m. and 9:30 p.m. The MAR was blank. 6) On 1/17/17, the NR indicated a tablet had been	F 431	on results.	

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F 431	Continued From page 66	F 431		

removed at 4:00 a.m. and 11:00 a.m. and 8:30 p.m., but the MAR showed administration at 7:20 p.m.

On 1/21/17, the NR indicated medication had been removed from the cart at 6:30 a.m., 12:40 p.m. and 8:00 p.m. the MAR indicated doses of the mediation had been administered at 12:39 p.m. and at 7:53 p.m.

On 1/22/17, the NR indicated medication had been removed at 8:00 a.m. and the MAR indicated it was administered at 8:02 a.m., however, there was also medication removed at 4:00 p.m. that was not noted on the MAR as administered.

On 1/24/17, the NR indicated medication had been removed at 5:30 a.m., as well as an unknown time as the time slot was left blank with the MAR indicating medication was administered at 10:15 a.m. Additionally the NR indicated medication was removed at 7:35 p.m. and administered at 7:45 p.m.

On 1/27/17, the NR indicated a dose of medication had been removed at 6:00 a.m. and 10:50 a.m. although the MAR indicated a dose of the mediation had been administered at 5:18 a.m., prior to the removal time noted on the NR.

The director of nursing (DON) was informed of the inconsistencies in R26's narcotic records on 1/27/17, at 11:54 a.m. The DON verified all narcotic removals required corresponding MAR documentation. The DON explained audits of the narcotic records were not a part of the consulting pharmacist's regular duties. The DON verified they did not pay for any services to complete

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F 431	Continued From page 67	F 431		

narcotic audits, nor had they completed any audits.

R104 expressed concerns 1/27/17, at 12:45 p.m. she had not been receiving a narcotic pain medicine as ordered "literally every night without fail." R104 stated she had complained to facility staff, but was told documentation indicated the medicine had been administered. R104 added, "The records indicate I'm getting it and that is a lie. I have told them right to their face that someone is stealing it."

R104's NR for 1/12/17 through 1/26/17, indicated R104 was ordered a dose of Dilaudid (a narcotic pain medication) of 2-4 mg tablets every 4 hours as needed for pain. The MAR for 1/12/17 through 1/19/17, indicated to give a dose of 1 tablet of 2 milligrams (mg) dilaudid every 4 hours as needed for pain for 1 week. The NR was compared to the MAR and revealed the following:

1) On 1/14/17 The NR indicated medication had been removed from the locked medication cart and the MAR indicated was administered at 9:38 a.m. however, another dose was also removed at 9:00 p.m. without documentation on the MAR it was administered.

2) On 1/15/17, the NR indicated doses were removed at 4:50 a.m. without documentation the medication was administered, and then removed again at 9:00 p.m. with administration on the MAR as given at 9:30 p.m.

During an interview with the consultant pharmacist on 1/27/17, at approximately 3:30 p.m. it was verified controlled substances (including narcotic pain medications) were to be

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F 431	Continued From page 68 stored securely in a double locked situation and an accurate accounting of use was to be maintained. The facility's 5/12, Storage of Medications policy directed staff to store and properly secure medications.	F 431		

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	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/30/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on January 30, 2017. At the time of this survey, Golden Livingcenter Chateau was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/24/2017

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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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter Chateau is a 4-story building, with a partial basement. The facility was constructed in 1963 and was determined to be of Type II(222) construction. The facility is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 69 beds and had a census of 64 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	NFPA 101 HVAC HVAC	K 521		3/8/17

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K 521	Continued From page 2 Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 64 residents. Findings include: On a facility tour between the hours of 1000 and 1500 on January 30, 2017, observation revealed that the facility was using their egress corridors as an exhaust plenum. This deficiency need not be corrected with the approval of an annual waiver. This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 521	Waiver requested for K521. See waiver supporting documentation.	

Name of Facility **2000 CODE**

GGNSC Minneapolis Chateau dba: Golden Living Center - Chateau

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K521 NFPA 101 HVAC	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because: The facility received an estimate on March 14, 2012 for the cost of upgrading the HVAC system to be in compliance with NFPA 90. The cost estimate for a complying HVAC is $432,250.00. This estimate does not include any costs of inflation that would incur since date of estimate, which could be significant. This estimate does not include costs of major structural engineer work or major structural work related to the HVAC upgrade, which will be needed according to the estimate scope. Also, this cost does not include the cost of financing, which will need to be done in able to afford the project. Financing will add approximately $86,400 to $194,400 to the overall costs of the project. Under current CMS reimbursement rates, it is estimated to take approximately a minimum of 8 to 15 years to recoup the costs. This approximation will need to be extended when taking into account the costs of current facility projects that are under way such as air handler maintenance, tub/shower room renovations, flooring replacements, plus routine equipment and service projects and non routine emergency maintenance or services. A complying HVAC system has a large scope of work included at this particular facility. A project with a scope of this scale will force the a high degree of disruption to the facility residents. The estimate states that the work will able to be done in 4 resident rooms at the same time. This has the potential of displacing 8 - 10 residents at the same time. This is especially challenging when the medical, mental, and psychological states of our residents are taken into consideration. We have some residents who prefer to remain in their rooms and get agitated, aggressive, and abusive when disturbed in this capacity. The resident's rooms are located on 2nd, 3rd, and 4th floor. The dining room, the kitchen, and staff offices are located on the first floor. On an average day, there is about 35 staff members with about 66 residents for a ratio of 1:1.89. The facility staffs at a rate of 4.77 hours per patient, per day. The building is 50 years old and there are no known plans for the facility to be replaced and no end date has been determined for the buildings usable life. There are concerns of whether or not the new HVAC system would put the facility out of compliance due the the fact that the corridors will be less than 6 feet and 8 inches tall, which is not allowed against LSC. There are also concerns about whether the building electrical system is adequate to handle the additional HVAC equipment required or if the penetration of load bearing walls to install required duct work would adversely affect the structural integrity of the building. B. The waiver of such unmet provisions will not adversely affect the health and safety of the patients, occupants or staff because: The type of building and the way the building is outfitted and staffed to ensure compliance and maximum safety for our residents. The facility is a type II (222) type construction. The interior finishes are of Class A or Class B. The walls, floors, ceiling and vertical opening resist the passage of smoke. The facility's life safety features are an EST and Notifier fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification; complete supervised automatic wet standpipe sprinkler system throughout ; portable fire extinguishers are located on all units; pyrochem kitchen hood wet chemical system. Annual service and maintenance contracts are in place to keep all systems in effective operating condition. The facility also has a fire safety plan that is in accordance with LSC 19.7.2.2. The facility does operate under safe smoking policies and procedures, fire policies, fire watch, and housekeeping and laundry operate under safe dryer policies. Two smoke compartments on each floor, so there is a total of eight smoke compartments in the entire building. The closest fire department is .93 miles away and has an average response time of 2-4 minutes. The facility is in compliance with all other safety requirements and there were no other safety deficiencies that were cited. This annual/continuing waiver has been approved in the past.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas R. Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal	Date 02/27/2017